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Chris Aiken, MD
Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Telepsychiatry

Learning Objectives
After reading these articles, you should be able to:

1. Evaluate the benefits and drawbacks of trazodone for both depression and insomnia.
2. Identify and manage a potentially lethal gastrointestinal side effect of clozapine.
3. Describe best practices for using telepsychiatry during the COVID-19 pandemic and beyond.
4. Summarize some of the current research on psychiatric treatment.

Trazodone: The Forgotten Antidepressant

Eugene Rubin, MD. Private practice, Bingham Farms, MI.

Dr. Rubin has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

If your practice is anything like mine, trazodone is your go-to hypnotic. As an antidepressant, it's an afterthought, dismissed as ineffective or intolerable since its release in 1981. Four decades and over 200 clinical trials later, it's a good time to see if we've missed any opportunities in this forgotten antidepressant.

Highlights From This Issue

Peter Yellowlees, MD shows us how to create more meaningful telepsych interactions (and do it on a budget).

Trazodone is the potentially well-tolerated and effective antidepressant we've all been neglecting, and two dosing tips can make it work better.

Constipation causes more fatalities than neutropenia on clozapine. The risk extends to other psychotropics, and inside is a three-step algorithm to manage it.

How trazodone works

Trazodone is a serotonergic antidepressant that is classified as a $5HT_2$ antagonist, but other mechanisms of action include serotonin reuptake inhibition, $5HT_{1A}$ agonism, and blockade of histamine, alpha-1, alpha-2, $5HT_{2A}$, and $5HT_{2C}$ receptors. (See our 4/27/20 podcast for a discussion of $5HT_{2A}$ and $5HT_{2C}$.)

Pros and cons

Trazodone has several advantages in that

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Q&A With the Expert

Telepsychiatry: From Crisis to Opportunity
Peter Yellowlees, MD

Professor of psychiatry and Chief Wellness Officer at University of California-Davis Health. Past President of the American Telemedicine Association.

Dr. Yellowlees has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

TCPR: Do patients like telepsych?
Dr. Yellowlees: Yes. The studies show very high levels of patient satisfaction, higher even than what we see with in-person care. Most of those studies were done before 2010, when the technology was not as good and patients often traveled to their primary care doctor's office to connect by telemed. I suspect the satisfaction is higher today when they can connect from the convenience of their home (Chan S et al, *Curr Psychiatry Rep* 2018;20(10):85).

TCPR: Does this high satisfaction extend to psychotherapy or just medication management?
Dr. Yellowlees: Both. There are several studies with cognitive behavioral therapy, and there's a long tradition of telephone therapy in psychoanalysis. Analysts often treat patients by phone when they move or go on holiday, and they argue that telepsychiatry in general makes sense because they don't want the patient to look at their face during the session.

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Trazodone: The Forgotten Antidepressant

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it is weight neutral, has few sexual side effects, and improves sleep. What has limited its use is daytime sedation, which affects about 1 in 3 patients who take it in the antidepressant dose. It can also cause dizziness, orthostasis, nausea, and cardiac arrhythmias. Priapism is a rare but dreaded side effect occurring in 1 in 6000 patients. This is more than just a painful, prolonged erection. Left untreated, it can lead to penile necrosis, and it can affect the clitoris in female patients as well.

Evening dosing

Trazodone has a short half life of 7–10 hours, and when it was first released, twice-daily dosing was recommended.

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That aggressive daytime dosing resulted in dizzy, sleepy patients who couldn't tolerate the drug. And it probably wasn't necessary, as the medication's antidepressant actions are delayed and aren't yoked to its serum levels. All-at-night dosing was later proven to work just as well as divided dosing, with significant gains in tolerability (Raatjes B and Dantz B, *Psychiatric Annals* 2011;42(3):148–157). However, by that time trazodone had been largely forgotten as an antidepressant, and interest shifted toward a branded, controlled-release version of trazodone, Oleptro.

Released in 2010, Oleptro attempted to resurrect trazodone for use in depression. By reducing the peak plasma levels, Oleptro claimed to cause less daytime sedation than instant-release trazodone. Unspoken in those claims was the fact that the manufacturer was comparing it to twice-daily dosing of trazodone. Oleptro, however, was discontinued in 2015, so controlled-release dosing is no longer an option.

Depression

More than two dozen double-blind placebo-controlled studies have shown trazodone (150–600 mg per day) to be as effective as other antidepressants, from the tricyclics to the SSRIs. It has also worked well in hospitalized patients with severe depression. The drug works better when titrated slowly, possibly because rapid titration can lead to spikes in the depressogenic metabolite, m-chlorphenylpiperazine (mCPP) (Schatzberg A, DeBattista C. *Schatzberg's Manual of Clinical Psychopharmacology*. Washington, DC: American Psychiatric Publishing; 2019).

Can trazodone cause depression?

Trazodone does not cause depression, but a handful of papers have linked its metabolite, mCPP, to dysphoria and anxiety, as well as to self-harm in adolescents (Shamseddeen W et al, *J Child Adolesc Psychopharmacol* 2019;29(7):573). mCPP is a $5HT_{2C}$ agonist that can have antidepressant effects when its levels are stable, but when those levels rise too quickly, anxiety and dysphoria can result.

mCPP is excreted from the body through CYP2D6 metabolism, so managing this problem means dosing trazodone cautiously in patients who are slow metabolizers at CYP2D6. That includes those on CYP2D6 inhibitors (eg, duloxetine, fluoxetine, paroxetine, quinidine, ritonavir) and those with genetic variations at CYP2D6 (more common in African American and Hispanic patients). You can raise the dose more slowly in these populations (eg, using half the usual dose at each step of the titration) but still aim for the same target dose.

Insomnia

Trazodone works in primary insomnia as well as insomnia secondary to depression (Jaffer KY et al, *Innov Clin Neurosci* 2017;14(7–8):24–34). It increases total sleep time by 30–50 minutes, more than many on-label hypnotics. Importantly, trazodone improves sleep quality, increasing the deep stages: 3, 4, and slow-wave sleep. Few on-label hypnotics can claim that. On the contrary, there's evidence that sleep architecture can worsen with benzodiazepines, particularly in high doses.

Despite these advantages, The American Academy of Sleep Medicine recommended against trazodone as a hypnotic. Their reasoning was that it lacked solid evidence, but their bar for acceptable evidence was very high (Sateia MJ et al, *J Clin Sleep Med* 2017;13(2):307–349). Trazodone can worsen next-day cognition and comes with a risk of falls in the elderly that is surprisingly similar to other hypnotics (Warner MD et al, *Pharmacopsychiatry* 2001;34(4):128–133; Watt JA et al, *CMAJ* 2018;190(47):E1376–E1383).

Trazodone has adrenergic effects that are similar to prazosin, and uncontrolled studies suggest it improves sleep and reduces nightmares in PTSD (Brownlow JA et al, *Curr Psychiatry Rep* 2015;17(6):41). Some experts use it first line for insomnia and nightmares in PTSD. It's also a preferred hypnotic in sleep apnea because it can lower the hypopnea index (Smales ET et al, *Ann Am Thorac Soc* 2015;12(5):758–764). Trazodone is often used for insomnia in bipolar disorder, but there are case reports of hypomania even at the low dose. Recently, an epidemiologic study raised questions about suicidality risks when trazodone is used as a hypnotic, which we cover in this issue's Research Update on page 6.

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Trazodone: The Forgotten Antidepressant

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Anxiety, akathisia, and beyond

For treating generalized anxiety disorder, trazodone worked better than placebo but worse than imipramine in a large randomized controlled trial (average dose 225 mg divided tid) (Rickels K et al, *Arch Gen Psychiatry* 1993;50(11):884–895). It relieved antipsychotic-induced akathisia in a small, placebo-controlled trial at 100 mg qhs (Stryjer R et al, *Clin Neuropharmacol* 2010;33(5):219–222). There is little evidence to support its use in panic disorder and OCD.

Managing side effects

If daytime fatigue persists with evening dosing, have the patient take trazodone 2–3 hours before bedtime. Orthostasis may improve by dividing the dose or taking it with food to reduce peak plasma levels. Taking trazodone after a meal can mitigate nausea. Priapism is best handled by education and screening for high-risk patients such as those with sickle cell anemia, leukemia, hypercoagulable states, and cocaine or methamphetamine use. Frequent morning erections are a warning sign, and an erection lasting longer than 2–4 hours mandates a trip to the emergency room.

How to use trazodone in depression

Some guidelines list trazodone as a first-line agent, and while I generally wouldn't start there, it's worth trying if your top 2 choices fail. Patients with insomnia, PTSD, sleep apnea, or anxiety are good candidates, as are those who want to avoid weight gain and sexual side effects. I'll also consider moving to an antidepressant dose (150–600 mg) when the patient is already on it for insomnia. Those at risk for hypotensive falls or cardiac disease are less ideal.

Start with 25–50 mg at bedtime and increase slowly to 150 mg at bedtime within 7–10 days. At that point, you can wait to see if your patient responds or increase by 50–75 mg per week to a total of 300 mg, all at bedtime. The maximum dose is 600 mg, and some patients respond to doses as low as 150 mg.

TCPR VERDICT: Trazodone is an effective antidepressant whose tolerability is greatly improved with nightly dosing, even in instant-release form. Its novel mechanism of action is a promising avenue for treatment-resistant patients, and its lack of weight gain and sexual side effects is a welcome advantage for others. Daytime somnolence, orthostasis, and drug interactions make it a second- or third-line option.

Expert Interview

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TCPR: Most of us have been forced to switch to telepsychiatry due to the coronavirus crisis, and a lot of psychiatrists aren't exactly glowing about it.

Dr. Yellowlees: That's been the case since day one. Most physicians believe in the magic of the in-person interaction, so they perceive telepsychiatry as a second-class approach. My view is very different. I think it's suboptimal to rely solely on in-person visits, much as it would be if a physician refused to use the telephone. The best way is to use a hybrid model where you see patients in person, also see them on video, and communicate through email or messaging. You have a broader relationship that way, and care is more accessible. Over time, that creates a better relationship.

TCPR: What advantages stand out for telepsychiatry?

Dr. Yellowlees: There are certain groups of patients who prefer video, like children and younger patients. When you see a child by video, you get a better sense of the child's home environment and family interactions. For example, when children act out in the office, the parents will often leave behavior management up to you. But in a televisit, that's not possible, so you get a better view of what their parenting skills are like and can coach them in real time.

TCPR: What other groups do better with telepsychiatry?

Dr. Yellowlees: Patients who have a hard time engaging in treatment, like those with PTSD or agoraphobia, can do better with telepsych. There is some evidence that seeing them on video for the first few sessions makes it easier to engage them in the long run. Also, those who can't make it to the office because of physical limitations or privacy needs, like celebrities, are a good fit.

TCPR: Is there a risk that televisits will enable avoidance in agoraphobia?

Dr. Yellowlees: Yes, but if they won't come to see you in the first place, then you can't even get to first base, so why not start in their home and teach them some techniques that might get them out of the house? When I see patients with agoraphobia, I'll have them go to places they haven't been to and take a selfie there. Then they can show me their progress. Likewise with patients who hoard: I can watch them at home cleaning up or see the results on video.

TCPR: I've heard psychiatrists complain that conversations are more superficial in telepsych.

Dr. Yellowlees: Actually, I find the opposite. People are more comfortable having intimate conversations on video than in person. It's less threatening. There's a large body of research showing that if you want to get an honest answer on a questionnaire, you should give it through a computer rather than in person. We found the same thing in telepsychiatry research. I've frequently had patients tell me intimate stories on video that they've never told before. They do that for three reasons. One is that the video makes me seem more distant, so they feel like they're less likely to run into me at the grocery store, and that creates more safety. The second is that I'm less intimidating on video. Let's say I'm seeing a woman who has been raped. In an office visit, she'll be less likely to tell me about the rape because of the gender dynamics, but it's safer from a distance. The third is that video is more egalitarian. Patients don't have to come to my office on my terms and wait for me. So it brings us closer to the same level (Kocsis BJ and Yellowlees P, *Telemed J E Health* 2018;24(5):329–334).

TCPR: How can we connect better with patients during digital visits?

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Expert Interview

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Dr. Yellowlees: Start off on a good note. You shouldn't just jump in with clinical questions. I'll start by noticing something in their room and saying, "That's an interesting picture, can you aim your camera there and show me that?" I encourage my patients to use their phones, tablets, or laptops because I want them to walk me around their garden and introduce me to anyone they are comfortable with in their home. I want to see their pets. I may want to look in their fridge if we're working on eating habits or if I'm concerned about self-care. You see all sorts of things in patients' homes, and these are opportunities for connection. You might learn you both like the same sports team. Think of these as home visits, not just televisits.

TCPR: What if patients can't be at home or their home isn't private?

Dr. Yellowlees: That happens particularly when I treat physicians, and I'll encourage them to see me from their car using a smartphone. The car is actually a very private place.

TCPR: When is telepsychiatry less ideal?

Dr. Yellowlees: There are patients who are phobic or paranoid about technology, but that's getting less and less common. The only relative contraindication is when dangerousness is an active concern because it's more difficult to hospitalize someone long distance—not that it's particularly easy from the office either. In both situations you'd need to contact the police, but there's one difference with telepsych: You need to call the police station where the patient is located, which may not mean calling 911 because 911 routes to your local police. Another facet of telepsychiatry is that you should document the address where the patient is located, because legally that is where the consultation takes place. I also like to get a cell phone number in case the video breaks up, and the phone number for an emergency contact whom the patient trusts.

TCPR: If the consultation officially takes place where patients are located, does that mean you have to be licensed in the state where they connect from?

Dr. Yellowlees: Yes, though that regulation has been dissolved temporarily during the coronavirus crisis. In normal circumstances this can cause difficulties. If your patient travels to another state, say for a holiday or college, then legally you should not see the patient on video in that state, even for one session. I would advise one or two pro-bono phone or email contacts just as for patients we see in person who travel, then ask a colleague to take over if the patient is going to be out of state continually. About half of the states participate in a telemedicine compact that simplifies the process of getting multiple licenses, but there is still a cost hindrance.

"Right now during the coronavirus outbreak they're allowing any system, but that's not going to last and I would encourage psychiatrists to get a HIPAA-compliant system. You have that option, so it's hard to justify not using it. And I don't think a consent to communicate insecurely through Skype or FaceTime would hold up in court."

Peter Yellowlees, MD

TCPR: Are there any other documentation requirements that are unique to telepsychiatry?

Dr. Yellowlees: That varies by state, so you'll want to check in on that. Two resources to start with are the APA's Telepsychiatry Toolkit (www.psychiatry.org/psychiatrists/practice/telepsychiatry) and the American Telemedicine Association (www.americantelemed.org).

TCPR: What about controlled substances?

Dr. Yellowlees: With the coronavirus crisis, the government has removed the long-standing obstacles to prescribing controlled substances over video, so even maintenance medications for addictions can be prescribed through telepsychiatry. But generally the rule is that you have to see the patient in person at least once a year to maintain controlled substances through telepsychiatry visits (as required by the Ryan Haight Act). That may change in the future.

TCPR: Is it necessary to use a HIPAA-compliant platform, or can you just have the patient sign a consent to communicate insecurely through Skype or FaceTime?

Dr. Yellowlees: Right now during the coronavirus outbreak they're allowing any system, but that's not going to last and I would encourage psychiatrists to get a HIPAA-compliant system. You have that option, so it's hard to justify not using it. And I don't think a consent like that would hold up in court.

TCPR: How do you know if your system complies with HIPAA?

Dr. Yellowlees: The company you purchase it from should give you a business associate agreement that essentially says the company is unable to look at your transmissions.

TCPR: What's the ideal telepsychiatry setup for a provider on a low budget?

Dr. Yellowlees: You don't need a fancy system, and there are lots of good ones that will cost you about $50–$100 per month. I usually mention Zoom, Vsee, and Vidyo, two of which I use personally. The easiest thing to do is to run video on your smartphone or iPad. I stand the device up beside my laptop so that I can see the patient while I'm writing my notes.

TCPR: Are there advantages to a more expensive setup?

Dr. Yellowlees: Not really. With today's cell phones you can get a high-definition picture, much better than what we got in the old days when some of those patient satisfaction studies were done. Quality audio is actually much more important than quality video. If you're going to do a lot of telepsychiatry, I'd suggest an echo-cancelling microphone so there's no feedback from the speakers. A good one is ClearOne's Chat 50 speakerphone.

TCPR: How do you make eye contact in a telepsych visit?

Dr. Yellowlees: If you look at the camera, it will seem that you're making eye contact with the patient. So you want the patient's image to be as close to your camera as possible. I use a split screen where my image is on the

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A Potentially Lethal Side Effect You Probably Never Heard Of

Chris Aiken, MD. Editor-in-Chief of TCPR. *Practicing psychiatrist, Winston-Salem, NC.*

Dr. Aiken has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

In January 2020, the FDA issued a strong warning about constipation on clozapine. With a fatality rate of 1 in 1000, this is not just a nuisance side effect, and it can happen with other antipsychotics and psychotropics as well. This type of constipation is caused by slowing of the gut, or gastric hypomotility, and it requires a unique approach. Fiber supplements, for example, could be dangerous. In this article I'll show you how to manage it.

Slowing of the bowels

Antipsychotics can slow the bowels, mainly through anticholinergic effects but also through serotonin antagonism at $5HT_3$ and $5HT_4$. Clozapine, which slows the bowels in 50%–80% of patients, is the worst offender. On average, it takes 4 times longer than normal for food to pass through the intestines when a patient is on clozapine.

The dreaded outcome in all this is *paralytic ileus:* when the bowels grind to a paralyzing halt. Paralytic ileus is one step from intestinal obstruction, which can progress to bowel ischemia, perforation, sepsis, and death. About 1 in 1000 clozapine-treated patients die from bowel complications, 3–6 times higher than the rate of death from neutropenia on clozapine.

The danger is higher in the elderly, especially in those taking anticholinergics, which increase the risk of intestinal ileus 6-fold when taken with clozapine. The FDA advises minimizing other constipating medications with clozapine, and calls out the anticholinergics by name. Benztropine (Cogentin) and diphenhydramine (Benadryl) are two anticholinergics often used in schizophrenia. Other constipating meds to watch for are iron, treatments for overactive bladder, and iron, NSAIDs, and treatments for urine incontinence.

The problem is not unique to clozapine. There are a few other psychotropics to watch for that can slow the bowels. Tricyclic antidepressants, high-potency first-generation antipsychotics (eg, haloperidol, fluphenazine), and opioids have a risk of paralytic ileus that is comparable to clozapine's, though the problem is less likely to lead to fatalities on these. Among the second-generation antipsychotics, quetiapine and olanzapine have a risk of ileus that's 50% less than clozapine's but more than that of other atypical antipsychotics (Chen HK and Hsieh CJ, *Schizophr Res* 2018;195:237–244).

Warn the patient

Paralytic ileus is a medical emergency, and the FDA recommends educating patients about it before starting clozapine. First, advise them of the symptoms of hypomotility, as these indicate a need for more aggressive treatment of constipation:

- Fewer than 3 bowel movements a week
- Hard or dry stools
- Difficulty passing gas

When those symptoms are paired with the more serious signs below, referral to an urgent care center is warranted:

- Moderate to severe abdominal pain lasting > 1 hour
- Nausea, vomiting
- Abdominal bloating or swelling
- Bloody diarrhea

From prevention to treatment

The *Porirua Protocol* is a step-by-step algorithm developed in Porirua, New Zealand, for constipation on clozapine. The protocol reduced the prevalence of gastrointestinal hypomotility on clozapine from 86% to 50% in a small study (Every-Palmer S et al, *CNS Drugs* 2017;31(1):75–85). It starts with preventative therapy.

1. **Prevention.** All patients are given docusate (Colace) 100 mg qhs with senna (Sennosides, Ex-Lax, or Senokot) 17.2 mg qhs along with their first clozapine prescription (Every-Palmer S et al, *CNS Drugs* 2017;31(1):75–85). Docusate softens the stool by pulling water into it, while senna addresses hypomotility more directly by stimulating peristaltic activity in the gut. The two are available over the counter and come as a combo pill, Peri-Colace (the generic form is labeled "stool softener with stimulant laxative"). They should be taken with a full glass of water.
2. **First intervention.** If the patient goes 48 hours without a bowel movement, increase the preventative regimen to docusate 100 mg bid with senna 17.2 mg bid.
3. **Second intervention.** After 4 days without a bowel movement, send the patient for a physical exam by a primary or urgent care provider to see if enemas or manual disimpaction are needed. If disimpaction is required, stop the senna and docusate. If not, add polyethylene glycol (MiraLAX) 17 g bid. These treatments can be rolled back in the order they were added if diarrhea develops.
4. **Specialist care.** When constipation continues beyond those steps, the primary care provider or gastroenterologist should take over the treatment.

This protocol can be adapted for hypomotility due to other psychotropics by making the preventative step the first-line intervention and moving through the steps as needed from there.

Avoid fiber supplements

Fiber supplements and bulk-forming laxatives may work for everyday constipation, but they should be avoided when slow motility is the cause. Otherwise, the bulk they form can block the intestines. Items to avoid include psyllium (Metamucil), methylcellulose (Citrucel), wheat dextrin (Benefiber), polycarbophil (FiberCon), and fibrous foods like prune juice. The most important dietary tip is to drink lots of water, which keeps fibrous foods from congealing into an obstruction.

TCPR VERDICT: The risk of bowel obstruction has changed the standard of care with clozapine. Warn patients about the problem, inquire routinely about the frequency of bowel movements, intervene early with senna and docusate, and know when to avoid bulk-forming agents. These steps are helpful for other constipating psychotropics, particularly in vulnerable populations like the elderly.

To learn more, listen to our 5/18/20 podcast, "Constipation and Psych Meds: An Expert Interview With Jonathan Meyer." Search for "Carlat" on your podcast store.

Research Update IN PSYCHIATRY

SUICIDE

Study Ignites Controversy Over Trazodone and Suicide

REVIEW OF: Lavigne JE et al, *J Gen Intern Med* 2019;34(8):1554–1563

STUDY TYPE: Observational comparative safety study

Trazodone is one of the most widely prescribed sleep aids in the US despite lacking FDA approval for insomnia. But what if patients taking trazodone attempted suicide at a rate over 1.5 times that of those taking zolpidem (Ambien)? Lavigne and colleagues arrived at this potentially alarming conclusion in their observational safety study.

The authors mined data from the Department of Veterans Affairs (VA) to compare the rate of suicide attempts in veterans treated with various sedative-hypnotics, including trazodone, zolpidem, hydroxyzine, and benzodiazepines. Close to 350,000 patients met study criteria. The authors matched the patients in terms of psychiatric and medical comorbidities, inpatient days, disability ratings, concomitant medications, and several other variables. To control for other confounding variables, they used a "propensity score," which is an estimate of the likelihood that a given patient would be prescribed zolpidem. This process resulted in four groups of about 75,000 patients divided according to type of sleep medication.

The primary endpoint was suicide attempts as detected in medical records. The rate of attempts was higher only when the trazodone group (n = 57) was compared to zolpidem (n = 38), a 61% increase in attempts. There was no mention of completed suicides.

Before you take your patients off trazodone, remember that observational studies have some glaring limitations. Despite the use of sophisticated statistics, it is impossible to control for all confounding factors. In this study, the authors acknowledge that they did not control for nightmares, and trazodone was a first-line treatment for nightmares in this population. This is an important confound, because the trazodone group may have already been at higher risk of suicide due to greater symptomatic distress. Although the authors controlled for comorbidities, it's still possible that physicians were more likely to prescribe trazodone than zolpidem to patients with signs of addiction or impulsivity.

The analysis also failed to account for drug interactions. This is important because CYP2D6 inhibitors can increase levels of the trazodone metabolite, m-chlorphenylpiperazine (mCPP). Abrupt increases in this metabolite, which can happen when a CYP2D6 inhibitor is introduced, have been linked to dysphoria and anxiety, as well as to self-harm in adolescents (Shamseddeen W et al, *J Child Adolesc Psychopharmacol* 2019;29(7):573).

TCPR'S TAKE

While the apparent association of trazodone with suicidality raises concern, the study does not prove causation and may illustrate that nightmares and possibly drug interactions correlate with suicide attempts in a population of veterans. Prospective controlled trials in varied populations are needed before making recommendations against the use of trazodone.

—Eugene Rubin, MD. Dr. Rubin has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

To learn more, listen to our 5/11/20 podcast, "Trazodone and Suicide: An Interview With Vaughn McCall." Search for "Carlat" on your podcast store.

Expert Interview

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bottom and the patient's image is on top—closer to the camera—so there is little difference between our eye-to-eye angle and the camera angle.

TCPR: What about lighting?

Dr. Yellowlees: You want to avoid backlighting, which casts a shadow over your face. Dim the lights that face the camera from behind you, and place a bright light—like a flexible reading lamp—above the computer and aimed at your head. You should be about 2 feet from the camera.

TCPR: How is billing different for telepsychiatry?

Dr. Yellowlees: It varies by state. I usually bill an evaluation and management (E&M) code and psychotherapy code for a 30-minute appointment, with the same codes I use for in-person visits. You are required to modify the code with "GT" or "95" to indicate that it was done by telemedicine, and some insurers require you to change the place of service to "02" for tele instead of "11" for office.

TCPR: How is the reimbursement?

Dr. Yellowlees: Medicare has historically been the biggest barrier to reimbursement. They've insisted that patients who are seen by telemed live in a tightly defined rural geographic region (*Editor's note:* For a list of underserved ZIP codes, see "Downloads" at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses). That has been changed for the length of the current crisis, and Medicare is now paying for doctors to use video with their patients in any state, as long as the physician is fully licensed in at least one US state. That will undoubtedly change after this crisis, but I hope not by much. Medicare pays the same rates as for in-person consults, as does Medicare/Medicaid in most states. In California we have a law that forces insurers to pay the same for telepsych as they do for in-person visits, and many states are moving in that direction.

TCPR: Does anyone pay more for telepsychiatry?

Dr. Yellowlees: No, but if you are seeing a patient in a clinic, the clinic can bill a facility fee (code Q3014),

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CME Post-Test

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This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Learning Objectives (LO) are listed on page 1.

1. Your patient wants to know if trazodone helps with sleep issues. What information about trazodone for insomnia should you share with her? (LO #1)
   [ ] a. Although trazodone can be effective for sleep, it has many metabolic side effects, including significant weight gain
   [ ] b. Trazodone has been shown to work for both primary insomnia and insomnia secondary to depression
   [ ] c. Trazodone has been shown to increase nightmares in patients with PTSD
   [ ] d. Trazodone can help patients fall asleep faster but decreases overall sleep quality

2. Which of the following statements about prescribing controlled substances over video during the COVID-19 pandemic is true? (LO #3)
   [ ] a. Maintenance medications for addiction can be prescribed only if you've been seeing your patient for at least 12 months
   [ ] b. Maintenance medications for addiction can be prescribed through telepsychiatry
   [ ] c. The provision that clinicians must see a patient in person at least once every 2 years to maintain controlled substances through telepsychiatry has been revoked
   [ ] d. Maintenance medications for addiction cannot be prescribed through telepsychiatry

3. The Porirua Protocol for preventing constipation recommends starting which treatment along with a patient's initial dose of clozapine? (LO #2)
   [ ] a. Fiber supplements [ ] b. Polyethylene glycol (MiraLAX) [ ] c. Docusate and senna [ ] d. Docusate

4. In a 2019 study evaluating trazodone and attempted suicide, the rate of attempts was lower in the group taking trazodone compared to the group taking zolpidem. (LO #4)
   [ ] a. True [ ] b. False

5. Which medication carries little to no risk of paralytic ileus? (LO #2)
   [ ] a. Haloperidol [ ] b. Lithium [ ] c. Oxycodone [ ] d. Quetiapine

6. One limitation in a 2019 study on trazodone and attempted suicide included: (LO #4)
   [ ] a. High dropout rate in the high-dose trazodone group compared to the low-dose group
   [ ] b. No control for nightmares as a confounding factor
   [ ] c. No adjustment for days' supply and mental health history
   [ ] d. Different comorbidities in high-dose vs low-dose trazodone patients

Expert Interview

Continued from page 6

which usually pays about $25. And you can charge for two physicians at the same time if you're doing collaborative care with a primary care physician (PCP) through telepsychiatry. In those cases I'll generally see new referrals for 35–40 minutes, and then for the last 10 minutes I'll consult with both the patient and the PCP. The PCP would then prescribe the medications and put in any orders, and both of us can bill for that time.

TCPR: Physician morale is at an all-time low. How can telepsychiatry help?

Dr. Yellowlees: Telepsychiatry saves you time. You can complete your notes during the visit. Just place your cell phone's camera near your laptop and touch-type as you talk. Let the patient know what you're doing. It helps to have a quiet keyboard—search for "silent keyboard" on Amazon. There's also less in-and-out time with patients entering and leaving the room, which saves you time, and fewer no-shows. If a patient no-shows for an office visit it's hard to get them in, but with telepsych you could phone the patient and start the visit. Patients can see you even when they are feeling physically under the weather. The biggest plus is geographic flexibility. You're no longer bound to your office. I routinely see patients from my home, but you could also practice telepsych while traveling.

TCPR: What does the future look like after this crisis settles?

Dr. Yellowlees: Right now, many of us are seeing patients 100% on telepsychiatry. I hope that in the future, patients will have more choice and most of us will be practicing in a hybrid manner. Sometimes we'll still want patients to come in, but there are advantages to both types of visits, and our patients will be best served by having more choice and a more flexible relationship with us.

TCPR: Thank you for your time, Dr. Yellowlees.

Editor's note: Dr. Yellowlees' textbook, *Telepsychiatry & Health Technologies*, is available through the APA Press, 2018.

To learn more, listen to our 5/4/20 podcast, "Top Telepsychiatry Tips." Search for "Carlat" on your podcast store.

Research Theme Park: Food and Mood (5/25/20). This month's bonus podcast will examine a new study of diet and depression, how a daily dose of blueberries improves mood and memory, the neuroprotective effects of tea, and how salt and fat can harm the brain. Search for "Carlat" on your podcast store.

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In Brief

Psychiatric Effects of the Chloroquines: During the coronavirus outbreak, prescriptions for chloroquine and hydroxychloroquine have climbed 5-fold to 10-fold as as people turn to these experimental therapies for COVID-19. Their psychiatric properties are worth knowing. The chloroquines readily cross the blood-brain barrier, where they create a number of undesirable effects, increasing serotonin, acetylcholine, and glutamatergic transmission and causing toxic metabolites to accumulate. The drugs have known associations with suicide, psychosis, mania, and depression (Mascolo A et al, *Inflammopharmacology* 2018;26(5):1141–1149).

Drug interactions are another problem. As moderate CYP2D6 inhibitors, the chloroquines can raise levels of many psychiatric medications. They also prolong QTc and increase the risk of neutropenia on clozapine. These effects can linger, as the chloroquines have unusually long half-lives of 20–40 days.

Lithium and the Coronavirus: Lithium has also been proposed as a potential therapy for COVID-19. Lithium improves immune function, increasing neutrophils, lymphocytes, leukocytes, and natural killer cells. It also has direct antiviral activity. It has been used to treat herpes and impedes the replication of over a dozen viruses, including four coronavirus strands. Lithium has never been tested against the current novel coronavirus (Nowalk JK and Walkowiak J, *F1000Research* 2020;9(93)).

While lithium's properties may be welcome news for patients who are taking it, they should be warned that viral illnesses raise the risk of lithium toxicity, mainly through dehydration, diarrhea, and the use of nonsteroidal anti-inflammatories (NSAIDs), which raise lithium levels by unpredictable degrees.