Care Manager Orientation to the Use of Psychiatric Medication

For SPIRIT Care Managers

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With support from the AIMS Center
Learning Objectives

• Familiarity with existing resources for learning about medication treatment of psychiatric disorders

• Understanding how to take a medication history and access medication information

• Understanding how to assist collaborative care team in management of commonly encountered medication treatment situations
Why Do Care Managers Need to Know About Medication Use?

• CM role in supporting medication treatment:
  – CM can catch otherwise missed opportunities to support adherence (compared with usual care where adherence < 50%)

• CM management of common benign side effects can facilitate adherence

• Familiarity with the reasons why medication trials fail can help CMs manage patient care and improve outcomes
Ongoing Learning is the Core Task

- The medication knowledge base is massive
- **MEMORY CAN BE UNRELIABLE**
- Information Sources: Epocrates, AIMS, known clinic/PCP resources, your psychiatric consultant
- The key - know where to find:
  - Good information, quickly, in useful form
Medication Management: Role of SPIRIT Care Manager

• Gathering history

• Coordinating with PCP and Study Psychiatrist
  – Why did they suggest that?

• Recognizing Common Problems
  – Rx dose isn’t working
  – Patient is reluctant to start new prescription
  – Lack of partner or family support regarding taking medication
  – Patient lacks information about benefits of medication

• Supporting Treatment Adherence
  – The art of the elevator speech:
    • The 2-wk appointment speech
    • How does this help when I have so many problems?
    • Chapter 17 SPIRIT Manual – sample scripts to work with patient ambivalence about taking medication
What Are They Taking Now?

• AKA the “Medication Reconciliation.”
• If unclear about current meds, ask patient to bring in pill bottles from home
• Ask: Anything else pass your lips other than food and drink? How often?
  – Supplements?
  – OTC meds?
  – Things your friends or family lent you?
Prior Psychiatric Medications

- Name of medication
- What did you think it was for?
- What was the dose?
- How long did you take it?
- Why did you stop?
  - Got better
  - Got worse
  - Side effects
    - Weight
    - Sexual dysfunction
    - Dry mouth
    - Movement problems
  - Forgot!
Special Medication History Situations

• Controlled substances
  – Benzos
  – Opioids
  – "Muscle relaxants"
  – Sleep aids like Ambien and Lunesta
  – Stimulants
    • Often misused, sold

• Thyroid
  – Tied to mood disorder, use of lithium

• Corticosteroids (Prednisone, etc.)
  – Can affect mood
Taking a Medication History

• Outline is useful

<table>
<thead>
<tr>
<th>Medication History Template</th>
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<tbody>
<tr>
<td>Patient Name:</td>
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<tr>
<td>Medication Name</td>
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Providing Education About Psychotropic Medications

- Anticipate common questions and manage misconceptions
  - “I’m worried I’ll become dependent on my medication.”
  - “Medications are mind-altering drugs, and I’m not sure I want that.”
  - “Medications are ‘happy pills’ or ‘will make me a zombie’.”
  - “Once I get better, can I quit my medication?”
  - “I only take my medication when I have symptoms.”
  - “I heard medication can make you suicidal.”
  - “Will medication affect my sex life?”
  - “My mom took ____ (medication) ____ and it didn’t help.”

- Give verbal and written information about medications and plan
- Ask patient if she has concerns about the current medication plan
- When stumped, remember you have a team for a reason!
Starting Treatment with Medications

• How did you decide which medication to use?
  – Start with working diagnosis
  – Different people respond differently - we can't tell ahead of time
  – All SSRIs are equally likely to be effective for PTSD
    • We choose practically, on the basis of fewest side effects, or affordability
  o Bipolar treatment may require a combination of medications including mood stabilizers, antipsychotics
  o Trial and error - we may need to try more than one
Starting Treatment with Medications

• Anticipate and troubleshoot treatment adherence challenges:
  — Likeliness of taking the medication every day. How will you remember to take it?
  — Need for monitoring labs
  — Barriers such as cost, insurance coverage, distance from pharmacy/transportation, schedule, family and friend support
  — Belief that medication can or can’t help – what informs this?
Starting Treatment with Medications

• Initiation
  – Make a specific plan
    • It is a lot harder to take medications than it looks – good to have a plan

• Ask/Say:
  – When are you going to pick it up?
  – How will you pay for it?
  – When are you going to start it? “Let’s pick a specific day.”
  – How are you going to remember to take it?
    • Consider using checklist, mediset, titration calendar
  – Who will you call if you have questions?
Starting Treatment with Medications

• Prepare the patient for:
  – **Treatment effectiveness**: “It generally takes 2+ weeks to start feeling better.”
  – **Side effects**: “These are common side effects patients sometimes feel in the beginning of treatment.” “Not everyone experiences side effects.”
  – **Close follow-up**: “I will follow you closely to help you assess if the medication is working.” “Call me if you have concerns or before you discontinue taking the medication.”
  – **What improvement looks like**: based on patient report and screens - track gradual improvement.
Follow-Up Sessions

Be prepared for Session 2

*Patient may report:*

- **Little improvement.** “This isn’t helping at all.”
- **Unwelcome side effects.** “We want to know about those and can help you manage them.”

*We can:*

- **Normalize the slow start.** “This is normal and not a sign that you’re not getting well.”
- **Maintain hope.** “It can sometimes take a few trials to get it right.”
Managing Side Effects

• Making the call on whether what patient reports is “normal”
  o “I feel restless” “My back hurts.” “I haven’t slept for three days.”

• Gather information then consult with psychiatrist or PCP
  o When did it start?
  o Were you having this before you began the medication?
  o How bothersome is it?
  o Are you having any other symptoms with this?

• Specific side effects
  o Sexual dysfunction
    — Over 50% for SSRIs. You have to ask – rarely volunteered
  o Agitation
    — Often early and transient (2-3 days)
  o SSRIs can precipitate mania!
Enhancing Adherence: What if I want to stop my medication?

• Good reasons to stop a medication:
  o Intolerable side effects
  o Dangerous interactions with necessary medications
  o The medication was not indicated to start with (e.g., bipolar depression)
  o Medication has been at maximum therapeutic dose without improvement for 4-8 weeks

• Direct to PCP to discuss length of treatment
• Discuss continuing medications even when feeling better
• Help patient write down questions
• Get input from psychiatric consultant
Enhancing Adherence: Relapse prevention

• Reframe the ongoing use of medications
  o A personal decision
  o Enhancing quality of life
  o Reinforce positive effects
  o Sometimes [e.g., bipolar] “It is your call. If you were my [brother], I would recommend continuing.”

• Discuss relapse prevention
  o Role of medications
  o Focus on staying well
  o For many people, mood stability is precious, and can't just be switched back on when you lose it
  o Warning signs
  o Role of early intervention

You can come back to us
What are recommended treatments?

<table>
<thead>
<tr>
<th>Bipolar</th>
<th>PTSD</th>
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</thead>
<tbody>
<tr>
<td>Medication plus psychotherapy</td>
<td>Medication or psychotherapy or both</td>
</tr>
<tr>
<td>Medication alone</td>
<td>“Toughing it out” or marijuana</td>
</tr>
<tr>
<td>Psychotherapy alone</td>
<td></td>
</tr>
</tbody>
</table>
What medications ARE effective?

<table>
<thead>
<tr>
<th>Bipolar</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium!!!</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td></td>
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<tr>
<td>Depakote</td>
<td>SSRIs: fluoxetine, sertraline,</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>citalopram, escitalopram,</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>paroxetine</td>
</tr>
<tr>
<td>Lurasidone</td>
<td>SNRIs: venlafaxine,</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>desvenlafaxine, duloxetine</td>
</tr>
<tr>
<td>Risperidone</td>
<td>mirtazapine</td>
</tr>
<tr>
<td>Olanzapine / fluoxetine</td>
<td>Prazosin (sleep disturbance)</td>
</tr>
</tbody>
</table>

Antidepressants

SSRIs: fluoxetine, sertraline, citalopram, escitalopram, paroxetine
SNRIs: venlafaxine, desvenlafaxine, duloxetine mirtazapine
What are some ineffective medications for bipolar disorder and PTSD?

• Benzodiazepines
  - Increase avoidance and potentiate fear conditioning

• Hypnotics
• Gabapentin
• Hydroxyzine
• Propranolol
• Stimulants

• Bipolar: Antidepressant monotherapy
  - Antidepressant medications can induce mood instability and precipitate mania

• PTSD: Limited role for antipsychotic medications
Medication: Startup Procedures

• Inform and educate
• Labs or other medical evaluation if needed
• Dose titration over days to weeks
  o Lessens risk of initiation-related side effects
  o Early on, watch for side effects. Encourage patience. It is too soon to call response or failure
• Monitor with PHQ-9, SPIRIT mania scale, PCL-5
• Multiple medication trials are par for the course
  o Uncomplicated depression: 70% in remission after 3 changes
• Give each trial a fair shot!
Psychopharm overview

- Knowing about receptors is not that helpful
- Avoid the term “chemical imbalance” with patients
  - It suggests a non-existent certainty when treatment is of necessity pragmatic
    - Medication “treats the emotional and physical symptoms of [condition].”
    - For bipolar: goals to reduce mood instability, end mania/mixed states, prevent recurrence

Steven Stahl’s Creative Textbooks
Depression: Antidepressants and Suicidality?

• SSRI’s much safer in overdose than older antidepressants, but not perfectly safe.
  - Other psychotropics, especially lithium are more risky

• Do antidepressants cause suicidality?
  - Black box warnings for all medications for treatment of depression
  - Real risk appears low: "Suicidal behavior" in adolescent trials, not completed suicide
  - Significantly increased suicide rates in localities where SSRI use dropped [Australia] [Kids in US] – because depression is much more dangerous than antidepressant medication

  • "If you are concerned, call me."
  • "If you are extremely concerned, stop the meds and come in, we can always start again."
Make Use of Your Psychiatric Consultant

• Questions to ask
  o “What is this medication being recommended for?”
  o “What should I tell the patient about this medication?”
  o “What are the common side effects? Do you have tips for those?”
  o “Are there serious risks that I should warn the patient about?”
  o “How does this medication interact with the patient’s other medications and/or with alcohol?”
  o “How will we know if the medication is working?”

• Ask for explanations. It makes everyone smarter
  o “I'd like to know about...”
  o “The PCP read @ .... in the NY Times...”

Every consultation is an opportunity to learn
A med you don’t know? Look it up!

• Find out what programs do the PCPs in your clinic use
  - Micromedex
  - Lexicomp
  - Up-to-Date
  - Epocrates

SPIRIT manual Chapter 6

Psychotropic Medications for Bipolar Disorder

Pharmacotherapy for bipolar disorder includes: 1) treatment of acute mood episodes, and 2) maintenance treatment to prevent mood episode recurrence. Acute episode treatment includes treatment of all bipolar depressive episodes, all bipolar manic episodes, and all mixed episodes. Maintenance treatment includes prevention of treatment-emergent depressive episodes, manic episodes, and mixed episodes, and treatment of persistent depressive and/or manic symptoms.

Medications and antipsychotic medications that treat bipolar disorder may address specific phases of acute illness or be used during maintenance treatment (see Table 1 for details). For example, lamotrigine is effective in treating acute bipolar depression and acute maintenance treatment of bipolar illness. For many patients, use of lithium is advisable. For many patients, use of lithium is advisable.

Table 6.1 Psychotropic Medication Tables

<table>
<thead>
<tr>
<th>Medication</th>
<th>Relative Advantages</th>
<th>Relative Disadvantages</th>
<th>Side Effects</th>
<th>Contraindications or Major Drug Interactions</th>
<th>Initial Tests</th>
<th>Monitoring Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamotrigine</td>
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Table 6.2 Strategies for Managing Medication Side Effects

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Strategy</th>
</tr>
</thead>
</table>
| Sedation    | - Give medication at bedtime
|             | - Try caffeine
|             | - Consider antihistamines or H2 blockers
| Activation / tachy / tremor | - Start with small doses (especially with underlying anxiety disorder)
|             | - Take with meals
|             | - Consider anticholinergics
| Headache    | - Lower dose
|             | - Try anticonvulsants
| Insomnia    | - Review sleep hygiene
|             | - Treat with haloperidol or risperidone

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