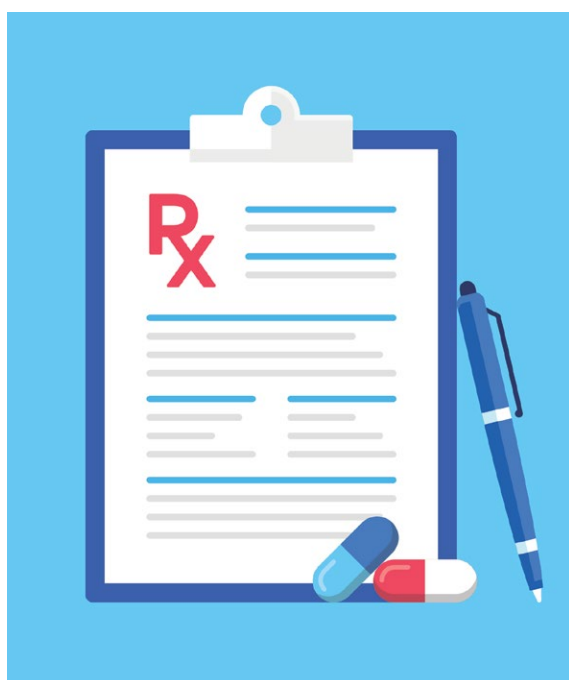


Should psychiatrists prescribe nonpsychotropic medications?



VECTOR COOKIES/SHUTTERSTOCK

In certain scenarios, prescribing a nonpsychotropic medication is the logical choice

In our experience, most psychiatrists are uncomfortable with prescribing a medication when they feel that doing so would be outside their scope of practice. But there are many situations when prescribing a nonpsychotropic medication would be the correct choice. In this article, we discuss the scope of psychiatric practice, and present 4 case studies that illustrate situations in which psychiatrists should feel comfortable prescribing nonpsychotropic medications.

Defining the scope of practice

What is the scope of a psychiatrist's practice? Scope of practice usually describes activities that a health care practitioner is allowed to undertake as defined by the terms of his/her license. A license to practice medicine does not include any stipulation restricting practice to a specific medical specialty. However, a local entity may delineate scope of practice within its organization. For instance, local practice standards held by the Detroit Wayne Mental Health Authority (DWMHA) state "Psychiatrists...shall not exceed their scope of practice as per DWMHA credentialing and privileging. For example, a Psychiatrist...who [has] not been appropriately privileged to deliver services to children shall not treat children, excepting crisis situations."¹

Like physicians in other specialties, psychiatrists are not limited to prescribing only a subset of medications commonly associated with their specialty. But for many psychiatrists, prescribing nonpsychotropic medications is complicated by

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individual and local factors. On one hand, some psychiatrists do not feel it is their role to prescribe nonpsychotropic medications,² or even some psychotropic medications that may be more complex to prescribe, such as lithium, clozapine, or monoamine oxidase inhibitors.³⁻⁵ However, many feel comfortable prescribing complex combinations of psychotropic medications, or prescribing in a way that does not necessarily make sense (eg, prescribing benztropine as prophylaxis for dystonia when starting an antipsychotic).

Reviewing an average day at one urban psychiatric clinic, these questions seem to come up in half of the patient population, especially in patients with chronic mental illness, multiple medical comorbidities, and limited access to health care. When a young patient walks in without an appointment with an acute dystonic reaction secondary to the initiation of antipsychotics a couple of days ago, there is no hesitation to swiftly and appropriately prescribe an IM anticholinergic medication. But why are psychiatrists often hesitant to prescribe nonpsychotropic medications to treat other adverse effects of medications? Lack of knowledge? Lack of training?

Psychiatrists who practice in hospital systems often have immediate access to consultants, and this availability may encourage them to defer to the consultant for treatment of certain adverse effects. We have seen psychiatrists consult Neurology regarding the prescription of donepezil for mild neurocognitive disorder due to Alzheimer's disease, or Endocrinology regarding prescription of levothyroxine for lithium-induced hypothyroidism.

However, there are numerous scenarios in which psychiatrists should feel comfortable prescribing nonpsychotropic medications or managing medication adverse effects, regardless of whether they consider it to be within or outside their scope of practice. The following case examples illustrate several such situations.

CASE 1

Ms. W, age 30, has been diagnosed with schizophrenia. She requests a refill of quetiapine, 800 mg/d. This medication has been clearly beneficial in alleviating her psychotic

symptoms. However, since her last visit 3 months ago, her face appears more round, and she has gained 9 kg. Further evaluation indicates that she has developed metabolic syndrome and pre-diabetes.

Metabolic adverse effects, such as metabolic syndrome, diabetic ketoacidosis, and cardiovascular disease, are well-known risks of prescribing second-generation antipsychotics.⁶ In such situations, psychiatrists often advise patients to modify their diet, increase physical activity, and follow up with their primary care physician to determine if other medications are needed. However, getting a patient with a serious mental illness to exercise and modify her/his diet is difficult, and many of these patients do not have a primary care physician.

For patients such as Ms. W, a psychiatrist should consider prescribing metformin. Wu et al⁷ found that in addition to lifestyle modifications, metformin had the greatest effect on antipsychotic-induced weight gain. In this study, metformin alone had more impact on reversing weight gain and increasing insulin sensitivity than lifestyle modifications alone.⁷ This is crucial because these patients are especially vulnerable to cardiac disease.⁸ Metformin is well tolerated and has a low risk of causing hypoglycemia. Concerns regarding lactic acidosis have abated to the extent that the estimated glomerular filtration rate (eGFR) limits for using metformin have been lowered significantly. After reviewing the contraindications, the only knowledge needed to prescribe metformin is the patient's kidney function and a brief understanding of the titration needed to minimize gastrointestinal adverse effects.⁹ Thus, prescribing metformin would be a fairly logical and easy first step for managing metabolic syndrome, especially in a patient whose motivation for increasing physical activity and modifying his/her diet is doubtful.

CASE 2

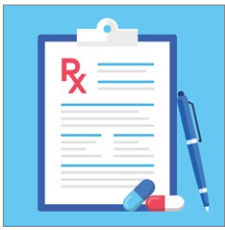
Mr. B, age 45, has major depressive disorder that has been well-controlled on paroxetine, 40 mg/d, for the past 2 years. He has no history of physical illness. On his most recent visit, he appears uncomfortable and nervous. After a

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Prescribing nonpsychotropics

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In most cases, psychiatrists should be able to address sexual adverse effects of SSRI use

long discussion, he discloses that his sex life isn't what it used to be since starting paroxetine. He is bothered by erectile problems and asks whether he can "get some Viagra."

Sexual adverse effects, such as erectile dysfunction, are frequently associated with the use of selective serotonin reuptake inhibitors.¹⁰ Although managing these adverse effects requires careful evaluation, in most cases, psychiatrists should be able to treat them.¹⁰ The logical choice in this case would be to prescribe one of the 4 FDA-approved phosphodiesterase-5 inhibitors (sildenafil [Viagra], tadalafil [Cialis], vardenafil [Levitra], and avanafil [Stendra]). However, Balon et al¹¹ found that few psychiatrists prescribe phosphodiesterase-5 inhibitors, although they believed that they should be prescribing to treat their patients' sexual dysfunction. Managing these adverse effects is important not only for the patient's quality of life and relationship with his/her partner, but also for the therapeutic alliance. In a systematic review of 23 trials, Taylor et al¹² examined >1,800 patients who were prescribed a medication to address sexual dysfunction secondary to antidepressants. They found that for men, adding a phosphodiesterase-5 inhibitor was appropriate and effective, and for women, adding bupropion at high doses should be considered.¹² Like many other adverse effects, sexual adverse effects surely play a role in medication compliance. Dording et al¹³ found that the addition of sildenafil, 50 to 100 mg as needed, resulted in increased treatment satisfaction and overall contentment in 102 patients who complained of sexual dysfunction in the follow-up phase of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) antidepressant trials. In most cases, with proper psychoeducation, prescription of phosphodiesterase-5 inhibitors is fairly straightforward.

CASE 3

Ms. G, age 22, was recently discharged from an inpatient psychiatric unit after an episode of mania. She was prescribed carbamazepine, 600 mg/d, and ziprasidone, 40 mg twice a day, and appears to be doing well on this regimen. When asked about what led to her admission,

she recalls having an elevated mood, increased energy, hypersexuality, impulsivity, and poor judgment. She reveals that she had several sexual partners during her manic episode, and worries that if such behavior occurs again, she may get pregnant. Yet Ms. G was not prescribed birth control upon discharge.

Contraception. We believe that psychiatrists have an obligation to protect patients from consequences of mental illness. Much the same way that psychiatrists hope to prevent suicide in a patient who has depression, patients should be protected from risks encountered in the manic phase of bipolar disorder. Another reason to prescribe contraceptives in such patients is the teratogenic effects of mood stabilizers. Pagano et al¹⁴ reviewed 6 studies that examined common forms of hormonal birth control to determine their safety in patients with depression or bipolar disorder. They found that overall, use of hormonal contraception was not associated with a worse clinical course of disease.

Many available forms of birth control are available. When prescribing in an outpatient setting, a daily oral medication or a monthly depot injection are convenient options.

CASE 4

Mr. P, age 65, has bipolar I disorder and is stable on risperidone long-acting injection, 37.7 mg bimonthly, and lithium, 1,200 mg/d. He reports that he is doing well but has noticed a recent decrease in energy and weight gain without any change in mood. Laboratory testing conducted prior to this visit revealed a thyroid-stimulating hormone (TSH) level of 4 mU/L (normal range: 0.4 to 4.0 mU/L). Six months ago, Mr. P's TSH level was 2.8 mU/L. The resident supervisor suggests discussing the case with an endocrinologist.

Thyroid function. The impact of lithium on the thyroid gland is well established; however, psychiatrists' response to such changes are not.¹⁵ Gitlin¹⁶ reviewed the many adverse effects of lithium and presented various management strategies to address findings such as Mr. P's. Two important points are that lithium should not be discontinued in light of hypothyroidism, and synthetic

Scenarios in which psychiatrists might consider prescribing nonpsychotropic medications

Condition/situation	Medication(s) to consider prescribing
Metabolic syndrome	Metformin
Erectile dysfunction secondary to antidepressant use	Phosphodiesterase-5 inhibitor (sildenafil, tadalafil, vardenafil, avanafil)
Women who are at risk of unintended pregnancy	Hormonal contraception
Hypothyroidism	Levothyroxine
Uncomplicated hypertension	Antihypertensive medication (thiazide diuretics, calcium channel blockers, angiotensin-converting enzyme inhibitors, angiotensin II receptor antagonists, and beta blockers)

thyroxine (levothyroxine) can be initiated and titrated to return TSH levels to a normal range.¹⁶ Levothyroxine can be started at low doses (eg, 25 to 50 mcg/d) and increased every 6 weeks until a normal TSH level is achieved.¹⁷ Managing lithium-induced clinical or subclinical hypothyroidism can prevent further pathology and possible relapse to depression.

Incorporating integrated care

In all these cases, the prescription of a medication with which some psychiatrists are not comfortable prescribing would have been the logical, easiest, and preferable choice. Of course, when initiating any medication, boxed warnings, contraindications, and drug–drug interactions should be reviewed. Initial dosages and titration schedules can be found in every medication's FDA-approved prescribing information document (package insert), as well as in numerous reference books and articles.

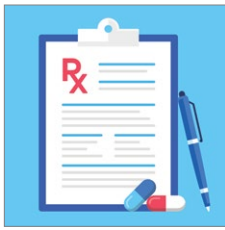
We acknowledge that prescribing a nonpsychotropic medication is not always a psychiatrist's best choice, and that in patients with multiple medical comorbidities and drug–drug interactions that are not clearly defined, referring to or consulting a specialist is appropriate. We in no way support reckless prescribing, but instead present an opportunity to expand the perception of what should be considered within a psychiatrist's scope of practice, and call for further education of psychiatrists so that they are more comfortable managing

these adverse effects and/or prescribing at least some nonpsychotropic medications. For example, metabolic syndrome, uncomplicated hypertension, and hypothyroidism (not necessarily lithium-induced) could be managed by psychiatrists practicing integrated care (*Table*).

We exhort integrated medical care during this time of a physician shortage; however, we do not practice this way. Interestingly, physicians in primary care, such as those in family medicine or obstetrics and gynecology, frequently attempt to treat patients with psychiatric conditions in an attempt to provide integrated care. Numerous articles have discussed these efforts.^{18–20} However, this type of integrated care seems less frequent in psychiatry, even though the practice of modern psychiatry in the United States shows substantial overlap with the practice of physicians in primary care specialties.²¹ There are few articles or practical guidelines for psychiatrists who wish to treat patients' physical illnesses, particularly patients with severe mental illness (see *Related Resources*, page 56). If we practice in an integrated manner to treat one of the simple conditions we described above, we can eliminate the need for a patient to visit a second physician, pay another copay, pay another bus fare, and take another day off work. This can be particularly helpful for patients who at times have to decide between paying for groceries or for medications. Having one clinician manage a patient's medications also can decrease the risk of polypharmacy.

Clinical Point

We in no way support reckless prescribing, but hope to expand what should be considered a psychiatrist's scope of practice



Prescribing nonpsychotropics

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We hope that psychiatrists can start to practice as the primary care physicians they claim they are, and should be

In addition to the case scenarios described in this article, there are more clinical situations and nonpsychotropic medications that psychiatrists could manage. Considering them outside the scope of psychiatric practice and being uncomfortable or ambivalent about them is not an excuse. We hope that psychiatrists can increase their expertise in this area, and can start to practice as the primary care physicians they claim they are, and should be.

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Related Resources

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Drug Brand Names

Avanafil • Stendra	Metformin • Fortamet,
Benzotropine • Cogentin	Glucophage
Bupropion • Wellbutrin,	Paroxetine • Paxil
Zyban	Quetiapine • Seroquel
Carbamazepine • Carbatrol,	Risperidone long-acting
Tegretol	injection • Risperdal Consta
Clozapine • Clozaril	Sildenafil • Viagra
Donepezil • Aricept	Tadalafil • Cialis
Levothyroxine • Levoxyl,	Vardenafil • Levitra
Synthroid	Ziprasidone • Geodon
Lithium • Eskalith, Lithobid	

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Bottom Line

Many psychiatrists are uncomfortable prescribing nonpsychotropic medications, but there are numerous clinical scenarios in which the practice would make sense. This could include cases of metabolic syndrome, sexual dysfunction secondary to antidepressant use, or other adverse effects of commonly prescribed psychotropic medications.