The Prescription of Psychotropic Medications for Patients Discharged From a Psychiatric Emergency Service

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Objective: Considerable debate exists about the value and wisdom of initiating "definitive" pharmacotherapies, particularly antidepressants, in the psychiatric emergency setting. We evaluated the nature and prevalence of medication prescriptions for patients discharged from an urban psychiatric emergency service and the extent to which pharmacotherapy initiation was predictive of follow-through with aftercare.

Method: Records were reviewed for 675 consecutive individuals evaluated and discharged from a community-based psychiatric emergency service over a 3-month period (January 2003–March 2003). Information was obtained regarding diagnoses, past and current treatments, and demographic and clinical features, as well as outcomes for the subgroup of patients who received aftercare appointments within the institutional system.

Results: Fifty-five percent of psychiatric emergency service visits resulted in discharge, with psychotropic drug prescriptions given to about 30% of this group. Prescriptions most often included antidepressants (64%), benzodiazepines (25%), nonbenzodiazepine sedatives (20%), antipsychotics (18%), and mood stabilizers (10%). After controlling for potential confounders, the decision to prescribe was significantly associated with a clinical diagnosis of major depressive disorder or bipolar disorder and the preexisting use of psychotropic medications. Nonprescribing occurred most often in discharged patients who had suicidal ideation, substance abuse or dependence, and an existing outpatient psychiatrist. Follow-up emergency service and new outpatient appointments were more often given to patients discharged with a prescription, but follow-through with aftercare was not more likely in this group.

Conclusions: Psychiatrists in an emergency service prescribe antidepressants or other major psychotropics for about one third of discharged patients, rarely in the presence of suicidality or substance abuse or dependence, and with little evidence that initiating such medications in the emergency setting promotes more successful bridging to outpatient treatment.

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The psychiatric emergency service (PES) has traditionally been regarded as an environment focused more on the acute triage, management, and disposition of psychiatric problems than on the initiation of their definitive treatments.[1,2] In recent years, however, the role of the PES has evolved in response to pressures created by visits from growing numbers of patients without existing mental health providers, difficulty accessing outpatient treatment in a timely fashion, greater restrictions on the criteria for justifying inpatient hospitalization, and shortened lengths of hospitalization resulting in more frequent return visits to the PES.[3,4] Over the past 4 decades, PES visits have increased substantially.[5,6] Consequently, the PES has come to represent a multifaceted component of mental health services—providing, among other roles, a novel portal of entry to the broader mental health system. Two central questions arise from this transformation: (1) When and how should the PES setting provide "definitive" diagnostic evaluation and treatment initiation, including pharmacotherapy? and (2) Does the initiation of "definitive" treatment from the PES enhance the likelihood of patients' entry and follow-through with subsequent outpatient treatment?

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Survey data suggest that 40% to 70% of psychiatrists regularly prescribe medications for patients they discharge from a PES setting.[2,7] Little is known about the extent to which PES interventions usually aim to (1) "temporize" clinical problems (e.g., by providing anxiolytic or antiagitation medication for which response can be judged over hours within a PES setting), (2) modify existing drug regimens (e.g., via dosage adjustments), or (3) initiate long-term pharmacotherapies de novo (such as antidepressants or mood stabilizers, for which response typically is judged over days and weeks). In this article, the concept of "definitive" treatment is used to designate the latter of these 3 circumstances, alongside consideration of dosage adjustments and renewals of current medications.

Hesitation on the part of clinicians to prescribe "definitive" medications from the PES touches on a number of issues. Perhaps foremost among these has been concern about the potential toxicity and lethality in overdose of (mainly older classes of) psychotropic drugs.[1] However, the availability of newer medications with substantially wider safety margins than their predecessors has considerably lessened this issue. A second issue involves the confidence with which a psychiatric disorder that warrants ongoing pharmacotherapy can be established from a single evaluation that occurs in an emergent and often crisis-laden context.

An additional factor pertains to the delayed pharmacodynamic effects of most psychotropic agents, apart from antiagitation effects, since clinical efficacy usually is not evident for at least 1 to 4 weeks after beginning standard antidepressants, mood stabilizers, or antipsychotic agents. In one respect, hastening the initiation of such medications could potentially shorten the eventual time until symptomatic improvement can meaningfully begin. On the other hand, considering medications apart from a broader, multidimensional treatment plan could obscure the importance of nonpharmacologic aspects of appropriate psychiatric care.

A final concern involves the obligate responsibilities for subsequent clinical monitoring after a prescription is written. This issue bears on the possible catalytic effects of a medication prescription to promote outpatient follow-up after PES discharge. Factors that mediate this transition are likely complex and have not been extensively studied.[8–10] Interestingly, direct referral from PES settings has been suggested as one risk factor for poorer adherence with outpatient treatment.[11] It has been estimated that about half of the psychiatric emergency service facilities in the United States provide direct aftercare services,[2] but it is unknown whether this added level of intervention results in better patient adherence to treatment, fewer missed subsequent appointments, or better clinical outcomes.

The purpose of the current study was to provide empirical data on the above issues by identifying the prevalence with which psychotropic medications are prescribed from the PES setting and factors associated with clinicians' prescribing decisions for discharged patients. The aims of this study were 2-fold: first, to examine clinical and other factors that may influence prescribing decisions in the psychiatric emergency service, and second, to examine whether follow-up with an aftercare referral was more likely for patients who were discharged from a PES with versus without a prescription. The authors' goal was to obtain observations that might better inform policy guidelines, as well as generate hypotheses to inform the design of future studies in this area.

METHOD

The study group consisted of 675 individuals who were consecutively evaluated over a 3-month period from January through March 2003 within the PES of the Cambridge Hospital. The total number of visits reflects new encounters plus unplanned revisits; planned follow-up visits conducted within the emergency service were subsumed within the index visit. Dispositions included inpatient hospitalization (psychiatric or detox unit) or discharge to home. Discharged patients could be referred for follow-up in the PES and/or for new outpatient psychiatric treatment or returned to their preexisting outpatient treatment.

The study site was the PES of a large community-based academic general hospital affiliated with Harvard Medical School. Whenever clinically indicated, patients seen in the PES who lacked an existing outpatient psychiatrist were routinely referred to the outpatient department of the Cambridge Health Alliance for ongoing treatment within about 1 week of their initial presentation. If patients failed to keep a follow-up appointment, a "No-Show Follow Up Form" was completed, which involved a risk assessment of the patient, documentation of attempts to contact the patient, consideration of the need for more active outreach, and contact with other treaters (e.g., psychotherapists or primary care physicians). A total of 29 attending and resident psychiatrists participated in the initial evaluation and treatment of patients admitted to the PES. PES records were reviewed by 2 of the authors (C.L.E. and S.A.B.) using a rating sheet developed by us, which systematically captured demographic and clinical information regarding presenting symptoms, current treatments, past hospitalizations and suicide attempts, substance abuse or dependence, and clinical chart diagnoses.

The study protocol was approved by the Institutional Review Board of the Cambridge Health Alliance. Written subject consent to participate was not obtained due to the nature of the retrospective chart review, in which records were de-identified of personal health information (PHI) as required by the Health Information Privacy and Portability Act (HIPAA).

Table 1. Characteristics of Patient Visits Leading to Hospitalization or Discharge From a Psychiatric Emergency Service[a]

Variable	Total Visits (N = 675)	Hospitalization (N = 303)	Discharge (N = 370)	OR	95% CI
Age, mean (SD), y	35.0 (14.1)	35.1 (13.6)	34.9 (14.4)	1.00	0.99 to 1.01
Female, N (%)	304/675 (45.0)	109/303 (36.0)	195/370 (52.7)	**0.50**	**0.37 to 0.69**
White, N (%)	460/668 (69.0)	222/301 (73.8)	238/365 (65.2)	**1.51**	**1.08 to 2.11**
Married, N (%)	80/667 (12.1)	36/301 (12.0)	44/364 (12.1)	0.99	0.62 to 1.58
Undomiciled, N (%)	107/654 (16.5)	60/296 (20.3)	47/357 (13.2)	**1.68**	**1.10 to 2.55**
Employed, N (%)	236/631 (37.4)	95/289 (32.9)	141/342 (41.2)	**0.70**	**0.50 to 0.97**
Past psychiatric hospitalizations, N (%)	388/658 (59.0)	212/301 (70.4)	176/356 (49.4)	**2.45**	**1.18 to 3.37**
Current psychosis, N (%)	145/662 (21.9)	105/300 (35.0)	40/361 (11.1)	**4.32**	**2.88 to 6.48**
Current suicidal ideation, N (%)	257/666 (38.6)	179/298 (60.1)	78/367 (21.3)	**5.57**	**3.96 to 7.84**
History of suicide attempt, N (%)	249/656 (38.0)	139/298 (46.6)	110/357 (30.8)	**1.96**	**1.43 to 2.70**
Drug abuse or dependence, N (%)	254/671 (37.9)	133/303 (43.9)	121/367 (33.0)	**1.59**	**1.16 to 2.18**
Alcohol abuse or dependence, N (%)	293/671 (43.8)	148/303 (48.8)	145/367 (39.5)	**1.46**	**1.08 to 1.99**
Current psychiatrist, N (%)	310/663 (46.8)	164/301 (54.5)	146/361 (40.4)	**1.76**	**1.29 to 2.40**
Currently taking medications, N (%)	408/667 (61.2)	189/300 (63.0)	219/366 (59.8)	1.14	0.84 to 1.57

[a]Includes psychiatric hospitalization, inpatient detoxification, or transfer to nonpsychiatric services. Data on hospitalization versus discharge were available on 673 of the 675 total patient visits. Denominators for individual analyses varied based on the availability of complete data, as noted.

Table 2. Primary Chart Diagnoses for Visits Resulting in Discharge From a Psychiatric Emergency Service With or Without a Prescription[a]

Clinical Diagnosis	Full Sample (N = 647)	Discharged Visits (N = 349)	Visits Resulting in Discharge Without a Prescription (N = 240)	Visits Resulting in Discharge With a Prescription (N = 109)	OR	95% CI
Major depressive disorder, N (%)	196 (30.2)	96 (27.5)	48 (20.0)	48 (44.0)	**3.25**	**1.92 to 5.15**
Substance abuse/dependence, N (%)	132 (20.4)	65 (18.6)	57 (23.8)	8 (7.3)	**0.25**	**0.12 to 0.55**
Psychotic disorders, N (%)	102 (15.7)	36 (10.3)	28 (11.7)	8 (7.3)	0.60	0.26 to 1.36
Bipolar disorder, N (%)	77 (11.9)	39 (11.2)	31 (12.9)	8 (7.3)	0.53	0.24 to 1.20
Anxiety disorders, N (%)	46 (7.1)	39 (11.2)	20 (8.3)	19 (17.4)	**2.32**	**1.18 to 4.56**
Other mood disorders, N (%)	37 (5.7)	24 (6.9)	20 (8.3)	4 (3.7)	0.42	0.14 to 1.25
Adjustment disorders, N (%)	24 (3.7)	23 (6.6)	12 (5.0)	11 (10.1)	2.13	0.91 to 5.00
Other disorders, N (%)	33 (5.1)	27 (7.7)	24 (10.0)	3 (2.8)	**0.27**	**0.08 to 0.90**

[a]Data are presented for categorical subgroups with available data on a primary diagnosis.

Data were analyzed using SPSS-PC (Version 11.5; Chicago, Ill.). Dichotomous variables were analyzed by χ^2. Group differences were presented using descriptive statistics with odds ratios (ORs) with corresponding 95% confidence intervals (CIs). A final multivariate logistic regression model was generated from the preceding univariate analyses, while controlling for confounding variables. All statistical tests were 2-tailed with an alpha level of .05. When independent univariate analyses were conducted to screen candidate variables for entry into a multivariate logistic regression model, p values were not adjusted for multiple comparisons.

RESULTS

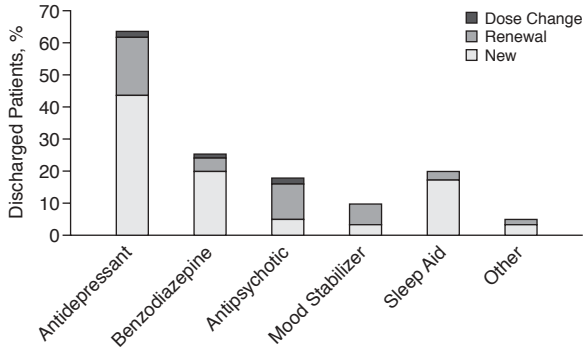
Table 1 summarizes demographic and clinical characteristics for the total study group, with subdivisions for patient visits that did versus did not result in discharge from the psychiatric emergency service. Three hundred seventy (54.8%) of the 675 total visits resulted in discharge. Discharge from the psychiatric emergency service versus hospitalization was significantly more likely to occur for patients who were women, nonwhite, domiciled, employed, previously not hospitalized, nonpsychotic, nonsuicidal, and without past suicide attempts and drug or alcohol abuse.

Data for prescriptions at discharge were available for 368 of the 370 visits resulting in discharge. One hundred ten (29.9%) of these 368 visits resulted in patients receiving a medication prescription when discharged.

Clinical diagnostic data were available for 648 of the 675 visits. Table 2 summarizes the primary clinical diagnoses of patient visits resulting in discharge, with comparisons for those that did or did not receive a prescription. Among visits resulting in discharge, a primary diagnosis of major depressive disorder was associated with over a 3-fold increased likelihood for receiving a prescription, while a primary anxiety disorder diagnosis was over twice as likely to lead to a prescription. By contrast, discharged visits with a primary substance abuse or dependence diagnosis had about a 75% reduced likelihood of receiving a prescription. "Other diagnoses" (e.g., attention-deficit/hyperactivity disorder, dementia, conduct disorders) also were less likely to receive a prescribed medication upon discharge.

The breakdown of medication categories prescribed for discharged visits is summarized in Figure 1. The mean ± SD number of prescribed medications per visit

Figure 1. Breakdown of Prescriptions by Category at Discharge From a Psychiatric Emergency Service[a]



[a]110 Patient visits resulting in a prescription at discharge. Patients were able to receive > 1 prescription per visit.

was 1.55 ± 0.75 (range: 1–4) for those ultimately discharged. From among the 110 patient visits leading to discharge with a prescription, 168 prescriptions were written. One hundred five (62.5%) of these 168 were new prescriptions; 58 (34.5%) of 168 were renewals of existing medications; and 5 (3.0%) of 168 represented dosage adjustments to existing medications. Among the most frequently prescribed medications (i.e., antidepressants, benzodiazepines, and nonbenzodiazepine sleep aids), new prescriptions were more common than renewals. Among less frequently prescribed medications (i.e., antipsychotics and mood stabilizers), renewals were more common than new prescriptions.

Factors Associated With the Decision to Prescribe Medications

The decision to prescribe a medication for discharged patients was first examined relative to patients' current treatment status. These included instances in which patients did not have an outpatient psychiatrist (72/110, or 65.5%), were unable to reach an existing treater (19/110, or 17.3%), or were waiting to begin a treatment that had previously been scheduled (19/110, or 17.3%).

Univariate analyses were next conducted with a series of independent variables potentially associated with the decision to prescribe medications for patient-visits leading to discharge. Candidate variables, summarized in Table 3, were chosen a priori as an initial step toward screening for subsequent entry into a multivariate logistic regression model of nonprescribing versus prescribing of medications. Resultant associations that achieved a significance level of $p < .05$ were retained for entry into the final regression model. In addition, variables that were nonsignificant from univariate analyses were screened as potential confounding variables by individually adding them back to the provisional regression model, which contained those variables significant at the $p < .05$ level. Variables in which the original odds ratio was altered by greater than or equal to 10% of its original value were considered confounders and therefore also entered into the final model.[12] This latter procedure revealed newly significant variables, including suicidal ideation and having a bipolar diagnosis, as well as the presence of several confounding variables, including employment, taking outpatient medications, drug abuse/dependence, suicidal ideation, and the presence of a bipolar diagnosis.

The final logistic regression model is presented in Table 4. The only variables that remained independent significant predictors of prescription of psychotropic medications are as follows: receiving a prescription was less likely for patients who had an existing outpatient psychiatrist, suicidal ideation, or diagnosis of substance abuse or dependence. Receiving a prescription was more likely for those who had a diagnosis of bipolar disorder or major depressive disorder and for those who were currently taking medications as an outpatient.

Of note, differences in PES shift were associated with prescribing decisions. Daytime PES shifts were composed of both attending and resident physicians while nighttime shifts more often were composed of resident rather than attending staff. No significant differences were observed between resident and attending physician status with regard to prescribing patterns.

Adherence With Follow-Up Appointments

A follow-up appointment within the psychiatric emergency service was made for 84 (22.8%) of the 368 patient-visits that resulted in discharge. Such internal follow-up appointments within the emergency services facility were significantly more likely to have been made for those who were given a prescription (53 appointments [48.2%] of 110 discharges resulting in a prescription) than those not given a prescription (31 appointments [12.0%] of 258 discharges unaccompanied by a prescription) ($\chi^2 = 57.26$, df = 1, $p < .001$; OR = 6.81, 95% CI = 4.01 to 11.57). The scheduled follow-up appointment was kept by 36 (67.9%) of 53 emergency service discharges that had been accompanied by a prescription versus 21 (67.7%) of 31 emergency service discharges that were unaccompanied by a prescription ($\chi^2 = 0.00$, df = 1, $p = .986$; OR = 1.01, 95% CI = 0.39 to 2.60). PES follow-up appointments were equally likely to have occurred whether patients had received a new prescription (27/42 new prescriptions), the renewal of an existing prescription (7/9 renewal prescriptions), or a dosing change for an existing prescription (2/2 dosage changes) ($\chi^2 = 1.601$, df = 2, $p = .449$).

A referral for new outpatient treatment, separate from an internal follow-up visit within the emergency services facility, occurred for 137 (37.3%) of 367 discharges. Such referrals occurred for 81 (73.6%) of 110 discharges that had been accompanied by a prescription and 56 (21.8%) of 257 discharges that had been unaccompanied by a

Table 3. Univariate Analyses of Screening Factors Chosen A Priori in Association With Receiving a Prescription at Discharge From a Psychiatric Emergency Service[a]

Variable	Prescription N = 110	No Prescription N = 258	χ^2 (df = 1)	p	OR	95% CI
Gender			1.88	.170	1.37	0.87 to 2.15
Female	64/110	130/258				
Male	46/110	128/258				
Race			1.32	.250	0.76	0.48 to 1.21
White	65/107	171/255				
Nonwhite	42/107	84/255				
Marital status			2.78	.096	1.73	0.90 to 3.30
Married	18/109	26/253				
Not married	91/109	227/253				
Employed			.792	.373	1.24	0.78 to 1.97
Yes	45/103	94/238				
No	57/103	144/238				
Homeless			1.42	.233	0.65	0.32 to 1.33
Yes	11/110	36/246				
No	99/110	210/246				
Current psychiatrist			35.20	< .001	0.20	0.12 to 0.35
Yes	19/110	126/249				
No	91/110	123/249				
Seen in 7:00 am to 3:00 pm shift			9.31	.002	2.01	1.28 to 3.17
Yes	64/110	105/257				
No	46/110	152/257				
Seen in 3:00 pm to 11:00 pm shift			2.78	.096	0.67	0.43 to 1.07
Yes	41/110	120/257				
No	69/110	137/257				
Seen in 11:00 pm to 7:00 am shift			5.31	.021	0.34	0.13 to 0.88
Yes	5/110	32/257				
No	105/110	225/257				
Taking outpatient medications			3.37	.067	0.66	0.42 to 1.03
Yes	58/110	160/254				
No	52/110	94/254				
Past hospitalization			7.88	.005	0.52	0.33 to 0.82
Yes	42/110	133/245				
No	68/110	112/245				
Drug abuse			0.98	.323	0.78	0.48 to 1.27
Yes	32/110	88/256				
No	78/110	168/256				
Alcohol abuse			8.21	.004	0.50	0.31 to 0.81
Yes	31/110	113/256				
No	79/110	143/256				
Suicidal ideation			3.28	.070	0.58	0.32 to 1.05
Yes	17/110	61/255				
No	93/110	194/255				
Psychosis			0.64	.425	0.74	0.35 to 1.57
Yes	10/110	30/251				
No	100/110	221/251				
Any depression diagnosis			17.46	< .001	2.66	1.67 to 4.23
Yes	61/109	78/241				
No	48/109	163/241				
Any psychotic diagnosis			1.662	.197	0.62	0.29 to 1.30
Yes	10/109	34/241				
No	99/109	207/241				
Any substance abuse or dependence			14.58	< .001	0.35	0.20 to 0.61
Yes	20/109	94/241				
No	89/109	147/241				
Any bipolar diagnosis			0.00	.953	1.02	0.55 to 1.90
Yes	17/109	37/241				
No	92/109	204/241				
Any anxiety diagnosis			1.10	.294	1.31	0.79 to 2.18
Yes	32/109	58/241				
No	77/109	183/241				
Any adjustment disorder diagnosis			3.69	.055	2.07	0.97 to 4.15
Yes	14/109	16/241				
No	95/109	225/241				

[a]Individual sample sizes varied across analyses, as indicated, based on the availability of complete data; denominators refer to number of patients who did or did not get a prescription.

Table 4. Logistic Regression Model of the Decision to Prescribe Medications for Patients Discharged From a Psychiatric Emergency Service

Variable	OR	95% CI
Existing outpatient psychiatrist	**0.106**	**0.046 to 0.242**
Any past hospitalizations	0.948	0.477 to 1.885
Alcohol abuse	0.712	0.346 to 1.466
Drug abuse	1.334	0.625 to 2.849
Suicidal ideation or behavior	**0.410**	**0.193 to 0.873**
Current major depressive disorder	**2.948**	**1.619 to 5.366**
Diagnosis of substance abuse or dependence	**0.218**	**0.093 to 0.511**
Diagnosis of bipolar disorder	**2.485**	**1.050 to 5.877**
Seen in 7:00 am to 3:00 pm shift	1.550	0.860 to 2.794
Seen in 11:00 pm to 7:00 am shift	0.627	0.202 to 1.945
Currently taking medications as outpatient	**2.131**	**1.042 to 4.358**
Currently employed	0.726	0.399 to 1.323

prescription ($\chi^2 = 88.51$, df = 1, $p < .001$; OR = 10.03, 95% CI = 5.98 to 16.82). Data on the follow-up status of 137 new outpatient referrals were available for 117 cases. The remaining 20 cases were referred outside of the Cambridge Hospital system. Follow-through was made by 60 (51.3%) of the 117 cases given referrals to new outpatient treatments. Such outpatient appointments were made and kept by 38 (53.5%) of 71 cases that had received a prescription and 22 (47.8%) of 46 cases that had not been given a prescription ($\chi^2 = 0.362$, df = 1, p = .547; OR = 1.26, 95% CI = 0.60 to 2.64). Outpatient follow-up appointments were equally likely to have been kept by patients who had been given a new prescription (25/49 new prescriptions), a renewal of an existing prescription (12/21 renewal prescriptions), or a dosing change for an existing prescription (1/1 dosing changes) ($\chi^2 = 1.102$, df = 2, p = .576).

DISCUSSION

To our knowledge, this is the first study to empirically assess the characteristics of patients who receive a prescription at discharge from the PES setting and to examine the relationship between prescriptions and follow-through with subsequent outpatient treatment. The data indicate that a substantial minority of patients receive a prescription at discharge from a PES setting. When prescriptions are given, they are more often for new rather than renewal medications and are generally given to discharged patients with depression in whom suicidal features and substance abuse or dependence are absent.

At least 2 clinical implications emerge from the present findings. First, even though a substantial number of discharged patients received prescriptions, it is not clear that such practices enhanced the likelihood of follow-through with subsequent outpatient treatment. However, it should be noted that the present study did not examine possible clinical benefits other than adherence to follow-up—such as symptom reduction, enhanced quality of life, risk for future suicide attempts, or improved psychosocial functioning. Further prospective research is needed to examine the potential impact of PES prescribing practices on these domains.

Second, given our finding that prescribing from the PES does not robustly mediate follow-through with aftercare, the reluctance by clinicians to prescribe a new medication for PES patients with suicidal or substance abuse features could reflect clinical wisdom for presentations that involve high impulsivity or treatment nonadherence. On the other hand, the findings also raise concern about the potential undertreatment of such patients. That patients with substance use disorders frequently visit and are discharged from PES settings points to the chronic unmet clinical needs of this subpopulation.

Our finding that aftercare is not improved by patients' having received a psychotropic prescription from the PES also prompts the need for reevaluating the goals and criteria for emergency room prescribing. Factors associated with the successful follow-through of aftercare recommendations following discharge from a psychiatric emergency setting remain poorly understood. Jellinek[8] observed an association between successful follow-up and age, education level, and a diagnosis of depression. Other investigators have identified the presence of depression and the absence of homelessness and alcohol or other substance use disorders as predictive of adherence with aftercare following initial assessment in an emergency department setting.[9] Additional correlates of successful follow-up with aftercare following an initial emergency psychiatric appointment, as summarized by Cremniter et al.,[13] have included patient age, education level, diagnoses of depression, and the characteristics and skills of the PES clinician.

Another consideration raised by these data is the apparent comfort with which PES clinicians prescribe antidepressants as opposed to mood stabilizers or antipsychotics in patients with bipolar disorder. The current findings indicate that patients with psychotic disorders were more often hospitalized than those with affective or other disorders. Since a bipolar diagnosis among discharged patients increased the likelihood of receiving a prescription, the use of antidepressants (as opposed to mood stabilizers or antipsychotics) in this setting could potentially be ineffective or, in some cases, lead to worsened outcomes (such as antidepressant-induced mania or mixed states with associated suicidality). The best approach to emergency management of untreated bipolar disorder remains unclear in practice.

There are a number of limitations noteworthy in the current study, related primarily to the retrospective protocol design. First, the findings reflect practice patterns from a single urban community-based institution, and, until replicated, their generalizability to other institutional settings may be limited. Aftercare referrals were made in-

ternally in the majority of cases, and systematic data on follow-through were unavailable for a small minority of patients who received external psychiatric referrals. In addition, data were unavailable regarding medication adherence after PES discharge, and this factor represents a potentially significant mediator of follow-through and outcome. Diagnoses were based on chart records as determined by clinician assessment, rather than by validation through prospective research-based interviews. It is possible this limitation may have led to the underestimation of comorbid diagnoses or the extent to which DSM-IV criteria were fulfilled in all instances. However, prior studies indicate high reliability among diagnoses made by PES clinicians.[14] Other clinical features not systematically assessed—such as Axis II psychopathology—may also bear on the decision not to prescribe medications for suicidal patients discharged from the PES. A final consideration involves the 3-month time period of data collection, which precluded consideration of possible seasonal variation in features such as suicidality or mania.

The protocol design also did not directly query PES staff on determinants of prescribing behavior that they themselves may have recognized. Factors related to the decision-making process associated with contemporary psychotropic drug prescriptions are relatively understudied, and data have thus far mainly identified demographic characteristics (e.g., psychiatrist age[15]) or physicians' concerns about side effects[16] in choosing from among available agents. Further study is needed to help clarify additional features related to symptom severity thresholds or clinical context as influencing decisions about when and where to initiate ongoing pharmacotherapies.

The current findings indicate that about one third of outpatient visits to an urban community-based psychiatric emergency service resulted in a psychotropic drug prescription, most often an antidepressant, and usually in connection with (1) a diagnosis of major depressive disorder or bipolar disorder, (2) preexisting medication use, and (3) the absence of substance abuse or dependence, suicidal ideation, or a current psychiatrist. Although patients who received prescriptions were more likely to be referred to new outpatient psychiatric treatment, they were not more likely to follow through with these referrals, compared with patients who did not receive prescriptions. Future clinical research efforts are needed to address outcomes after discharge from the PES setting, and the extent to which prescribing from the PES influences clinical course independent of follow-through with recommendations for ongoing clinical monitoring.

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