Use of Prescription Medication in Drug Court

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Outline

- My background
- General approach to diagnosis, difficulties
- Treatment
- Specific medication and drug thoughts
- Questions, please

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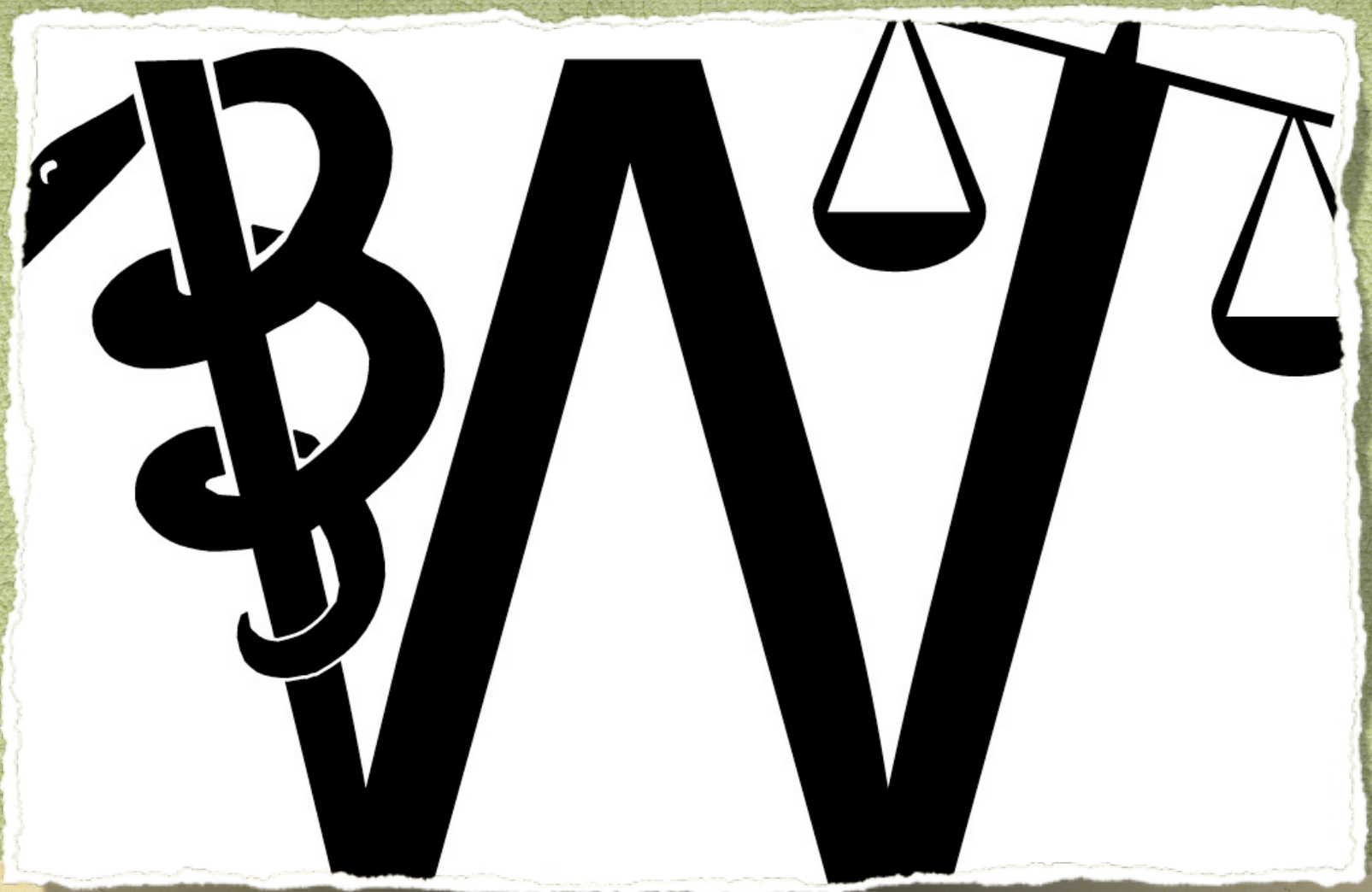

Oak Hill Forensic Psychiatry

Minnesota, Wisconsin, and Iowa

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St. Peter, Minnesota

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PSYCHIATRY

Oak Hill Psychiatry Clinic

St. Peter, Minnesota

Forensic Psychiatry

- Medical school training and degree (M.D.) as any physician receives.
- One year of general medical internship (ER, neurology, surgery, delivering babies, et cetera).
- Then, 3 years of residency training in psychiatry.
- Additional training: fellowship in Forensic Psychiatry.

Forensic Psychiatry

- Most of my work is that which a general psychiatrist would be doing.
- In my forensic role, the interface between medicine and the law is my focus.
- Mental illness diagnoses and substance use disorders are rarely “excuses” in the legal sense.

Forensic Psychiatry

- Thus, my approach is that genetics or "the hand life deals you" is generally only one portion of your trajectory in life.
- Another portion (most?) of a patient's trajectory is dependent on their day-to-day choices.
- My role perhaps limited?

Psychiatry and Drug Court

- In "drug court," I also view my role as limited.
- Medications are not the sole answer in most cases.
- Patients accept this to varying degrees.
- So many other factors (AA, NA, family, friends, court, therapy, groups, outreach, work, school, etc.).

Dual Diagnoses

- Dual diagnoses and comorbidity used interchangeably.
- Two (or more) illnesses in an individual at the same time.
- Examples: bipolar disorder and marijuana dependence, depression and alcoholism, anxiety disorder and cardiac disease.

Dual Diagnoses

- Today, we are using the term to indicate one or more psychiatric diagnoses co-morbid with one or more chemical abuse or dependence diagnoses.
- Each illness may affect the course, severity, manifestation, response to treatment, and other factors of other illnesses.

Is It "Dual Diagnoses"?

- Intoxication
- Withdrawal
- Substance-induced mood disorder
- Substance-induced psychotic disorder
- Leave differential wide and in place for a time

Is It "Dual Diagnoses"?

- Mr. Braun is a 24-year-old man who has been committed as Mentally Ill and Dangerous (MI & D) due to killing his step-mother during an episode of mania with psychosis.
- He believed that she was going to Hell. Yet, he could save her due to being imbued with the power of God.

Is It "Dual Diagnoses"?

- Complicating the picture, he rarely had more than a month of sobriety from alcohol and other drugs.
- Now, he finds himself at Minnesota Security Hospital with an average of 5 - 9 years of a hospital stay.
- On significant doses of an anti-psychotic mood stabilizer.

Is It "Dual Diagnoses"?

- Discussion with patient --> tapering of medications. Had tried before the one-year mark without success (return of symptoms).
- Over the coming months, appeared to be stable and without symptoms.
- Next, he underwent the long process of challenging his MI & D commitment.

Is It "Dual Diagnoses"?

- Does he have bipolar disorder or a protracted substance-induced mood and psychotic disorder?

- We may never know “for sure.”

Potential Psychiatric Dx.

- Somatoform: conversion disorder, somatization disorder.
- Cognitive: ADHD, dementia, autism.
- Mood: depression, bipolar, (anxiety d/o).
- Psychotic: schizophrenia, delusional d/o, schizoaffective d/o.

Substance Diagnoses

- Substance use: non-problematic use.
- Substance mis-use: using in a manner not intended or prescribed.
- Substance abuse: see DSM-IV-TR (DSM-5).
- Substance dependence: see DSM-IV-TR (DSM-5).

Co-Morbid

- In general across many settings:
  - Patients in substance abuse programs have co-occurring mental disorders 1/2 - 3/4 (50 - 75%) of the time.
  - Patients in mental health programs have co-occurring substance use disorders 1/4 - 1/2 (25 - 50%) of the time.

Co-Morbid

- In those with serious mental illnesses, over one in five had a substance use disorder in the past year.

= 20.3 Million w/ SUD

11.2 Million

9.2 Million

36.7 Million

= 45.9 Million w/ MI

Co-Morbid

- Why are they related? Why do they overlap?
- Many drugs of abuse affect dopamine and serotonin production, release, use, and effects.
- Psychosis (dopamine), anxiety and mood (serotonin).
- Withdrawal symptoms can last weeks to months (year or more?).

Co-Morbid

- Diagnostic difficulties:
  - Drugs and alcohol can
    - cause psychiatric symptoms in anybody.
    - cause symptoms to last longer.
    - exacerbate pre-existing illness.
    - mask pre-existing illness.

Clarifying Diagnoses

- Patient characteristics that might point toward co-occurring psychiatric diagnoses:
  - Family history
  - Symptom onset before drug use or symptoms during a lengthy abstinence
  - The longer symptoms continue after last use, the more likely it is to be co-morbid dxs.

Clarifying Diagnoses

- Generally, I try to keep the differential wide and in-place for a while.
- Axis I: Depression NOS (primary MDD versus substance-induced versus adjustment disorder versus [...])

Clarifying Diagnoses

Withdrawal

mood problems:

- normal in early abstinence
- resolves w/ time
- responds to behavioral and 12-step measures

Psychiatric

mood problems:

- not “normal”
- won’t resolve w/o treatment
- behavioral and 12-step measures won’t hurt

Clarifying Diagnoses

- Visual hallucinations: Generally indicative of substance-induced problems (or medical--certain dementias, tumors, delirium, electrolyte disturbances).
- Auditory hallucinations: More consistent with primary psychosis (schizophrenia, schizoaffective disorder).

Clarifying Diagnoses

- Paranoia: less specific.
  - Substances: cocaine, stimulants, occasionally with THC
  - Axis I: mania, psychotic disorders
  - Axis II: paranoid personality disorder (not a common diagnosis)

Clarifying Diagnoses

- Mania:
  - Methamphetamine, cocaine
  - Ecstasy (MDMA)
  - Hallucinogens
  - Rx medications: prednisone
  - Medical causes
  - Perhaps alcohol and benzodiazepine withdrawal

Clarifying Diagnoses

- Outside records are very helpful.
- The time that I have with each patient is limited, especially at follow-up visits.

Treatment

- Generally, avoid other drugs (prescribed) with similar effects.
- Benzodiazepines: Ativan, Xanax, Valium, Klonopin, Librium, Restoril, Versed, Ambien, Sonata, Lunesta.
- Stimulants: Adderall, Ritalin, Vyvanse, Concerta.

Treatment

- Sleep, how to address this?
  - Tincture of time.
  - Optimize sleep hygiene: diet, exercise, caffeine use.
  - Sleep medicine referral.

Treatment

- Medical care:
  - Consider avoiding *elective* procedures during first year of recovery.
  - Coordination of care.
  - Avoiding prescribing outside one's scope or practice.

Treatment

- ADHD:
  - Avoid stimulants, so other options include:
    - bupropion (Wellbutrin), venlafaxine (Effexor), clonidine, guanfacine, atomoxetine (Strattera).
  - Controlled release stimulants have less abuse potential, but still not = 0!

Treatment

- ADHD:
  - Patients with *true* ADHD diagnosis in childhood, only 30% will carry significant symptoms into adulthood.

Treatment

- General thoughts:
  - Avoid polypharmacy, a symptom for each drug and a drug for each symptom.
  - Many patients with substance use disorders like to use drugs, Rx or otherwise, abusable or otherwise.
  - Is a symptom a “blip on the radar” or something needing treatment with an Rx?

Treatment

- General thoughts:
  - Decision to treat with medications should have a clear goal, should have considered other treatment options (therapy, groups, outreach, etc.) and one option can be doing nothing, “watchful waiting.”

Treatment

- Important to address both.
  - If not, poorer outcomes.

Suicide

- To avoid suicide, would you rather have depression or cocaine addiction?
- Increase in odds of suicide attempt:
  - alcohol use = 8 times more likely
  - divorce = 11
  - major depression = 41
  - cocaine use = 62

Specific Drugs

- Marijuana:
  - Depending on genetic make-up, can be associated with twice greater risk of developing schizophrenia.
  - Loss of IQ points (up to 8) with dependence before age 18.

Specific Drugs

- Marijuana adversely affects many areas:
  - anxiety, depressive symptoms, suicidality, behavior problems, neurocognitive deficits (learning, memory, IQ drops), poorer sleep, respiratory problems, cancer.

Specific Diagnoses

- Antisocial personality d/o: highest likelihood of co-morbid substance use.
- Borderline personality d/o: substance use associated with predictable and significant clinical worsening.

Specific Diagnoses

- Eating disorders
  - 50% of people with an eating disorder also have substance use disorders (compared to about 10% of the general population).
  - 35% of females with a substance use disorder report having an eating disorder (compared to 1 - 3% of the general population).

Interesting Things I've Learned…

- PCP epidemic in the St. Peter & Mkto. area?
- Again outside records are very helpful, saves me from "re-inventing the wheel."
- A small set of patients seem wary of what I might "impose" onto them, medication-wise, and tend to respond to reassurance.

Summary

- They generally are “just like any other patient.”
- If sobriety continues, there can often be a paring down of the diagnostic list.
- Close monitoring of prescriptions.
- Most patients feel that the experience (drug court) as a whole is helpful.

Thank-you!

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Anti-psychotics

- 1st generation:
  - chlorpromazine (Thorazine)
  - prochlorperazine (Compazine)
  - fluphenazine (Prolixin)
  - haloperidol (Haldol)
  - loxapine (Loxitane)
  - thioridazine (Mellaril)
  - thiothixene (Navane)
  - pimozide (Orap)
  - perphenazine (Trilafon)
  - trifluoperazine (Stelazine)

Anti-psychotics

- 2nd generation:
  - aripiprazole (Abilify)
  - clozapine (Clozaril)
  - **iloperidone (Fanapt)**
  - ziprasidone (Geodon)
  - risperidone (Risperdal)
  - paliperidone (Invega)
  - **lurasidone (Latuda)**
  - **asenapine (Saphris)**
  - quetiapine (Seroquel)
  - olanzapine (Zyprexa)

Anti-psychotics

- Most are simple oral pills, some rapid-dissolve
- Saphris is a sublingual tablet (less effective if swallowed) that can be sublingual, between the cheek and gums, absorbed via mucosa
- 2nd generation anti-psychotics have some long-acting injected: Risperdal Consta (2 weeks), Invega Sustenna (4 weeks), Zyprexa Relprevv (2 – 4 weeks)

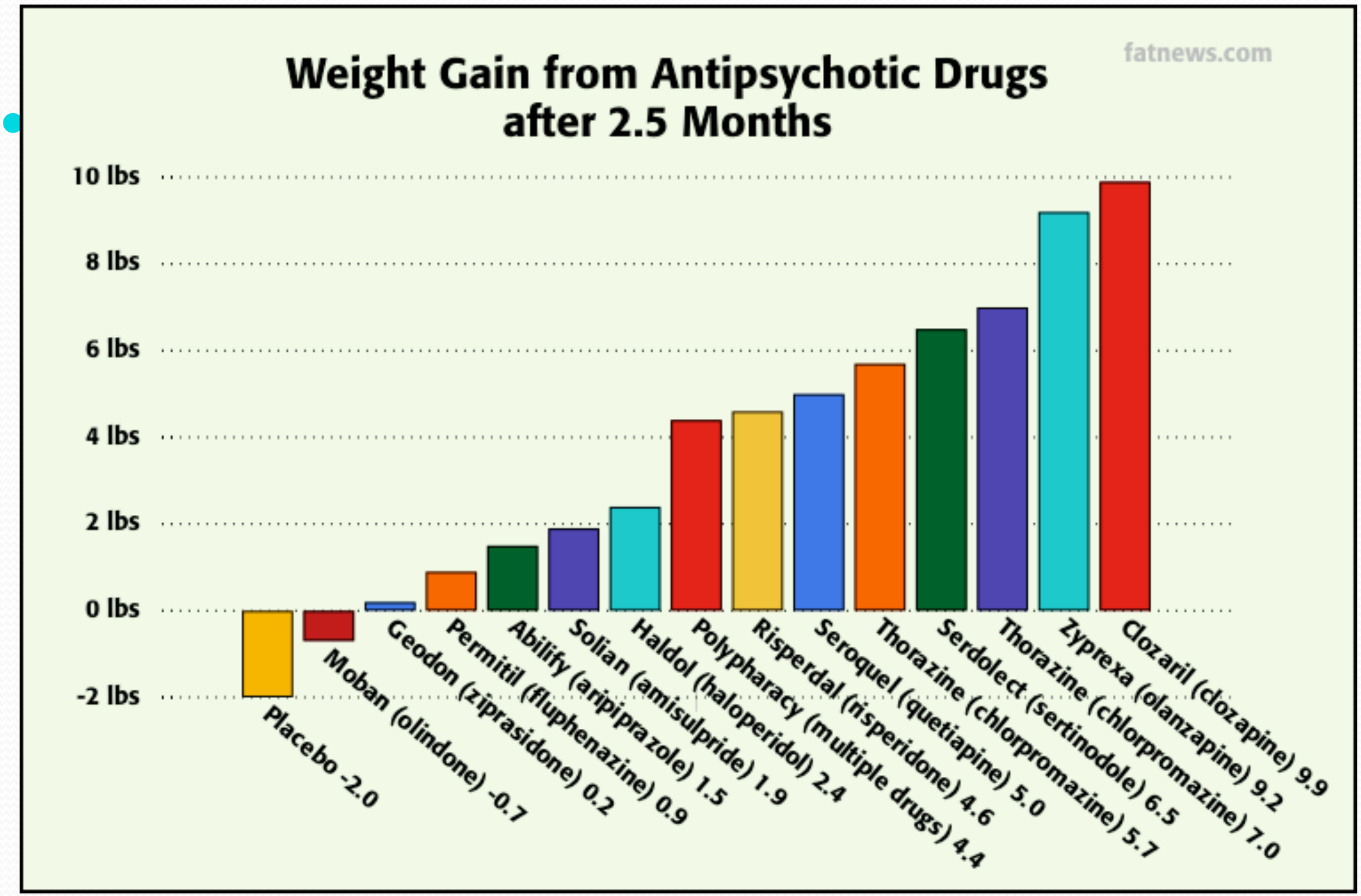
Anti-psychotics

- Latuda is the only anti-psychotic (only psychotropic medication overall, actually) that is pregnancy class B. All others are class C.
- B = Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant women OR Animal studies have shown an adverse effect, but adequate and well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus in any trimester.

Anti-psychotics

- C = Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

Anti-psychotics: Side Effects



Anti-psychotics: Side Effects

- Weight gain: possible with any/all of them, but there are general patterns (see previous graph).
- Newer ones (Fanapt, Saphris, Latuda) are supposed to be more weight neutral.
- Likely from a combination of appetite stimulation and inducing more sedentary living (pill itself has negligible calories).

Anti-psychotics: Side Effects

- Tardive dyskenisia and other movement disorders
- Sedation
- Cardiac conduction effects
- Metabolic effects (glucose, lipids)
- Leukopenia effects (Clozaril most notable)
- Sexual side effects

Anti-psychotics: Action

- As with many of the psychiatric medications, exact mechanism is unknown.
- However, dopamine antagonism (blockade) appears to correlate to the anti-psychotic effect of the class.

Mood-stabilizers

- (essentially all of the anti-psychotics again)
- The anti-seizure mood stabilizers: blocks or alters voltage-sensitive sodium channels, inhibits repetitive firing, stabilizes membranes, but “exact mechanism unknown”
- Lithium or Li+: also interacts with sodium channels, however… exact mechanism unknown

Mood-stabilizers

- For the mood-stabilizers, likely all of the anti-seizure medications have been tried at one time or another.
- Frequently used are: Depakote, Lamictal, Tegretol, Trileptal, Topamax, Neurontin
- Most have weight gain (except Topamax), can affect sodium levels, sedation.
- Lamictal and rash

Mood-stabilizers

- Lithium
  - Side Effects: thirst, metallic taste, increased frequency or urination, fine head and hand tremor, drowsiness, and mild diarrhea
  - Blood levels monitored (lithium toxicity - severe diarrhea, vomiting, drowsiness, muscular weakness, and lack of coordination, withhold)

Anti-depressant

- Most antidepressants block the re-uptake of a neurotransmitter of one or more of the bioamines: serotonin, norepinephrine, dopamine.
- SSRI = selective serotonin reuptake inhibitor
- SNRI = serotonin and norepinephrine RI
- Miscellaneous or other

Anti-depressant

- SSRI: Lexapro, Celexa, Paxil, Prozac, Prozac Weekly, Zoloft, Luvox
- SNRI: Cymbalta, Effexor, Pristiq
- Others: TCA, MAOI, Wellbutrin, trazodone, Oleptro, Remeron, Viibryd
- Many uses: depression, anxiety, OCD, PTSD, borderline PD, trichotillomania, premature ejaculation, chronic pain

Anti-anxiety

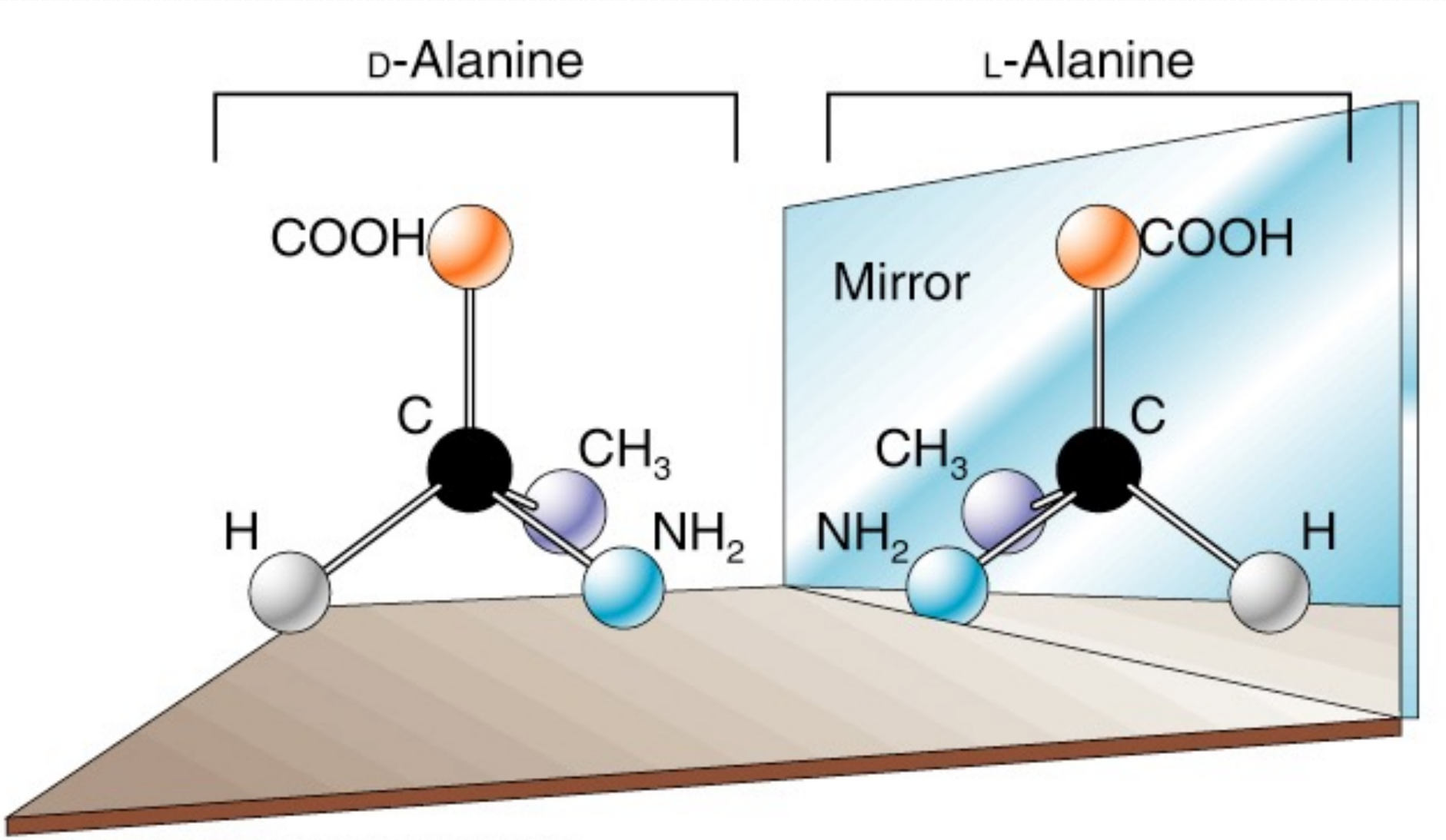
- Benzodiazepines
  - diazepam (Valium)
  - lorazepam (Ativan)
  - alprazolam (Xanax)
  - clonazepam (Klonopin)
- Nonbenzodiazepines
  - busipirone (BuSpar)
  - Benadryl, Vistaril, Gabapentin, blood pressure medications, etc.

Stimulants, ADHD Medications

- Strattera (atomoxetine), Tenex/Intuniv (guanfacine), Wellbutrin, Effexor
- Stimulants are generally either Ritalin derivatives or Adderall derivatives.
- Stimulant side effects: weight loss, loss of appetite, sleep disturbance, psychosis, anxiety

Newer Medications

- Lexapro (escitalopram)



Newer Medications

- Lexapro (escitalopram)
- Celexa (citalopram) is actually a mixture of two molecules, mirror images of each other. One (S-citalopram) appeared to be the therapeutic molecule, the other (R-citalopram) interfering and side-effect promoting.

Newer Medications

- Pristiq (desvenlafaxine)
- Effexor (venlafaxine) is converted in our bodies to many metabolites, including desvenlafaxine.
- Blatant patent extender or useful drug filling a need, filling a void?

Newer Medications

- Vyvanse (lisdexamphetamine)
  - Is a "pro-drug," converted in the body (mostly red blood cells) to an active drug that is similar to Adderall
  - Less abuse potential as the conversion is rate-limited, no "rush" with IV, snorting, inhaled/smoked, etc.
  - Still is classified as a stimulant (one month's worth with no refills)

Newer Medications

- Saphris, Latuda, Fanapt
  - Again, useful medications filling a void or “me too” medications?
  - Improvements in weight gain, metabolic effects.
  - “Hail Mary” attempts in non-responders.
  - Saphris with sublingual
  - Latuda with category B for pregnancy

Newer Medications

- Viibryd (vilazodone)
  - Has only been out for about 5 – 6 weeks as of 8/11/11. The claim is that it has novel ways of acting (not just a reuptake inhibitor). I have only about 3 – 4 people on this and none have yet come for follow-up.