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Hospital Psychiatry Fact Book

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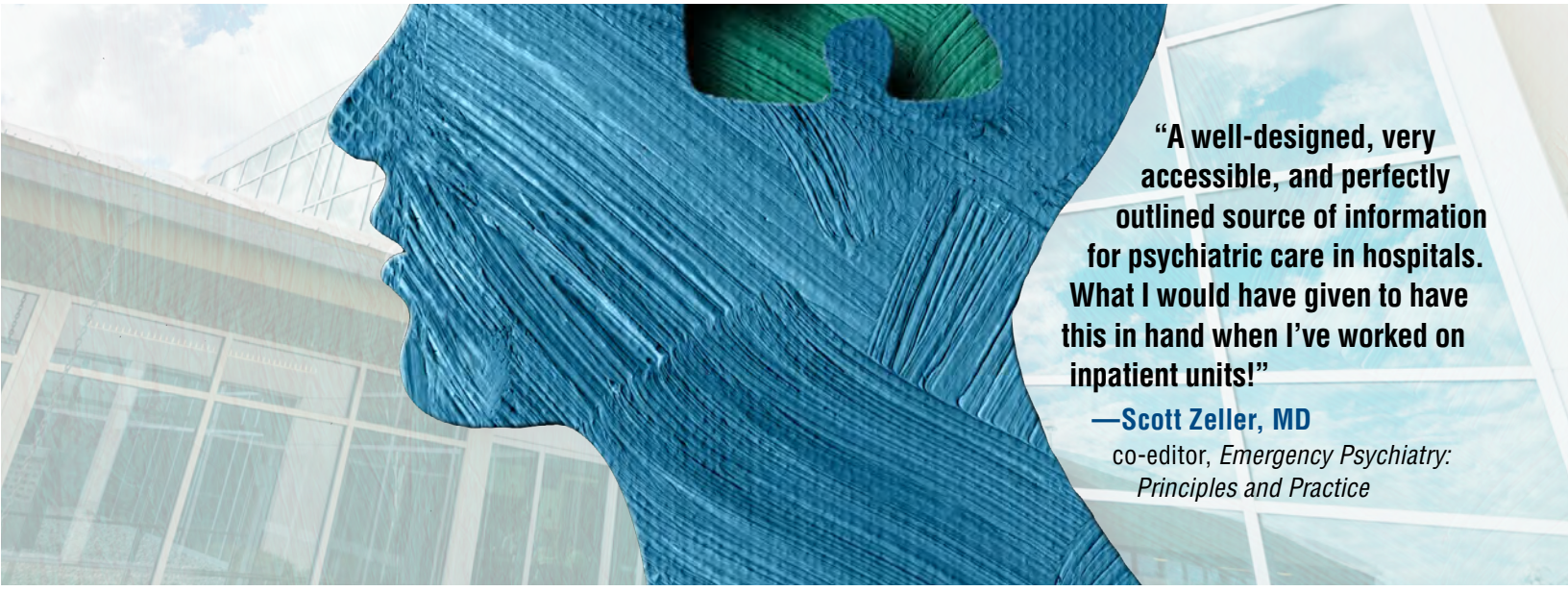

"A well-designed, very accessible, and perfectly outlined source of information for psychiatric care in hospitals. What I would have given to have this in hand when I've worked on inpatient units!"

—Scott Zeller, MD
co-editor, *Emergency Psychiatry: Principles and Practice*

Victoria Hendrick, MD
Daniel J. Carlat, MD

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HOSPITAL PSYCHIATRY FACT BOOK

FIRST EDITION

Victoria Hendrick, MD

Editor-in-Chief, *The Carlat Hospital Psychiatry Report*

Clinical Professor, David Geffen School of Medicine at UCLA

Director of Inpatient Psychiatry, Olive View–UCLA Medical Center, Los Angeles, CA

Daniel J. Carlat, MD

Publisher, *The Carlat Report* newsletters and books

Associate Clinical Professor, Tufts University School of Medicine, Boston, MA

Published by Carlat Publishing, LLC

PO Box 626, Newburyport, MA 01950

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Publisher and Editor-in-Chief: Daniel J. Carlat, MD
Deputy Editor: Talia Puzantian, PharmD, BCPP
Senior Editor: Ilana Fogelson

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Introduction

Inpatient psychiatric care in the United States faces many challenges, from a shortage of beds and psychiatrists to the pressures of managed care. These obstacles can make the system feel overwhelming. As an inpatient psychiatrist, you'll encounter demanding workloads and patients eager for discharge. Hospital administrators will require meticulous documentation and completion of numerous forms. And yet, there is nothing as endlessly fascinating and rewarding as working in a psychiatric inpatient unit. You have a front row seat to the human drama, and the "actors" reach out to hoist you onto the stage—because you are the key player in resolving all manner of crises.

This book was born of our delights and frustrations working in several inpatient units over our careers. Its purpose is to help you get your work done efficiently. We'll cover everything from reviewing old charts and handling administrative tasks to navigating forensic issues and managing psychiatric emergencies. Our advice derives from a combination of sources, including our own experiences, interviews with highly experienced unit staff, and the scientific literature (though oddly enough, there's not much published on how to do inpatient psychiatry). While there are already some good inpatient psychiatry textbooks around, most of them are comprehensive textbooks of psychiatric practice rather than truly useful manuals—so we wrote our own.

To complement what we've covered in this book, we've also put together a variety of online resources at www.thecarlatreport.com/inpatient. These include more in-depth coverage of daily inpatient routines, interview techniques, and patient management strategies, plus practical tools like downloadable scales and patient handouts. We hope these will help you navigate the complexities of inpatient psychiatry with even more confidence.

Enjoy the book, but more importantly, enjoy the work.

Victoria Hendrick, MD
Daniel J. Carlat, MD

Psychiatric Admission Notes: Structure and Key Elements

Admission notes are meant to serve as a succinct summary of why the patient is hospitalized, their mental status, the diagnosis, and your initial treatment plan. Current electronic health record software often spits out admission notes that are excessively long and are often ignored. To the extent that you have control over your admission notes, try to keep the narrative sections concise and to the point. They should generally be no longer than 1,000 words.

To help with this, we've provided a comprehensive template. It includes structured fields and suggested language to guide your admission documentation, as well as placeholders for specific data and descriptions that you can customize for each patient. The goal is to standardize the documentation process, making it easier for you to capture all necessary information thoroughly and concisely.

Patient Name

Preferred Language

Date of Admission

Chief Complaint

Exact quote from patient of why they believe they are here.

Identifying Information

"[Patient name] is a [age]-year-old [race] [gender] with a history of [diagnoses], admitted from the [ED/medical unit/xxx facility] for assessment and treatment of [xxx]."

Admission Legal Status

Typical broad options include "voluntary" and "involuntary," but each state has specific legal designations.

History of Present Illness

How and when patient got to the hospital

"On [date], the patient [self-presented/was brought in by xxx] after 911 was called by [person]."

Reason/precipitant

Describe events, symptoms, and behaviors leading to the patient's presentation.

ED report

Include observations and assessments by ED staff, as well as reports by family, friends, police, or EMTs.

Life stressors

Describe any significant life stressors contributing to the current situation.

Example

"On June 24, 2024, the patient was brought in by ambulance after 911 was called by a neighbor. The patient had been experiencing increasing paranoia and hallucinations, which culminated in aggressive behavior toward a family member. ED staff noted the patient was agitated and disoriented upon arrival. The patient's family reported a history of schizophrenia with recent noncompliance with medication. EMTs observed the patient making incoherent statements and displaying aggressive behavior during transport. Recent job loss and the death of a close relative have been significant stressors for the patient."

Past Psychiatric History

Prior psychiatric admissions

List dates of previous admissions, names of facilities, lengths of stay, and reasons for each admission. Example format: "[Date] at [facility name], [length of stay], for [reason]."

Medication history

List all psychiatric medications the patient has tried in the past, including dosages and durations. Include any adverse effects experienced with each medication.

Safety risks and incidents

- If there is no history, state, "Patient denied any history of suicide attempts or violent acts."
- If there is a history, describe each suicide or homicide attempt, each act of violence, and each other relevant safety issue.
- Access to firearms:
  - "Patient denied access to firearms."
  - "Patient endorsed access to firearms, including [type and location]."

Medicare and Medicaid: Overview and Billing

Many psychiatric inpatients are covered by Medicare or Medicaid, and some ("dual eligible" patients) are covered by both. These are essential sources of coverage for many psychiatric inpatients, especially in facilities serving low-income populations. In geriatric psych facilities, nearly 100% of patients are covered by these insurances. As a clinician, you don't need to know the intricacies of insurance policies, but since these two public programs have an outsize influence in hospitals, you should learn the basics of whom they cover and how they work.

Medicare

Who is eligible for Medicare?

- Anyone 65 or older.
- Anyone who is disabled (as defined by the Social Security Administration) and who has been receiving Social Security Disability Insurance checks for 24 months.

What are the different types of Medicare?

- *Part A* (Mnemonic: Remember **A** for **A**dmission to a hospital): Covers hospitalization, skilled nursing facilities (rehab), home health care, and hospice. Does not cover nursing home stays—those are covered by Medicaid. Everyone gets Part A at 65 as long as they have worked and paid taxes into the system. Part A is free for most people.
- *Part B* (Mnemonic: Remember **B** for **B**and-Aid): Covers physician services, diagnostic tests, ambulances, and outpatient surgery. It is optional, and if a person wants it they must pay a premium, although it's not very expensive. The premium covers only about one-third of the actual insurance cost; the government picks up the rest of the tab. In addition to the premium, there's a 20% copay on most services covered by Part B. If a person forgoes obtaining Medicare Part B, their individual insurance may not cover the costs for services that Part B would typically cover.
- *Part C* (Mnemonic: Remember **C** for **C**ommercial Medicare) *or Medicare Advantage:* Private insurance offered by various commercial companies; wraps Part A, B, and D benefits into a single product. There are hundreds of Medicare Advantage plans available, although each one covers a limited region, so any given person will typically be choosing from less than 40 plans. Each plan charges its own premium, copay, etc, and the coverage will also vary.
- *Part D* (Mnemonic: Remember **D** for **D**rug): Provides payments for prescription drugs. There are many plans to choose from, and the average premium in 2024 was about $56 per month. Different plans have different deductibles and copays. The infamous Part D "donut hole" (or coverage gap) works like this: A patient's plan will pay for the first $5,030/year of medications. Once the patient reaches this limit, they enter the coverage gap and will have to pay 25% of the cost of their medications until they reach the catastrophic coverage threshold, which is $8,000 in 2024. After that, Part D kicks in again and will cover most of the remaining costs.

Medicare: Psychiatric hospital implications

- *Coverage/payment:* Medicare covers psychiatric hospitalization through Part A. The basic benefit is up to 90 days per benefit period and up to 190 days of lifetime coverage. Medicare pays the hospital a per-diem rate according to the Inpatient Psychiatric Facility Prospective Payment System. In 2024, the per-diem rate was $895.63/day. This is a bundled payment covering all the services provided during an inpatient stay, including psychiatric services.
- *Utilization review:* Medicare has no "concurrent review," meaning that unlike many insurance plans, neither you nor your social worker (or utilization review staff) will have to keep asking an insurance reviewer for more days of coverage. You can concentrate on treating your patient, and if a longer admission is necessary, so be it. However, you're not completely off the hook, because the government may still conduct postadmission audits to ensure a patient's hospital stay was medically necessary. If the documentation of the patient's need for inpatient care is weak, the Centers for Medicare & Medicaid Services (CMS) can demand to be reimbursed the amount of money they paid the hospital.
- *Certification of need:* You might be familiar with the annoying requirement that you sign a certification form periodically for your Medicare patients. Many hospitals still require an inked signature, and the forms must be signed by a physician—psychiatric nurse practitioners are not allowed to sign them. However, if you don't recall ever signing these forms, your hospital might use an automated system that handles certifications as part of the admission and billing workflow. So what are these forms about? Medicare requires that you certify the need for an inpatient stay at the time of admission and no later than the 12th day of admission. It's partly an antifraud measure—you are being held accountable for the decision to admit a patient and to extract a large amount of money from the government for ongoing psychiatric care. More relevant to patient care, this also means that throughout the admission, you must demonstrate in your daily notes that inpatient treatment is needed and can be "reasonably expected to improve the patient's condition or for diagnostic study."
- *Quality metrics:* At most hospitals, you are required to document that you fulfilled various elements of quality care. This is part of Medicare's quality reporting program, in which hospitals can get paid a little bit more if they prove that these practices were done. Each year, Medicare might add new quality measures that hospitals must track and report on. On the plus side, sometimes Medicare removes a reporting requirement when there is no justification for it. For example, in 2024, CMS removed the requirement that we report on patients discharged on multiple

How to Identify and Respond to Self-Injurious Behaviors

Self-injurious behaviors (SIB) are among the most pressing concerns you will face on an inpatient psychiatric unit. They require a balance of swift medical intervention, empathy, and stringent safety measures. Here we review practical tips for preventing and managing SIB.

Assess Risk for SIB

- Common diagnoses associated with SIB include borderline personality disorder, developmental disorders, and major depression with psychosis or suicidality.
- Patients with a prior history of SIB are at high risk of engaging in these behaviors on the unit.

First, Ensure the Patient Is Safe

- Remove any objects that a patient might use for self-harm. This includes sharp objects, belts, and shoelaces.
- Review the level of observation in patients with a history or risk of SIB. Depending on the severity, this can range from 15-minute checks to continuous 1:1 supervision.
- For patients who have injured themselves, see the "Medical Management of Self-Injurious Behaviors" fact sheet in this section for specific evaluation and management recommendations regarding common self-injuries.

Therapeutic Interventions

Work with your unit's social worker, psychologist, and occupational therapist to provide these interventions:

- Cognitive behavioral therapy to address negative thought patterns and develop healthier coping mechanisms.
- Dialectical behavior therapy, especially for patients with borderline personality disorder, to improve emotional regulation and reduce self-harming behaviors.
- Mindfulness exercises and stress reduction techniques to help manage impulses.
- Skill-building sessions focusing on communication, interpersonal skills, and emotional self-awareness.
- Working with the patient to create a safety plan. Identify triggers and develop coping strategies, like listening to music, practicing deep breathing, or talking with a trusted nurse.

Medication Management

- Consider prescribing antidepressants, such as selective serotonin reuptake inhibitors, for patients with underlying depression contributing to SIB.
- In cases of severe mood swings or bipolar disorder, mood stabilizers or second-generation antipsychotics may be appropriate.
- If you prescribe sedative-hypnotics for acute anxiety or agitation, monitor their use to avoid dependency.

Additional Tips

- Listen actively and validate the patient's feelings. By making the patient feel understood, you reduce the sense of isolation that often accompanies SIB.
- Encourage distraction techniques, such as art therapy, journaling, exercise, or group therapy.
- Involve the patient's family or support system in their care plan, where appropriate and with the patient's consent. This creates an extended support network for the patient during and after hospitalization.

Bulimia Nervosa

Patients with bulimia nervosa often present with complex challenges, including the cycle of binge eating and purging, as well as associated medical complications. The goal in the inpatient setting involves not only breaking the binge-purge cycle but also addressing the underlying psychological issues and preparing the patient for sustained recovery. This fact sheet outlines the essential steps in assessing and treating bulimia nervosa in an inpatient setting.

DSM-5 Diagnostic Criteria

- Recurrent episodes of binge eating.
- Recurrent inappropriate compensatory behaviors to prevent weight gain, such as vomiting, excessive exercise, fasting, or misuse of laxatives.
- Both of the above behaviors occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not exclusively occur during episodes of anorexia nervosa.

Initial Assessment

- *Psychiatric:* Along with confirming the diagnosis of bulimia, inquire about comorbidities like depression, anxiety disorders, substance use disorders, and borderline personality disorder.
- *Medical:* Symptoms related to regular purging include electrolyte imbalances, dental erosion, and GI issues. Labs should evaluate electrolytes, kidney function, and liver enzymes. Hypokalemia is common, especially in patients who induce vomiting, leading to cardiac issues. An ECG is recommended if electrolyte abnormalities are detected.

Interdisciplinary Treatment Protocol

Inpatient treatment of bulimia aims to stop the binge-purge cycle and address the patient's underlying psychological issues.

- *Nutritional counseling:* Counseling is an essential aspect of treatment. The goal is not to restore weight, but to establish regular eating patterns without binging and purging.
- *Meal and post-meal supervision:* Supervised meals prevent binge episodes, and post-meal monitoring (typically for one to two hours) helps ensure no purging behaviors.
- *Medical monitoring:* This can include monitoring vitals, electrolytes, and any other medical concerns, typically overseen by a medical professional.
- *Individual psychotherapy:* Cognitive behavioral therapy is the primary evidence-based treatment for bulimia. Goals include recognizing and altering distorted thought patterns and behaviors related to eating.
- *Group therapy:* This can offer support, psychoeducation, and skills training.
- *Aftercare planning:* Having a plan for care following discharge is essential for maintaining recovery. This includes outpatient therapy, dietary guidance, and medical monitoring.
- *Pharmacotherapy:* Unlike anorexia, medications play a central role in treating bulimia.
  - First line: Selective serotonin reuptake inhibitor (SSRI) antidepressants have been approved for bulimia treatment. They can help reduce the frequency of binge-purge episodes and improve mood. Fluoxetine (Prozac) is the first-line agent, starting at 20 mg daily, with a target dose of 60 mg daily. Other SSRIs are also effective, and the target dose is higher than the usual antidepressant dose (eg, sertraline 150 mg daily, escitalopram 30 mg daily). Avoid paroxetine due to the risk of weight gain. Avoid citalopram due to the risk of QT prolongation.
  - Second line: Tricyclics (especially desipramine), topiramate, trazodone, monoamine oxidase inhibitors.
  - Avoid bupropion in bulimia due to an increased risk of seizure.

Catatonia

Catatonia is a syndrome marked by an apparent lack of responsiveness to external stimuli, despite the individual appearing to be awake. While it's often linked with schizophrenia, you'll also see catatonia among patients with depression, bipolar disorder, schizoaffective disorder, and brief psychotic episodes.

Prevalence

- Occurs in about 10% of acute psychiatric inpatients.

Symptoms/Diagnosis

- Immobility, staring, mutism, waxy flexibility, posturing, echolalia, echopraxia, stupor, stereotypy, purposeless activity.
- Bush-Francis Catatonia Rating Scale (BFCRS): The gold standard for diagnosing catatonia. It's a 23-item scale for assessing symptoms and monitoring treatment response. See: www.thecarlatreport.com/BushFrancisCatatoniaRatingScale
- DSM-5 criteria: Requires at least three catatonic symptoms like stupor, catalepsy, mutism, etc.

Types of Catatonia

- *Retarded catatonia:* Patient stares and appears nonresponsive but is alert.
- *Excited catatonia:* Involves pointless, impulsive movements; may appear agitated or combative.
- *Malignant catatonia:* Dangerous and associated with autonomic instability; may evolve rapidly.

Differential Diagnosis

- Neuroleptic malignant syndrome.
- Encephalitis.
- Malignant hyperthermia.

Treatment

- Benzodiazepines:
  - Lorazepam (Ativan): First line, effective in 70% of cases.
    - Start with "Ativan challenge," with 1–2 mg IV or IM TID.
    - Most patients respond to 6–20 mg daily, usually within six to 10 days.
    - Monitor for respiratory depression, especially in high-risk populations like elderly patients, obese patients, or patients with cardiovascular or respiratory illnesses.
    - Once the patient is stabilized, continue benzodiazepines for three to six months before gradually tapering the dose; some patients may need long-term benzodiazepine therapy to avoid relapse.
  - Valproic acid: 500–1500 mg/day.
- N-methyl-D-aspartate (NMDA) receptor antagonists: Case reports have been promising.
  - Memantine: Start at a low dose (5 mg/day) and titrate up as tolerated and as symptoms require, to a maximum of 20 mg/day.
  - Amantadine: Typical doses are 100–400 mg/day.
- Antipsychotics: Used rarely as they can exacerbate catatonia.
- Electroconvulsive therapy: Used if no response to pharmacological interventions.

Monitoring and Follow-Up

- Use a scale like the BFCRS to monitor progress.

Psychogenic Polydipsia: Diagnosis and Treatment

Patients with psychogenic polydipsia (PP) consume excessive amounts of water, making their blood dangerously dilute. This condition is surprisingly common, with a prevalence of 3%–25% in institutionalized patients. You'll see it most often among patients with schizophrenia, but it also occurs in patients with mood and anxiety disorders.

Diagnosis

Clinical manifestations

- Suspect PP in patients who often complain of thirst or who repeatedly request or consume large amounts of water.
- Neuropsychiatric manifestations of hyponatremia (a consequence of water intoxication) include nausea, headache, cramping, dysarthric speech, lethargy, and confusion. Seizures and delirium occur in extreme cases.

Labs

- Obtain a basic metabolic panel. Sodium will be low (<135 mEq/L).
- Obtain a urine sample for urine osmolality and sodium. Both will be low (urine osmolality <100 mOsmol/kg; urine sodium <10 mEq/L).

Differential Diagnosis

- *Diabetes mellitus:* The primary problem is hyperglycemia, which leads to polyuria because excess glucose in the urine draws excess water along with it. The excess thirst is a result of the dehydration caused by the polyuria. Key diagnostic features are hyperglycemia and glucosuria (glucose in the urine)—neither of which occur in PP.
- *Diabetes insipidus:* The primary problem is inadequate production/response to antidiuretic hormone (ADH). Urine is dilute, but unlike PP, serum sodium will be high as the serum is concentrated from free water loss.
- *Syndrome of inappropriate antidiuretic hormone secretion (SIADH):* The primary problem is too much ADH, caused by medications including oxcarbazepine, carbamazepine, and serotonergic antidepressants. The kidneys absorb excessive water, so serum sodium levels will be low, but urine will be concentrated, unlike in PP.

Treatment

- *Water restriction:* The most important treatment strategy for PP is fluid restriction, which is harder than it sounds. Patients with PP are often highly driven to consume water. If you try to limit their water intake, they may find surreptitious ways of drinking water (eg, from the toilet or sink). Limit water to 1000–1500 mL/day; this will quickly resolve hyponatremia. Patients may need 1:1 supervision if you suspect they are drinking water surreptitiously.
- *Sodium supplementation:* Prescribe sodium chloride tablets, 1–3 g daily.
- *Discontinue certain medications:* Some medications exacerbate PP—these are typically anticholinergic antipsychotics that cause dry mouth, such as chlorpromazine, diphenhydramine, and tricyclic antidepressants. In response, patients may drink more water.
- *Transfer to medicine floor:* In severe cases, with serum sodium levels in the low 120s or below, patients will require transfer to a medicine unit for closely monitored sodium repletion using IV saline (a 3% saline solution, rather than the usual 0.9%).
- *Long-term treatment:* There is no established long-term treatment for PP, but naltrexone 50 mg daily may help.

Appendix A: National Mental Health Resources

Providing patients with resources as they transition from inpatient psychiatric units to outpatient care is vital for their continued support and recovery. Here are several valuable national resources.

General Mental Health Resources

National Alliance on Mental Illness (NAMI)

- **Website:** www.nami.org
- **Phone:** 1-800-950-NAMI (1-800-950-6264)
- **Description:** Offers support groups, education programs, and advocacy for individuals with mental illness and their families.

Mental Health America (MHA)

- **Website:** www.mhanational.org
- **Description:** Provides resources for mental health awareness, including screening tools and information on various mental health conditions.

National Institute of Mental Health (NIMH)

- **Website:** www.nimh.nih.gov
- **Description:** Offers extensive information on mental disorders, current research, and educational materials.

Crisis and Suicide Prevention Resources

988 Suicide and Crisis Lifeline

- **Website:** www.suicidepreventionlifeline.org
- **Phone:** 988
- **Description:** Offers free and confidential support 24/7 for individuals in distress, along with suicide prevention and crisis resources.

American Foundation for Suicide Prevention (AFSP)

- **Website:** www.afsp.org
- **Description:** Provides resources for suicide prevention, including education, advocacy, and support for those affected by suicide.

Substance Use Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)

- **Website:** www.samhsa.gov
- **National Helpline:** 1-800-662-HELP (1-800-662-4357)
- **Description:** Offers comprehensive information and support for substance use disorders, including treatment referrals and support services.

Anxiety and Depression Resources

Anxiety and Depression Association of America (ADAA)

- **Website:** www.adaa.org
- **Description:** Provides information on prevention, treatment, and symptoms of anxiety, depression, and related conditions.

Depression and Bipolar Support Alliance (DBSA)

- **Website:** www.dbsalliance.org
- **Description:** Offers peer-led support groups and resources for individuals living with depression and bipolar disorder.

Veteran Services

Veterans Crisis Line

- **Website:** www.veteranscrisisline.net
- **Phone:** 988, then press 1
- **Description:** Provides 24/7 confidential support for veterans and their loved ones experiencing mental health crises or suicidal thoughts.

LGBTQIA+ Resources

The Trevor Project

- **Website:** www.thetrevorproject.org
- **Phone:** 1-866-488-7386