Psychopharmacology for Collaborative Care Managers

Objectives/Outline

Topics

Diagnostic assessment in primary care

- Use of symptom measures to aid diagnosis

Antidepressant medications

- Cautions
- Medication selection
- Addressing common patient concerns

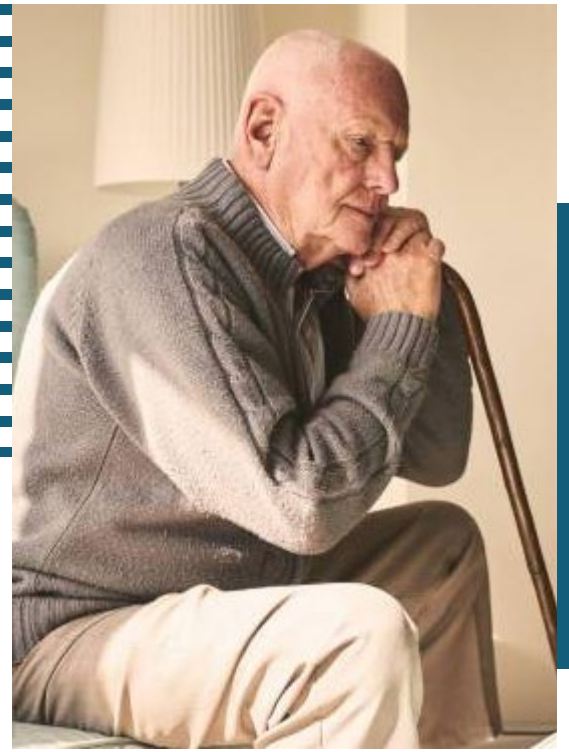
Objectives

- Understand the psychiatric and medical-decision related to starting an antidepressant medication
- Recognize the common antidepressant medications and their relative advantages and disadvantages
- Anticipate and be able to address common patient concerns

Case Presentation

Dr. Kim refers a patient to you:

"Mr. M. is an 80 y/o man with HTN and CAD, recently moved to assisted care facility. Family says he isn't like himself anymore, doesn't want to do anything. They think he's depressed. He's not sure. Should I start him on an antidepressant?"



What do you do?

Medication Assessment

1

Diagnostic Assessment

2

Contraindications/Cautions

3

Medication Selection

4

Patient Education

Diagnostic Assessment

Clinical History

- Does the chief complaint and history suggest a primary depressive or anxiety disorder according to DSM5 criteria?
- Are there any features suggestive of another disorder, either somatic or psychiatric?

Symptom measures (PHQ-9, GAD-7, PCL-5)

- Increases diagnostic efficiency and thoroughness
  - Include DSM5 symptoms for making diagnosis
- Establishes severity
- Allows tracking of treatment response

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	(1)	2	3
2. Feeling down, depressed, or hopeless	(0)	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	(3)
4. Feeling tired or having little energy	0	1	2	(3)
5. Poor appetite or overeating	0	(1)	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	(0)	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	(2)	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	(0)	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	(0)	1	2	3

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	(2)	3
2. Feeling down, depressed, or hopeless	0	1	(2)	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	(3)
4. Feeling tired or having little energy	0	1	(2)	3
5. Poor appetite or overeating	0	(1)	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	(1)	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	(2)	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	(0)	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	(1)	2	3

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	(2)	3
2. Not being able to stop or control worrying.	0	(1)	2	3
3. Worrying too much about different things.	0	1	2	(3)
4. Trouble relaxing.	0	(1)	2	3
5. Being so restless that it's hard to sit still.	(0)	1	2	3
6. Becoming easily annoyed or irritable.	0	(1)	2	3
7. Feeling afraid as if something awful might happen.	0	(1)	2	3

What are the diagnostic implications of a GAD-7 of 12 if the PHQ-9 is 22 vs. 5?

PCL-5

In the past month, how much were you bothered by:
1. Repeated, disturbing, and unwanted memories of the stressful experience?
2. Repeated, disturbing dreams of the stressful experience?
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
4. Feeling very upset when something reminded you of the stressful experience?
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
6. Avoiding memories, thoughts, or feelings related to the stressful experience?
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
10. Blaming yourself or someone else for the stressful experience or what happened after it?
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
12. Loss of interest in activities that you used to enjoy?
13. Feeling distant or cut off from other people?
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?
16. Taking too many risks or doing things that could cause you harm?
17. Being "superalert" or watchful or on guard?
18. Feeling jumpy or easily startled?
19. Having difficulty concentrating?
20. Trouble falling or staying asleep?

Trauma = exposure to actual or threatened death, serious injury, or sexual violence

Causes of “Secondary” Depression

Psychiatric

- Nearly any psychiatric disorder could present with depression
- Not necessary/feasible to screen for all disorders
- After assessing for MDD, GAD, PTSD, and substance use, base additional screening on initial complaints and any other symptoms patient mentions (e.g., paranoia, mood swings)

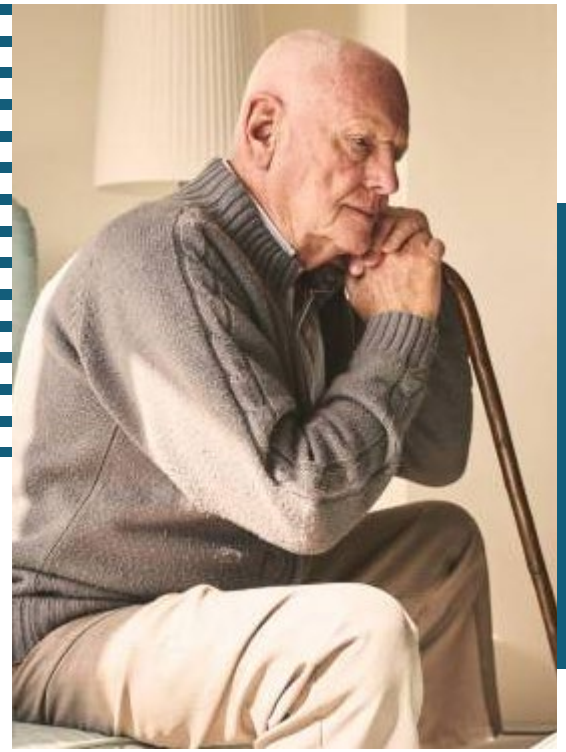
What medical/neurologic causes of depression would you think about for Mr. M?

Medical/Neurologic Causes

- **These should be assessed by PCP and reviewed by Psychiatric Consultant**
- Obstructive sleep apnea
- Chronic pain
- Hypothyroidism, endocrine disorders
- Anemia
- Infectious disease: HIV, TB, Mono
- Cancer
- Neurologic disorders (e.g., dementia, stroke, Parkinson’s)
- Autoimmune disorders (e.g., lupus)
- Medications: beta blockers, interferon, steroids, hormones, antibiotics, statins, anticonvulsants

Case Follow-up

- His PHQ-9 is 14, loss of interest started 1 month ago after moving
- GAD-7 is 9, no history trauma, no substance use
- Medical history positive for a heart attack 10 years ago with bypass surgery, has hypertension and high cholesterol, treated with medications (beta blocker, ace inhibitor, statin, and aspirin)
- PCP notes indicate no new medical complaints, no abnormal physical exam findings, no medication changes in past 6 months
- All lab work is normal



>>> What is the most likely diagnosis? Or what else would you want to know before making the diagnosis?

>>> Ok to start antidepressant medication?

Contraindications/Cautions

Relative Contraindication: Bipolar Disorder

- Risk of causing mania
- Risk is reduced by mood stabilizers
- May still be effective for comorbid anxiety disorder w/ mood stabilizer
- **Screen all patients for bipolar before starting antidepressant**

Only in rare cases are SSRIs absolutely contraindicated

Caution with:

- Pregnancy
- Other serotonin-related medications
- Certain medical conditions (e.g., seizures, bleeding, liver, or kidney disease)
- Certain medications (e.g., for HIV or anticoagulants)
- **Psychiatric consultant should review these cautions**

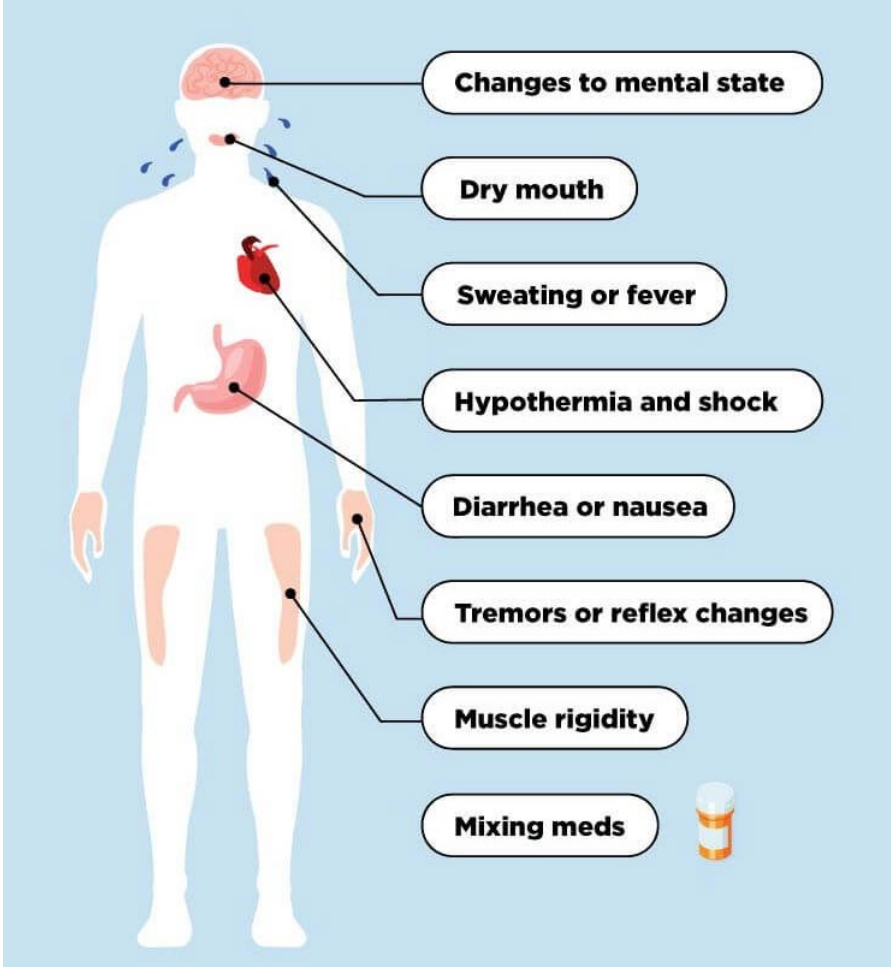
Serotonin Syndrome

Rare but dangerous consequence of excessive serotonin activity

Causes: overdose of antidepressants, combination of medications that affect serotonin

Other pro-serotonin drugs include:

- Tramadol and other opiates
- Triptans for migraine headaches
- Stimulants and drugs of abuse: cocaine, ecstasy (MDMA)
- Anti-nausea medications, some antibiotics
- St. John's Wort



Which symptoms are most concerning?

Antidepressant Medication Selection

Antidepressants

- SSRIs
- SNRIs
- Bupropion (Wellbutrin)
- Mirtazapine (Remeron)
- TCAs
- Other/new

SSRIs

Fluoxetine (Prozac)

Sertraline (Zoloft)

Paroxetine (Paxil)

Citalopram (Celexa) & Escitalopram (Lexapro)

- All FDA approved for major depressive disorder
- Some also FDA approved for anxiety disorders
  - All considered effective for anxiety

- What is the relationship between Celexa and Lexapro?

SSRIs: Common Side Effects

Gastrointestinal: nausea, diarrhea, constipation, loss of appetite, vomiting (infrequent)

Sexual Dysfunction: impaired libido or orgasm

Sleep & Energy: Insomnia, somnolence, drowsiness, fatigue, lightheaded, weak

Nervousness and **Agitation**

Dry Mouth

Less Common (<10%): sweating, tremor, dry eyes

Which side effects can be symptoms of depression or anxiety?

SSRIs: Addressing Side Effects

Assess side effects to:

- determine if related to antidepressant or another medical cause
- decide to continue or stop medication

Care Manager should:

- Ask if any side effects routinely
- If side effects present, assess:
  - Timing—was it clearly after the medication?
  - Severity and frequency—getting better, worse, or staying the same?
  - Patient distress—do they want to stop the medication or give it more time?

PCP/nurse or psychiatric consultant should be made aware of all side effects in case further assessment is needed

SNRIs

Venlafaxine (Effexor) & Desvenlafaxine (Pristiq)

Duloxetine (Cymbalta)

- **Efficacy and side effects similar to SSRIs**
- **Advantage vs. SSRIs:** also effective for neuropathic pain (e.g. from diabetes, fibromyalgia)
- **Disadvantage vs. SSRIs: greater hypertensive effects (mild)**
- **Mechanism:** Blocks reuptake of **norepinephrine** and serotonin

Atypical Antidepressants

Bupropion (Wellbutrin)

Advantage vs. SSRIs: Suppresses appetite, less sexual dysfunction, stimulant-like

Disadvantage vs. SSRIs: not effective for anxiety disorders

Mechanism: stimulates release of dopamine and norepinephrine

- Also effective for smoking cessation
- **Caution in patients with seizure history**

Mirtazapine (Remeron)

Advantage vs. SSRIs: Sedating and stimulates appetite, useful for insomnia and weight loss

Disadvantage vs. SSRIs: Sedation and weight gain

Mechanism: blocks serotonin receptors, increases serotonin and norepinephrine release

Tricyclic Antidepressants (TCAs)

Nortriptyline

Amitriptyline

- Older generation, replaced by SSRIs
  - Significant **anticholinergic side effects**
  - **Dangerous in overdose (cardiac arrythmias)**
- Still used for migraine headaches, nerve pain, sleep
- **Should not be first choice for depression/anxiety**

Choice of Initial Antidepressant

25-year-old woman with depression, no other psychiatric or medical history

- Which antidepressant would you start?
- What if she has comorbid PTSD?

A. Sertraline

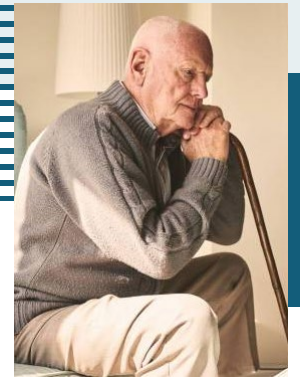
B. Venlafaxine

C. Buproprion

D. Mirtazepine

What about Mr. M, who is 80 y/o with HTN, CAD, and no significant pain/neuropathy, no separate anxiety disorder?

What if Mr. M has severe insomnia and weight loss?



What if initial treatment fails?

Options for the next step include:

Increase dose

Switch to another antidepressant

- SSRI to other SSRI is as good as switching to SNRI/bupropion/mirtazapine

Add a second “augmenting” antidepressant from other class

- SSRI + bupropion or mirtazapine are common choices

Augment with an antipsychotic or other medication

- VA trial found augmentation with aripiprazole (Abilify) was more effective than switch to bupropion

After 2 failures, scrutinize diagnosis, consider intensifying treatment

Patient Education

The Nuts and Bolts

Antidepressants need to be taken **daily, NOT as needed**

All antidepressants take **2-4 weeks to see a benefit**

Most side effects resolve in a few days, serious side effects are rare

Antidepressant should be **continued for at least 6 months**

If the first antidepressant doesn't work out, there are many other options

Antidepressant FAQ

Q: Are antidepressants just a placebo?

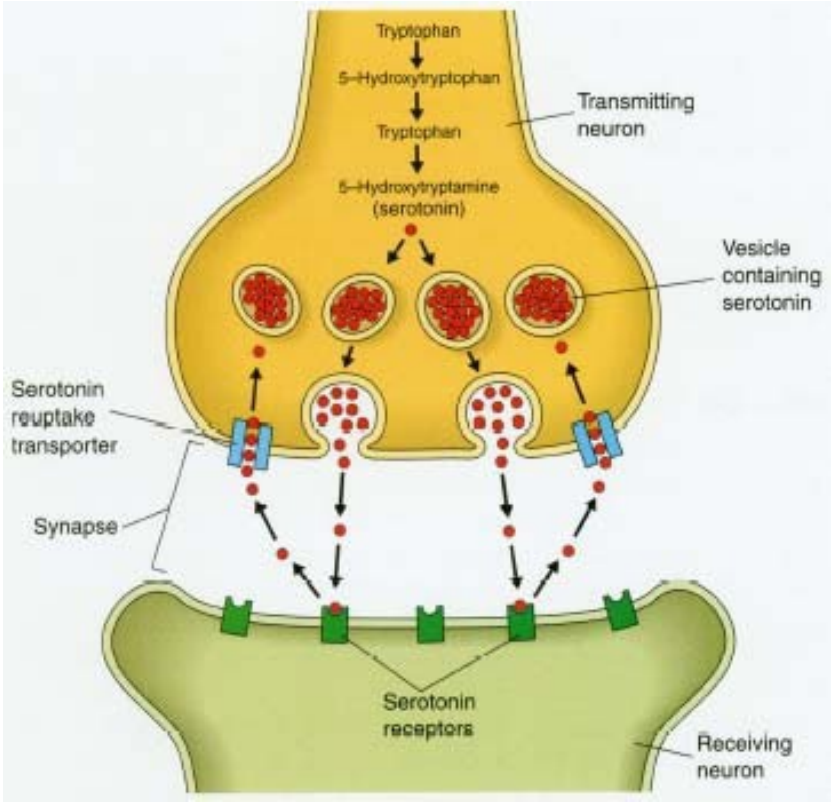
A: Antidepressant trials consistently show superiority to placebo: about 30% will get better with a placebo compared to 40% with an antidepressant

- Placebo response is high with depression, some consider this part of antidepressant treatment

Antidepressant FAQ

Q: How do these medications work?

A: Brain cells communicate with one another through chemicals that go between them. These medications affect the activity of those chemicals.



Antidepressant FAQ

Q: Do antidepressants cause suicide?

A: FDA warning—increase in suicidal thoughts and behaviors in those under 24 years old, no established increase in suicide death. Risk not shown in older patients.

Antidepressant FAQ

Q: Are antidepressants addictive? Can I stop them any time?

A: Very rarely abused, not considered addictive, and no dangerous withdrawal syndromes.

Discontinuation syndrome may occur, “brain zaps,” malaise, can last a few days and can be addressed by slower taper

Antidepressant FAQ

Q: Do antidepressants turn people into zombies?

A: Most are not sedating nor cause problematic slowing of cognition. Some report emotional flattening. Patients often have a friend/relative that “acts like a zombie” but this could be due to depression itself or other medications. Antidepressants do not cause loss of insight/awareness.

Sidebar: Qualitative Study of AD Experience

N 1747

Positive experiences of antidepressants		Negative experiences of antidepressants		Mixed experiences of antidepressants	
54 % (*n* 939)		16 % (*n* 273)		28 % (*n* 489)	
Positive themes	Example of coded data	Negative themes	Example of coded data	Mixed themes	Example of coded data
Necessary for disease treatment	*No different to a diabetic taking their insulin.*	Ineffective	*Useless despite trying several different kinds.*	Benefits vs side effects	*Very unfortunate side effects in terms of weight gain and sexual dysfunction which lead to me stopping the treatment despite its benefits for my mood and anger issues.*
A life saver	*Antidepressants have been a lifeline, without them I would be dead.*	Unbearable side effects	*A major cost to my sex life*	Calmer but not myself	*Good at removing my anxiety and fear but it made me feel dead inside.*
Meeting social obligations	*The medication I'm on is assisting me to function as an individual and to work and contribute to the community and society and to cope with things in my workplace.*	Loss of authenticity/ Emotional numbing	*Feel alienated from myself and my emotions.*	Fear of dependence versus stopping medication	*Very useful but I am now too scared to come off them and constantly worry about long term effects of being on citalopram 20mg per day*
Getting through difficult times	*Helpful for getting through a busy, tiring and stressful time in my life.*	Masks real problems	*A distraction that means I don't address the real issue.*	Finding one that works	*Useless until I found the one that worked for me.*
A stepping stone to further help	*Provided the 'lift' I've needed to get started with other things like CBT, regular exercise etc.*	Loss of control	*A sign of failing to cope.*		

Content category: Other 2 % (*n* 46)

Gibson, BMC Psychiatry 2016

Antidepressant FAQ

Q: Am I going to be on this medication forever?

A: Recommend at least 6 months after achieving remission to avoid relapse, indefinite treatment if multiple prior episodes. Message to patients is: “it’s up to you how long you take this medication and whether you find the benefits outweigh the costs.”

Resources

Antidepressant Treatment Algorithm
https://www.jpshealthnet.org/sites/default/files/tmap_depression_2010.pdf

General Information on Integrated Care
http://www.integration.samhsa.gov/

Patient Handout
http://www.nimh.nih.gov/health/publications/depression-easy-to-read/index.shtml

Questions?