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Emerging Technologies in Hospital Psychiatry

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Transforming Psychiatric Documentation: The Rise of AI Scribes

Patrick Buckley, MD, MBA. Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA.

Dr. Buckley has no financial relationships with companies related to this material.

If you're like many busy inpatient psychiatrists, clinical documentation often competes with direct patient care for your time and energy. This burden is real and contributes to high burnout rates in psychiatry (Tai-Seale M et al, *J Am Med Inform Assoc* 2023;30(10):1665–1672). Fortunately, new tools are emerging to help. Artificial intelligence (AI) scribes can streamline your documentation, but it's important to understand both their benefits and their potential pitfalls before integrating them into your workflow.

What are AI scribes?

AI scribes automatically generate structured clinical documentation from recorded patient interviews. Unlike basic dictation that transcribes speech word for word, these tools use AI to summarize a clinical interview into a coherent note. If you want a deeper dive into how this works, a recent review in *Current Psychiatry Reports* offers a helpful overview for mental health clinicians (King DR et al, *Curr Psychiatry Rep* 2023;25(12):839–846).

Although there are many commercially available AI scribes, they all follow a similar process (Buckley P et al, *Focus* 2025;23(1):44–48). After obtaining patient consent, you activate the scribe on your smartphone or computer at the start of your interview. The scribe records the

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Q&A With the Expert

Beyond Meds: TMS in Acute Psychiatric Care
Nicholas Trapp, MD, MS

Assistant Professor of Psychiatry; Director, Electroconvulsive Therapy Services, University of Iowa Health Care, Iowa City, IA.

Dr. Trapp has no financial relationships with companies related to this material.

CHPR: Dr. Trapp, please start with a quick overview of transcranial magnetic stimulation (TMS).

Dr. Trapp: Sure. TMS is a form of noninvasive brain stimulation that allows us to activate different regions of the brain. It's pretty much what the name suggests—"transcranial" meaning it goes across the skull and into the brain without surgery, and "magnetic" in that it uses pulsed electromagnetic energy to influence brain activity. When these magnetic pulses hit the brain repeatedly, the neurons respond by generating electrical signals. So, in a way, we're tapping into the brain's natural electrical system to modulate activity using an external device. Depending on the size of coil used, we can target areas as small as a quarter or much larger regions. TMS is most commonly used to treat depression, but it's also FDA cleared for OCD, migraine headaches, smoking cessation, and major depressive disorder with anxious distress.

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Expert Interview – Beyond Meds: TMS in Acute Psychiatric Care

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CHPR: Who qualifies for TMS, and has that changed over time?

Dr. Trapp: That's evolved a lot. TMS was first FDA cleared in 2008 for adults with major depressive disorder who had failed just one antidepressant. The clearance was pretty narrowly defined. Since then, FDA labeling has broadened to include more treatment-resistant forms of depression. In practice, insurance companies often require patients to fail several medications before covering TMS. TMS can be used alongside medications or on its own, and it is also being explored for maintenance. So, it's become more flexible and accessible.

CHPR: How does TMS translate to the inpatient setting? Would patients with treatment-resistant depression be the best candidates?

Dr. Trapp: Yes, exactly. That's been the most common indication. What's neat about TMS is that it's really just a tool for interacting with the brain. You can use it diagnostically with single pulses to test circuits, like stimulating the motor cortex to see motor-evoked potentials in the hand. But when we apply repetitive stimulation, we can modulate brain activity for therapeutic purposes. The most reliable antidepressant effects come from targeting the left prefrontal cortex.

CHPR: How does the response to TMS compare to antidepressants or ECT?

Dr. Trapp: That's still being actively studied. There aren't many large head-to-head trials, but one important study—the ASCERTAIN-TRD trial—looked at depressed patients who had failed medication to compare the benefits of switching to a new antidepressant, augmenting with aripiprazole, or starting TMS (Papakostas GI et al, *Mol Psychiatry* 2024;29(8):2287–2295). TMS outperformed switching meds and did about as well, maybe slightly better, than augmentation. So, in many clinicians' minds, TMS is moving up the treatment algorithm, especially for people with treatment-resistant depression.

CHPR: Are you seeing TMS used more on inpatient units?

Dr. Trapp: Honestly, it's still tough to pull off. Insurance coverage and logistics are big hurdles. We've done it in some cases using the standard outpatient protocol of one session per day. But the response is slow—it often takes two to four weeks or more—so we might start TMS in the hospital and finish it outpatient. That could all change with accelerated protocols. The best known is Stanford's SAINT protocol: 10 short sessions a day for 5 days (Cole EJ et al, *Am J Psychiatry* 2020;177(8):716–726). The median time to response was two or three days. But logistics are still challenging. Do you bring a TMS machine onto the unit for occasional use? Do you escort patients off the ward multiple times a day for treatment? How do you work TMS around inpatient unit activities such as group therapy, meals, rounds, and medication administrations? Any solution requires close coordination and scheduling with nursing and other inpatient teams. So while interest is growing, inpatient TMS isn't routine yet.

CHPR: And how long is a typical TMS treatment course, aside from the accelerated protocols?

Dr. Trapp: Standard TMS is five sessions a week for six to seven weeks. Some programs taper at the end. SAINT condenses 50 sessions into 5 days. We're seeing exploration of even more compact options, like 20 sessions in a single day, but those data are not published in a peer-reviewed form yet. Some patients prefer the gradual approach, taking just a bit of time each day; others want to get it done fast, especially if they're from out of town or very ill. So far, the safety profile looks similar across protocols.

CHPR: How long is each individual session?

Dr. Trapp: With the theta burst protocol, which is the fastest one, a session takes about three minutes. The SAINT protocol uses a modified version that takes about 10 minutes per session. Older protocols can take 20–40 minutes.

CHPR: What side effects should we be aware of, especially with accelerated protocols?

Dr. Trapp: TMS is generally well tolerated. The main side effects are headache and scalp discomfort. Some people get jaw pain if facial muscles are activated. Lightheadedness or, rarely, fainting can occur. The most serious risk is seizure, but it's extremely rare. For most patients, the risk is estimated to be about 1 in 30,000. It may be higher in higher-risk populations, like patients with underlying seizure disorders or other risk factors, but it's still very rare, maybe 1% incidence. Risk factors include things like seizure disorders, moderate or severe traumatic brain injury, alcohol withdrawal, or severe sleep deprivation. But with proper precautions, it's very safe.

CHPR: So aside from patients at risk for seizures, are there other groups we should be especially cautious with?

Dr. Trapp: Even seizure disorders aren't an absolute

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Expert Interview – Beyond Meds: TMS in Acute Psychiatric Care

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contraindication. You can still do TMS safely in some of those patients, but you have to take appropriate precautions. The biggest absolute contraindication is having ferromagnetic material in the head or neck, because TMS induces a powerful magnetic field, about the strength of a 1.5 Tesla MRI. It can deactivate your badge or your credit card if you hold it too close to the coil. And if there's magnetic material inside the body, the magnet can pull it, push it, or even heat it up, which is obviously dangerous. That said, most modern surgical implants are non-ferromagnetic, like titanium. But cochlear implants are a concern because they have coiled wires that could interact with the magnetic field. A 2021 study in *Journal of Clinical Neurophysiology* showed that anything within 10 centimeters of the coil could be at risk, but beyond that is usually fine (Rossi S et al, *Clinical Neurophysiology* 2021;132(1):269–306). If someone has a pacemaker or deep brain stimulator, we always consult with the device manufacturer or surgeon.

CHPR: Can TMS induce mania?

Dr. Trapp: Yes, but it's rare. When it happens, it's usually in people with undiagnosed bipolar disorder. Some people don't realize they have bipolar disorder until they have a manic episode during treatment. The rate of spontaneous mania in the general population is similar to that induced by TMS, but it's something we monitor closely. If it occurs, we usually stop treatment.

CHPR: You mentioned earlier that the coil size can vary. Is there a reason to use different-sized coils?

Dr. Trapp: Yes. Some coils are designed to stimulate a broad area, and others are more focused and precise. Coils with broader and deeper electric fields may help ensure we don't "miss the target," but they also lack the precision to focally stimulate specific brain networks. We still don't know how important it is to be focal and precise with our stimulation, and there's still debate about the best targeting strategy. However, both "deep" TMS coils and more superficial and focal coils seem to be effective at inducing an antidepressant effect.

CHPR: And how receptive are patients to TMS?

Dr. Trapp: I'd say they are very receptive overall. TMS doesn't have systemic side effects and doesn't involve medications or implants. People who've had bad experiences with meds often like the idea of a noninvasive option. Some are nervous at first. They'll ask questions such as "Will it change my personality?" or "Is it going to mess with my brain?" But usually once they see how it works, try it out, or talk to someone who has had treatment, they feel reassured.

"People who've had bad experiences with meds often like the idea of a noninvasive option. Some are nervous at first. They'll ask questions such as "Will it change my personality?" or "Is it going to mess with my brain?" But usually once they see how it works, try it out, or talk to someone who has had treatment, they feel reassured."

Nicholas Trapp, MD, MS

CHPR: And what about relapse rates once they've completed the course of treatment?

Dr. Trapp: That's one of the big challenges. There's no FDA-cleared maintenance protocol yet, so most people do an acute course and then wait and see how long benefits last. About 50% relapse within a year. Some need another course at 6 or 12 months (Senova S et al, *Brain Stimul* 2019;12(1):119–128). This suggests potentially greater durability with TMS compared to something like ECT, assuming no maintenance is available for either. However, with maintenance treatment, relapse rates drop significantly for ECT, and you would imagine the same holds true for TMS. This needs to be studied in more detail. The good news is that if TMS worked for someone once, their chances of responding again are high—around 80% (Kelly MS et al, *J Neuropsychiatry Clin Neurosci* 2017;29(2):179–182). We do talk about maintenance TMS with some patients, but there's no agreed-upon frequency yet. Weekly? Monthly? We need more data. Most insurers don't cover maintenance TMS, and we're forced to wait until symptoms return to consider another treatment course.

CHPR: Do you try to taper off benzodiazepines, like we often do with ECT?

Dr. Trapp: Not typically. Some retrospective data suggest benzodiazepines might blunt TMS response, so some providers use that as a reason to taper or stop them. And while we don't have strong prospective data yet to prove that, there's also a solid theoretical rationale. If TMS works by enhancing neuroplasticity, increasing synaptic density, or modulating cortical excitability, benzodiazepines can potentially dampen all of those mechanisms. So, in practice, we do talk to patients about it, especially if they're not responding as well as expected or if reducing benzodiazepines is a good idea for other reasons. In those cases, we might suggest trying to taper down or discontinue the benzodiazepine, if it's safe and appropriate. But again, we need more data to definitively support those management decisions.

CHPR: Are there patient populations who respond better than others to TMS?

Dr. Trapp: People with long-standing or severe treatment resistance are less likely to respond. TMS studies in adolescents have been mixed, but it is FDA cleared down to age 15. Geriatric patients seem to respond about as well as younger adults (Bacila CI et al, *J Clin Med* 2025;14(10):3609). TMS is currently FDA cleared up to age 86 as well, and probably only up to that age because of limited sample sizes at higher ages.

CHPR: TMS would seem like a good choice for geriatric patients since they are more susceptible to medication side effects and drug interactions.

Dr. Trapp: Yes, absolutely.

CHPR: Now that we have a better idea of which patients can benefit most from TMS, can you tell us more about the logistics involved in starting it?

Dr. Trapp: For the SAINT protocol, you need access to a functional MRI (fMRI) scanner. So first, the patient needs to get the fMRI scan, which is then uploaded to the cloud. Magnus Medical—the company that commercialized the SAINT

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protocol and owns the patent on the software—processes that scan and sends back a personalized target based on the individual's brain activity. Once we have that target, we use neuronavigation equipment to deliver TMS precisely to that spot. With standard TMS, we usually rely on a scalp-based targeting method, which is simpler and cheaper but less personalized. Whether the fMRI-guided targeting actually improves outcomes is still being studied, but early data are promising. If it turns out to make a big difference, that's great—we'll have a more precise, imaging-based way to deliver treatment. But if it doesn't add much, it may just be slowing things down and adding complexity and cost without significant benefit. Access to an MRI scanner capable of doing resting-state functional imaging often means involving radiology departments with the right expertise, so it's not something every hospital can do yet.

CHPR: There's more to it than I'd realized.

Dr. Trapp: Definitely. Another key piece is the financial logistics. The SAINT protocol is the first TMS protocol to receive a "new technology add-on payment" designation for inpatient use, which helps cover the extra resources needed. But here's a wrinkle: This designation comes from the Centers for Medicare and Medicaid Services, and it only applies to inpatient units that are classified as part of a general medical facility. There's now active advocacy underway to change this, because it severely limits access to the protocol outside of select hospitals. And it highlights a bigger issue in psychiatry—we don't have many treatments, besides ECT, that involve this level of technological complexity and coordination. Administering such treatments requires a reimbursement and practice infrastructure that goes beyond meds or therapy, and changing medical practice in such a radical way can be very difficult. So figuring out how to navigate reimbursement and logistics is a key part of making TMS and other device-based treatments more widely available.

CHPR: Is there anything else we should know about TMS?

Dr. Trapp: Staffing and training is an overlooked piece. TMS is usually delivered by a technician who completes a certification program, who is supervised by a physician. This certification program is hospital based, not nationally standardized. It's similar to how ECT staff are credentialed. Several people around the country, including myself, are working on developing training standards for clinicians and technicians. We're also creating a credentialing process for brain stimulation fellowships, which would offer more formalized training paths for psychiatrists, neurologists, or neurosurgeons interested in this area to augment and expand upon their training. There's a lot of new technology coming—not just TMS and ECT, but also focused ultrasound, transcranial electrical stimulation, new minimally invasive forms of brain stimulation, and more. Most of us didn't learn much about these interventions in residency, though that's starting to change. I think in the future, we'll see more fellowship-trained brain stimulation specialists. It may not be required to deliver TMS, but especially for the newer, more advanced treatments, it'll be a valuable path forward.

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

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Transforming Psychiatric Documentation: The Rise of AI Scribes

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conversation, converts the audio to text, analyzes it, and generates a draft note in standard SOAP (Subjective, Objective, Assessment, Plan) format. You then review and edit the note for accuracy and completeness before signing off.

What can AI scribes do?

AI scribes have advanced quickly, and features that once sounded aspirational are already part of some tools. Many systems now pull data directly from the chart, including medication lists, problem lists, and labs. Others let you upload or select templates and can learn from your edits, gradually adapting to your phrasing and structure. And because many AI scribes are embedded within major electronic health records (EHRs), you can activate the scribe, review drafts, and finalize notes without leaving the chart. These capabilities vary by platform and health system, but they're becoming more common in everyday practice.

How can AI scribes help inpatient psychiatrists?

1. **Save time.** A large rollout at Permanente Medical Group found that clinicians using AI scribes spent significantly less time on documentation after work (Tierney AA et al, *NEJM Catal Innov Care Deliv* 2025;6(5):0040). I've found that using an AI scribe saves me about 20 minutes on each initial evaluation, which amounts to significant time savings over the course of a busy week.

2. **Strengthen rapport.** When you no longer need to look down at a keyboard or notebook, you can maintain better eye contact and active listening. Verbalizing your thought process out loud for the scribe can also help patients understand your reasoning in real time.

3. **Support billing.** Well-structured notes help coders verify the complexity of medical decision making and the need for inpatient care, which can in turn reduce denials and audit risk.

4. **Reduce burnout.** A big part of burnout comes from the mental juggling act of managing complex patient data while needing to produce detailed notes. AI scribes lighten that cognitive load considerably (Hudson TJ et al, *Mayo Clin Proc Digit Health* 2025;3(1):100193).

Challenges and risks to consider

AI scribes are promising, but like any technology, they have drawbacks and risks that must be taken into account.

Accuracy

AI scribes can mischaracterize parts of a psychiatric interview, especially subtle cues like changes in tone, hesitations, or culturally influenced expressions of distress. They may also miss the context

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behind a patient's words. For example, a statement like "I sometimes wonder if life is worth it" could be mis-summarized as active suicidal ideation. In addition, scribes can introduce factual errors or outright "hallucinations," ie, plausible sounding but incorrect (or completely nonsensical) statements.

Bias

Because AI systems reflect their training data, accuracy may be lower for patients underrepresented in those data, including non-native English speakers and some patients with psychosis.

Privacy and medicolegal concerns

Knowing that their sensitive psychiatric conversations are being recorded may inhibit some patients from speaking freely. You must verify that your AI scribe is compliant with federal and state regulatory standards, including HIPAA. It is also important to clarify how patient recordings are stored, whether they are considered part of the medical record, and when they are deleted. In addition, confirm that AI scribes are permitted within your institution—some hospitals currently allow AI documentation only for medical services, not psychiatry. The American Psychiatric Association provides a resource containing key privacy and regulatory compliance questions to ask potential AI scribe vendors, along with responses on the topic from several companies (www.tinyurl.com/48ft733h).

Cost

AI scribes aren't cheap. Most companies charge a monthly subscription, usually somewhere between $100 and $400 per clinician. That can be a significant expense for smaller practices. Bigger hospitals sometimes negotiate lower prices because they buy many licenses at once. A few products also need specific devices or extra setup, which can add to the cost.

Training and onboarding

Getting comfortable with a new tool takes time. Users require training on how to use the AI scribe, review drafts efficiently, and troubleshoot common issues, like handling transcription gaps and correcting formatting issues.

Practical implementation tips for AI scribes in inpatient psychiatry

Successful use of AI scribes hinges on more than having the right software. Keep these practical considerations in mind as you implement AI scribes on your unit.

1. **Obtain explicit consent.** Explain the purpose of the scribe, how recordings are stored, and how patient data are protected. Confirm that the patient agrees to the tool's use before you activate it. Let patients know they are free to opt out at any time, in which case you turn off the scribe and revert to conventional documentation. Here is an example script you can use to obtain consent: "I use an artificial intelligence scribe so I can focus on our conversation instead of typing. It securely records our discussion to help me document your visit. The tool is HIPAA compliant, and recordings are later deleted. Do I have your permission to use it?"
2. **Use structured verbal cues.** Signal shifts in topics to help the scribe organize content under the right headings. For instance, you might say, "Let's discuss your family history" or "Now I'd like to review your medications and any side effects" to signal a transition to the medication section. These verbal signposts help ensure the scribe groups information correctly.
3. **Summarize key points aloud.** Periodic recaps not only reinforce understanding for the patient but also highlight essential details for the scribe to capture.
4. **Review drafts carefully.** Look for inaccuracies or mischaracterizations, which can be subtle. The scribe is just a tool, and you are still responsible for your documentation.
5. **Collaborate with IT.** Early discussions with your hospital's IT team can clarify institutional policies on AI use, how data storage functions, what AI tools are available, and what new AI features might be coming soon.
6. **Start with low-stakes interviews.** Begin using the scribe with routine follow-ups, rather than high-complexity cases, until you're more confident in the use of the tool and the quality of its output.

Emerging trends and the future of AI in inpatient psychiatry

In my experience, AI scribes have already become noticeably more accurate and useful since I started using them two years ago. As these tools continue to learn from psychiatric interviews and clinician feedback, they will capture subtle details and nuances more reliably across different patient populations. Future versions will get even better at matching your personal style, preferred phrasing, and note structure rather than relying mainly on templates.

Beyond drafting notes, AI is likely to take on other routine tasks on inpatient units. You may soon see automatic discharge summaries that pull key details from the chart, saving you the effort of weaving together multiple notes (Ganzinger M et al, *Sci Rep* 2025;15(1):16466). Decision-support tools could draw on the latest evidence to suggest treatment options based on data in the patient's record. AI coding assistants might flag missing details and help you avoid undercoding. As these tools evolve, keeping up with new features will help you use them safely and effectively. The American Psychiatric Association maintains an updated resource page on Artificial Intelligence in Psychiatric Care that can help you stay current (www.tinyurl.com/yz8rdpmx).

CARLAT VERDICT

AI scribes can make your documentation smoother, especially in the hectic inpatient setting where notes often spill into after-hours time. Many tools already plug into the EHR, adapt to your preferred templates, and even learn from your edits, freeing you up for more focused, patient-centered conversations instead of endless charting. They may also help reduce burnout. Just be sure to review drafts carefully—scribes can misinterpret patient statements and occasionally add errors or hallucinations. To make the scribes work well, you'll need to get clear consent from patients, use structured verbal habits during interviews, review the drafts carefully, and stay in close touch with IT to keep things running safely and smoothly.

Q&A With the Expert

AI-Assisted Therapy

Omer Liran, MD, MSHS

Co-Director, Cedars-Sinai Virtual Medicine; Assistant Professor, Department of Psychiatry & Behavioral Neurosciences; Co-Founder and CTO, Xaia, Los Angeles, CA.

Dr. Liran is co-founder of Xaia, a company that develops AI-assisted therapy and clinical documentation tools. This content has been peer-reviewed to ensure it remains balanced and educational. Relevant financial relationships have been mitigated.

CHPR: Dr. Liran, please begin by telling us a little about yourself.

Dr. Liran: I'm a psychiatrist at Cedars-Sinai Medical Center in Los Angeles, and I co-direct the medical center's Virtual Medicine lab. Our lab uses artificial intelligence (AI) and virtual reality (VR) to improve care for patients and lighten the bureaucratic load on physicians.

CHPR: What drew you to bringing these kinds of technologies to psychiatry?

Dr. Liran: I've been fascinated by AI for a long time, and especially with how VR, augmented reality (AR), and AI can be applied in health care. Psychiatry faces a worsening shortage, and we're not training enough new psychiatrists to meet demand. I believe technology has to be part of the solution.

CHPR: How can AI and VR be a solution to that problem?

Dr. Liran: We see them as ways to extend a psychiatrist's reach. The field is moving toward platforms that can assist with every stage of the patient encounter—for example, by helping with intakes through synthesizing information from the chart and from structured AI chat interactions that gather basic history before the visit. Some next-generation systems also incorporate an AI scribe or copilot during the encounter to help document the conversation *(Editor's note: See "Glossary of Terms" table on page 7)*. They can also highlight potential safety concerns and instantly pull up information you might need, like for medication side effects. And they're also evolving toward assisting with after-visit documentation, such as drafting clinical notes that include a differential, proposed treatment plan, and even coding recommendations. Taken together, these tools give psychiatrists more time to focus on their patients and boost patient and provider satisfaction.

CHPR: For clinicians who are interested in integrating AI into their work, what's the best place to start?

Dr. Liran: The easiest entry point is to use AI scribes or speech-to-text tools that many EHRs already support *(Editor's note: See article on page 1 for more on AI scribes)*. These can cut down on documentation almost immediately. Beyond that, the APA Learning Center and the Digital Medicine Society have courses on topics like generative AI in health care *(Editor's note: See "Where to Start With AI" table on page 7)*.

CHPR: Does the technology also have a direct therapeutic role for patients, beyond supporting clinicians?

Dr. Liran: Absolutely. Depending on the platform, AI tools can be used to teach skills such as relaxation training or breathing interventions. A growing area of development is longitudinal care, like programs in the style of cognitive behavioral therapy in which patients can practice skills between sessions, complete homework, then review their progress with the AI at the next session. The idea is to extend the reach of psychotherapy by supporting the skills-based components with AI while the clinician handles the relational and diagnostic parts of care.

CHPR: Are there ethical or legal issues we should be aware of?

Dr. Liran: Safety is the biggest concern. If the AI mishandles a suicidal patient, the results could be tragic. Good systems have multiple built-in safeguards, but the risk isn't zero. And there's the worry about people using general chatbots to replace therapists. Unsupervised models can just tell people what they want to hear or amplify delusions, and that can be very dangerous. If a manic patient believes they're the emperor of the world, a chatbot might just agree with that. There have been recent reports of chatbots reinforcing psychosis (Fieldhouse R, *Nature* 2025;646:18–19).

> **"Even when the technology flags a safety concern, escalation still falls on a human clinician. The AI isn't calling 911. That's also the point where human connection really matters. I don't believe AI, even when it's super-intelligent, will ever make psychiatrists obsolete, because there's something special about human connection, about people talking to each other."**
>
> Omer Liran, MD, MSHS

CHPR: How can clinicians tell whether an AI therapy tool is safe and reputable?

Dr. Liran: Look for four things: (1) Clinical oversight: Does it connect to a provider? (2) Evidence: Has it been studied? (3) Safeguards for crises, and (4) Credibility: Is it affiliated with a trusted health system or university? Those are good signs you're dealing with a responsible product.

CHPR: How do different systems out there compare to one another?

Dr. Liran: There is now a broad spectrum of digital mental health tools, ranging from unsupervised wellness chatbots like Woebot, Wysa, or Replika, to app-based structured therapy programs such as Headspace, SilverCloud, or Meru Health, and finally to clinician-integrated platforms that are designed to work alongside psychiatric care. The key distinctions *Continued on page 7*

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are safety guardrails, evidence base, and how care is escalated when symptoms worsen.

CHPR: Speaking about how care is escalated, what happens if a patient is in crisis—for example, if they are suicidal?

Dr. Liran: Some platforms already attempt to detect when a patient may be at risk and notify the clinician, and this is likely to become more sophisticated over time. But even when the technology flags a safety concern, escalation still falls on a human clinician. The AI isn't calling 911. That's also the point where human connection really matters. I don't believe AI, even when it's super-intelligent, will ever make psychiatrists obsolete, because there's something special about human connection, about people talking to each other. I'd be worried about a future where AI that only *mimics* empathy is left to care for patients on its own.

Glossary of Terms

- **Artificial intelligence (AI):** Computers that mimic aspects of human reasoning, like understanding language or spotting patterns.
- **Virtual reality (VR):** A headset-based experience that immerses patients in a fully digital environment, such as a beach or forest.
- **Augmented reality (AR):** A mix of digital and real life (eg, overlaying virtual images or text into real surroundings via a phone or glasses).
- **Scribe:** An AI assistant that listens during the visit and helps with documentation, flagging safety issues and suggesting next steps.
- **Copilot:** An AI tool that runs in the background during a clinical encounter to assist the clinician (eg, drafting notes, pulling up relevant information, or flagging safety concerns).
- **Chat/AI chat:** A structured conversation where the AI asks patients questions and records their responses, following a clinician-designed workflow.

CHPR: How have patients felt about sharing their personal details with an AI?

Dr. Liran: Survey data so far suggest that many people feel comfortable disclosing sensitive information to AI, reporting for example that they find it to be nonjudgmental and patient (Spiegel BMR et al, *NPJ Digit Med* 2024;7(1):22). Some patients do report that the tone can feel robotic or emotionally flat, which is a reminder that this isn't a substitute for human connection. But for many, especially early in treatment, that sense of psychological safety can lower the barrier to opening up.

CHPR: What are the interfaces usually like?

Dr. Liran: Many systems run on VR and AR headsets like the Quest and the Apple Vision Pro, but those are quite expensive. Mobile versions are generally much more accessible. On a phone, patients can talk with it by voice just like a conversation, or switch to text mode (which younger patients seem to prefer these days) and it looks like any other chat app.

CHPR: It's too bad the headsets are so expensive. They provide such an immersive experience.

Dr. Liran: It really is the future, but we're not quite there yet. When headsets become lighter, more comfortable, and more like glasses, people will use them more. Right now, I can't wear a headset for more than 30 minutes before it feels too heavy. And in hospital settings, especially psychiatric units, there are added concerns. You don't want to hand patients a device with cords and straps that could pose risks. So, while the technology is promising, it still has practical limitations.

CHPR: Are there certain patients whom you think AI tools are better suited for than others?

Dr. Liran: AI tends to be most helpful for patients who are stable enough to engage with structured therapeutic content. That includes many patients with anxiety disorders, mild to moderate depression, insomnia, chronic pain, or stress-related conditions. We need to be more cautious with patients who are highly dysregulated, actively psychotic, manic, or in acute crisis, where misinterpretation of language or delayed escalation could cause harm (Grabb D et al, *arXiv preprint arXiv*:2406.11852). There are also practical considerations. For example, VR headsets are not a good fit for patients who are severely agitated or behaviorally disorganized, because the hardware itself can become a safety risk. However, a non-immersive tool, such as a scribe assisting the clinician or a simple breathing or meditation module on a mobile device, may still be appropriate in those cases—as long as the clinician remains in charge of the overall course of care.

Where to Start With AI

Examples of AI Documentation/AI Speech Tools Already in Use

- EHR-embedded AI scribes (eg, Epic)
- Dictation platforms (eg, Nuance Dragon Medical One)
- Ambient scribes that transcribe visits in real time (eg, Nuance DAX, Sunoh.ai, DeepScribe)

Educational Resources

- **APA Learning Center CME:** Courses such as *AI Explained: Practical Applications for the Modern Psychiatrist* (education.psychiatry.org)
- **Digital Medicine Society:** Short course on generative AI in health care (dimesociety.org)
- **"How Artificial Intelligence Helps Doctors Focus on Their Patients":** A free video overview on how AI documentation tools work in clinical settings and reduce charting burden (www.tinyurl.com/56yybyau)
- **Artificial Intelligence and Machine Learning for Primary Care (AiM-PC):** Free curriculum relevant to psychiatrists on the fundamentals of AI and machine learning, ethical and social implications, how to critically evaluate AI tools, and practical guidance on integrating AI into clinical encounters (www.tinyurl.com/yvwmykxz)
- **Artificial Intelligence in Health Care:** Free audio and video series from the American Medical Association (www.tinyurl.com/4p5zv892)

CHPR: Where do you see this technology in five years?

Dr. Liran: The technology is accelerating extremely fast. If we had this conversation six months ago, it would be different from today. These tools will become far more capable, but also riskier. AI models have complex internal decision-making processes that we don't fully understand, with unpredictable outputs. We need strong safeguards and clinician oversight to steer them toward good.

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

Telepsychiatry in Hospital Psychiatry: From Stopgap to Standard Care

James A. Bourgeois, OD, MD. Vice Chair, Hospital Psychiatry Services; Professor of Clinical Psychiatry, University of California, Davis Medical Center, Sacramento, CA.

Dr. Bourgeois has no financial relationships with companies related to this material.

You're covering a small hospital via telepsychiatry. Police bring in a man found yelling in traffic about government surveillance. The nurse starts the video, but he won't talk and glares at the screen, saying, "I know what this is." The team isn't sure if he's refusing care or too paranoid to engage. They ask: Can you assess him like this? Should they place a hold? And how do you decide, through a screen, what meds or safety measures to use if he escalates?

Cases like this are now routine for hospital psychiatrists, especially those working remotely. Telepsychiatry has become a standard part of emergency and inpatient care, driven by workforce shortages, after-hours needs, and, not least, the COVID-19 pandemic (Gujral K et al, *Telemed J E Health* 2025;31(9):1074–1095). Here's how it works, what challenges to expect, and how to make it go smoothly.

Why hospitals are turning to telepsychiatry

For hospital psychiatrists, telepsychiatry isn't just a convenience; it's increasingly the only way to ensure timely consultation. Hospitals of every size are turning to telepsychiatry to fill widening coverage gaps. Many facilities lack in-person psychiatric services, especially after hours or in rural regions (Natafgi N et al, *Curr Psychiatry Rep* 2021;23(11):72). Smaller hospitals may have only sporadic access to general psychiatrists, who may not be current in emergency or consultation-liaison psychiatry.

Telepsychiatry helps bridge those gaps. Hospitals that have on-site coverage during the day often bring in remote psychiatrists for nights and weekends. Facilities that don't need full-time staff can access psychiatric care as needed without a permanent team. Correctional settings and state hospitals rely on telepsychiatry to manage persistent staffing shortages.

What telepsychiatry looks like in practice

Most hospital telepsychiatry uses a hybrid model. On-site nurse practitioners or physician assistants handle assessments and patient interaction, while the psychiatrist joins remotely to guide care, join rounds, and document. Thanks to modern electronic health records (EHRs), which have features like embedded video, shared notes, and secure messaging, this setup is more seamless than ever (Vakkalanka PV et al, *Telemed J E Health* 2023;29(8):1224–1232).

If you provide telepsychiatry, your role varies by setting. On medical floors or in the emergency department (ED), you usually function as a consultant, with the admitting or ED physician entering orders and implementing safety measures. However, when treatment or restraint decisions are based on your recommendations, responsibility is shared, and your documentation should clearly reflect your assessment, your rationale, and any limitations of the telepsychiatric evaluation. On an inpatient psychiatric unit, you serve as the attending psychiatrist and enter orders directly.

One legal note: You must be licensed in the patient's state and credentialed at the hospital. Practicing across state lines without the proper licensure remains a common and risky pitfall (Shore JH et al, *Telemed J E Health* 2018;24(11):827–832).

Practical workflow tips

Unlike outpatient telehealth, where patients log in from home, hospital-based telepsychiatry uses hospital-owned tablets or carts. Nurses usually handle setup, like booting up the device, positioning the camera, and standing by to assist or ensure safety. If you're consulting on an agitated or confused patient, be prepared for mishaps like damaged devices. Hospitals often keep backup tablets for this reason.

Before the telepsychiatry encounter

- Review labs, vitals, and nursing notes ahead of time.
- Ask ED or floor staff to stay nearby during the interview.
- Clarify who's responsible for orders and safety precautions; don't assume it's understood.
- Confirm the patient's legal status and capacity. For voluntary patients, obtain and document consent for telepsychiatry. For involuntary patients, proceed as clinically indicated, seeking assent when possible and documenting assent or refusal.
- Check that the patient is in a private setting and that the connection is clear and secure.
- Have a backup plan in case the video fails (eg, switching to a phone call).

During the interview

- Express empathy out loud. In video visits, nonverbal cues often get lost. Make your support explicit. Phrases like "I can see this is overwhelming" can go a long way.
- If a patient seems paranoid or overstimulated, consider starting with audio only, then switching to video once rapport is built.
- If needed, walk on-site staff through basic neurologic or movement checks to help assess for catatonia, akathisia, or other medication-related syndromes.
- When delirium is a concern, ask on-site staff to complete a brief proxy screen such as the Stanford Proxy Test for Delirium (Maldonado JR et al, *Psychosomatics* 2020;61(2):116–126).

After the evaluation

- Summarize the differential and provide clear recommendations. For example: "This patient is exhibiting acute mania with severe disorganization and poor judgment. Initiate a psychiatric hold for danger to self or grave disability. Start olanzapine 10 mg PO now and 5–10 mg PO every 6 hours as needed for severe agitation. If the patient refuses oral medication or becomes unsafe to manage, notify on-site clinician for in-person evaluation and consideration of emergency IM medication. Obtain urine tox screen, CMP, and ECG to check for

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Telepsychiatry in Hospital Psychiatry: From Stopgap to Standard Care
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substances, metabolic disturbances, and QT prolongation."
- Confirm who's entering orders and following up on safety precautions.
- Coordinate with social work for collateral and discharge planning.
- Document the encounter clearly, including safety plans, sitter levels, who assisted on-site, and any technical issues during the visit.

Where telepsychiatry can fall short

Telepsychiatry works well most of the time, but it has limits. You'll likely run into these common scenarios:

- A paranoid patient may refuse to engage, thinking the video camera is part of the conspiracy.
- A severely depressed or catatonic patient may barely speak, making the interview ineffective.
- For conditions where the physical exam is critical (eg, serotonin syndrome, neuroleptic malignant syndrome, medication toxicity), you'll need to rely on the ED team or escalate to in-person care. Close collaboration with on-site staff is key to overcoming these gaps.

CARLAT VERDICT

Telepsychiatry has become a core part of hospital psychiatric care, not just for emergencies or rural sites, but across EDs, med-surg units, and even psychiatric floors. It's efficient, flexible, and increasingly easy to implement thanks to EHR-integrated video tools. Still, some cases demand hands-on assessment. Know when to ask for help, make your communication explicit, and don't assume your note speaks for itself.

Research Updates IN PSYCHIATRY

COGNITION

Are We Missing a Potentially Reversible Contributor to Cognitive Impairment?

Susan L. Siegfreid, MD. Dr. Siegfreid has no financial relationships with companies related to this material.

ORIGINAL STUDY: Bajaj JS et al, *JAMA Network Open,* 2024;7(1):e2353965

STUDY TYPE: Retrospective cohort study

Distinguishing dementia from hepatic encephalopathy (HE) isn't always straightforward, especially when cirrhosis hasn't been diagnosed. This national VA study asked how often liver disease might be an unrecognized, and potentially reversible, contributor to cognitive decline in older veterans labeled with dementia.

Researchers analyzed records from 177,422 veterans with a dementia diagnosis but no prior cirrhosis diagnosis. Using the Fibrosis-4 (FIB-4) index (age, aspartate/alanine aminotransferase, and platelet count), they looked for signs of advanced liver disease. About 10% had FIB-4 scores over 2.67 (suggesting advanced fibrosis) and 5% had scores over 3.25 (suggesting cirrhosis). Among those in the latter group, more than 95% had imaging or lab evidence consistent with cirrhosis. High FIB-4 scores were more common in non-White, Hispanic, urban-dwelling veterans and in those with alcohol use disorder, hepatitis B or C, or chronic kidney disease.

The study did not report how many of these veterans actually had clinical HE, although prior literature shows that this condition occurs in at least 30%–40% of patients with cirrhosis (Vilstrup H et al, *Hepatology* 2014;60(2):715–735).

CARLAT TAKE

When evaluating cognitive decline, it's worth remembering that not every "dementia" is neurodegenerative. This VA study found that a meaningful subset of older adults labeled with dementia had FIB-4 scores suggestive of advanced fibrosis (the stage just before cirrhosis) or cirrhosis, and many in the highest-risk group had corroborating lab or imaging findings. Advanced fibrosis or cirrhosis doesn't necessarily mean a patient has HE, but HE is common in this stage of liver disease and can contribute to cognitive symptoms. Because HE can mimic dementia and is at least partly reversible, running a quick FIB-4 check can be worthwhile, especially in patients with alcohol use, viral hepatitis, or unexplained lab abnormalities. For a FIB-4 calculator, see: www.tinyurl.com/fdfe5nn. It's a low-effort screen that might uncover a reversible cause of cognitive decline.

DEPRESSION

Ketamine Shows Only Modest Advantage Over Midazolam in Inpatient Depression Treatment

Victoria Hendrick, MD. Dr. Hendrick has no financial relationships with companies related to this material.

REVIEW OF: Jelovac A et al, *JAMA Psychiatry* 2025;82(12):1216–1224

STUDY TYPE: Randomized, double-blind, active-placebo pragmatic trial

Ketamine is increasingly used off-label for depression, often in a series of infusions, but does it really outperform a control treatment when added to standard inpatient care? This study enrolled 65 adults hospitalized for major depression and randomized them to receive up to eight twice-weekly intravenous infusions of ketamine (0.5 mg/kg) or the active placebo midazolam (0.045 mg/kg) along with usual treatment. Symptoms were tracked during the infusion phase and for six months after.

Midazolam was selected as the control because it offers some psychoactive effects that help preserve blinding. But importantly, prior studies have suggested

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that benzodiazepines, including midazolam, may transiently reduce anxiety or dysphoria, which could obscure ketamine's antidepressant effects (Wilkinson ST et al, *Neuropsychopharmacology* 2019;44(7):1233–1238).

By the end of treatment, response and remission were somewhat higher with ketamine (47% and 44%) than with midazolam (33% and 30%), but the difference did not reach statistical significance. Self-rated symptoms, cognition, quality of life, and costs were also similar. The study fell short of its planned enrollment due to constraints related to the COVID-19 pandemic.

The article did not specifically analyze suicidal ideation outcomes, though prior ketamine literature suggests antisuicidal effects within hours to days, especially in patients with severe depression.

CARLAT TAKE

Ketamine didn't statistically outperform midazolam, but let's not write it off. The study had strengths, including its randomized design and long follow-up, but two key limitations stand out. Midazolam isn't an inert placebo; it can have short-term mood-modulating effects that make it harder to detect ketamine's true antidepressant properties. And the smaller sample size, related to COVID-19 disruptions, reduced the study's power to pick up more subtle differences. Still, ketamine produced higher response and remission rates, suggesting that a larger, adequately powered trial might have detected a clearer benefit. This study tempers the early enthusiasm but doesn't close the door, and ketamine may still play a role for some patients with severe or treatment-resistant depression.

NEUROMODULATION

From Acute to Maintenance: The Role of ECT in Long-Term Psychiatric Care

Victoria Hendrick, MD.

REVIEW OF: Jørgensen A et al, *JAMA Psychiatry* 2024;81(12):1207–1214

STUDY TYPE: Retrospective observational study

Despite the effectiveness of ECT for acute psychiatric episodes, preventing relapse after treatment represents a major clinical challenge. While we often rely on medications to sustain remission, continuation and maintenance ECT (c/mECT) may offer an alternative approach. Despite its potential, there's been little large-scale research on its real-world efficacy or cost-effectiveness—until now.

This Danish cohort study followed 19,944 patients who received ECT from 2003 to 2022. Among them, 1,533 patients (7.7%) received c/mECT, most frequently those with schizophrenia (odds ratio [OR] 2.1) or schizoaffective disorder (OR 2.4). Patients with unipolar depression were less likely to receive c/mECT (OR 0.6).

The study defined continuation ECT (cECT) as treatments within 180 days of the acute series (aECT), spaced 7–90 days apart, and maintenance ECT (mECT) as ongoing treatments beyond that time frame with similar intervals. Researchers tracked outcomes such as hospitalization and suicidal behavior during the year following ECT, while also analyzing the financial impact by comparing hospital stays and treatment costs. They controlled for diagnoses, medication history, and sociodemographic factors.

Patients receiving c/mECT showed a clear advantage. Hospitalizations dropped significantly, with a 32%–49% reduced risk compared to those treated with aECT alone. This protective effect was especially pronounced in the first six months. Financially, c/mECT proved its value by reducing overall costs, largely by preventing costly hospital readmissions.

On the downside, c/mECT didn't show a meaningful impact on suicide prevention during the study period. Despite this, its ability to curb relapses and cut costs makes it a valuable option for patients with severe and treatment-resistant psychiatric conditions. The study had some limitations, including the lack of randomized controls, which introduces the possibility of selection bias.

CARLAT TAKE

This study makes a strong case for using c/mECT to keep patients in remission after acute ECT, especially those with difficult-to-treat conditions like schizophrenia or severe psychiatric illnesses that haven't responded well to medications. Although the study had some limitations, the large sample size lends weight to the findings. If c/mECT isn't already on your radar for your most challenging cases, it's worth reconsidering.

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This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com.

1. Which of the following strategies can enhance the performance of artificial intelligence (AI) scribes during psychiatric interviews?
   - [ ] a. Avoid summarizing out loud to minimize bias in documentation
   - [ ] b. Use structured verbal transitions to signal topic changes
   - [ ] c. Conduct interviews in a nonclinical setting to reduce distraction
   - [ ] d. Limit patient responses to yes/no format to simplify analysis

2. According to Dr. Trapp, what is the most serious but rare side effect associated with transcranial magnetic stimulation (TMS)?
   - [ ] a. Mania
   - [ ] b. Cognitive decline
   - [ ] c. Hypertension
   - [ ] d. Seizure

3. According to Dr. Liran, which patient population may be least appropriate for unsupervised use of immersive AI-based therapy tools?
   - [ ] a. Patients with anxiety or chronic pain
   - [ ] b. Patients experiencing acute mania
   - [ ] c. Patients with mild depression
   - [ ] d. Patients seeking stress reduction

4. Which of the following is a typical responsibility of on-site nursing staff during hospital-based telepsychiatry encounters?
   - [ ] a. Performing targeted physical assessments under remote guidance
   - [ ] b. Entering psychiatric orders into the system for the remote psychiatrist
   - [ ] c. Diagnosing psychiatric conditions based on video observations
   - [ ] d. Troubleshooting network issues on the psychiatrist's end

5. What was the clinical implication of the 2024 VA study examining veterans with dementia and elevated Fibrosis-4 (FIB-4) scores?
   - [ ] a. High FIB-4 scores confirmed widespread Alzheimer's disease
   - [ ] b. Many patients likely had undiagnosed cirrhosis contributing to cognitive symptoms
   - [ ] c. FIB-4 scores did not correlate with imaging or lab findings
   - [ ] d. Cirrhosis was ruled out in nearly all patients with cognitive decline

6. What is a major limitation of current AI scribes in psychiatric care?
   - [ ] a. They are only compatible with paper records
   - [ ] b. They lack HIPAA compliance
   - [ ] c. They may misinterpret statements and introduce factual errors
   - [ ] d. They completely replace the need for clinician review

7. True/False: According to Dr. Trapp, geriatric patients are generally good candidates for TMS because they tend to tolerate the treatment well and are more susceptible to medication side effects.
   - [ ] a. True
   - [ ] b. False

8. According to Dr. Liran, how can AI tools support longitudinal care in therapy?
   - [ ] a. They allow patients to avoid traditional treatment entirely
   - [ ] b. They automate psychiatric diagnoses without clinician input
   - [ ] c. They enable patients to practice skills and complete therapy homework between sessions
   - [ ] d. They prescribe medication refills based on symptom tracking

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Note From the Editor-in-Chief

As we begin the new year, an important development in depression treatment is underway. The FDA has just cleared the first at-home brain-stimulation device for major depressive disorder: the Flow Neuroscience FL-100 headset. It pairs with a mobile app so patients can use it at home while still being monitored by their clinician, typically in 30-minute sessions over several weeks. Similar versions have already been in use outside the U.S. since 2019, and U.S. availability is expected in the second quarter of 2026. This device is likely to make neuromodulation more accessible while also raising important questions about patient selection (it is not cleared for use for patients considered treatment-refractory, although that terminology remains somewhat vague), clinical oversight, and reimbursement.

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