Quick and Dirty Psychiatry 2019: Practical Approaches for Managing Mental Illness

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Disclosures

• Neither Dr. Johnson or Dr. Neal have actual or potential conflict of interest in relation to this program/presentation.

• We will be discussing “off label” uses of medications
Discussion Group

• QDhomelesspsych@groups.io
Objectives

• After participating in this session, attendees will be able to:
  • Determine appropriate psychopharmacological interventions for mentally ill homeless individuals
  • Summarize general indications and side effects of commonly prescribed psychiatric medications
  • Describe the influence of homelessness on development of psychopharmacological treatment plan
Prevelance

• Rate of severe psychiatric illness ranges from one-third to one-half.
  • Mood disorder = 20% - 30%
  • Schizophrenia = 10% - 15%

• Substances are a huge issue
  • Substance use = 20% - 30%
  • Alcohol = ~60%
• Impairments in global cognition w/o SPMI
  • MSE (cut-off of 24) = approx. 21%
  • With examination in other cognitive batteries upwards of 80%

• Observed decreases in IQ with SPMI
  • Average to low-average in the general homeless pop.

• Focal deficits in verbal and visual memory, attention, speed of information processing, and executive functioning
Likely multifactorial etiology:
  - Substance use
  - Head trauma
  - Influence of poverty
  - Malnourishment
  - Mental illness
• Impairments may influence social functioning
  • Ability to adapt and reintegrate
  • Problem solving and skill acquisition
• Adherence to outpatient medical services
• Maintenance of independent housing
• Possible impact on the effectiveness of skills training and rehabilitation programs
Perceived entitlement

• This population has MANY needs (medical, financial, psychosocial)
• Sometimes few people offering help
• Patients often feel unheard
• What’s being offered is not always what they want
Treating Mental Illness In The Homeless

Clinical Pearls and Recommendations
Therapeutic Alliance
Tip #1: Be Honest

• Establish collaborative relationship: “What are you willing to take”
• Ask questions
  • “What can I do that would be helpful for you?”
  • “What’s your understanding of why you’re here today?”
• Set boundaries
  • “Here’s what I can do and can’t”
  • “Here’s what I will do and won’t do”
• Consistency
  • Say what you mean, and mean what you say
Tip #2: Keep it Simple

• Most evidence suggests that our meds are at least “equally effective” to each other...so use what you’ve got
• Once daily formulations if possible
• Avoid medications that NEED calorie requirements
• Avoid (if possible) meds that REQUIRE lab monitoring
• Try to use meds that can address multiple symptoms
• Avoid (if possible) meds with potential street value
Depressive Disorders
Tx Pearls for Depression

• Adequate dose and duration
  • At least 4 weeks at therapeutic dose = adequate trial
  • Be patient and minimize multiple switches

• Think symptomatically...algorithms don’t always fit
  • Chronic pain + depression = SNRI
  • Low energy or apathy = SNRI or NDRI
  • Sleep or appetite disturbance = NaSSA

• Try to to use meds with longer half-lives

• Don’t be afraid to talk about sex
  • Anorgasmia
  • Decreased libido
  • Erectile dysfunction
Antidepressants

• Fluoxetine
  • Very long half-life = good for poor or intermittent adherence

• Sertraline
  • Safest in patients with cardiac hx
  • Only SSRI with no significant impact on QTc

• Citalopram/Escitalopram
  • Reported higher risk for prolonged QTc

• Bupropion
  • Useful for comorbid ADHD, smoking cessation
  • Lowers seizure threshold
• Mirtazapine
  • Useful for comorbid insomnia, poor appetite and in trauma related disorders
  • Evidence to suggest benefit in substance use disorders
  • Potentially earlier onset of action

• Venlafaxine and paroxetine
  • Have very short half life w/ very uncomfortable discontinuation syndrome
  • Paroxetine very anticholinergic

• Duloxetine
  • Good for patients with pain.
  • Check AST/ALT due to potential liver toxicity

• Atomoxetine*
  • Indicated for ADHD, but has antidepressant activity (NRI)
Anxiety Disorders
Tx pearls for anxiety disorders

- Normalize...but don’t minimize
  - Triggers?
  - Evolutionary perspective
  - “distress or impairment”
- Provide reassurance
  - Panic attacks vs cardiac vs. pulmonary
- Try non-medication options
  - Meditation
  - Exercise
  - Distraction
  - Mindfulness
  - Substance abuse tx
Medication Options

• Antidepressants

• Buspar
  • Useful for antidepressant sexual side effects
  • Generally two to three times a day dosing

• Gabapentin*
  • Useful for comorbid alcohol use disorder and chronic pain
  • Abuse potential
  • Drug of interest with DEA

• Clonidine/Guanfacine*
  • Useful comorbid opioid use disorder and/or trauma disorders
  • Dehydration/hypotension

• Propranolol*

• Antihistamines
Bipolar Disorder
Tx Pearls for Bipolar Disorder

• Confirm the diagnosis
• Get comfortable with ambiguity
  • Significant diagnostic overlap w/ personality disorders, ADHD and substance use
• Depakote and Lithium are considered first-line for mood stabilization...but with caveats
• Use of antidepressants is controversial
• Psychoeducation can be very useful
Mood stabilizers

• Lithium
  • Can be dosed once daily
    • Easier on the kidneys
    • Improves adherence
  • Hydration status is important*
  • Use caution if prescribing with diuretics, NSAIDs, metformin, ACE inhibitors...
  • Recommended to check EKG and thyroid before start
  • Epstein’s anomaly not as common as once thought

• Valproate
  • Avoid in women of child-bearing age
  • Easier to dose and requires less monitoring than lithium
  • Good for individuals with anger/aggression/impulsivity
• Lamotrigine
  • Indicated only for bipolar depression
  • Poor evidence for management of mania
  • Requires very slow titration (25 mg/week)
  • Must restart at beginning if off med for more than 3 days
  • Valproate can double levels

• Carbamazepine/Oxcarbazapine
  • Agranulocytosis
  • Cytochrome inducer...beware with OCP use

• Second Generation Antipsychotics
Psychotic Disorders
Tx pearls for psychotic disorders

• Side effect profiles matter
  • FGA = increased risk of EPS and dyskinesia
  • SGA = metabolic risks and prolactin elevation

• All adherence isn't equal...so use long-acting injectables whenever possible*

• Treat early and “aggressively”
  • 5yr critical period
  • LAIs have evidence suggesting neuroprotection

• Be aware of impact on QTC

• Avoid antipsychotic polypharmacy

• DON’T use for sleep

• Titrate slowly to avoid side effects...and to gain alliance
Oral medications

- Ziprasidone/lurasidone
  - Requires 350 – 500 kCals for absorption
  - Ziprasidone = twice daily dosing

- Olanzapine
  - Very effective...but will likely cause weight gain

- Quetiapine
  - Useful for mood and psychosis
  - Weight gain is NOT dose dependant
  - Has “street value”
Oral and Long-acting medications

• Risperidone
  • Increased risk of EPS, hyperprolactinemia at higher doses (>6mg)
  • Long acting option = Q2 weeks and Q4 weeks

• Paliperidone
  • Active metabolite of risperidone
  • If tolerated risperidone in past, will likely tolerate
  • Long acting option = Q 30 days and Q 90 days

• Aripiprazole
  • Useful with co-morbid mood symptoms
  • Long acting option = Q 30 days and Q 60 days
  • Can shorten QTc
  • Partial D2 agonist – helpful in hyperprolactinemia

• Haloperidol/fluphenazine
  • Long acting = Q2 to 4 weeks
Substance Use Disorders
Tx pearls for substance use disorders

- High association with other psychiatric illnesses
  - When in doubt err on the side of treating
  - But make diagnoses with caution in active substance use
  - Substance of choice can be diagnostically helpful

- Don’t take being manipulated personally

- Relapse is part of the disease course

- Maintain non-judgmental stance

- Focus on strengths and troubleshooting

- Harm reduction!!!
Medication options

• Gabapentin
  • Evidence for use in alcohol use disorders alone or in combination with naltrexone

• Topamax
  • Evidence in alcohol use disorders
  • Can impact cognition (up to 25%)

• Naltrexone
  • Useful in alcohol and opioid use disorders
  • May be useful in behavioral addictions

• Clonidine/Guanfacine
  • Can be helpful in opioid use disorders
  • Potential role in minimizing stress-induced drug cravings

• N-acetylcysteine
Trauma Related Disorders
Tx pearls for trauma related disorders

• There's no magic pill
• Focus on the most distressing symptoms
Medication options

- **Prazosin**
  - Useful for trauma related nightmares
  - Slow titration
  - Monitor blood pressure and orthostasis

- **Cyproheptadine**
  - Also for trauma related nightmares
  - Appetite stimulant
  - Potential anxiolytic effect

- **Clonidine**

- **Guanfacine**

- **N-Acetylcysteine** *

- **SSRIs**
Insomnia
Tx pearls for insomnia

• No really good options...EVERYONE sleeps poorly
• Suggest earplugs
• Over the counter medications are probably just as effective as off label meds
  • Most generally rely on antihistaminic side effect
• Dose potentially sedating meds at night
• Avoid medications with potential for abuse or physiologic dependence
Med options

• Antihistamines
• Trazodone
  • Buzzword side effect = priapism
  • Doses greater than 200mg aren't necessarily more effective
  • Can worsen nightmares
• Mirtazapine
  • Generally thought to be more sedating at lower end of dosing
• Ramelteon
  • Non-benzodiazepine receptor activity
  • Usually requires patient assistance – very expensive
• Melatonin
  • Over the counter supplement
  • Evidence suggests that it may reduce metabolic side effects related to SGA use
In summary....
• Be patient focused
• Therapeutic alliance is the key
• Even if patient declines treatment...keep seeing them and making the recommendation
• Use what you’ve got
• Meet patients where they are
• Having a partner in crime helps
• Don’t assume patients are adherent, even if they say they are
Questions?
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References


