CENTER OF EXCELLENCE IN NEWCOMER HEALTH MINNESOTA

DEPARTMENT OF HEALTH

Managing Psychiatric Medications in a Newly Arrived Patient

Some challenges arise when caring for newly arrived patients: reconciling medications prescribed in another health system, determining whether medications and doses are appropriate in the U.S., and addressing medications that may carry significant risks. In addition, for more complex patients or those on controlled medications, access to psychiatry care in your health system may be difficult or delayed.

Jessica Deffler, MD, provides insight into this emerging health topic through a newcomer scenario below. Dr. Deffler is an assistant professor in the Department of Family and Community Medicine at Thomas Jefferson University Hospital in Philadelphia, PA. She practices full spectrum primary care at the Hansjorg Wyss Wellness Center, a primary care office specializing in newcomer health.

Case Presentation

A 36-year-old man from South Africa presents to primary care for his domestic medical examination. The clinician does not receive records of an overseas medical examination, but the patient brings a medication list with him. He reports that his primary care provider in South Africa prescribed alprazolam 0.5 mg daily for anxiety and insomnia, duloxetine 120 mg daily for depression, and trazodone 50 mg for sleep. He has been taking these medications consistently for several years. He has approximately four weeks of medication remaining and requests refills so that he does not run out while establishing care in the United States.

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1. How should primary care clinicians caring for newcomers **manage psychiatric regimens** that include multiple medications, including benzodiazepines and antidepressants, when psychiatric consultation may be delayed?

Start by confirming the current regimen

Aim to establish rapport and partner with the patient. Medication changes can provoke anxiety or feel threatening, particularly when a patient has been stable on a regimen prescribed by a clinician for many years in their previous country of residence.

When completing the history and physical, review:

- Dose, frequency, and timing of each medication, both as prescribed, and how frequently the patient actually takes the medication.
  - Helpful questions to ask: “How many days per week do you take your medication?” and “How do you take this medication each day?”
- The indication for each medication, and current mood symptoms, including suicidal ideation.
- How long the patient has been taking each medication.
- Benefits and side effects of each medication.
- Previous medication trials or failures.
- History of discontinuation and withdrawal.
- Alcohol and substance use.
- Other prescription, over-the-counter, herbal, and traditional medications or supplements.

It is helpful to advise new patients to bring their medication bottles, pictures, or lists to the visits.

Determine patient’s primary care plan

Assess whether the patient will remain with the practice after the domestic examination or whether they will establish care with another primary care provider (PCP) closer to their home. Also assess whether the patient’s mental health condition is appropriate to be managed in primary care, or whether they require specialist care. Psychiatric consultation is recommended when there is diagnostic uncertainty, significant symptom burden, suicidality, severe substance use disorder, complicated medication regimens with potential interactions, or a need for a more complex benzodiazepine taper.

If another PCP will assume care, still communicate the concerns and anticipated plan to the patient, and to the receiving clinician if possible.

Avoid abrupt discontinuation of benzodiazepines

Long-term benzodiazepine therapy, especially if the medication is taken on a scheduled basis, carries more risks and should be addressed carefully. Benzodiazepines can cause physical dependence, as well as other risks, especially for elderly patients. Patients taking them regularly for longer than a month are more at risk of withdrawal if they are abruptly discontinued.

In this case, if the clinician determines that the risks of continued alprazolam outweigh its benefits, the medication should be tapered gradually rather than abruptly discontinued. Given alprazolam’s short duration of action, the clinician may want to change to a longer acting benzodiazepine such as clonazepam for the taper. The taper could be proposed as a slow taper, beginning with small reductions in dose, approximately 5-10% of the total daily dose every four weeks. Some patients may be able to taper more quickly, while others may require a slower taper, and this should be individualized.

Continue appropriate antidepressant treatment while reassessing the dose

First, determine whether the medication is appropriate for the patient's diagnosis, effective, and not causing bothersome side effects. Even if the medication was prescribed outside of the U.S., it does not necessarily need to be changed if it is safe and effective, and available for prescription in the U.S.

In this case, the patient is taking duloxetine 120 mg daily. Duloxetine is an available treatment for major depressive disorder in the U.S. If the patient is reporting side effects from the medication, it would be reasonable to discuss whether the patient would be open to reducing to the 60 mg/day dosage, especially since duloxetine generally has little added benefit in doses above 60 mg/day and has more reported side effects at higher doses. In addition, if the medication does not seem effective for the patient's depression, a taper off of duloxetine and starting an SSRI such as escitalopram or sertraline, which are also first-line for depression and anxiety in the U.S., could be recommended.

It would be appropriate to continue trazodone for insomnia if it is effective, as it is overall a safer medication than benzodiazepines or other sedative-hypnotics for sleep.

This patient could also be offered a referral to counseling or psychotherapy for their depression and anxiety.

2. How should clinicians **discuss differences in prescribing practices** between the United States and South Africa?

- Avoid framing the conversation around the inappropriateness of medications prescribed in South Africa.
- Discuss that the patient's medications are not necessarily wrong, but that prescribing practices and formularies vary between countries.
- Emphasize the patient's safety, as well as convenience, of switching to safer or formulary medications in the U.S.

The clinician should emphasize their responsibility to care for the patient's wellbeing and safety, maintaining a patient-centered approach. This approach avoids disparaging the health system or previous provider in the patient's home country and helps to build rapport with the patient.

3. What should clinicians **consider when medications have different names**, formulations, or availability in the United States?

Medication reconciliation is important when patients change health systems, as patients may be taking medications that are available under different brand names or formulations in different countries. For example, acetaminophen, or Tylenol, is called paracetamol in other countries.

Clinicians should identify redundant medications (medications with similar mechanisms) and drug interactions. For example, a patient taking diclofenac may not realize that ibuprofen or naproxen prescribed in the United States belongs to the same NSAID class.

Encourage patients to bring the following items to their visits:

- Medication bottles or photographs.
- Written medication lists.
- Over-the-counter medications.
- Vitamins and supplements, or herbal remedies.

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