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Learning Objectives

After reading these articles, you should be able to:

1. List the risk factors for QTc prolongation.
2. Assess for and manage various paraphilic disorders and delusional misidentifiction syndromes.
3. Identify next steps when served with a valid subpoena for patient records.
4. Summarize some of the current research findings on psychiatric treatment.

QT Intervals in Psychiatric Practice

Paul Barkopoulos, MD. Clinical Assistant Professor, Psychiatry & Biobehavioral Sciences, UCLA David Geffen School of Medicine and Olive View UCLA Medical Center, Los Angeles, CA. Victoria Hendrick, MD. Editor-in-Chief, The Carlat Hospital Psychiatry Report*; Chief, Inpatient Psychiatry, Olive View UCLA Medical Center.*

Dr. Barkopoulos and Dr. Hendrick, authors for this educational activity, have no relevant financial relationship(s) with ineligible companies to disclose.

As psychiatrists, we constantly face the reality that many psychiatric drugs affect cardiac conduction. While psychotropics carry a variety of possible cardiac side effects, in this article we will focus on QT interval prolongation.

What is QT interval prolongation, and why are we concerned about it?
The QT interval represents the time it takes for the heart ventricles to contract and relax. Since heart rate variations affect this measurement, we typically look

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Highlights From This Issue

Lead article
We summarize essential points for keeping patients safe when they take QT-prolonging psychiatric medications.

Lead Q&A
Paraphilic disorders are difficult to manage on inpatient psych units. Dr. Holoyda reviews tips for working with these challenging patients.

Q&A on page 7
You've received a subpoena. Now what? Dr. VanDercar educates us about how to respond.

Article on page 9
We review delusional misidentification syndromes, including Capgras syndrome, Fregoli syndrome, and others.

Q&A With the Expert

Paraphilic Disorders
Brian Holoyda, MD, MPH, MBA

Forensic psychiatrist, Portland, OR.

Dr. Holoyda, expert for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.

CHPR: Dr. Holoyda, please tell us about yourself.
Dr. Holoyda: I am a forensic and correctional psychiatrist. I completed my training in psychiatry and forensic psychiatry at the University of California, Davis. I provide psychiatric treatment to pre-trial detainees at a jail in the Bay Area of California. In addition, I conduct forensic psychiatric evaluations for attorneys on a variety of psycholegal issues, including sexually violent predator determinations, violence risk assessments, malpractice allegations, and emotional injury claims.
CHPR: Can you give us an overview of paraphilic disorders?
Dr. Holoyda: Paraphilic disorders are a diagnosis category in DSM-5. In DSM-IV-TR they were referred to as paraphilias, but DSM-5 distinguishes between a paraphilia and a paraphilic disorder. A paraphilia is an intense and persistent sexual interest in an atypical, sexually arousing object or act.

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Expert Interview – Paraphilic Disorders

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A paraphilic disorder, in contrast, is a psychiatric diagnosis characterized by a paraphilia that causes distress or impairment or has led to personal harm or risk of harm to others. As you can see in DSM-5, all the paraphilic diagnoses now have the word "disorder" at the end. For example, pedophilia became pedophilic disorder, exhibitionism became exhibitionistic disorder, etc. Individuals with paraphilias do not necessarily have a disorder, as their atypical sexual interests may not cause them distress or impairment, or they may engage in atypical sexual behaviors with consenting human partners.

CHPR: Is there anything else we should know to diagnose paraphilias and paraphilic disorders?

Dr. Holoyda: There are a few other key points. First, we typically identify paraphilias and paraphilic disorders based on what DSM-5 refers to as "anomalous activity preferences" or "anomalous target preferences." These terms mean that somebody has an atypical interest in either a certain type of activity that is abnormal or a partner or object that is abnormal. Second, the atypical sexual interest associated with a paraphilic disorder is typically preferential, meaning that the person will seek out that type of sexual activity or sexual interaction before they seek out normative sexual activity.

CHPR: In our inpatient psychiatry unit, we periodically admit patients with psychiatric disorders who are also registered sex offenders, typically against children. But not all registered sex offenders meet criteria for paraphilic disorders, right? Can you review the distinction?

Dr. Holoyda: A person with a history of an offense involving a minor does not necessarily have a pedophilic disorder. Sex offenses are criminal offenses defined by state statute, whereas the paraphilic disorders are psychiatric disorders. People with paraphilic disorders may not engage in behavior that would result in a sex offense, and people who commit sex offenses do not necessarily have a paraphilic disorder. Interestingly, possessing child pornography is a greater indicator of pedophilic interest than committing a hands-on offense against a child. People actively seek out pornography that appeals to their sexual interest, whereas somebody could engage in a hands-on offense against a child for other reasons—for example, while under the influence of substances or because consenting adult partners are not available.

CHPR: Can you review treatment approaches for paraphilic disorders?

Dr. Holoyda: The main treatment model was put forth by the World Federation of Societies of Biological Psychiatry (WFSBP). The organization recently updated its guidelines on medication management for paraphilic disorders in 2020, and I would strongly encourage readers to look at them (Thibaut F et al, *World J Biol Psychiatry* 2020;21(6):412–490). Basically, they recommend escalating levels and numbers of treatment based on a person's risk. If a person is having atypical sexual fantasies or thoughts or urges that are bothersome to them, but they are deemed to be at low risk of acting on them or the fantasies do not entail hands-on offenses against others, then the recommendation is cognitive behavioral therapy (CBT). With escalating risk—for example, a patient having urges to commit a sexual behavior that would be a hands-on offense—then a psychiatrist should be more concerned and should consider offering medication treatments.

CHPR: What kinds of medication treatments?

Dr. Holoyda: For low-level paraphilias, we use SSRIs, which have long been a mainstay of treatment for paraphilic disorders. We do this for a few reasons. First, as a side effect of the activation of serotonin receptors, SSRIs can reduce libido and an individual's ability to obtain an erection or have an orgasm. Second, the urges or fantasies of paraphilic disorders have been likened to compulsions or obsessive thoughts in OCD. So, by using high-dose SSRIs, we can dampen some of those urges and thoughts. Third, a lot of folks with paraphilic disorders have accompanying anxiety and depressive symptoms that make the thoughts and urges more distressing, so by reducing the associated symptoms, they might be less distressed and therefore less fixated on their thoughts and urges.

CHPR: Are there any randomized controlled trials of SSRIs for paraphilic disorders?

Dr. Holoyda: Not to my knowledge. Despite this, the WFSBP guidelines specifically recommend sertraline and fluoxetine for patients with mild paraphilic disorders.

CHPR: What about hormonal interventions?

Dr. Holoyda: There is a category of anti-androgen or testosterone-lowering medications, which includes steroid analogues like medroxyprogesterone acetate and the GnRH analogues like triptorelin, leuprorelin, and goserelin. The rationale for using anti-androgen medications is that reducing free testosterone reduces libido, can reduce the frequency of erections and masturbation, and can decrease typical and atypical sexual fantasies.

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EDITORIAL INFORMATION

Publisher: **Daniel Carlat, MD**

Editor-in-Chief: **Victoria Hendrick, MD**

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Executive Editor: **Janice Jutras**

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

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CHPR: How do you choose which anti-androgen medication to use?

Dr. Holoyda: The only steroid analogue available in the US is medroxyprogesterone acetate, which comes in a depot form called Depo-Provera. It increases the destruction of testosterone by the liver, suppresses the hypothalamic-pituitary-gonadal axis, and increases testosterone binding to testosterone-binding globulin, which increases the clearance of testosterone from the bloodstream. According to the WFSBP, there have been about 600 published cases of Depo-Provera for the treatment of paraphilic disorders and sex offenders. Some studies have shown a complete disappearance of paraphilic sexual behavior and fantasies within one or two months of starting treatment. In the latest guidelines, however, the WFSBP recommends against the use of Depo-Provera due to side effects, like fatigue, weight gain, hot flashes, and migraine headaches.

CHPR: This is surprising—a completely effective treatment, yet they don't recommend it because of some side effects?

Dr. Holoyda: Indeed, the WFSBP opined that the risks of Depo-Provera outweigh the benefits based on currently available research. They noted a similar concern for significant side effects with the hormonal analogue cyproterone acetate, which is not available in the US, but did not recommend against its use.

CHPR: What other anti-androgen medications are there?

Dr. Holoyda: The second commonly used anti-androgen medication class is GnRH analogues. Typically, GnRH is released from the anterior pituitary gland in a pulsatile fashion, which stimulates the production of luteinizing hormone and follicle-stimulating hormone, which then stimulate the production and release of testosterone. GnRH analogues give a continuous rather than pulsatile dose of GnRH, which shuts down the hypothalamic-pituitary-gonadal axis.

CHPR: Have there been any randomized controlled trials of GnRH analogues for paraphilic disorders?

Dr. Holoyda: There are relatively few published data on them and no randomized controlled trials. As with Depo-Provera, however, studies have found complete disappearance of deviant sexual fantasies and a reduction in nondeviant sexual behavior in folks who are treated with GnRH analogues. The WFSBP recommends their use for severe paraphilic disorders.

CHPR: So why are GnRH analogues more highly recommended?

Dr. Holoyda: First, they tend to be better tolerated than hormonal analogues like Depo-Provera and cyproterone acetate. Second, it is easier to monitor patients' compliance with GnRH analogues because they have a more predictable effect on plasma testosterone levels.

CHPR: I recently read an article about the opposite of a GnRH analogue for paraphilic disorders: a GnRH antagonist, degarelix (Firmagon). Can you say something about that agent?

Dr. Holoyda: Yes, this is a new approach. In 2020, a Swedish group published a randomized clinical trial on degarelix. The researchers compared degarelix versus placebo and assessed 52 men with pedophilic disorder on several domains of child sexual abuse, like degree of sexual preoccupation, impaired self-regulation, empathy, and individual self-rated risk. They found that degarelix resulted in significantly decreased risk scores at both two and 10 weeks compared to placebo, and they suggested that the medication may produce rapid onset of treatment for men with pedophilic disorder (Landgren V et al, *JAMA Psychiatry* 2020;77(9):897–905). Of course, more studies are needed, but this study gives us hope that we may have yet another medication in our arsenal to treat paraphilic disorders.

CHPR: Have you encountered any problems with administering these medications?

Dr. Holoyda: The side effects are significant and should not be taken lightly. These medications are feminizing; they can cause uncomfortable side effects like hot flashes, growth of breast tissue, and weight gain. GnRH agonists specifically can result in bone demineralization. Folks should get their bone density measured on a yearly basis when they take these medications. Furthermore, sexuality is a primary element of being a human, so many clinicians are not willing to give patients a medication that totally shuts down their sexual interests, even if they are atypical and problematic. On the other hand, many folks in the community do not seek treatment for atypical sexual interests because they are not aware that effective treatments are available to help them have more normal sex lives and sexual interests. They may also fear that they will be reported to police for having sexual thoughts or fantasies involving children.

CHPR: That brings up the question about reporting. I assume that if a patient is having atypical sexual thoughts, but has not acted on them, then there's no mandated reporting requirement.

Dr. Holoyda: Right. That conversation is one that a provider would have with the patient when doing an informed consent for treatment. If the patient is presenting for evaluation and treatment of atypical sexual fantasies or urges, then they need to know that, as a mandated reporter, you will make a report if you have concern that there is child sexual abuse going on. In most states, the standard for reporting is "reasonable suspicion" that abuse has occurred. This does not mean that

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"If the patient is presenting for evaluation and treatment of atypical sexual urges, they need to know that you will make a report if you have concern that there is child sexual abuse going on. In most states, the standard for reporting is 'reasonable suspicion' that abuse has occurred. This does not mean that you must be 100% certain; it just means that you suspect there might be sexual abuse going on."

Brian Holoyda, MD, MPH, MBA

Expert Interview – Paraphilic Disorders

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you must be 100% certain; it just means that you suspect there might be sexual abuse going on. As psychiatrists, we are mandated to report to local law enforcement or the county child welfare agency. It is also important to know that most states provide reporters immunity from civil or criminal liability that might result from a report. I would encourage people to look at their own state's statutes about that issue.

CHPR: Returning to the subject of treatments, what about nonpharmacologic therapies?

Dr. Holoyda: Psychotherapy for sexual offending usually follows a CBT-type model based on the risk-need-responsivity, or RNR, principle. The first R, risk, refers to identifying the degree of risk that the individual poses and matching the level of treatment to that risk. The N, need, refers to identifying the individual's dynamic sexual violence risk factors to be targeted with treatment. And the final R, responsivity, refers to tailoring treatment to the individual's strengths, needs, and abilities. There are some organizations, like the Association for the Treatment of Sexual Abusers, that report a significant reduction in the recidivism rate with psychological interventions, but the data are quite mixed on the benefits of nonmedication treatments for sexual offending and paraphilic disorders. And there was a recent large-scale study conducted in the UK penal system that demonstrated increased rates of re-offense for individuals who received psychological interventions (www.tinyurl.com/54capywf).

CHPR: It sounds like the data are really inconclusive for psychological interventions.

Dr. Holoyda: Right, and for that reason, medications should absolutely be part of the mainstay treatment course for patients with paraphilic disorders.

CHPR: When working with these patients, we often encounter placement issues as many facilities will not take a sex offender. We work with patients' probation or parole officers, but the options for placement are often very limited.

Dr. Holoyda: Sex offender registration laws in this country have made it extremely difficult to find housing for sex offenders because there are many rules about where they can and cannot live. That is one major reason why a lot of sex offenders end up being homeless and then frequently get violations for not updating their address history with probation. That is an unintended consequence of this type of legislation, so I absolutely hear you.

CHPR: Thank you for your time, Dr. Holoyda.

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QT Intervals in Psychiatric Practice

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at QTc intervals, where the "c" stands for "corrected" (see "What's the QTc?" sidebar on page 5). Normal QTc intervals are <430 ms for men and <450 ms for women (see "QTc Interval Measurements" table).

We worry about prolonged QTc intervals because they increase the risk of abnormal heart rhythms like torsades de pointes (TdP). Translating to "twisting of the points," TdP is a form of ventricular tachycardia in which the QRS complexes appear to twist around the isoelectric line (see "Rhythm Strip of Prolonged QT Interval and Torsades de Pointes" figure on page 6). Most cases terminate spontaneously, but some progress to potentially deadly ventricular fibrillation. The risk of TdP increases several-fold with QTc intervals >500 ms (Trinkley KE et al, *Curr Med Res Opin* 2013;29(12):1719–1726).

QTc Interval Measurements

	Adult Men (ms)	Adult Women (ms)
Normal	<430	<450
Borderline	431–470	451–480
Prolonged	>470	>480

Which patients are most at risk?

Patients at most risk are those over age 65, female, and/or with a history of heart disease (see "Risk Factors for QT Prolongation/TdP" table for more risk factors). Congenital long QT syndrome places patients at significant risk, but this condition is rare, occurring in only one out of every 5,000–7,000 patients. Additional risk factors include acute illnesses (eg, renal failure), electrolyte imbalances (low potassium, calcium, or magnesium), bradycardia, and concurrent use of more than one QT-prolonging drug. Just one additional factor might push a patient into the at-risk category.

Risk Factors for QT Prolongation/TdP

Non-Modifiable Risk Factors	Modifiable Risk Factors
• Female sex • Age >65 • Congenital long QT syndrome • History of drug-induced QT prolongation • History of heart disease • Metabolizer status	• Concurrent use of more than one QT-prolonging drug • Drug interactions • Drug toxicity • Severe acute illness • Bradycardia • Starvation/anorexia nervosa • Inadequate dose adjustment of hepatically metabolized drugs in patients with hepatic cirrhosis, or of renally metabolized drugs in patients with acute kidney injury or chronic kidney disease • Risk or presence of hypokalemia, hypomagnesemia, or hypocalcemia

Adapted from: Funk MC et al, Am J Psychiatry *2020;177(3):273–274*

To identify high-risk patients, we obtain vital signs and baseline labs (electrolytes, hepatic panel, CBC) and review all prescribed medications. We correct modifiable risk factors like hypokalemia and, whenever possible, eliminate concurrent QT-prolonging medications.

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Top QT-Prolonging Non-Psychotropic Meds

- Certain antibiotics (eg, azithromycin, levofloxacin, erythromycin)
- Antihistamines (eg, diphenhydramine, hydroxyzine)
- Antiemetics (eg, ondansetron)
- Antiarrhythmics (eg, quinidine, amiodarone)
- Antifungals (eg, fluconazole)
- Antivirals (eg, anti-HIV meds)
- Certain anticancer medications (eg, tamoxifen)
- Certain diuretics (eg, furosemide due to its resultant hypokalemia)

Adapted from: Fazio G et al, World J Cardiol *2013;5(4):87–93*

Which medications are likely to significantly prolong QT intervals?

The most notorious QT-prolonging non-psychotropic meds are antiarrhythmics, antibiotics, antihistamines, antiemetics, and antivirals (see "Top QT-Prolonging Non-Psychotropic Meds" table). Diuretics like furosemide increase the risk due to their tendency to produce hypokalemia. There is a helpful registry that categorizes medications by their risk of QT prolongation available at the website www.CredibleMeds.org.

Among psychiatric meds, thioridazine, chlorpromazine, ziprasidone, pimozide, methadone, IV haloperidol, citalopram (>40 mg/day), and tricyclic antidepressants produce the most worrisome QT prolongation. In overdose, many additional medications have the potential to prolong the QT interval.

What's the QTc?

You might remember from medical school that the "c" in QTc stands for "corrected" heart rate. Most QTc values are generated via ECG automated reports and use the Bazett formula (QTc = QT / $\sqrt{RR}$), which is generally accurate within 60–100 beats per minute.

The formula overestimates the QTc for faster heart rates and underestimates it for lower heart rates. For heart rates at the extremes, alternatives such as the Fridericia formula (QTc = QT / $RR^{1/3}$) or Framingham formula (QTc = QT + 0.154 × [1-RR]) are used (Postema PG and Wilde AAM, *Curr Cardiol Rev* 2014;10(3):287–294).

How do we manage patients on QT-prolonging psych medications?

Prior to beginning a QT-prolonging medication like ziprasidone, we obtain a baseline ECG. We then obtain another ECG once the drug reaches steady state (ie, after five half-lives). Certainly, ECGs should be repeated in patients with new-onset palpitations, syncope, chest pain, or shortness of breath. Also, we obtain baseline electrolytes and repeat these once the drug reaches steady state and annually thereafter (see "Steps to Minimize Risk of TdP" table).

If the baseline or follow-up ECG shows a QTc interval of 470–500 ms (for males) or 480–500 ms (for females), we consider substituting the medication with an alternative, non-QT-prolonging agent, or else we try to reduce the medication dose when possible. We weigh the risks and benefits before making any medication changes—many patients with borderline QTc intervals can safely continue their medications. Just be vigilant for any potentially worrisome symptoms like syncope or shortness of breath.

Another cause for worry is a sudden increase of 60 ms or more in the QTc interval. In these cases, we follow the steps mentioned above—in other words, we try to substitute the medication with a non-QT-prolonging agent, reduce the dose when possible, and correct any electrolyte imbalances.

When should we obtain a cardiology consultation?

If a follow-up ECG reveals a QTc interval of 500 ms or more, we immediately discontinue the medication and obtain a cardiology consultation. Cardiologists are likely to recommend continuous ECG telemetry or repeat ECGs every two to four hours until normalized (Trinkley et al, 2013).

It's wise to obtain cardiology consultations for patients with heart disease, with multiple QT-prolonging risk factors, on particularly high-risk medications (eg, IV haloperidol), who experience sudden increases in QTc, and/or whose QTc interval reaches or exceeds 500 ms. We also recommend

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Steps to Minimize Risk of TdP

Minimize risk factors

- Whenever possible, select medications that do not prolong the QT interval
- Prescribe the lowest effective dose of any QT-prolonging medication
- Correct underlying causes of electrolyte abnormalities or drug-induced bradycardia

Educate patient

- Instruct patient to contact their primary care provider or go to the emergency room if they experience palpitations, lightheadedness, dizziness, or syncope

Monitoring parameters

At every visit

- Inquire about any history of unexplained syncope, palpitations, dizziness, chest pain, or shortness of breath

ECG

- Baseline prior to initiation of QT-prolonging drug
- Once QT-prolonging drug reaches steady state (five half-lives)
- With changes in patient's clinical status (eg, new onset of syncope or palpitations)

Electrolytes

- Baseline prior to initiation of QT-prolonging drug
- Once QT-prolonging drug reaches steady state (five half-lives)
- Annually thereafter

When/how to modify therapy

If baseline or follow-up ECG shows QTc interval of 470–500 ms (males) or 480–500 ms (females):

- Consider discontinuing offending agent when an appropriate drug that does not cause QT interval prolongation can be substituted, or reduce the medication dose*
- If a follow-up ECG reveals an absolute increase in QTc ≥60 ms, correct electrolyte imbalances (if any) and consider discontinuing offending agent when an appropriate drug that does not cause QT interval prolongation can be substituted*
- If a follow-up ECG reveals a QTc interval ≥500 ms, discontinue offending agent; additional follow-up ECG should be immediately repeated to ensure accuracy and then continuous ECG telemetry monitoring should be performed, or a 12-lead ECG should be repeated every two to four hours until normalized

*Weigh the risks and benefits before making any medication changes. Many patients with borderline QTc intervals can safely continue their medications. Be vigilant for any potentially worrisome symptoms like syncope or shortness of breath.

Adapted from: Trinkley KE et al, Curr Med Res Opin *2013; 29(12):1719–1726*

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cardiology consults when patients on QT-prolonging agents report new-onset syncope, dizziness, or palpitations.

It's helpful to consult pediatric cardiologists when prescribing QT-prolonging medications to children as little is known about the effects of these medications in this population (Funk MC et al, *Am J Psychiatry* 2020;177(3):273–274). Adding to the complexity, QT values vary at different stages of childhood and adolescence.

Special populations

Electrolyte imbalances associated with eating disorders (especially anorexia nervosa and bulimia) and malnutrition (eg, following prolonged use of substances like alcohol and methamphetamines) increase the risk of QT prolongation. These patients should be monitored closely with repeat ECGs and electrolyte panels at least yearly, and with any new-onset symptoms such as dizziness or syncope.

Contrary to what many might believe, patients with implanted pacemakers and cardioverters/defibrillators are not protected against QT prolongation and TdP. Pacemaker settings do not allow for capture of TdP, and QT-prolonging medications may interfere with cardioversion. This can result in life-threatening, recurrent ventricular arrhythmias, known as an electrical or ICD storm (ICD stands for "implantable cardioverter defibrillator"). These patients are at greater risk, not less (Funk et al, 2020).

QT prolongation and TdP risks associated with specific psychiatric medications

Nearly every category of psychiatric medication includes low-risk and high-risk options. Here we will summarize data for specific medications, much of it drawn from the APA Resource Document on QTc Prolongation and Psychotropic Medications (Funk et al, 2020; see "Risk of QT Prolongation With Psychiatric Medications" table for a quick reference).

Antidepressants

While all SSRIs/SNRIs can increase the QT interval, they are generally considered safe. Sertraline is the best-studied SSRI and appears safe even in patients with QT-prolonging risk factors. Citalopram, which carries an FDA warning of QT prolongation above 40 mg daily, has minimal effects on the QTc interval in healthy patients, even when the dose is escalated to 60 mg. However, for patients with risk factors such as age >60 years, the QT prolongation can become clinically significant above 20 mg daily. Escitalopram's QT prolongation is not clinically significant, and it does not carry an FDA warning (Trinkley et al, 2013).

Tricyclic antidepressants, particularly amitriptyline and maprotiline, produce risky QT prolongation in cardiac patients and in overdose. Venlafaxine on rare occasions can prolong the QT interval, particularly in elderly patients. Since data on mirtazapine are contradictory, the FDA advises that it should be used cautiously in patients at risk for QT prolongation. Bupropion appears to have little effect on the QTc interval at therapeutic doses and is a reasonable option for patients at risk for ventricular arrhythmias. Desvenlafaxine and duloxetine similarly appear to have little effect on the QTc interval. Data on newer antidepressants (levomilnacipran, vilazodone,

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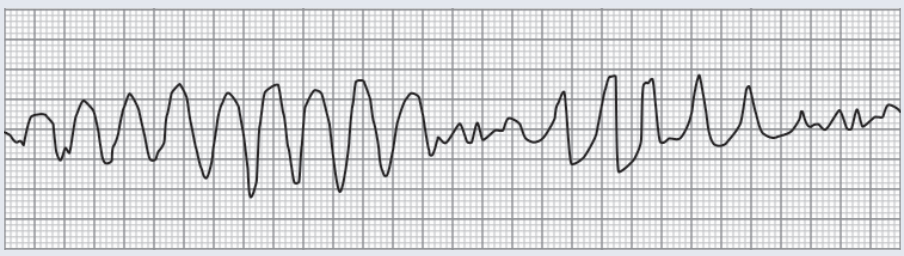
Rhythm Strip of Prolonged QT Interval and Torsades de Pointes



Risk of QT Prolongation With Psychiatric Medications

Antidepressants	Risk
Amitriptyline	+++
Bupropion	+
Citalopram	+++ (especially for doses >40 mg and for patients >60 years)
Clomipramine	++
Desvenlafaxine	+
Duloxetine	+
Escitalopram	+
Fluoxetine	+
Levomilnacipran	Inconclusive
Maprotiline	+++
Mirtazapine	+/++ (use cautiously for patients at risk of QT prolongation)
Paroxetine	+
Sertraline	+
Trazodone	+
Venlafaxine	++
Vilazodone	Inconclusive
Vortioxetine	Inconclusive
Antipsychotics	
Aripiprazole	--
Asenapine	+
Brexpiprazole	+
Chlorpromazine	+++
Clozapine	++
Fluphenazine	++
Haloperidol (IV)	+++
Haloperidol (oral/IM)	++
Iloperidone	++
Loxapine	++
Lurasidone	+
Risperidone	+/++
Olanzapine	+
Paliperidone	+/++
Perphenazine	++
Pimozide	+++
Quetiapine	++
Thioridazine	+++
Ziprasidone	++/+++
Mood Stabilizers	
Carbamazepine	+
Lithium	++/+++ (elevated risk if level >1.2 mEq)
Valproic acid	+
Anxiolytics	
Benzodiazepines	--
Buspirone	--
Stimulants	
Amphetamines	+
Atomoxetine	+
Methylphenidates	+
Others	
Buprenorphine	--
Methadone	+++

Adapted from: Funk MC et al, Am J Psychiatry *2020;177(3):273–274; Beach SR et al,* Psychosomatics *2013;54(1):1–13*

Q&A With the Expert

A Primer for Psychiatrists on Subpoenas

Ashley H. VanDercar, MD, JD

Psychiatrist, Northcoast Behavioral Healthcare, Northfield, OH.

Dr. VanDercar, expert for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.

CHPR: Dr. VanDercar, you recently gave us helpful tips for testifying in court. Today I'd like to ask you about subpoenas. Can you give us tips about how to handle them?

Dr. VanDercar: First, you need to know what type of subpoena you received *(Editor's note: see "Things to Consider When You Receive a Subpoena" table on page 8)*. Typically, it'll be either a *subpoena ad testificandum* (a subpoena to testify) or a *subpoena duces tecum* (a subpoena to provide documents). The two can come together, where you'll be subpoenaed to testify and bring your records with you. Attorneys sometimes waive the obligation to testify if the records are sent ahead of time. Second, you need to think about how to balance any legal duties you might have for disclosure and your obligations to maintain confidentiality of protected health information (Mossman D, *Current Psychiatry* 2015;14(12):33–36). If you're a clinician on an inpatient psychiatric unit, you have people who are trained to deal with this issue. Specifically, you have a hospital attorney. Whether you are at a hospital or elsewhere, you also have your malpractice carrier. Make good use of these resources. Subpoenas can be tricky.

CHPR: Why are they tricky?

Dr. VanDercar: If you aren't familiar with dealing with them, it's easy to make a mistake. When you receive a subpoena, ask yourself: Why did I get this? Often, physicians' minds go to the thought that they might be getting a subpoena because of an impending lawsuit—for instance, there might already be a malpractice lawsuit and the attorneys are considering adding the physician as a co-defendant. But you might just be getting a subpoena because one of your patients is filing for disability, or they might be suing a third party for psychological damages and they want your records to substantiate their claim. Next, determine if the subpoena is valid. It might be from an attorney who is overreaching, either because they are asking you to appear in a jurisdiction you don't have to go to or because they are requesting things they can't ask for. If an attorney is issuing the subpoena, seeking your records, they are primarily concerned with obtaining the documents. You, however, need to be concerned with whether you can legally release the records without violating your legal duties to protect patient confidentiality.

> **"When you receive a subpoena, you need to think about how to balance any legal duties you might have for disclosure and your obligations to maintain confidentiality of protected health information."**
>
> Ashley H. VanDercar, MD, JD

CHPR: How do you know if a subpoena is valid?

Dr. VanDercar: Get advice from the legal department at your hospital and/or your malpractice carrier. They will look at who signed the subpoena, whether that person can legally issue subpoenas in your jurisdiction (particularly if they are across state lines), and whether they can request the documents that they are asking for.

CHPR: So, if the subpoena is valid, is it safe for us to release records?

Dr. VanDercar: Being valid is the first step, but not the only step. A valid subpoena doesn't necessarily give the clinician carte blanche to disclose all the patient's records—there are exceptions and caveats. First, some states have more restrictive privacy laws than those that apply on a federal level (eg, HIPAA). Second, although it's beyond the scope of this interview, there are very important differences between clerk- or attorney-issued subpoenas, grand jury subpoenas, and administrative agency subpoenas. In many cases, if you receive a grand jury or administrative subpoena, you can release records without patient consent or notice, though it is important that you only release exactly what is requested. The same is true if you receive a judge- or magistrate-signed order to release records; in that case, it is a court order, but you again need to limit your disclosure to that which is requested. For a clerk- or attorney-issued subpoena, before releasing subpoenaed records, there are additional things that you need to look into. Specifically, you need to check that the patient has either consented to the release of the records or been notified and given an opportunity to object. There are additional considerations with psychotherapy notes and certain types of substance use treatment centers. Again, consult your legal department.

CHPR: How will we know if the patient has consented to the release or been given an opportunity to object?

Dr. VanDercar: Sometimes a subpoena will be accompanied by a signed patient release. Check to make sure it is HIPAA compliant and adequately authorizes the release of the requested records. Alternatively, the subpoena might be accompanied by a statement that the patient has been given adequate notice to object and has not done so. If neither of

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Expert Interview – A Primer for Psychiatrists on Subpoenas

Continued from page 7

these things accompany the subpoena, you can obtain a release yourself, or you can formally notify the patient about the request, giving them an opportunity to contest the disclosure of their records if they choose.

CHPR: What do you do if the patient does not agree to the disclosure of their records?

Dr. VanDercar: In those cases, the patient's attorney can try to have the subpoena quashed. But if a judge denies the motion and orders the release of the records, then you will need to turn over the requested documents. As clinicians we have a duty of confidentiality, but in the end we must obey the law and court orders.

CHPR: Thank you for your time, Dr. VanDercar.

Disclaimer: The information in the table and the interview transcript is for educational purposes only. It should not be construed as, and does not constitute, legal advice.

Things to Consider When You Receive a Subpoena

Question	Considerations
What type of subpoena is it?	*Subpoena ad testificandum:* A subpoena to testify. *Subpoena duces tecum:* A subpoena to produce documents.
Why did I receive the subpoena?	My patient is seeking disability benefits. My patient is involved in a legal case and my records are being sought as evidence for one side or the other. I'm about to be sued.
Is the subpoena valid?	Does the person who signed it have the authority to subpoena that which they are requesting, and do they have jurisdiction over me? If the answer is yes to both questions, the subpoena is most likely valid.
Can I release the records requested in the subpoena?	Most likely yes, if any of these criteria are met: • The patient authorized their release using a HIPAA-compliant form, with specific authorization for the records being released • The patient was given a legally adequate opportunity to object to the release of the records and chose not to • There is a valid court order requiring the release of these specific records Under certain circumstances, records can still be released without meeting any of the above criteria. For example, consent and notice are often unnecessary when responding to administrative or grand jury subpoenas.

Source: www.tinyurl.com/ydu4vpwt

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QT Intervals in Psychiatric Practice

Continued from page 6

vortioxetine) are too sparse to draw conclusions on QT prolongation risks.

Antipsychotics

All antipsychotics increase the QTc, but low-potency first-generation drugs, particularly thioridazine, appear most prone. IV haloperidol has been associated with TdP, and the FDA recommends cardiac monitoring during administration. Ziprasidone produces the most clinically significant QT prolongation among the second-generation agents. There is an FDA warning for quetiapine, though QT prolongation is modest even at 750 mg daily. Asenapine, brexpiprazole, clozapine, lurasidone, olanzapine, paliperidone, and risperidone do not appear to cause clinically significant QT prolongation, and aripiprazole's effects on the QT interval are minimal.

Mood stabilizers

Lithium can impact the QTc significantly when levels exceed 1.2 mEq/L or in the context of hypokalemia. Carbamazepine, lamotrigine, and valproate do not cause QT prolongation.

Anxiolytics

Benzodiazepines and buspirone have little effect on the QTc interval.

Stimulants

Amphetamines and methylphenidates do not produce clinically significant effects on the QTc interval in most cases. However, be cautious when using these agents for patients with suspected heart disease.

Others

Buprenorphine confers less risk than methadone and should be used for patients with QTc >450 ms. Methadone should not be initiated until risk factors for QT prolongation are evaluated and addressed (eg, hypokalemia), and ECGs should be obtained at baseline and periodically, especially for daily doses above 120 mg (Martin JA et al, *J Addict Dis* 2011;30(4):283–306). Be cautious when using diphenhydramine and hydroxyzine as they are often co-prescribed with other QT-prolonging medications—the use of two or more QT-prolonging medications greatly increases the risk of QT interval prolongation.

CARLAT VERDICT

Most patients can safely take psychiatric medications with little worry about QT prolongation. Whenever possible, avoid the combined use of QT-prolonging medications, and be careful with certain patients, especially those older than 65 or with heart disease or electrolyte imbalances. Monitor ECG and electrolytes regularly after prescribing citalopram >40 mg (>20 mg for patients over age 60), IV haloperidol, methadone, thioridazine, or ziprasidone; and for any patients with new-onset syncope, palpitations, or dizziness.

Who's Who? A Review of Delusional Misidentification Syndromes

Adrienne Grzenda, MD. Clinical Assistant Professor of Psychiatry & Biobehavioral Sciences, UCLA David Geffen School of Medicine and Olive View UCLA Medical Center, Los Angeles, CA.

Dr. Grzenda, author for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.

Your new patient is a 30-year-old male with schizophrenia, disorganized type. His mother comes to the unit to visit, but he refuses to meet with her. He tells staff that the woman looks and sounds like his mother but is an impostor. His mother visits again two days later, and he demands that staff not allow her on the unit, saying "That lady is trying to trick me, but I don't know who she is, and I don't want her visiting anymore!"

Patients with delusional misidentification syndromes (DMS) are some of the most fascinating patients you'll treat in your career. These syndromes are defined as psychotic phenomena involving a mistaken belief that a familiar person or object has been replaced or transformed. While not specifically mentioned in the DSM-5, they are usually categorized as delusional disorders. In this article we will review these perplexing conditions, including their workup and management.

Types of DMS

Capgras syndrome and variants

The most common and best-characterized form of delusional misidentification is Capgras syndrome, where individuals believe that their loved ones have been replaced by identical-looking impostors. The delusion was named after Joseph Capgras, a French psychiatrist who described the syndrome in a study he published in 1923.

Capgras syndrome appears most frequently with psychotic illnesses (56%), but dementias, delirium, traumatic brain injuries, and other medical conditions account for a large proportion (43%; Pandis C et al, *Psychopathology* 2019;52(3):161–173). When the underlying illness is a psychiatric disorder, patients tend to be younger at syndrome onset and predominantly female. They experience higher rates of paranoia, mood symptoms, auditory hallucinations, and aggression, and the impostor is typically a parent. In contrast, when the underlying illness is dementia, delirium, or another medical condition, patients tend to be older and report more visual hallucinations, and the impostor is typically the spouse or an inanimate object. An unusual variation of Capgras is subjective Capgras syndrome, in which patients believe that doppelgängers or doubles of themselves exist and act independently (see "Primary DMS and Subtypes" table).

Fregoli syndrome and variants

Fregoli syndrome is the opposite of Capgras syndrome. Instead of believing family members are strangers, patients with Fregoli syndrome believe that strangers they meet are familiar people in disguise, like a spouse or friend, typically with the intention of persecuting them. A variant is intermetamorphosis, in which the individual believes that familiar people and strangers swap identities while maintaining their original appearances. Alternatively, the individual may believe that people cannot recognize them (reverse Fregoli syndrome).

Others

Truman Show delusion. In this delusion—named after the 1998 movie—a person believes that their entire life is a staged reality show that is broadcast for others' entertainment. For a fascinating description of an example, listen to the *This American Life* podcast episode called "Seeing Yourself in the Wild" (www.thisamericanlife.org/677/transcript).

Cotard syndrome. People with Cotard syndrome believe they are dead or that parts of their body are missing or putrefied.

Prevalence

Estimates of the prevalence of DMS vary widely, largely due to inconsistent syndrome definitions and sparse research, but Capgras syndrome is by far the most frequent presentation, followed by Fregoli syndrome. Overall, about 14% of patients with psychiatric diagnoses experience Capgras syndrome, but the rate ranges from 8% to 50% depending on the underlying diagnosis. The risk is highest among individuals with schizophreniform and brief psychotic disorders (Salvatore P et al, *Psychopathology* 2014;47(4):261–269).

What causes DMS?

We don't understand the pathology underlying these syndromes in most patients. However, in cases where patients have underlying brain lesions, these lesions typically occur in the bifrontal and right hemispheric areas of the brain (Darby R et al, *J Neuropsychiatry*

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Primary DMS and Subtypes

Syndrome/Subtype	Features
Capgras syndrome	The patient believes that a spouse, family member, or other familiar individual has been replaced by a physically identical impostor
Reverse Capgras syndrome	A variant of Capgras syndrome in which the patient believes that they themselves are the impostor (often a famous or admired figure)
Subjective Capgras syndrome (subjective doubles)	A variant of Capgras syndrome in which the patient believes that they have a double (doppelgänger) who acts independently
Fregoli syndrome	The patient believes that strangers are familiar people in disguise
Reverse Fregoli syndrome	A variant of Fregoli syndrome in which the patient believes that others do not recognize them
Intermetamorphosis	A variant of Fregoli syndrome in which the patient believes that familiar people and strangers in the environment have exchanged identities while maintaining their original physical appearance; in reverse intermetamorphosis, the patient believes that they themselves have been transformed

Continued from page 9

Clin Neurosci 2016;28(3):217–222). Impaired connectivity between the temporal lobe regions involved in identifying faces and objects, and the limbic system areas that control emotions and beliefs, may contribute to these syndromes as well (Coltheart M et al, *Annu Rev Psychol* 2011;62:271–298). The individual can identify someone or something but cannot attach the appropriate emotional reaction. The familiar face no longer "feels right," leading to the conclusion that the person or object must be an impostor. Genetic vulnerability contributes to the risk, given that 50% of patients with these syndromes have a family history of psychosis (Kimura S, *Biblioteca Psychiatric* 1986;(164):121–130).

Assessment and management

As with any unusual presentation of psychosis, we should first do a standard workup to rule out medical or neurological causes. However, in most cases, the underlying issue is a primary psychotic disorder.

In your interviews with these patients, make sure to ask focused questions about whether they are thinking about harming others. About 60% of patients with these syndromes have physically attacked someone in relation to the misidentification (Silva JA et al, *Psychopathology* 1994;27(3-5):215–219). Anger and delusions involving persecution, spying, and conspiracy are especially associated with violence. On the other hand, Cotard syndrome is associated more with a risk of suicide than homicidal urges (Bott N et al, *Front Psychol* 2016;7:1351).

Treatment usually involves antipsychotics, and clozapine is particularly effective even when the underlying etiology is neurological. One review described remission rates of 60%–70% with antipsychotics in general (Pandis et al, 2019), but there have been few high-quality studies of treatment outcomes. If there is underlying depression or bipolar disorder, add antidepressants or mood stabilizers as needed. Case reports have described successful treatment with electroconvulsive therapy and cognitive behavioral therapy. However, many patients' delusions remain fixed despite multiple trials of medications and other interventions. We don't know why some patients improve with treatment while others don't.

Your patient agrees to start clozapine and reaches a dose of 300 mg daily. After two weeks on this dose, his mother visits again, and she is delighted to hear her son greet her with "Hi, Mom! I missed you."

CARLAT VERDICT

Capgras syndrome, the belief that a loved one has been replaced by an impostor, is the most common delusional misidentification syndrome, but you might encounter several other subtypes. They occur among patients with psychiatric as well as neurologic and medical conditions, so be sure to complete a thorough workup. Clozapine appears helpful even when the underlying cause is neurological.

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Research Update IN PSYCHIATRY

SMOKING CESSATION

Smoking Cessation Intervention for Hospitalized Patients

Richard Moldawsky, MD. Dr. Moldawsky, author for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.

REVIEW OF: Brown RA et al, *JAMA Psychiatry* 2021;78(8):839–847

STUDY TYPE: Randomized clinical trial

Adults with serious mental illness tend to smoke heavily and die at much younger ages than the general population. Smoking is forbidden in psychiatric hospitals, so patients become abstinent during their inpatient stays and usually manage their withdrawal symptoms with nicotine replacement therapy (NRT). However, most patients resume smoking soon after discharge.

The authors of this study reasoned that the forced abstinence during patients' hospital stays could jump-start efforts to promote smoking cessation after discharge. They compared usual care, consisting of NRT patches and smoking cessation information, with a systematic approach called sustained care. Its main components were 1) a motivational interviewing session, 2) free access to cessation counseling after discharge (phone, text, or web-based), 3) telephone counseling for three months, and 4) free NRT patches.

This NIMH-funded study took place in a private psychiatric hospital in Austin, Texas. Adults who smoked more than five cigarettes a day were randomized to usual care (n=173) or sustained care (n=169). All subjects smoked an average of 17 cigarettes per day at baseline. The most common discharge diagnoses were depression, substance-related disorders, bipolar disorder, and schizophrenia. Hospital length of stay averaged six days. Two-thirds of subjects were economically disadvantaged (defined as household annual income <$25,000)—a factor that, in addition to serious mental illness, contributes to low rates of success in achieving smoking cessation.

The main outcome measure was smoking abstinence for the past seven days, verified by salivary cotinine analysis. Since the use of nicotine products results in elevated cotinine levels, exhaled carbon monoxide was measured in subjects who reported recent NRT use. Subjects were followed at one, three, and six months post-discharge and their use of smoking cessation

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Learning Objectives (LO) are listed on page 1.

1. Which second-generation antipsychotic produces the most clinically significant QT prolongation (LO #1)?
   [ ] a. Asenapine [ ] b. Lurasidone [ ] c. Ziprasidone [ ] d. Olanzapine

2. According to a 2017 study conducted in the UK penal system, what effect did psychological interventions have on rates of sexual re-offense (LO #2)?
   [ ] a. Increased rates
   [ ] b. Decreased rates
   [ ] c. Eliminated sexual re-offense entirely
   [ ] d. No effect

3. According to Dr. VanDercar, if a judge denies a patient's motion to quash a subpoena and orders the release of the patient's records, the provider is not required to turn over the requested documents (LO #3).
   [ ] a. True [ ] b. False

4. In a 2021 study on smoking cessation among patients with serious mental illness, what was a primary component of the sustained care smoking cessation approach (LO #4)?
   [ ] a. NRT patches only
   [ ] b. Smoking cessation information and pharmacotherapies
   [ ] c. Free motivational counseling via phone, text, or web
   [ ] d. In-person counseling for one week and NRT patches for three months

5. What type of patients are at the highest risk of QT prolongation (LO #1)?
   [ ] a. Patients over the age of 45
   [ ] b. Male patients
   [ ] c. Patients with a history of heart disease
   [ ] d. Women with QTc intervals of less than 450 ms

6. Which of the following is true regarding delusional misidentification syndromes (LO #2)?
   [ ] a. Cotard syndrome is associated more with a risk of suicide than homicidal urges
   [ ] b. About 10% of patients have physically attacked someone they misidentified
   [ ] c. Clozapine is an ineffective treatment, especially when the underlying cause is neurological
   [ ] d. Fregoli syndrome is the most frequent presentation followed by Capgras syndrome

7. According to Dr. VanDercar, which type of subpoena requires a clinician to make sure the patient has consented to or been notified about the release of their records (LO #3)?
   [ ] a. Grand jury subpoenas
   [ ] b. Clerk-/attorney-issued subpoenas
   [ ] c. Administrative subpoenas
   [ ] d. No subpoenas require patient consent for record release

8. According to a 2021 study on smoking cessation, in addition to serious mental illness, which factor is associated with low rates of success when attempting to quit smoking (LO #4)?
   [ ] a. Length of hospital stay
   [ ] b. Number of cigarettes smoked per day
   [ ] c. Household income <$25,000
   [ ] d. Type of nicotine replacement therapy (NRT)

Research Update

Continued from page 10

treatments (eg, counseling, NRT, bupropion, varenicline) was recorded.

The sustained care group was significantly more likely to be abstinent than the usual care group at six months (8.9% and 3.5%, respectively; p=0.01). The sustained care group was also significantly more likely (75% vs 41%; p=<0.001) to use smoking cessation treatments in the six months following discharge.

CARLAT TAKE

This intervention shows that adults with serious mental illness can be successfully engaged in smoking cessation treatment following hospital discharge. Though only a small proportion of patients receiving sustained care achieved abstinence, it was substantially higher than the proportion of patients who did not participate in the post-discharge program. Given the significantly shorter life expectancy of patients who smoke, such a program deserves wider application.

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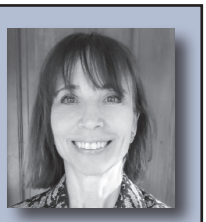
Note From the Editor-in-Chief



In our previous July/August/September issue, we shared information about 988, the new three-digit national suicide prevention lifeline number. Now there's another new hotline: The National Maternal Mental Health Hotline launched on Mother's Day and provides free, confidential counseling 24/7 for expecting and new mothers. The number is 1-833-9-HELP4MOMS (1-833-943-5746). Callers speak or text with trained crisis workers who speak English and Spanish and can obtain translation services for more than 60 other languages. Individuals who contact this hotline also receive referrals to local resources, like support groups and mental health clinics. It's encouraging to see a new, free, and easily accessible counseling resource for pregnant and postpartum mothers—a group that, despite its high need for mental health services, often lacks access to care.

Sincerely,
Victoria Hendrick, MD
vhendric@ucla.edu

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