SPEAKER NOTES

Let's Discuss Meds

Summarized by Thomas T. Thomas

It has been a while since we had a speaker on medications for mental illness. At our May 25 meeting, we heard from **Jeffrey Johns, MD,** who is the Medical Director of the City of Berkeley Mental Health. We asked him to give an overview of the medication issue and how it permeates compliance with interventions and recovery.

Dr. Johns has been with Berkeley Mental Health (BMH) since 2008. He supervises a staff of two psychiatrists, four nurses, and administrators. He noted that five years ago, BMH left its Adult Clinic at Martin Luther King, Jr. Way and Derby Street, but it is now back at that site after renovations. He also said that Steven Golnic-McClurg, BMH's Manager of Mental Health, had stepped down and they were looking for a replacement. Overall, with the Covid pandemic, staffing is a challenge: nurses, social workers, marriage and family therapists, and administrative staff are in short supply.

BMH recently instituted a homeless full-service team. They currently serve 35 patients and hope to expand that to 40 or 50. The city also has a specialized care unit for people in crisis who can be served without resort to the police. And finally, they have expanded coordination with primary medical care, instituting a database, the Community Health Record, that gives BMH staff access to emergency rooms, hospitals, and primary care for their patients.

"People with severe mental illness die about twenty-five years before the average American," Dr. Johns said, attributing this to a lack of primary care. He also noted that these patients are more at risk for Covid, and that people with schizophrenia are four times more likely to die from the disease.

He also said that the state of psychiatry has not changed much in recent years, compared to advances in infectious diseases like Covid and Hepatitis C. The biggest change he noted was in substance abuse, with the increased potency of available street drugs like heroin and methamphetamine.

At BMH, they tend to treat patients with severe mental illness with the "tried and true" medications, like risperidone, olanzapine, and haloperidol. One of the innovations in this area is the introduction of long-acting injectable antipsychotics. These can be given in three- and six-month doses, so that the patient only needs to take medication twice a year, and this helps with compliance. Patients on these medications no longer have to make the decision to take their meds every day.

Finally, after the doctor's introductory remarks, before taking questions, he thanked NAMI East Bay for its advocacy. And he thanked families for their individual advocacy for their loved ones.

Q. We recently had a letter from a woman whose relative nearly died at Santa Rita jail because his meds were not being monitored. Does the jail have psychiatrists?

A. Santa Rita has good psychiatrists with a standard of care that they try to live

up to. But there is a shortage of psychiatrists. And when the psychiatrists want to see a patient, they depend on the deputies to bring the patient to them. So yes, there is probably not enough medication monitoring.

Q. When you see a new patient, what decisions go into medication prescribing? Do you consider family history?

A. Ideally, yes. We talk to family members and look into the patient's records. It can be hard to get enough information from an initial two-hour interview. An in-depth evaluation happens over time, rather than just in the first interview.

Q. NAMI family members have things to share, such as how meds are working with our ill relative. But do you always need the patient to sign the HIPAA (Health Insurance Portability and Accountability Act) release to give feedback?

A. Yes, and it's frustrating for the doctor. We can always listen to the family's concerns but maybe not answer back. However, we can give generic information and non-medical advice. We can get a patient's permission for generalized information to be shared. Most patients will sign a release, but not all.

Q. What is your opinion of the newer medication for adolescents and young adults known as Latuda? My son has an overlapping diagnosis between bipolar disorder and attention deficit hyperactivity disorder.

A. Latuda (generic: lurasidone HCl) may not be as good for schizophrenia and bipolar 1 as risperidone, but it can help. If a person can tolerate Latuda and respond, he may want to stay with it.

Q. Can a person have a psychotic break after an accident, like falling off his bicycle, or after an operation, like for appendicitis?

A. I don't know about that. We would want to do a psychiatric evaluation in any case. The cause might be a brain injury or medication side effect.

Q. How do you decide which patient needs these long-acting injectables? And are they all done with the needle, rather than pills?

A. The long-acting meds are all injectable. Taking them is always voluntary. The criteria for prescribing them are, first, safety, has the patient had any bad reaction to the pill form? Second, efficacy, is the patient responding well to the pills? And finally, is the patient having trouble taking the pill form regularly?

Q. You talk about "severe mental illness" or "serious mental illness." Are there levels to mental illness?

A. There are various definitions of "severe." Some diagnoses like schizophrenia, schizo-affective disorder, bipolar 1, and PTSD (post-traumatic stress disorder) are considered severe. The county mental health systems in California consider the level of impairment: does the illness interfere with the patient's ability to hold a job, have a relationship, or achieve some other goal? If not, then the illness may not be severe. The definition is how the patient acts on it.

Q. What are the medications for treating hallucinations and delusions?

A. Medications are better at treating hallucinations, which involve sensory impairments, than delusions, which are more complex neural situations.

For hallucinations, Zyprexa (generic: olanzapine), Risperdal (generic: risperidone), Haldol (generic: haloperidol), or Clozaril (generic: clozapine) are

commonly prescribed. Clozapine is sometimes the most effective, but it can be toxic and needs to be monitored. But you can seldom remove *all* hallucinations.

Dealing with delusions—which are really the patient's cognitive ideas about how the world works—is tougher, although they are sometimes linked to hallucinations. Then you have to talk to the patient, try to understand his or her thinking, and make room for discussion and a different idea: "Is this the *only* way the world works?" Each patient is different, and some are aware of their delusions while others are not. Some can have delusions and still function.

Q. How do you get diagnosed in the first place?

A. If you have private insurance, you can see a psychiatrist through them. People who come to BMH must live in Berkeley and most are provided with insurance through MediCal, California's implementation of Medicaid. A psychiatrist bases the diagnosis on observation and assessment, and collects the developmental and family history, medical and substance abuse history, before prescribing treatment.

Q. If a person has had only one psychotic break, gets on medication, then has no psychosis, do they stay on the meds forever?

A. Good question—and a controversial one. For schizophrenia, it's generally recommended to stay on medication. With other diagnoses, you can sometimes consider lowering the dosage. But there are not many studies in this area.

Q. My son is having weight gain as a side effect, and this leads to depression. Do the new meds have less side effects?

A. Weight gain is not inevitable. Sometimes you can talk to the patient about diet and exercise. The newer medications like Latuda and Abilify (generic: aripiprazole) are not as strong but have less weight gain. In medications for mental illness, there have been no recent, revolutionary discoveries, nothing really new is coming forward. The research funding—from the federal government and pharmaceutical industry—is now focused more on infectious diseases.

Q. My son has bipolar disorder with severe anxiety, but the psychiatrist does not want to treat him with antidepressants.

A. Antidepressants can trigger a manic episode. You can try a mood stabilizer like Depakote (generic: sodium valproate) or Lamictal (generic: lamotrigine).

Q. How do you treat someone who refuses medication because they don't think they're sick?

A. Then you have to focus on what they want. Do they want better sleep? Less anxiety? Taking their prescribed medication can help with that. And family feedback, showing them how meds have helped in the past, also works.