HHP Care Model and Disease Management Webinar Series

Psychiatric Pearls for the Primary Care Provider

Thursday, May 27, 2021
5:30pm – 6:30pm

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

Moderator – 05/27/21

Andy Lee, MD
Medical Director, *Hawai‘i Health Partners*
Chief of Staff, *Pali Momi Medical Center*
Hawai‘i Pacific Health

HAWAI‘I PACIFIC HEALTH | HAWAI‘I HEALTH PARTNERS

Disclaimer:

- The following is intended as information resource only for HHP/HPH providers, clinicians, administrative and clinical leaders.

- Specific areas may not pertain directly to your clinical practice area and/or may not be applicable to your practice based on your existing workflows, infrastructure, software (e.g. EHR), and communications processes.

Webinar Information

- You have been automatically muted.
  You cannot unmute yourself.
- You will be able to submit questions via the Q&A section.
  - Due to time constraints, any unanswered questions will be addressed this week and posted on the HHP website
- A recording of the meeting will be available tomorrow on the HHP website and intranet.

How to Claim CME Credit

1. Step 1: Confirm your attendance
   - You should have completed a brief questionnaire before joining today's live webinar.

2. Step 2: HPH CME team will email you instructions
   - Complete and submit evaluation survey that will be emailed to you within one week of the offering.
   - Your CE certificate will be immediately available to you upon completion of your evaluation.
   - Questions? Email hphcontinuingeduc@hawaiipacifichealth.org

CME Accreditation Statement

- In support of improving patient care, Hawai‘i Pacific Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
- Hawai‘i Pacific Health designates this webinar activity for a maximum of 1.0 AMA PRA Category 1 Credit (s) ™ for physicians. This activity is assigned 1.0 contact hour for attendance at the entire CE session.

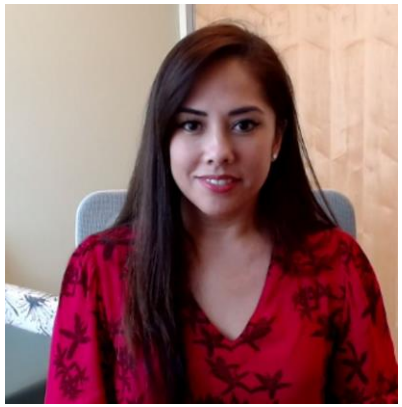
JOINTLY ACCREDITED PROVIDER™

INTERPROFESSIONAL CONTINUING EDUCATION

Disclosures

- The planners and presenters of this activity report no relationships with companies whose products or services (may) pertain to the subject matter of this meeting

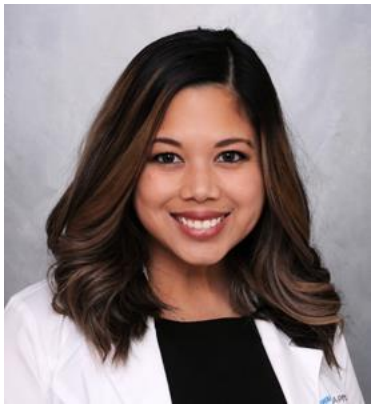
Psychiatric Pearls for the Primary Care Provider



Shaylin Chock, MD

Psychiatrist, Kapiʻolani Behavioral Health Services, Hawaiʻi Pacific Health

Assistant Professor, Department of Psychiatry, University of Hawaiʻi – John A. Burns School of Medicine



Mary Rose Nino, MD

Pediatrician, Hawaiʻi Pediatrics, Hawaiʻi Health Partners

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

May is Mental Health Month

Prevalence of Mental Illness

- Pre-pandemic
  - 1 in 5 US adults experience mental illness each year
  - 1 in 20 US adults experience serious mental illness each year
  - 1 in 6 US youth (6-17) experience a mental health disorder each year
  - Suicide is the 2nd leading cause of death among people aged 15-34

1) Nami.org and World Health Organization (WHO)

The shortage of physicians in the US

- Known PCP shortage
- "Steepest deficits among psychiatrists“
- Fewer than ½ the adults get the help they need in a given year

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions company in the United States.

Corporate Office:
Merritt Hawkins
8840 Cypress Waters Blvd #300
Dallas, Texas 75019
800-876-0500

Eastern Regional Office:
Merritt Hawkins
100 Mansell Court East
Suite 500
Roswell, GA 30076
800-306-1330

The Silent Shortage

A White Paper Examining Supply, Demand and Recruitment Trends in Psychiatry

Introduction

Merritt Hawkins, the nation's leading physician search and consulting firm, produces a series of surveys, white papers, speaking presentations and other resources intended to provide insight into physician recruiting, physician supply and demand, physician compensation trends and a range of related topics.

In addition to its own research and analysis, Merritt Hawkins is contracted by third parties to conduct various research projects. Third parties that Merritt Hawkins has partnered with on such initiatives include **The Physicians Foundation, the American Academy of Physician Assistants, the North Texas Regional Extension Center/Office of the National Coordinator for Health Information Technology, the Society for Vascular Surgery, Trinity University, the Indian Health Service, the American Academy of Surgical Administrators, and the Association of Managers of Gynecology and Obstetrics.** Merritt Hawkins also has submitted oral and written expert testimony to **Subcommittees of the Congress of the United States.**

This white paper examines supply, demand, and recruiting trends in the specialty of psychiatry.

Screening Tools

- PHQ-9 (Patient Health Questionnaire, 9 items)
  - Self-administered (<5min)
  - Excellent sensitivity and specificity, including postpartum depression
  - Suicide item is sensitive in primary care settings
  - Measured against clinical interview
- GAD-7 (Generalized Anxiety Disorder Scale, 7 items)
  - Self-administered (<5min)
  - Good sensitivity and specificity for GAD
  - Fair sensitivity for panic and social phobia
  - Low sensitivity for PTSD

Mulvey- Day, N. et al. Screening for Behavioral Conditions in Primary Care Settings: A Systematic Review of the Literature. J Gen Intern Med. 2017. 33(3): 335-346.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

https://www.mdcalc.com/phq-9-patient-health-questionnaire-9

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

Proposed Management by PHQ-9 Score

Score	Depression Severity	Proposed Action
0-4	None-Minimal	None
5-9	Mild	Watchful waiting; repeat at follow up
10-14	Moderate	Treatment Plan, consider counseling, follow up and/or pharmacotherapy
15-19	Mod Severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, referral to mental health specialist and/or collaborative management

Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Psychiatric Annals 2002;32:509-521.

Treatment Response and Plan by Change in PHQ-9 Score (after 4-6 weeks)

Score	Treatment Response	Treatment Plan
Drop of 5 points from baseline	Adequate	No treatment change needed Follow up in 4 weeks
Drop of 2-4 points from baseline	Possibly inadequate	May warrant an increase in antidepressant dose or increase therapy intensity Follow up in 2- 4 weeks
Drop of 1 point from baseline	Inadequate	Increase dose; Augmentation Add psychotherapy if not done Informal or formal psychiatric consultation Follow up in 1-2 weeks

Chung H, Pietruszewski P. Clinical Staff Webinar, National Council Depression Care Collaborative. 2015

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than 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 is 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

(For office coding: Total Score T____ = ____ + ____ + ____)

https://www.mdcalc.com/gad-7-general-anxiety-disorder-7

Proposed Management by GAD-7 Score

Score	Symptom Severity	Proposed Action
5-9	Mild	Monitor
10*-14	Moderate	Possible clinically significant condition
>15	Severe	Active treatment probably warranted

*For Panic Disorder, Social Phobia, & PTSD, cutoff score of 8 maybe used for optimal sensitivity/specificity

Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7.
Kroenke K, Spitzer RL, Williams JBW, Monahan PO, Löwe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med 2007;146:317- 325.

Suicide Risk Factors

- **Known mental health condition**
- **Family history**
- **Substance Use**
- **Intoxication**
- **Access to firearms**
- **A serious or chronic medical illness**
- **Gender**
- **History of trauma or abuse**
- **Prolonged stress**
- **Recent tragedy or loss**
- **Recent life change**

CDC and NIMH

Suicide Warning Signs

- **Increase alcohol and drug use**
- **Aggressive behavior**
- **Withdrawal from friends, family and community**
- **Dramatic mood swings**
- **Impulsive or reckless behavior**
- **Collecting and saving pills or buying a weapon**
- **Giving away possessions**
- **Tying up loose ends**
- **Saying goodbye**

CDC and NIMH

My patient is suicidal...

- Imminent danger
  - Call 911 (if your clinic is not on a medical campus)
  - let them know you have a patient who is in imminent danger and likely needs a MH1
- Not exactly sure if imminently dangerous
  - Local Crisis number: Hawaii CARES

Psychopharmacology

- Antidepressants
  - SSRI
  - SNRI
  - Others
- Antianxiety
  - In addition to SSRI/SNRI
- Antipsychotics
  - Monitoring
  - Managing side effects

Choosing the right treatment(s)

- Basics (Lifestyle interventions)
  - Physical Activity
  - Sleep
  - Avoid Social Isolation
- Psychotherapy
  - Cognitive Behavioral Therapy (CBT)
  - Intrapersonal Psychotherapy (IPT)
- Medications
  - Moderate to severe depression/anxiety
  - First line
    - SSRI/SNRI

FDA Black Box Warning

- Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Insert established name] or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide.

Fda.gov

Black Box continued

- Possible theories:
  - Antidepressants uncover bipolar
  - Immature prefrontal myelination
  - Younger patients metabolize drugs faster
  - Worse sleep
- Results of the FDA warning
  - Decrease in prescribing of SSRI/SNRI
    - Increase in benzo and antipsychotics
  - Decreased rate of diagnosing MDD
  - Increase psychotropic drug poisoning (Suicide attempts)

Fornaro, M. et al., The FDA "Black Box" Warning on Antidepressant Suicide Risk in Young Adults: More Harm Than Benefits? 2019 Frontiers in Psychiatry, 10:294.
Friedman, R. Antidepressants' Black-Box Warning- 10 Years Later, N Engl J Med 2014; 371:1666-1668.
Brent, D. Antidepressants and Suicidality. Psychiatric Clin N AM 39 (2016) 503-512.

Black Box

- Suicidal events tend to occur early in treatment
  - See weekly for the first 4 weeks, or at least call
  - Check on pills remaining--> non adherence associated with nonresponse--> withdrawal symptoms or natural progression of illness
- Stop or lower dose if... mania, agitation, akathisia, worsening depression, severe anxiety, or new-onset suicidal ideation

Fornaro, M. et al., The FDA “Black Box” Warning on Antidepressant Suicide Risk in Young Adults: More Harm Than Benefits? 2019 Frontiers in Psychiatry, 10:294.
Friedman, R. Antidepressants' Black-Box Warning- 10 Years Later, N Engl J Med 2014; 371:1666-1668.
Brent, D. Antidepressants and Suicidality. Psychiatric Clin N AM 39 (2016) 503-512.

Possible Side Effects of SSRI/SNRI

- Gastrointestinal
- Sexual side effects
- Anti-cholinergic
  - Dry mouth
  - Urine retention
  - Confusion
- Drowsiness
- Insomnia/Agitation
- Headaches
- Bruxism (Teeth grinding/clenching)
- Orthostatic hypotension
- Weight gain
- QTC prolongation

Numerous articles, adaptations from Up to Date Apri 2021, epocrates.coml

SSRI	Start	Target Dose	Dose Limits	Half-Life	Pearls
Citalopram (Celexa)	20	20-40*	10 to 40	35hr	Less med interaction >40mg need ECG
Escitalopram (Lexapro)	10	10-20	5 to 30	27-32hr	Less med interaction
Fluoxetine (Prozac)	20	20-60	10 to 80	*~9 days	
Fluvoxamine (Luvox)	50	50-200	25-300	15.6 hr	Withdrawal
Fluvoxamine CR	100	100-200	100-300		
Paroxetine (Paxil)	20-25	20-50	10-50	21hr	Avoid in pregnancy
Sertraline (Zoloft)	50	50-200	25-300	26hr	Absorption better with food OK c Breastfeeding Possible diarrhea

Adapted from Up to Date April 2021, www.epocrates.com

SNRI	Start	Target Dose	Dose Limits	Half life	Pearls
Desvenlafaxine (Pristiq)	25-50	50-100	50-400 (no evidence that greater than 50 is more effective)	11hr	Less sexual SE
Duloxetine (Cymbalta)	30-60	60	30-120	9hr	Avoid in patients with renal, liver, and heavy alcohol use
Venlafaxine (Effexor)	37.5-75	75-375	75-375	11hr	
Venlafaxine XR	37.5	75-375	75-375		
Levomilnacipran (Fetzima)	20	40-80	20-120	12hr	
Milnacipran (Savella)	12.5	100-200	50-300	9hr	

Adapted from Up to date April 2021, www.epocrates.com

Serotonin Modulators

Serotonin Modulators	Start	Target Dose	Dose Limits		
Nefazodone	200	300-600	50-600		
Trazodone	100	200-400	100-600		Take with food
Vilazodone	10	40	10-40		
Vortioxetine	10	20	5-20		

Adapted from Up to Date April 2021, www.epocrates.com

Atypical Agents	Start	Target	Dose Limits	
Bupropion (Wellbutrin)	200	300	100-450	"No" sexual SE Smoking cessation Not good for anxiety Concern for seizures
Bupropion SR (12 hr)	150	300	150-400	
Bupropion XL (24hr)	150	300	150-450	
Mirtazapine	15	15-45	7.5-60	Increases appetite Increased sedation

Adapted from Up to Date Apr 2021, epocrates.com

Additional Antianxiety Medications

- SSRI/SNRI
  - Venlafaxine and Duloxetine
- Buspirone (Buspar)

	Start	Target, dose limit	Relevant to GAD
Buspirone (Buspar)	10mg divided doses	10-60mg in divided doses	Non-benzo anxiolytic Augmentation for partial responders Slow onset and modest efficacy

- Benzodiazepines

Adapted from Up to Date, April 2021

Pharmacology for benzodiazepines

Drug	Adult oral total daily dose (mg)*	Comparative potency (mg)¶	Onset after oral dose (hours)	Metabolism	Elimination half-life (hours)Δ
Alprazolam	0.5 to 6	0.5	1	CYP3A4 to minimally active metabolites.	11 to 15 16 (older adults) 20 (hepatic impairment) 22 (obesity)
Alprazolam extended release	0.5 to 6 once daily	0.5	1		
Bromazepam◊§	6 to 30	7.5	1	CYP1A2. No active metabolite.	8 to 20
Chlordiazepoxide§	5 to 100	10	1	CYP3A4 to active metabolites.	30 to 100 Prolonged in older adults and hepatic impairment
Clonazepam	0.5 to 4	0.25 to 0.5	0.5 to 1	CYP3A4. No active metabolite.	18 to 50
Clorazepate	15 to 60	7.5	0.5 to 1	CYP3A4 to active metabolite.	36 to 200
Diazepam	4 to 40	5	0.25 to 0.5	CYP2C19 and 3A4 to active metabolites.	50 to 100 Prolonged in older adults and renal or hepatic impairment
Lorazepam	0.5 to 6 0.5 to 4 (hypnotic)	1	0.5 to 1	Non-CYP glucuronidation in liver. No active metabolite.	10 to 14
Oxazepam	30 to 120 15 to 30 (hypnotic)	15 to 30	1 to 2	Non-CYP glucuronidation in liver. No active metabolite.	5 to 15
Prazepam◊§	15 to 60	15	2 to 3	CYP3A4 to active metabolites.	30 to 200 Prolonged in older adults

Up to Date, April 2021

Liver Metabolism

Medication Metabolism in Psychiatry								*Updated Feb 2020, Copyright 2010, Brett Lu MD/PD*						
		Metabolized by P450 enzyme:						Inhibit - / Stimulate +						
		1A2	2B6	2C9	2C19	2D6	3A4	1A2	2B6	2C9	2C19	2D6	3A4	
SSRIs	citalopram				X	x	x							citalopram
	escitalopram				X	x								escitalopram
	fluoxetine			x		X				-	-	--	-	fluoxetine
	fluvoxamine	X				x		--		-	--		-	fluvoxamine
	paroxetine					X				-		--		paroxetine
	sertraline			x	x	x	x					-	-	sertraline
NDRI/NRI	atomoxetine				X	X								atomoxetine
	buproprion		X			x						-		buproprion
SNRIs	desvenlafaxine						x							desvenlafaxine
	duloxetine	X				X		-				-		duloxetine
	venlafaxine					X								venlafaxine
SARIs	trazodone						X							trazodone
	vilazodone				x	x	X							vilazodone
	vortioxetine					X								vortioxetine
alpha-2 antag	mirtazapine	x				x	X							mirtazapine
TCA	amitriptyline			X	X	x								amitriptyline
	clomipramine	x			x	X	x							clomipramine
	desipramine					X								desipramine
	doxepin					X								doxepin
	imipramine	x			x	X								imipramine
	nortriptyline					X								nortriptyline
MAOIs/others	selegiline	x		x	X		x							selegiline
	modafanil										-			modafanil

Lu, Brett, updated 2/2020

Potential Life Threating Responses

	Serotonin Syndrome	Neuroleptic Malignant Syndrome
Onset	WIth in 24 hours	Days to weeks
Neuromuscular findings	Hyperreactive (tremor, clonus, reflexes)	Bradyreflexia, severe muscle rigidity
Causative agent	Serotonin Agonist	Dopamine
Treatment agent	Benzodiazepines Cyoheptadine	Bromocriptine
Resolution	Within 24 hours	Days to weeks

Adapted from Up to Date, April 2021

Moving on to Bipolar & Schizophrenia

Mood Stabilizers & Antipsychotics

- Treatment of Bipolar Disorder &/Or Schizophrenia
  - Antipsychotics
    - Focus on Second Generation Antipsychotics (SGA)
  - Antiepileptics
    - Valproate
    - Topiramate
    - Lamotrigine
    - Carbamazepine

Antipsychotic Monitoring

Recommendations for metabolic risk factor monitoring in patients with severe mental illness or on antipsychotic medication

Risk factor	Timing of assessment					
	First year of antipsychotic				Ongoing monitoring*	
	Baseline	6 weeks	3 months	12 months	Quarterly¶	Annually¶
Personal and family history of diabetes, hypertension, or cardiovascular disease	X					X
Smoking status, physical activity, diet△	X	X	X		X	
Weight, body mass index△	X	X	X		X	
Blood pressure△	X	X	X		X	
Fasting glucose or HbA1c◊	X	X§	X	X		X
Lipid profile (fasting or nonfasting)	X		X	X		X

Up to Date Apr 2021

Urban, A. Therapeutic drug monitoring of atypical antipsychotics. Psychiatr. Pol. 2017; 51(6): 1059–1077

Second Generation Antipsychotics Side Effects

	Weight gain	Glucose abnormalities	Hyperlipidemia	Akathisia	Parkinsonism	Dystonia	Tardive dyskinesia	Prolactin elevation	Sedation	Anticholinergic	Orthostatic hypotension	QTc prolonga
Second-generation agents												
Aripiprazole	+	+	+	++	+	+	+	+	+	+	+	*
Asenapine	++	++	++	++	+	++	++	++	++	+	++	+
Brexpiprazole[¶]	+	+	++	++	+	+	+	+	++	+	+	*
Cariprazine[¶]	++	+	+	++	+	+	+	+	++	++	+	*
Clozapine[Δ]	+++	+++	+++	+	+	+	+	+	+++	+++	+++	++
Iloperidone	++	++	+	+	+	+	+	++	++	+	+++	+
Lumateperone[¶]	+	+	+	+	+	+	+	+	+	+	+	*
Lurasidone	+	++	++	++	++	++	++	+	++	+	+	*
Olanzapine	+++	+++	+++	++	++	+	+	++	+++	++	++	++
Paliperidone	++	+	++	++	++	++	++	+++	+	+	++	+
Pimavanserin	–	+	+	+	+	+	+	+	+	+	++	+
Quetiapine	++	++	+++	+	+	+	+	+	+++	++	++	++
Risperidone	++	++	+	++	++	++	++	+++	++	+	++	++
Ziprasidone	+	+	+	++	+	+	+	++	++	+	++	+++

From Up to Date, Apr 2021

SGA Weight Gain/Metabolic Syndrome

Low	Mild	Moderate	High
Aripiprazole	Asenapine	Iloperidone	Clozapine
Brexpiprazole		Paliperidone	Olanzapine
Cariprazine		Quetiapine	
Lumateprone		Risperidone	
Lurasidone			
Ziprasidone			

Aripiprazole < Seroquel = Risperidone < Olanzapine

AACAP Psychopharmacology Intensive Course at Annual Conference 9/2020

Urban, A. Therapeutic drug monitoring of atypical antipsychotics. Psychiatr. Pol. 2017; 51(6): 1059–1077

Treating SGA Weight Gain

- Metformin
  - Start 500mg with dinner
    - Kids <40kg start 250mg
  - Then weekly increase to 500mg BID till 2grams
  - SE: nausea, vomiting, diarrhea, vit B def, lactic acidosis rare if renal function WNL

- Topomax
  - Start 25mg
  - Then increase each week, end dose 100-200mg (pending symptoms)
  - Dose limiting- word finding problems

De Boer, N et al. Study Protocol of a randomized, double blind, placebo controlled, multicenter trail to treat antipsychotic-induced weigh gain: the Metformin-Lifestyle in antipsychotic users (MELIA) trial. BMC Psychiatry (2021) 21:4.
Ellul, P. Metformin for weight gain associated with second generation antipsychotics in children and adolescents: A systematic review and meta-analysis. CNS Drugs (2018) 32:1103-1112.

Treating Movement SE from SGA

- **Aesthesia**
  - Propranolol 20-40mg initial

- **Extra Pyramidal syndrome**
  - Diphenhydramine 25-50mg
  - Benztropine 1-2 mg
    - Anticholinergic Effects

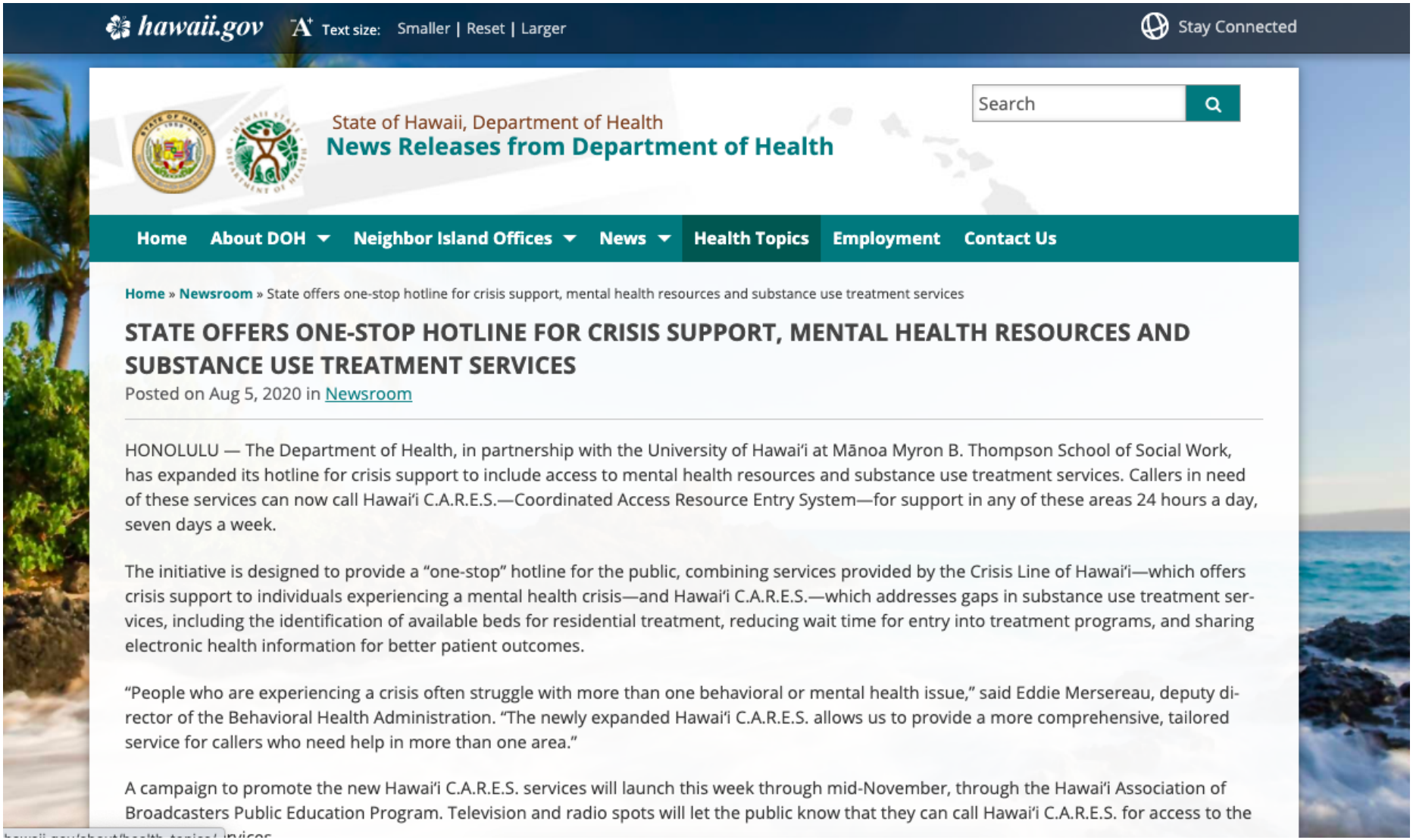
Up to Date April 2021

Resources

- Hawaii C.A.R.E.S. 24/7
  - (808) 832-3100
  - Neighbor Islands 1(800)753-6879
  - text ALOHA to 741741
    - Crisis Service Management
    - Case Coordinator

- Insurance Based Assistance
  - HMSA: Beacon Health Options (808) 695-7700
    - Request Case Coordinator

- State Based Mental Health Program
  - Adult Mental Health Division (AMHD)
    - 643-AMHD (2643)
  - Child and Adolescent Mental Health Division (CAMHD)
    - https://health.hawaii.gov/camhd/ 733-9333



hawaii.gov Text size: Smaller | Reset | Larger Stay Connected

Search

State of Hawaii, Department of Health
News Releases from Department of Health

Home | About DOH | Neighbor Island Offices | News | Health Topics | Employment | Contact Us

Home » Newsroom » State offers one-stop hotline for crisis support, mental health resources and substance use treatment services

STATE OFFERS ONE-STOP HOTLINE FOR CRISIS SUPPORT, MENTAL HEALTH RESOURCES AND SUBSTANCE USE TREATMENT SERVICES

Posted on Aug 5, 2020 in Newsroom

HONOLULU — The Department of Health, in partnership with the University of Hawai'i at Mānoa Myron B. Thompson School of Social Work, has expanded its hotline for crisis support to include access to mental health resources and substance use treatment services. Callers in need of these services can now call Hawai'i C.A.R.E.S.—Coordinated Access Resource Entry System—for support in any of these areas 24 hours a day, seven days a week.

The initiative is designed to provide a "one-stop" hotline for the public, combining services provided by the Crisis Line of Hawai'i—which offers crisis support to individuals experiencing a mental health crisis—and Hawai'i C.A.R.E.S.—which addresses gaps in substance use treatment services, including the identification of available beds for residential treatment, reducing wait time for entry into treatment programs, and sharing electronic health information for better patient outcomes.

"People who are experiencing a crisis often struggle with more than one behavioral or mental health issue," said Eddie Mersereau, deputy director of the Behavioral Health Administration. "The newly expanded Hawai'i C.A.R.E.S. allows us to provide a more comprehensive, tailored service for callers who need help in more than one area."

A campaign to promote the new Hawai'i C.A.R.E.S. services will launch this week through mid-November, through the Hawai'i Association of Broadcasters Public Education Program. Television and radio spots will let the public know that they can call Hawai'i C.A.R.E.S. for access to the

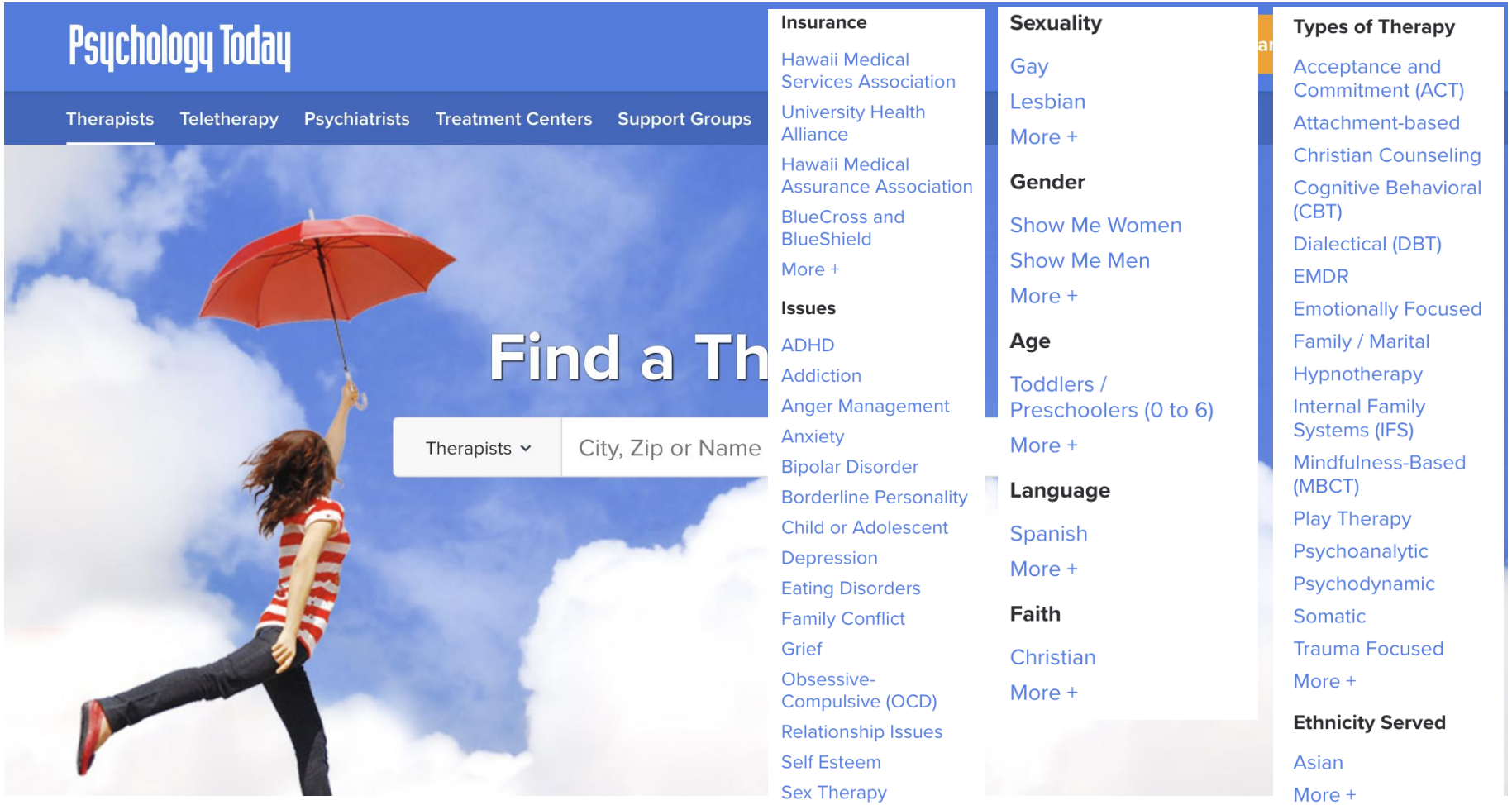
https://health.hawaii.gov/news/newsroom/state-offers-one-stop-hotline-for-crisis-support-mental-health-resources-and-substance-use-treatment-services/#:~:text=To%20access%20services%20through%20Hawai,also%20text%20ALOHA%20to%20741741

National/Web Based Resources

- psychologytoday.com
- Perinatal Psychiatric Consult Line
  - 1-877-499-4773
  - https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

- University of Washington: AIMS Program
  - https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications

psychologytoday.com



POSTPARTUM SUPPORT INTERNATIONAL

Get Help | Learn More | Professionals | Mind the Gap | Resources | News | About | Join Us | Donate

PERINATAL PSYCHIATRIC CONSULT LINE

PSI Perinatal Psychiatric Consult Line
1-877-499-4773

Medical Providers:

Professionals

Professionals Overview

Perinatal Psychiatric Consult Line

Provider Directory

Perinatal Mental Health Certification (PMH-C)

- Certification FAQs

PSI Annual Conference

Training

- Certificate Trainings
- Frontline Provider Trainings
- PSI Webinar Series
- MMH Free Webinar
- Request Training

https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/#:~:text=The%20PSI%20perinatal%20psychiatric%20consultation,patients%20and%20pre%2Dconception%20planning.

1-877-499-4773

Medical Providers:

Fill out this form to request an appointment with one of our psychiatric consultants.

The PSI perinatal psychiatric consultation line is a service provided at no cost.

The consultation line is available for medical professionals who have questions about the mental health care related to pregnant and postpartum patients and pre-conception planning. This consultation service is available for medical providers only.

The Perinatal Psychiatric Consult Line is staffed by reproductive psychiatrists who are members of PSI and specialists in the treatment of perinatal mental health disorders. The service is free and available by appointment.

Call 1-877-499-4773 and we will match you with an appointment. We will respond to your request within one business day.

The presentation of perinatal mental health disorder is not always straightforward, and medication is not always immediately effective. PSI's expert perinatal psychiatrists are available to share their skills and expertise with fellow medical professionals, providing necessary guidance and reassurance on any matter, but particularly those that may be more challenging.

- PSI Webinar Series
- MMH Free Webinar
- Request Training

More Resources

- Perinatal Mental Health Alliance for People of Color
- Susan A. Hickman Research Award
- CW Memorial Training Scholarship
- Screening Recommendations
- Perinatal Psychosis Related Tragedies
- State Perinatal Psychiatry Access Programs
- Research

Learn More about our Frontline Provider Trainings

https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/#:~:text=The%20PSI%20perinatal%20psychiatric%20consultation,patients%20and%20pre%2Dconception%20planning.

COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

NAME Generic (Trade)	DOSAGE	KEY CLINICAL INFORMATION
Antidepressant Medications*		
Bupropion (Wellbutrin)	Start: IR-100 mg bid X 7d, then ↑ to 100 mg tid; SR-150 mg qam X 7d then ↑ to 150 mg bid; XL-150 mg qam X 7d, then ↑ to 300 mg qam. Range: 300-450 mg/day.	Novel mechanism; **Contraindicated in seizure disorder** because it decreases seizure threshold; **stimulating; less effective for treating anxiety disorders;** 2nd line TX for ADHD;. ¢ **IR/SR/XL.**
Citalopram (Celexa)	Start: 20 mg qday X 7d, then ↑ to 40 mg. MAX: 40 mg qday (MAX: 20 mg qday if ≥60 y/o, hepatically impaired, a CYP2C19 poor metabolizer, or taking a CYP2C19 inhibitor).	Well-tolerated; minimal CYP450 interactions; good choice for anxious pt. **Caution: QTc prolong. dose dependent** ¢
Duloxetine (Cymbalta)	Start: 30 mg qday X 7d, then ↑ to 60 mg qday. Range: 60-120 mg/day.	SNRI; TX for neuropathic pain; **need to monitor BP;** 2nd line TX for ADHD. $
Escitalopram (Lexapro)	Start: 5 mg qday X 7d, then ↑ to 10 mg qday. Range 10-20 mg/d (~3X potent vs. Celexa).	Best-tolerated SSRIs; minimal CYP450 interactions. Good choice for anxious pt. ¢
Fluoxetine (Prozac)	Start: 10 mg qam X 7d, then ↑ to 20 mg qday. Range: 20-60 mg/day.	More activating than other SSRIs; long half-life reduces withdrawal (t½ = 4-6 d). ¢
Mirtazapine (Remeron)	Start: 15 mg qhs. X 7d, then ↑ to 30 mg qhs. Range: 30-45 mg/qhs.	Unique mechanism; Sedating and appetite promoting; Neutropenia risk so avoid in the immunosupressed. ¢
Paroxetine (Paxil)	Start: 10 mg qhs X 7d, then ↑ to 20 mg qday. Range: 20-60 mg/day.	SSRI; Anticholinergic; sedating; **Significant withdrawal syndrome.** ¢
Sertraline (Zoloft)	Start: 25 mg qam X 7d, then ↑ to 50 mg qday. Range: 50-200 mg/day.	SSRI; limited CYP 450 interactions; mildly activating, usual first-line during pregnancy/postpartum if breastfeeding. ¢
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 7d, then ↑ to 75 mg bid; ER-75 mg qam X 7d, then ↑ to 150 qAM. Range: 150-375 mg/day.	SNRI. More agitation & GI side effects than SSRIs; TX for neuropathic pain at 225 mg and above; **need to monitor BP; Significant withdrawal syndrome.** ¢ **IR $ ER.**
Nortriptyline (Pamelor)	Start: 25 mg qhs X 7d, then ↑ 25 mg qhs - q weekly to 75 mg qhs. Range: 75-150 mg/day.	TCA; Sedating; TX for neuropathic pain; Baseline EKG; Max dose in elderly: 100 mg; **Lethal in overdose.** ¢
*Antidepressant Medications warnings/precautions: 1) Potential increased suicidality in first few months, 2) Long term weight gain possible (except venlafaxine & bupropion), 3) Sexual side effects common (except bupropion & mirtazapine), 4) Withdrawal symptoms can occur with abrupt cessation (especially with SSRIs and SNRIs), 5) Increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs), 6) Risk for serotonin syndrome (except bupropion), when combined with medications or drugs effecting serotonin metabolism, 6) Hyponatremia sometimes seen with SSRIs and SNRIs in older adults.		
Antianxiety and Sleep (Hypnotic) Medications		
Alprazolam (Xanax)	Start: IR-0.25-0.5 mg tid. Usual MAX: 4 mg/d. ER-0.5-1mg qAM Usual MAX:3-6 mg/d	**Equiv. dose: 0.5 mg.** Onset: *rapid* . T½: 11 hrs. More addictive than other benzos and has uniquely problematic withdrawal syndrome. **Do not use as 1st line TX. Significant withdrawal syndrome.** ¢
Amitriptyline (Elavil)	Start: 10 mg qhs X 7d, then consider ↑ 25 mg qhs Range: 10-50mg/qhs	TCA; Sedating; TX for neuropathic pain; **Lethal in overdose.** ¢
Clonazepam (Klonopin)	Start: 0.25 mg bid Usual MAX: 4 mg/day.	**Equiv. dose: 0.25 mg.** Onset: *intermediate* . T½: 30-40 hrs. Helpful in TX mania. ¢
Diazepam (Valium)	Start: 5 mg bid. Usual MAX: 40 mg/day.	**Equiv. dose: 5 mg.** Onset: *rapid*. T½: 50-100 hrs. Caution with liver disease ¢
Lorazepam (Ativan)	Start: 0.5-1 mg bid to tid. Usual MAX: 6 mg/day. Insomnia: 0.5-2 mg qhs.	**Equiv. dose: 1 mg.** Onset: *intermediate*. T½: 12 hrs. No active metabolites, so safer in liver dz. ¢
Buspirone (Buspar)	Start: 7.5 mg bid. Range: 10-30 mg bid.	Non-benzo SSRI-like drug FDA approved for anxiety. May take 4-6 weeks to become fully effective. ¢
Hydroxyzine (Vistaril)	Start: 25-100 mg 3-4 X per day. Usual MAX: 400 mg/day.	Non-benzo Antihistamine FDA approved for anxiety. ¢
Prazosin (Minipress)	Start: 1 mg qhs. ↑ by 1mg q 2-3 d. Range: 4-6mg po qhs Usual MAX: 10 mg qhs.	alpha1 blocker used to TX PTSD-related nightmares. Warn about orthostasis ¢
Trazodone (Desyrel)	Start: 25-50 mg qhs. ↑ by 25-50mg q 1 wk Range: 50-200 mg qhs.	Commonly used as sleep aid; **inform about priapism risk in men.** ¢
Zolpidem (Ambien)	Start: 5-10 mg qhs. MAX: 10 mg qhs.	**T½: 2.6 hrs**. Potential for sleep-eating and sleep-driving. ¢ Available in longer acting form (CR $)
BENZODIAZEPINE EQUIVALENCY(oral administration): clonazepam 0.25mg ≈ alprazolam 0.5mg ≈ lorazepam 1mg ≈ diazepam 5mg		
*Benzodiazepine Medication warnings: 1) Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. 2) Benzodiazepines and zolpidem are DEA Schedule IV Controlled substances.		
Mood Stabilizers		
Divalproex (Depakote)	Start: 500 mg/day (bid, DR; qday, ER); increase dose as quickly as tolerated to clinical effect. Target serum concentration: **75 to 100 mcg/mL (DR) & 85-125 mcg/ml (ER).**	**Multiple black box warnings** including for hepatotoxicity, pancreatitis, and teratogenicity (Avoid in women of reproductive potential or should use effective contraception). Monitor LFTs, platelets, and coags initially and q3-6 mo. Weight gain common. $
Lamotrigine (Lamictal)	Start: 25 mg qday for wks 1 & 2; then 50 mg qday for wks 3 & 4; then 100 mg qday for wk 5; and finally 200 mg qday for wk 6+ (usual target dose). Dosage adjustment required when taken w/ drugs that ↓ (e.g., Tegretol, estrogens) or ↑ (Depakote) Lamictal concentration.	**Black box warning** for serious, life-threatening rashes requiring hospitalization and d/c of TX (Stevens Johnson syndrome @ approx. 1:1-2000). No drug level monitoring typically required. Need to strictly follow published titration schedule. Fewer cognitive and appetite stimulating side effects. No evidence that doses above 200 mg more effective for mood. Oral contraceptives may decrease serum concentration lamotrigine. ¢
Lithium	Start: 300 mg bid or 600 mg qhs. Target serum concentration: acute mania & bipolar depression: **0.8-1.0 meq/L**; Maintenance: **0.6-0.8 meq/L**. Available in ER form dosed once daily (usually at HS, Lithobid & Eskalith). Plasma levels related to renal clearance.	**Black box warning for toxicity**. Teratogenic (rare cardiac malform.) and will **need to inform women of reproductive potential of this risk**. Check Ca^{2+}, TSH and BMP before starting and q6-12 months thereafter. Advise pt about concurrent use of NSAIDS and HTN meds acting on the kidney which can decrease renal clearance of lithium leading to higher serum concentrations. ¢
Antipsychotic/Mood Stabilizers**		
Aripiprazole (Abilify)	**MDD adj tx**. Start: 2-5 mg/day; adjust dose q1+ weeks by 2-5 mg. Range: 5-10 mg/day.**Mania.** Start: 15 mg qday; Range: 15-30 mg/day. MAX: 15 mg qday. **Schizophrenia**. Start: 10-15 mg/day; ↑ at 2 week intervals; Range: 10-15 mg/day; MAX: 30 mg/day.	EPS: Mild; TD Risk: Mild; Sedation: Mild; Metabolic Effects: Mild. Very long half-life: 75 hrs. Least amount of sexual side effects. FDA indication for adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. **$$$**
Lurasidone (Latuda)	**Bipolar Dep:** Start/Initial: 20 mg qday; Range: 20-60 mg/day. MAX: 120 mg/day. **Schizophrenia:** Start/Initial Target: 40 mg qday Range: 40-160 mg qday. MAX: 160 mg/day.	EPS: Mild to Moderate; TD Risk: Unknown; Sedation: Moderate; Metabolic Effects: Mild. It is important to take Latuda with food (at least 350 calories) for optimal absorption (increased by up to three fold). Also, grapefruit juice should be avoided. **$$$**.
Olanzapine (Zyprexa)	**Mania.** Start: 10 mg qhs; Range: 10-20 mg/qhs. MAX: 20 mg/day. **Schizophrenia**. Start: 5 mg	EPS: Mild; TD Risk: Mild; Sedation: Moderate; Metabolic Effects: Severe. **Do not prescribe to patients with diabetes**. Need to screen glucose and

https://aims.uw.edu/sites/default/files/Psychotropics%20Medications_2018.pdf

https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications

On the horizon

- Integrative and/or collaborative care models
  - MY questions for the AUDIENCE to assist Behavioral Health with understanding your needs and willingness

Q&A

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

Next Webinar:

HHP Care Model & Disease Management Webinar Series:

Dermatology – Dr. Iris Noh

Thursday, June 10, 2021

5:30pm – 6:30 pm

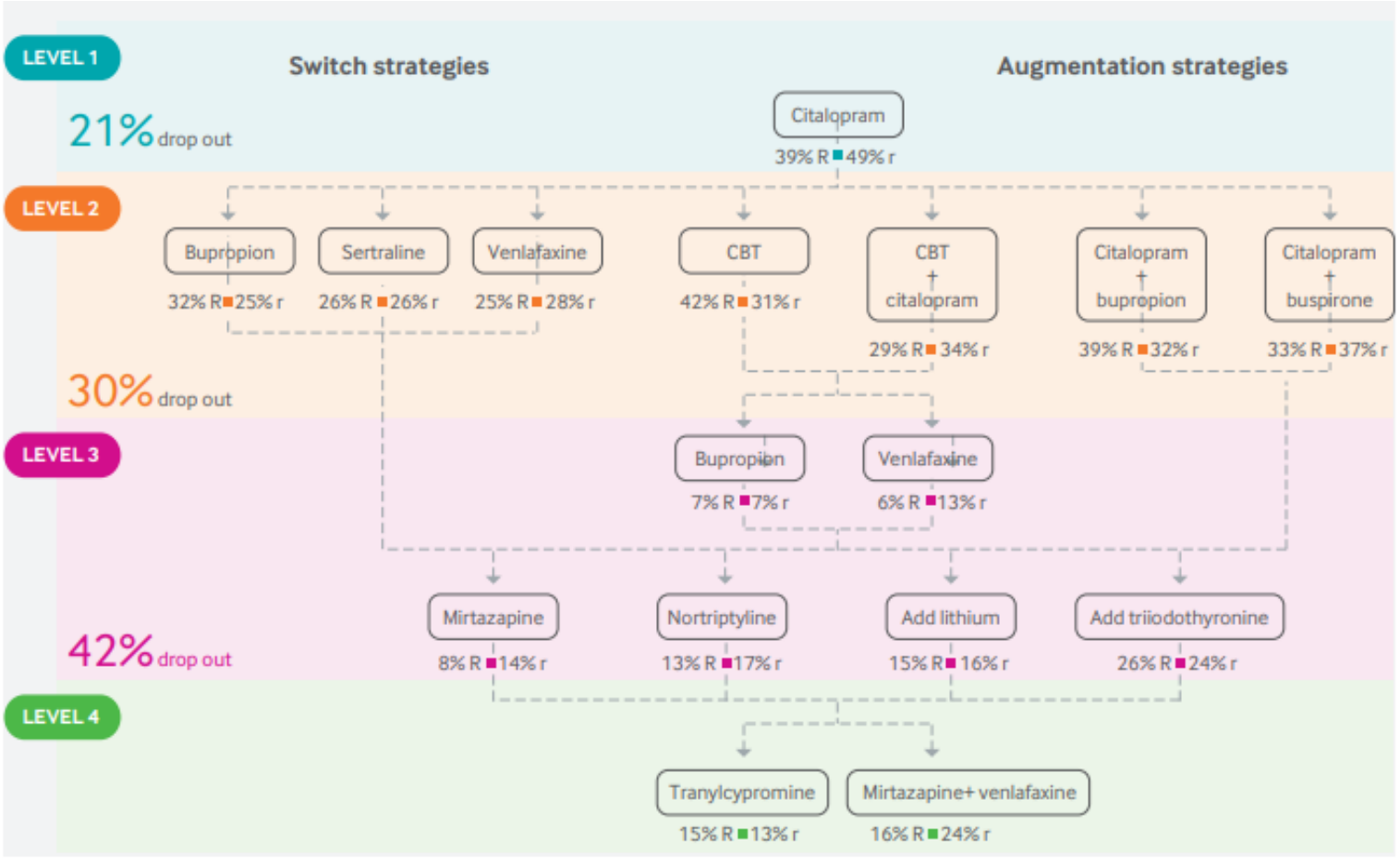
**Agenda is tentative and is subject to change*

Thank you!

- A recording of the meeting will be available afterwards.
- Unanswered question?
  - Contact us at info@hawaiihealthpartners.org

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

STAR-D



Sinyor M, Schaffer A, Levitt A. The sequenced treatment alternatives to relieve depression (STAR*D) trial: a review. Can J Psychiatry 2010;55:126- 35. .

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS

APPS

Breathe and Think (Kids)

Free

Meditation, mindfulness, yoga, acupressure

Free 7 day trial

Mindfulness and meditation, relaxation, music, sleep

Celebrities guide some exercises (i.e., LaBron James)

Free trial

Panic, anxiety, stress, 2-3 min meditation sessions

ax

Free

Focused on breathing rather than meditation or mindfulness training

Free +

Coloring book

Free version and paid plus

Activities, games, meditation

Free

Changing how you think

Free

Just as it sounds

APPS FOR KIDS

Stop Breathe and Think (Kids)

Meditation, mindfulness, yoga, acupressure

Free to try

$9.99/month

Mindful powers

Grade schoolers

Free to try

$4.99 for full app

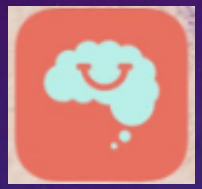
Sesame Street app

"Breath, think, do"

Toddlers

Calming down through breathing

Free



Smiling Mind

All Ages

Mindfulness & Meditation

Free

Super Stretch Yoga

Pre-K and grade school

Free

Worried Wendall & the Bad Germ

Ages 4 and up

Managing your worries about COVID19

Free

The Happy Child

General Parenting App

Free

Solitaire

Just for fun

Just as it sounds

Free

Major Depressive Disorder (DSM-V)

- At least 5 of the following symptoms have to have been present during the same 2-week period (and at least 1 of the symptoms must be diminished interest/pleasure or depressed mood):
  - Depressed mood: For children and adolescents, this can also be an irritable mood
  - Diminished interest or loss of pleasure in almost all activities (anhedonia)
  - Significant weight change or appetite disturbance: For children, this can be failure to achieve expected weight gain
  - Sleep disturbance (insomnia or hypersomnia)
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness
  - Diminished ability to think or concentrate; indecisiveness
  - Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- The symptoms cause significant distress or impairment in social, occupational or other important areas of functioning.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association; 2013.

Generalized Anxiety Disorder (DSM-V)

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
- The individual finds it difficult to control the worry
- The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months): Note: Only one item required in children.
  - Restlessness, feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association; 2013.