ECHO IDAHO:
Behavioral Health in Primary Care

De-Prescribing and Polypharmacy

10/02/2024

Jacob White, DO

General and Pediatric Inpatient and Consult-Liaison, St. Alphonsus, Cottonwood Creek

ECT Director, General and Pediatric Inpatient, Cottonwood Creek Behavioral Hospital

DISCLOSURE OF CONFLICT OF INTEREST

I have no financial relationship with or interest in a commercial interest connected with this presentation.

PNWU
Health Sciences

Boston Children's Hospital
Until every child is well™

HARVARD
MEDICAL SCHOOL

BRIGHAM YOUNG UNIVERSITY
1888
BYU
IDAHO
REXBURG, IDAHO

ARIZONA
WILDCATS

By the end of today's discussion, the participant will be able to:

- Recognize importance of deprescribing and which meds to prioritize and how to safely taper common psychiatric medications
- Describe general principles of prescribing multiple psychiatric medications
- Locate resources to help steer prescribing

Deprescribing

- Any time a new medication is started, consider (and describe to patient) when it can be stopped. If it is anticipated to be longer term, consider what interval you plan to check in on the medication and its effect
- Often required after severity of symptoms requiring inpatient level of care. Higher doses or frequencies often required for acute stabilization
- Ensure patient at each visit that you are actively reviewing medications and considering ways to simplify and streamline. (Some patients need reminded that less is more)
- Prioritize deprescribing or moving to PRN habit forming medications
- Review medications with special caution if there is a change in renal or hepatic function or after age 65

Benzodiazepines

From UpToDate:

“In the outpatient setting, we recommend **gradual reduction of the benzodiazepine by 25 to 50 percent every 1 to 2 weeks over a period of 6 to 10 weeks**. Within this range, individualization of the taper rate depends on patient capacity to tolerate withdrawal symptoms, as well as the dose and duration of benzodiazepine use. Some patients may require longer tapers but prescribers should set clear and realistic goals for decreases in dose.

Longer durations of use are associated with a higher likelihood of symptoms during the taper. **Subjective benzodiazepine withdrawal symptoms during taper can worsen as the reduced dose reaches 25 percent of the initial dose prior to improving as the dose reaches zero**

Our approach is to switch patients who are using a single short-acting benzodiazepine to a long-acting benzodiazepine, typically diazepam or chlordiazepoxide, at an equivalent dose. For those who are on several benzodiazepines, we add up the total daily dose and switch to a single long-acting agent at that equivalent dose.

There is no direct evidence that long-acting benzodiazepines perform better than short-acting benzodiazepines in a taper. However, **short-acting benzodiazepines are associated with higher dropout rates from benzodiazepine discontinuation studies, worse “rebound” anxiety (eg, return of underlying anxiety symptoms after benzodiazepine discontinuation), and more severe withdrawal symptoms compared with long-acting benzodiazepines**

Discontinuation of Antidepressant medications

- No standard definition for antidepressant discontinuation syndrome.
- One or more adverse effects which can occur when antidepressants that have been taken continuously for at least 4 weeks are discontinued.
- Commonly reported in events leading to psychiatric inpatient treatment.

- Most common symptoms:
  - Dizziness
  - Fatigue
  - Headache
  - Nausea

- Other common symptoms:
  - Anxiety
  - Chills without fever
  - Dysphoria
  - Sweating
  - Insomnia
  - Increased irritability
  - Muscle pain

Discontinuation of Antidepressant medications

- Typically antidepressant discontinuation syndrome can be avoided by tapering over two to four weeks prior to discontinuation.
    - Consider half-life (paroxetine and fluvoxamine highest risk of withdrawal of SSRIs)
    - SNRIs 4 weeks (venlafaxine by 37.5 mg/week)
    - Buproprion discontinuation reportedly uncommon; taper over 2 weeks recommended

- Moderate to severe withdrawal symptoms: restart antidepressant (if contraindicated, alternative antidepressant agent) at the dose at which there were no symptoms; the discontinuation syndrome should resolve within 1-3 days.

- If longer taper required the antidepressant dose can be decreased by a fixed percent, commonly 25% decrease.

General ideas with polypharmacy

- Aim for a clean and streamlined medication plan
- Optimize dose before adding another medications
- Clear indications (pt should be able to explain the med)
- If PRN indications overlap, make clear what is first and second line on the bottle
- No more than one medication from each class of medications (may require collaboration with pt's other providers)
- BID or daily dosing when possible
- Run medications through interaction

Resources

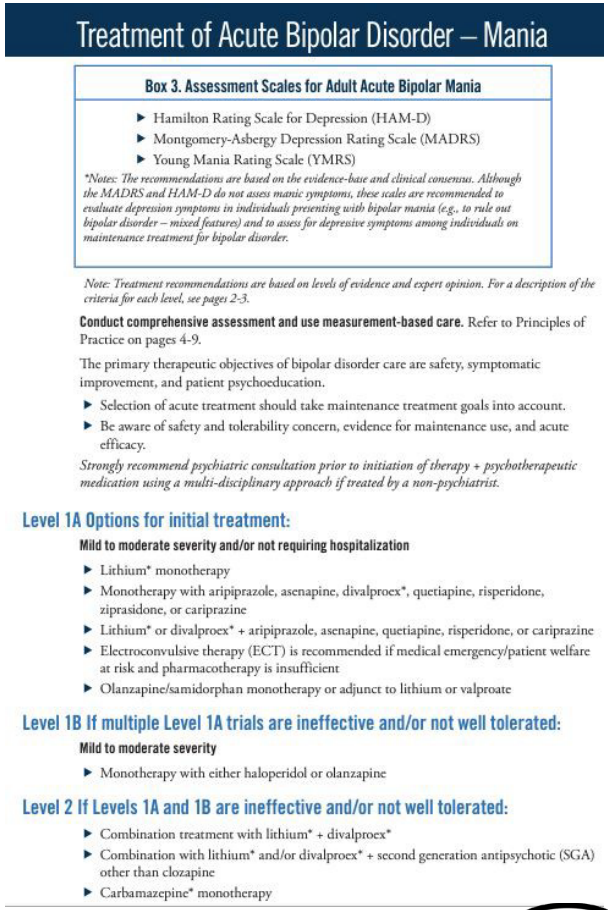
floridabhcenter.org

Comprehensive guide jointly maintained by University of South Florida and Florida Medicaid.

Spells out how to assess and clarify diagnosis and tools available for dx. Free access to many recommended questionnaires

Updated annually.

Guidelines specific to adults or kids with additional guidance for pregnant patients and kids with ASD and developmental issues.



Treatment of Acute Bipolar Disorder – Mania

Box 3. Assessment Scales for Adult Acute Bipolar Mania

- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asbergy Depression Rating Scale (MADRS)
- Young Mania Rating Scale (YMRS)

**Notes: The recommendations are based on the evidence-base and clinical consensus. Although the MADRS and HAM-D do not assess manic symptoms, these scales are recommended to evaluate depression symptoms in individuals presenting with bipolar mania (e.g., to rule out bipolar disorder – mixed features) and to assess for depressive symptoms among individuals on maintenance treatment for bipolar disorder.*

Note: Treatment recommendations are based on levels of evidence and expert opinion. For a description of the criteria for each level, see pages 2-3.

Conduct comprehensive assessment and use measurement-based care. Refer to Principles of Practice on pages 4-9.

The primary therapeutic objectives of bipolar disorder care are safety, symptomatic improvement, and patient psychoeducation.

- Selection of acute treatment should take maintenance treatment goals into account.
- Be aware of safety and tolerability concern, evidence for maintenance use, and acute efficacy.

Strongly recommend psychiatric consultation prior to initiation of therapy + psychotherapeutic medication using a multi-disciplinary approach if treated by a non-psychiatrist.

Level 1A Options for initial treatment:

Mild to moderate severity and/or not requiring hospitalization

- Lithium* monotherapy
- Monotherapy with aripiprazole, asenapine, divalproex*, quetiapine, risperidone, ziprasidone, or cariprazine
- Lithium* or divalproex* + aripiprazole, asenapine, quetiapine, risperidone, or cariprazine
- Electroconvulsive therapy (ECT) is recommended if medical emergency/patient welfare at risk and pharmacotherapy is insufficient
- Olanzapine/samidorphan monotherapy or adjunct to lithium or valproate

Level 1B If multiple Level 1A trials are ineffective and/or not well tolerated:

Mild to moderate severity

- Monotherapy with either haloperidol or olanzapine

Level 2 If Levels 1A and 1B are ineffective and/or not well tolerated:

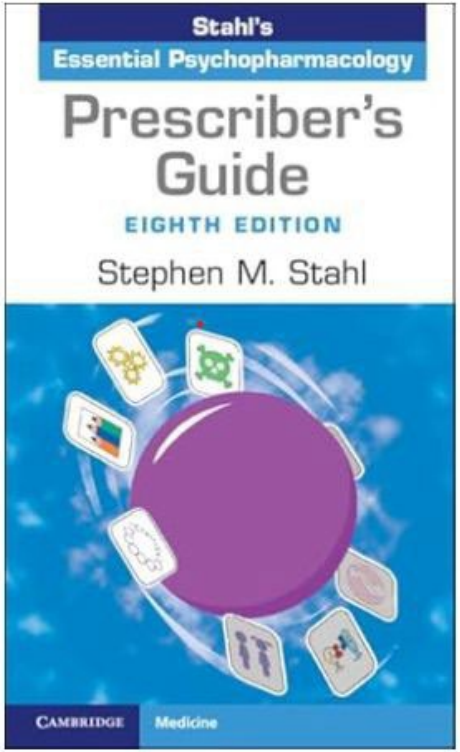
- Combination treatment with lithium* + divalproex*
- Combination with lithium* and/or divalproex* + second generation antipsychotic (SGA) other than clozapine
- Carbamazepine* monotherapy

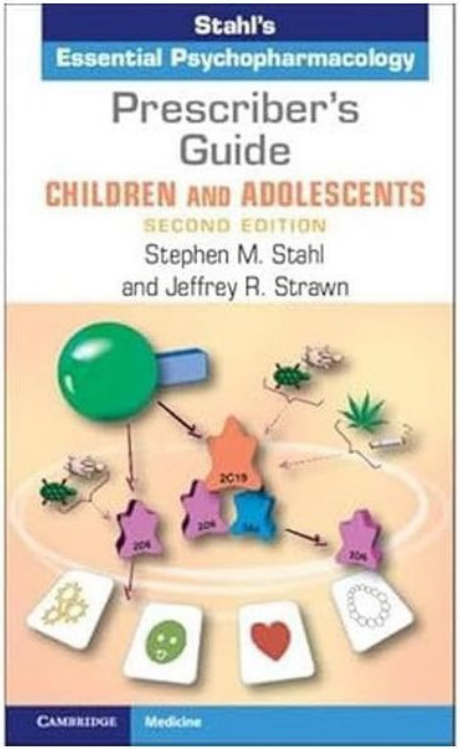
Project ECHO

University of Idaho
WWAMI Medical Education

Resources

The Carlat psychiatry podcast





Questions?

Project ECHO®

University of Idaho
WWAMI Medical Education