

Transforming the Psychiatric Inpatient Unit from Short-term Pseudo-asylum Care to State-of-the-art Treatment Setting

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Introduction

In past “Research to Practice” articles, I have tried to point out areas where clinical practice did not comport with research-derived evidence in the field of psychiatry. One area where I believe psychiatry has failed to capitalize on prodigious knowledge accrued from research pertains to treatment of the patients hospitalized for psychiatric disorders. For most psychiatrists and clinical psychologists, the hospitalization of a patient simply represents a last resort—a declaration that a patient’s clinical status has become so dire that attempting to manage his or her disease on an outpatient basis is either infeasible or too risky (e.g., due to the potential of harm to him- or herself or to others) or both. In this way, acute psychiatric units are seen mostly as places where patients can be maintained safely and securely while they are administered treatment that does not fundamentally differ from what they would have received as an outpatient, with the exception perhaps of more intense psychosocial intervention. Few providers view the inpatient psychiatric setting as one which affords opportunities for specialized, aggressive, biologically based assessment and treatments that are not feasible on an outpatient basis. After all, psychiatry does not have the equivalent of intravenous infusions and monitoring of acute disease biomarkers that characterizes the inpatient treatment of patients hospitalized for medical conditions such as diabetic ketoacidosis, sepsis, or acute angina.

When I first became the director of the adult inpatient psychiatric service at University of California San Diego (UCSD) Medical Center many years ago, I held those same conservative assumptions about psychiatric inpatient treatment. However, having nothing more than standard outpatient treatment approaches to offer profoundly ill inpatients eventually led me to adopt a philosophical orientation that inpatient units should leverage the inherent advantages and opportunities of the inpatient setting (e.g., the ability to monitor a patient 24 hours a day and adjust treatment rapidly) in the service of providing treatment options that are more aggressive and more sophisticated than standard outpatient approaches. In fact, I believe that not to do so is a significant disservice to hospitalized patients and an inefficient use of resources. That philosophy has, in turn, spurred my colleagues at UCSD and me to maintain an ever present eye toward the scientific literature for assessment and treatment techniques that offer the possibility of translating that philosophy into a reality. Indeed, it was surprising to find, right from the outset of our quest, that there was an extant and growing body of evidence to support established, biologically based interventions that are easily adapted and ideally suited for the inpatient settings. Over the years, we have adopted and sometimes innovated clinical protocols uniquely designed for the acutely ill psychiatric inpatient, such as rapid loading of medication, with the aim of stabilizing patients as quickly as possible.[1–3]

A protocol we frequently use to treat severely depressed inpatients, particularly ones who have not responded to standard outpatient treatments, is illustrative. In addition to intense psychosocial interventions, severely depressed patients admitted to our inpatient facility are likely to be offered an integrated, trimodality, biological treatment protocol aimed at “jump starting” their recovery, which comprises inpatient-oriented pharmacotherapy, partial wake therapy (also known as partial sleep deprivation), and morning bright light therapy.

While space prevents me from providing an in-depth description of these therapies or a full review of the scientific rationale for this protocol, I will briefly touch on each of these elements.

Inpatient-Oriented Pharmacotherapy

Inpatient-oriented pharmacotherapy can mean different things depending on each patient’s individual medication history. However, the general guiding principle is that what may be the best choice for the average outpatient with depression may not necessarily be the

optimal choice for an inpatient. For example, when considering inpatient-oriented pharmacotherapy, selective serotonin reuptake inhibitor (SSRI) medications do not occupy the exalted and uncontested first-choice status they occupy in the outpatient setting. Most patients admitted for depression will have already been on one or more SSRI without adequate response. In a previous installment of this “Research to Practice” column, I addressed the lack of evidence supporting the strategy of SSRI dose escalation in patients who have not responded to a therapeutic dose.[4] While there exists a controversy as to whether dual mechanism (serotonin-noradrenaline reuptake inhibitor [SNRI] and certain tricyclic) antidepressants have superior or equivalent efficacy compared to SSRIs for depression on the whole,^{5,6} the evidence in favor of their superior efficacy and perhaps faster onset of action is strongest among hospitalized patients and those whose depression is severe.[5–9] Concern over a heavier side effect load with these medications, especially early in the course of treatment, is obviated in inpatient settings where daily monitoring, dose adjustments, and ubiquitous psychological and medical support are available. As an example, when venlafaxine was the only SNRI on the market, our inpatient protocol included initiation and rapid upward titration of that drug to 375mg per day over five days—a procedure that was based upon a published report that it was efficacious and well tolerated in an inpatient setting.[10] We learned with time that this loading regimen was surprisingly well tolerated by most patients, but the confidence to implement such an aggressive regimen was derived from the ability to intensively monitor and, if need be, react rapidly (e.g., holding doses and prescribing hypnotics) to any adverse events that might emerge.

Wake Therapy

Many clinicians are probably aware of the remarkable antidepressant properties of wake therapy (WT), perhaps recalling learning about it during their residency (as I first did) where it was likely presented in a perfunctory manner, primarily as a scientific curiosity but not a viable therapeutic intervention for consideration. However, WT is arguably the most rapid and reliable antidepressant treatment, bar none. A committee on chronotherapeutics formed by the International Society for Affective Disorders (ISAD) recently reviewed the literature and concluded that WT, whether administered over the whole night or restricted to the second half of the night, provides “astonishing” improvements—typically within hours—in approximately 60 percent of patients with major depression, independent of diagnostic subgroups.[11]

One of the reasons WT has not been widely adopted, despite its well-established therapeutic benefits in depression, is that the benefits of a single episode of WT tend to be transitory and patients typically relapse within the following 24 hours, usually when they resume sleep. I have witnessed dramatic and rapid antidepressant effects induced by WT to be totally reversed with nothing more than a brief nap. However, what many clinicians in our field may not know is that there have been significant recent advances in developing ways to obviate or limit the relapse proclivity associated with WT-induced mood enhancement. Treatment effects may be stabilized by antidepressant drugs, lithium, shifting of sleep time (i.e., phase advancing), or morning light therapy.[11,12]

While it would be very difficult for even motivated patients to self administer WT, it is quite easily administered and monitored in motivated patients on an inpatient unit where 24-hour nursing is available.

Bright Light Therapy

The first evidence of the antidepressant properties of bright light therapy (BLT) came from studies of seasonal affective disorder. However, more recent research suggests that BLT may have therapeutic benefit in all subtypes of depression.[13] The strongest evidence are those that indicate BLT has a synergistic adjunct effect with antidepressant medication. Studies have generally shown that concomitant BLT enhances and accelerates the response to antidepressants.[14–16] As a recent review of BLT studies concluded, “Overall, bright light therapy is an excellent candidate for inclusion into the therapeutic inventory available for the treatment of nonseasonal depression today as an adjuvant therapy to antidepressant medication.”[17] BLT and WT are collectively referred to as “chronotherapy.”

BLT has been found to be beneficial in elderly patients with behavioral and mood disorders,[18] and when our department recently opened a specialized geriatric psychiatry inpatient unit at UCSD Medical Center, the utilization of chronotherapy was taken to a new level through the incorporation of therapeutic level lighting throughout the common areas.

Multimodality Treatment Protocol

When combined, pharmacotherapy and chronotherapy have multidirectional synergistic effects: BLT enhances and speeds the onset of action of the antidepressant medication, WT “jump-starts” the depression recovery process induced by BLT and the antidepressants, and the typical rapid loss of WT benefits are counteracted by concomitant administration of BLT and medication.[19–21] What is remarkable is that the cost and difficulty involved in implementing such a multimodal treatment protocol on an inpatient ward are negligible.

Conclusion

No doubt there are many barriers to transforming acute psychiatric inpatient wards into the vision of centers of psychiatric excellence as I propose in this article. Among these barriers is the current restrictive posture among the public and private sector third-party

healthcare payers who promote a very parochial definition of medical necessity for psychiatric hospitalization (i.e., imminent danger to self, others, or grave disability). Furthermore, there is no doubt that therapeutic holding of patients in a safe and secure physical environment will continue to be a crucial function of inpatient psychiatry units. Nevertheless, research and technology are advancing in our field, and the prospect of implementing more assessment and treatment options suited specifically for inpatient settings is likely to grow. Recent promising findings using intravenous ketamine to induce rapid depression recovery and portable actigraphy to objectively assess sleep and activity of inpatients are other examples of auspicious tools for the hospital-based psychiatry service.[22] Therefore, despite the obstacles, I believe that it is worthwhile for those in our field, particularly the growing group of psychiatric hospitalists and administrators, to seek to expand the role of psychiatric inpatient care and stake out a place for it at the leading edge, rather than the trailing edge of psychiatric care.

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