Transcript: More Than One: Considering Multiple Medications in a Recovery Plan

Complex Clinical Decisions Podcast Series

Hello and welcome to the Recovery to Practice Podcast Series of Complex Clinical Decisions and Psychopharmacology. I'm Curley Bonds, the Chief Deputy Director for Clinical Operations at the Los Angeles County Department of Mental Health, as well as the Clinical Professor of Psychiatry at UCLA, and a Professor of Psychiatry at Charles R. Drew University of Medicine and Science.

This series is hosted by the Substance Abuse and Mental Health Services Administration's Recovery to Practice Initiative. Our goal is to help our fellow clinicians explore recovery-related issues so that we can all help the individuals we work with reach their goals. In today's podcast we're going to focus on polypharmacy, where the use of multiple medications when working with individuals with serious mental illness. To help us, we'll be talking with two clinicians with a lot of insight on issues related to multiple medications in psychiatry, Dr. Scott Stroup and Dr. Hunter McQuistion.

We start our podcast with Dr. Stroup, who is a professor of psychiatry at Columbia University College of Physicians and Surgeons and a psychiatrist at New York Presbyterian Hospital. Dr. Stroup, welcome to the Recovery to Practice Podcast.

Thank you for asking me.

To begin with, when we say multiple medication in the context of serious and persistent mental illness, what are we really talking about and why might being on multiple psychiatric medications be a problem?

What we're talking about is the combination of different psychotropic medications. People with schizophrenia or bipolar disorder might be on combinations of psychiatric medications and medications for medical conditions, but that's not really our focus today. We're really talking about the combination of psychotropic medications, two or more antipsychotics or combinations of antipsychotics with antidepressant, mood stabilizers, or benzodiazepine. And a subtype is something called antipsychotic polypharmacy where people are on two or more antipsychotic medications.

And the reason we think it's a problem is because there's not a lot of evidence to support combinations of medications, and it leads to potential problems for the individual who is taking the medications. It makes it easier to get confused with the medication regimen, easier to make mistakes taking them. We know that the more medications you're on the less likely you are to take the medications, and then there are various kinds of interactions medications might have with each other. They might have additive side effects or they might interfere with the metabolism of each other, or one might interfere with the metabolism of the other and could change how it works.

So, in general, how often would you say the situation occurs clinically?

Well, there's a fair amount of data out there about schizophrenia in particular. You know, it's been recorded that at least around 20% of individuals with schizophrenia are on multiple antipsychotics, that would be antipsychotic polypharmacy. But we also know that antipsychotics are often combined with other medications. 30 to 50% may be on a combination of antipsychotic and a mood stabilizer, and about half on combination of an antipsychotic and antidepressant, so it's quite common. And it's also not rare for people to be on three or more psychotropics or four or more psychotropics at the same time.

Wow, so this can happen quite a lot. Why might individuals find themselves on multiple psychiatric medications?

I believe the most common reason is -- well, a couple things. One is people have different kinds of symptoms that are not addressed just by antipsychotic medication. So, people with schizophrenia may have hallucinations or delusions, but they also may have mood symptoms or they may have sleep disturbance or behavioral problems that people may -- someone might use antipsychotics to try to address those. So, that's one thing. Then the antipsychotic medications alone don't address all the issues that might need to be addressed.

The other is, it happens a lot when people end up in the hospital, someone is acutely ill and is in the hospital, there's a real urgency to try to help them feel better and get better and get out of the hospital as soon as possible, and there are various pressures to do that and to address them with medications. So, a common thing I've seen is people come out of an acute hospitalization on, you know, multiple medications, often one or two new medications, or even more. So, that's what I think happens.

So sometimes when people are having more serious symptoms or more severe episodes, they might add medications or a clinician might add them to help them in the process towards recovery. Is that sort of the motivation that you've seen?

Certainly, recovery is our goal. I think that may get a little confused in the inpatient hospitalizations, where there also is a motivation to get people out of such a restrictive setting right away, so medications may be used a little more liberally there to help people get outside of the hospital, where they can pursue their recovery in a less restrictive setting. It makes sense to address someone who -- you know, depressive symptoms with antidepressants or to treat anxiety symptoms with anxiolytics, at least on the face of it. It's just that there's not a lot of evidence that says that this works, no randomized control trials that really support that.

Dr. Stroup, as I understand it, your research focusses on effectiveness interventions and services for people diagnosed with schizophrenia and related illnesses. What do we really know about how multiple medications may affect these folks?

The evidence is pretty sparse. There have been a lot of small randomized control trials about adjunctive benzodiazepines or adjunctive mood stabilizers or antidepressants, but they're generally small, and the results are pretty inconsistent, and where there have been benefits the benefits have been pretty small and inconsistent. So, people have done these meta-analyses and systematic reviews of the literature, and when you look at those, the conclusion is almost always that the studies are pretty poor quality, the results are inconsistent, we need more studies, and there's not enough here to recommend one of these adjunctive treatments for the treatment of schizophrenia.

I should say, though, that there's one exception to that, is there does seem to be some growing evidence that antidepressants may have some benefits in schizophrenia. There have been benefits for negative symptoms and for depressive symptoms, so that's pretty good. On the other hand, there's been some evidence that benzodiazepines may be associated with higher rates of mortality, and so we don't know much, but we know to be cautious.

So, how does your research fit into all of this?

Well, one of the things I'm doing right now is trying to sort out how some of the different combinations of medications might affect outcomes. Because there's so many different psychotropic medications and so many different possible combinations, it's really hard to do that by way of a randomized control trial. So, I'm working with some colleagues on a study sponsored by the Patient-Centered Outcomes Research Institute, or PCORI, where we're using ten-years-worth of Medicaid data from across the country to try to look at treatment patterns and to make some inferences about how the different medications affect outcomes.

From that work, I've confirmed that polypharmacy is extremely common, but we're trying to sort it out. How does it compare when you add an antipsychotic to another antipsychotic or add an adjunctive benzodiazepine or an adjunctive mood stabilizer or an adjunctive antidepressant? And so, again these are very common strategies, and we're looking at how they affect outcomes like re-hospitalization rates, need for emergency room visits, and mortality. These aren't the most patient-centered outcomes, but we have talked to individuals with schizophrenia and talked to them about things they do care about, and they do care about hospitalization rates, and, certainly, they care about mortality, so these are things that are important.

Our work is still kind of preliminary, but I can say we can confirm that we're finding some benefits from antidepressants, and we're really not finding many benefits from mood stabilizers or benzodiazepines. In fact, there are some potential harms there that have been noted in other research.

That's really encouraging to hear. Ten years of data, that should be really powerful once you're done for the analysis, so something for all of us to look forward to. Can you describe a situation from your own practice where you were able to reduce the number of medications an individual was taking?

Sure. It's pretty common. I can think of a situation where someone was referred to me. It turns out they were coming out of the hospital, had been referred to a sort of rehabilitation setting, and they were doing not that great. They were on two different antipsychotics, they were on a mood stabilizer, and they were taking a benzodiazepine for sleep, and, you know, still were having lots of symptoms and lots of side effects. And my assessment was we needed to find a better way to treat their psychotic symptoms, and so what we did was we switched them to clozapine. We got their permission and were able to take someone who was on four different medications and gradually get them on clozapine, which was better at addressing their psychotic symptoms and not have such a complicated regimen. That can't always be done, but that's one example.

More commonly, people were on a bunch of medications and you can just gradually try to identify some that might not be necessary and discontinue one at a time slowly, and if it isn't needed, great. And if somehow it turns out the problems going back when you stop the medication, then you can always just restart it.

In that example that you just described, where you took someone who was on four medications and worked with them to go down to fewer medications, can you give us a sense of how you did that. I know that clinicians were often concerned about taking away or decreasing medications because something may go wrong. Maybe if you could give some thoughts about a safe or best way to go about that.

Sure. In that particular example, because the young man was really having a lot of symptoms and just not able to participate in the rehabilitation program he was working on, we ended up asking him to consider going back in the hospital for medication change, and that allowed us to make the changes relatively rapidly and get him over the clozapine pretty quickly. That's not always possible, but that is what we did in that situation. Otherwise, you know, going from a complicated regimen to a simple regimen is a much slower process that may involve a little bit of trial and error but would be trying to remove duplicate medications or medications that may not be needed, and with close follow up, you can work with someone to see how the changes are affecting them. And particularly when they're duplicate medications, they can be done away without any adverse consequences.

That's great. Your comments about clozapine remind me of a situation yesterday where I was supervising a nurse practitioner at our clinic who had an individual who had been treated with clozapine, along with some other medications, including a benzodiazepine and also an injectable typical antipsychotic, haloperidol. I'm wondering, we did have a conversation about some of the risks, but I wondered if you have any thoughts about, since clozapine is considered a gold standard, how often do people pile on things or attach things onto it? Any thoughts about?

It's pretty common, unfortunately. You know, clozapine is the only proven medicine for what they call treatment-resistant schizophrenia, but even it doesn't provide full relief for everyone. So, once you've tried

that and there's no other recommended of proven treatment, people will add things on. You know, there are a lot of different things have been studied, but nothing has been shown to be particularly efficacious when added onto clozapine. I think a common thing is to end up end up adding another antipsychotic in a low dose, but the efficacy is not so clear.

So, how do you articulate to the person that you're partnering to help them to understand how and why they may or may not benefit from multiple medications?

I think this is where you might have an advantage in an outpatient setting over an inpatient setting, where you might be a little more rushed to do things. But if you're working in an outpatient setting with someone who you've established a relationship or a good therapeutic alliance, then I think it gives you the opportunity to really consider the benefits and risks, the various options, and perhaps to be a little more patient. So, I think, in that sense, one of the things is to do some sort of psychoeducational, or I guess it's psychopharmacologic education to try not to address short-term problems with medications. You know, someone who has been doing fairly well comes in feeling sad one day or having no sleeping for a week, or feeling anxious, to try to understand what's going on with them and to see if you can get to the root cause of things rather than just add a medication to address the symptoms. You know, for example if someone is having trouble sleeping, you can find out what's going on in their life or go over sleep hygiene things to help avoid adding a sleep medication. That's sort of a simple idea, but if you teach people who have maybe meds have been offered often before for problems, that that may not be the best solution, you can keep things simpler.

I like that idea. Going back to the basics, doing education around things, of course, we all know that takes time, but it's worth it, I think, if you can avoid having someone exposed to unnecessary side effects. So, based on your experience and what you've seen in your practice and research, what pragmatic suggestions can you provide for the clinicians who are working with individuals with a serious mental illness who are taking multiple medications?

So, one of the things is, you know, if you've got people on a lot of medications, how can you simplify the regimen, or what might you be able to do? And there actually is a study that took people who were taking two antipsychotics for unclear reasons and tried to see what would happen if you took them off of one of them. It was a randomized control trial where people on two antipsychotics, any two antipsychotics, were randomized and they dropped one. And that was compared to people who were allowed to stay on both of them. And, in fact, the people who dropped one did just as well as the people who stayed on both of them, and they had fewer side effects.

I would say the bottom line on polypharmacy is that it's to be avoided, if possible, and the best way to deal with polypharmacy is probably prevention. So that would be to be cautious when someone presents with a new problem or a new issue to consider waiting a little bit or making dosage adjustments with their current medication before adding something. There are going to be situations where it makes sense and is helpful. But I would proceed with caution.

Dr. Stroup, thanks for taking the time to be with us and for sharing your thoughts.

Sure. Thank you. I appreciate the opportunity to talk about this.

Next up, we're speaking with Dr. Hunter McQuistion, a clinical professor of psychiatry and the medical director of psychiatry with Gouverneur Health in New York City. He has provided community-based treatment for people experiencing homelessness and mental illness. Welcome to the Recovery to Practice Podcast.

Thank you. I really appreciate it.

So, Dr. McQuistion, could you please tell us a little bit about the people you traditionally serve. Why are they on multiple medications?

Well, let me start with just some background. Currently, I'm chief of a department that essentially has the largest outpatient service in New York, New York City. As you mentioned, I cut my teeth working with homeless populations for many, many years, and I've seen all kinds of issues with that particular population; therefore, I think I really address psychopharmacology from a broader, essentially, psychosocial point of view, as opposed to, strictly speaking, a biological one.

The experience I've had working with those populations, and through the wide and relatively deep clinical experience I've had since then in the last 25 years or so, has really sensitized me towards engagement and, shall we say, the art and skills of prescribing medication and attitudes on psychopharmacology. The idea that really is to help a person to get from whatever his or her point A is to point B. And polypharmacy means many different things. It can be negative, as well as positive connotations, and it's sometimes necessary to use more than one medication, even though my overall philosophy is less is more.

For example, if you have a personal who has a psychotic depression, you end up using more than one medication, an antidepressant and an antipsychotic agent. That's, technically speaking, polypharmacy, but it is targeted.

So, you're making a distinction between putting several medications onto a particular illness or symptoms complex versus multiple medications to address different things with different targets. As clinicians, how do we bring a recovery-oriented approach to prescribing multiple medications?

Well, I think I mentioned a few minutes ago about moving a person in terms of their own goals from point A to point B, and I really think it goes back to whatever their own goals are, in terms of work and love.

As mental health practitioners, we are really their assistants, and I often say that there are two experts in the room when I'm with a person. I may the expert on pharmacology and on mental health, but they're the experts on them. And they're my guide, essentially, in terms of offering suggestions, from a medication point of view, that can help them move on to solving whatever problems they have at the moment, and then in a more far-reaching manner, achieve some of their life goals.

I really like that idea, aligning the treatment strategies that we offer with what the individual's goals are. In your opinion, how can prescribers do a better job of using evidence-based practices around prescribing multiple medications so that they can provide good clinical care?

While we engage our own activities with respect to prescriptions in using evidence-based processes, what we don't use so much are algorithms, and there are algorithms out there that can be helpful. TMAP is one example of that. Even beyond that, there's some very essential principles to really keep in mind, and there is actually a mnemonic that I could offer, and it is called SAIL, S-A-I-L.

The first thing is to keep the regimen simple, and I alluded to that a few minutes ago, in terms of less is more. You may need to use more than one medication, but you need to find specific target symptoms for those varying medications. The other is to think what's the evidence in terms of adverse effects, and to be very careful as far as asking the person who you're working with what are you experiencing and to expect X, Y, and Z possibly so that you can then avoid them experiencing those adverse effects, which then, in turn, could conceivably affect adherence. And then finally, indications, you give drug X for psychosis, drug Y for depression. But, at the same time, in terms of simplicity, may be the person who has a psychotic illness and is depressed is also anxious. Well, you know, there are some medications, for instance, serotonin reuptake inhibitors, that may target both anxiety and depression.

Finally, the L for SAIL is list, and that's just a real simple thing to do, is to make sure you have a list somewhere of the medications that a person is on, whether it's formal medication reconciliation device that is on your EHR or a piece of paper or something other your own hand-held device.

What kind of conversation should a prescriber have with an individual on multiple medications?

I mentioned SAIL, which is one pneumonic, S-A-I-L. There's another one called TIDE, T-I-D-E. T is for time, I is for individual variation, D is for drug-drug interactions, and E is for education. In the process of prescribing medications in a very sort of systematic way, you have to give enough time for a trial, and explaining what the medication does, what the chances are that it could be helpful, and how long it might need to be prescribed for in order to get an effect that the person would like. Oftentimes what happens, or sometimes what happens is that any a medication trial is attenuated prematurely and something else is added to it to synergize with it before that really needs to happen.

And I mentioned individual variability. That includes, obviously, the sort of emerging understanding of the genome and how medications are managed among different populations from a biological point of view. Certain people obviously are very sensitive to certain sensations, physical sensations that are side effects of medications, and in addition to educating them about the possibility that those occur but choosing medication around what the person feels would do them in the least amount of harm. This is a conversation that occurs not necessarily in 10 or 15 minutes, but, depending on how the person orients him or herself to the concept of taking a medication as an aid in their overall recovery, that conversation can maybe go on for many sessions.

You obviously have a lot of knowledge in this area. I'm wondering, for the prescriber working with an individual who is on multiple medications, say they come in having been in a hospital recently, what would you give in a way of the tip to the prescriber to launch the conversation about eliminating medications or reducing the number of medications?

What happens a lot of the time, if, for example, I'm seeing a patient who has been on five medications and is presenting to me with those medications on board already, me introducing the idea of diminishing the number of medications can actually be kind of frightening. One thing a person does not want is they don't want to start feeling worse. That has to be understood, and that has to do with engagement. Much like it's important to engage a person about starting their medication regimen and adding medications on in a well-informed but also empathic way, weaning medications away also requires knowledge, as well as empathy.

So, what I usually do is I bring up the idea, and we get into a conversation in terms of how the person feels about maybe getting off of a particular medication, and then, together, we make a decision over time, and it could be over ten minutes or it could be over ten sessions to start nicking away at the dosage of a certain medication, assuring them at all times that their sense of safety and security and ability to move through their lives and to move on is the single-most important thing.

So, I'm wondering if you could think of a time or clinical situation where having a person on multiple medications at some point in their treatment was both appropriate and maybe useful, and what factored into your making that decision, just to help us out so that we have a sense of that?

One of the most common scenarios is a person who presents who's seriously depressed with suicidal ideation, a sense of hopelessness, lack of any enjoyment whatsoever in what they're doing, maybe in trouble at work or in one of their relationships, for instance with their spouse, and is really, really, really tied up in knots by it and anxious, and so anxious that they're also having an incredible amount of trouble sleeping. And it's not unusual under these circumstances to prescribe an antidepressant medication, a serotonin uptake inhibitor, for example, and a sleep agent.

Now, this sleep agent could be a benzodiazepine. It may not be. We get into a conversation together about, well, what is the use of these two medicines? And we will say together, like, gosh, you know, this depression is awful, you know, the sleep is terrible, and I, as a practitioner, will say, my gosh, it's really, really important for you to be able to sleep and get some rest and get some of this off of your mind. And, as you know, the antidepressant is going to take a couple weeks, or more, to really have any kind of effect that you could feel. In the meanwhile, the idea is to help you not suffer as much as you are right now, so let's try 15 milligrams of this medication.

And by the way, this class of medication, sometimes people can become what they call habituated, where they can build up a tolerance to it and it can be hard to get off of. So, we'll really only do that for a couple of or few weeks at a time while the other medication is, if you will, kicking in. This kind of conversation occurs, and the person then usually asks, okay, well, I'm concerned about the habituation, and is there anything else I could be concerned about? Yeah, you know, if you're still tired through the morning, you need to give me a call and we can work something else out.

It's really important when you put somebody on a medication regimen and you work together with that, that you're really available, because a sense of safety is really important. And I don't mean just in the context of first do no harm that we're all taught in medical school; that being crucial unto itself, but the person needs to really feel that they have somebody on their side while they are moving forward in terms of relieving the pain and moving towards their own personal goals again.

You'll also encounter a person, for the first time, who is on an antidepressant, and for the last year-and-a-half, for some reason, never had the benzodiazepine withdrawn, and there is actually a dependence on it, not necessarily a severe physical dependence on it but a psychological dependence and a feeling that, well, if I get off this medication I'm never going to sleep again. So, that yields a whole different kind conversation around the concerns about sleep and education and orientation to a way to taper the medication in such a way that the ill effects of withdrawing a benzodiazepine are minimally experienced. Also offering an alternative with respect to potential sleep issues. That alternative can be cognitive behavioral interventions around insomnia.

And what I usually do in terms of the tapering is, unless there is some medical reason, \ I work that out on a case-by-case basis with the person I'm working with, and it can be over a couple of weeks. It can be over a couple of months. It can be over six months. But as long as we're working in the right direction towards decreasing the harm in the medication, then we are achieving our own objectives.

Those are really great real-life clinical situations, and I like the fact that you've given our listeners directional approach. From the begin, it's giving education, setting the stage, telling them that this is a time-limited intervention that's expected to change as your symptoms get better and your long-term medication kicks in. And then from the other direction, tapering someone off to let them know the reasons why might be beneficial. I just have one thought that came up in my practice recently. I have a gentleman who has been on Benzodiazepine for anxiety and for sleep for several years, and now has decided, for a variety of reasons, that among them cognitive difficulties and habituation, that he wants to be off. And we actually had to go to the process of finding a compounding pharmacy that can reduce the dose with him over time into very small, what I consider almost micro-doses of the medication to help him be able to reduce his use of it over time, and he's fully on board with that. So, thank you for those scenarios.

Right. No, I think I actually agree with that. I've done similar things as well, that people either nibble off little tiny pieces of the Benzodiazepine, or we have compounding as well. I think that's a brilliant idea.

So, what other factors or supports do you consider beyond medication?

This is the $64,000 question, because, in fact, medication is really just a tool to get to the other supports, and the purpose of having medication in one's armamentarium is really to enable that person to move ahead. For example, this is sort of a classic example of a person who has schizophrenia and has positive or active symptoms of schizophrenia, positive symptoms being maybe auditory hallucinations that are very distracting. The medication doesn't do anything like get them a job, but what it does do is it decreases the auditory hallucinations so that their attention and concentration and their focus can move on to the thing that is are important to them in their lives.

In other words, the white noise of the auditory hallucinations diminishes significantly so that they can then think about what can I do next, in terms of getting work or, gee, I really would like to go back to school. I think I can really handle it at this point. There aren't all these other things that are bothering me. And this goes very much in tune with recovery orientation. In the context that we what we do as prescribers is we give one little piece of the overall puzzle towards rehabilitation and recovery to the person, and the other

resources are things that we also know about already. They can be professional (or they can be what I call extra professional, the professional ones being simple therapy, professional psychosocial rehabilitation efforts, but also extra professional) and peer supports, both within and without or outside of the mental health system; family, community resources, whether it's a social network at school or work.

There are faith-based or spiritual resources available to a person if that's what's important to them. Many people, whether they're working on not working, get a lot of value out of volunteerism and community efforts, whether it is humanitarian or political, whatever it might be, and then activities that one can do one's self, you know, hobbies or sports or what have you. These are all the parts of a person's life to help them move through life. And medication can lower the barriers to being able to access those other supports that are really important to help a person move along.

I want to go back for a moment to one of your earlier comments, actually your background, having worked with people experiencing homelessness, and certainly where I am here in L.A. County we see a lot of press about the homeless population, as it's called, or the 60,000-or-so people who are living in tent cities or on the street, and I wonder if that population, in your mind, is particularly vulnerable to being on multiple medications, or does that seem to resonate with your experience?

The answer to that, of course, is the eternal it depends. And what I mean by that is it all depends on the support systems around the person who may happen to be homeless. And usually, in terms of the support systems for homeless person, especially if they're street homeless, they're very, very few. So, those individuals are, yes, in the context of our conversation today, which is polypharmacy, are more vulnerable to the side effects of medications if they're able to even, from a practical point of view, take them reliably. And the lack of cohesion in most systems of care also lend towards multiple prescriptions by multiple providers.

So, when I say, you know, it's important to keep a list, it's very important with that population to say, okay, who else have you seen lately, and have they prescribed any other stuff that you may be taking, and to take a full accounting of that, because unless you ask, it may not necessarily be volunteered.

Now, that isn't to say that it's inappropriate to prescribe for people who are homeless living in shelters, or even on the street, but it's important, again, to get into the same kinds of conversations as you can with anyone else, and especially with this population, less is more.

Well, I want to also ask maybe in terms of talking with folks who encounter who are multiple medications and maybe it's along the path of treatment, how do you talk to them if they're afraid or reluctant to make changes to their current medication?

It's all in the relationship, and what I mean by that is getting into a conversation about what the medications mean to them, addressing the concerns or fears that they may have in reducing the volume or the number of medications that they're taking. But it has everything to do with the psychotherapeutic skills that we have acquired over our training and for our own practice to better understand what a person's personal needs are and how to address them without, necessarily, the aid of perhaps an unnecessary medication.

It sounds almost as if you might be doing some type of engagement that would involve a bit of motivational interviewing perhaps to talk with someone about what the benefits or the not so great things about being on several medications are.

Yes. MI is a really wonderful tool for this. For those of us who have not had extensive psychotherapeutic training in our own education, that is a key skill to pick up. And even for those of us who have been around the block a few hundred times, it's really good to consult tools for motivational interviewing so we can remember what we might have forgotten.

I'm going to ask you the same question that I asked Dr. Stroup earlier. Based on what you've seen in your practice, what pragmatic suggestions can you provide for clinicians who are working with individuals with serious mental illness who are taking multiple medications?

The first is really just listen. Listen to how the person feels about the medication, how the person feels about their own situation, and how medication may or may not be helping, and what experiences they've had in the past with other medications or with decreasing the medications that they may have been on in the past and to, again, get into a collaborative conversation around the utility of any of these agents that they may happen to be on. How do you feel that this medication has been helping you? You know, what do you think are the down sides?

And, together, we do what we're trained to do as clinicians, you go through a risk/benefit analysis, the important thing to recall is that there's only one person in the room who is going to be putting the medication in their mouth, and that's the person who is been identified as the patient. For that reason, the we need to know that the person's own decision is the only thing that's going to change the medication regimen one way or the other.

Don't be afraid of using multiple medications, but do be afraid of doing it without thinking about target symptoms, individual variability, as far as metabolism, and most of all, what the patient, what the person wants and expects from those medications and whether the medications that you are prescribing will deliver on those expectations.

Dr. McQuistion, thanks for taking the time to be with us and for sharing your insights.

Thank you. It's been a pleasure.

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