Quick and Dirty Psychiatry 2019: Practical Approaches for Managing Mental Illness

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Disclosures

- Neither Dr. Johnson or Dr. Neal have actual or potential conflict of interest in relation to this program/presentation.

- We will be discussing "off label" uses of medications

Discussion Group

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Objectives

- After participating in this session, attendees will be able to:
  - Determine appropriate psychopharmacological interventions for mentally ill homeless individuals
  - Summarize general indications and side effects of commonly prescribed psychiatric medications
  - Describe the influence of homelessness on development of psychopharmacological treatment plan

Prevelance

- Rate of severe psychiatric illness ranges from one-third to one-half.
  - Mood disorder = 20% - 30%
  - Schizophrenia = 10% - 15%
- Substances are a huge issue
  - Substance use = 20% - 30%
  - Alcohol = ~60%

- Impairments in global cognition w/o SPMI
  - MSE (cut-off of 24) = approx. 21%
  - With examination in other cognitive batteries upwards of 80%
- Observed decreases in IQ with SPMI
  - Average to low-average in the general homeless pop.
- Focal deficits in verbal and visual memory, attention, speed of information processing, and executive functioning

- Likely multifactorial etiology:
  - Substance use
  - Head trauma
  - Influence of poverty
  - Malnourishment
  - Mental illness

- Impairments may influence social functioning
  - Ability to adapt and reintegrate
  - Problem solving and skill acquisition
- Adherence to outpatient medical services
- Maintenance of independent housing
- Possible impact on the effectiveness of skills training and rehabilitation programs

Perceived entitlement

- This population has MANY needs (medical, financial, psychosocial)
- Sometimes few people offering help
- Patients often feel unheard
- What's being offered is not always what they want

Treating Mental Illness In The Homeless

Clinical Pearls and Recommendations

Therapeutic Alliance

Tip #1 : Be Honest

- Establish collaborative relationship: “What are you willing to take”
- Ask questions
  - “What can I do that would be helpful for you?”
  - “What’s your understanding of why you’re here today?”
- Set boundaries
  - “Here’s what I can do and cant”
  - “Here’s what I will do and won’t do”
- Consistency
  - Say what you mean, and mean what you say

Tip #2: Keep it Simple

- Most evidence suggests that our meds are at least "equally effective" to each other…so use what you've got
- Once daily formulations if possible
- Avoid medications that NEED calorie requirements
- Avoid (if possible) meds that REQUIRE lab monitoring
- Try to use meds that can address multiple symptoms
- Avoid (if possible) meds with potential street value

Depressive Disorders

Tx Pearls for Depression

- Adequate dose and duration
  - **At least** 4 weeks at therapeutic dose = adequate trial
  - Be patient and minimize multiple switches
- Think symptomatically…algorithms don't always fit
  - Chronic pain + depression = SNRI
  - Low energy or apathy = SNRI or NDRI
  - Sleep or appetite disturbance = NaSSA
- Try to to use meds with longer half-lives
- Don't be afraid to talk about sex
  - Anorgasmia
  - Decreased libido
  - Erectile dysfunction

Antidepressants

- Fluoxetine
  - Very long half-life = good for poor or intermittent adherence
- Sertraline
  - Safest in patients with cardiac hx
  - Only SSRI with no significant impact on QTc
- Citalopram/Escitalopram
  - Reported higher risk for prolonged QTC
- Bupropion
  - Useful for comorbid ADHD, smoking cessation
  - Lowers seizure threshold

- Mirtazapine
  - Useful for comorbid insomnia, poor appetite and in trauma related disorders
  - Evidence to suggest benefit in substance use disorders
  - Potentially earlier onset of action
- Venlafaxine and paroxetine
  - Have very short half life w/ very uncomfortable discontinuation syndrome
  - Paroxetine very anticholinergic
- Duloxetine
  - Good for patients with pain.
  - Check AST/ALT due to potential liver toxicity
- Atomoxetine*
  - Indicated for ADHD, but has antidepressant activity (NRI)

Anxiety Disorders

Tx pearls for anxiety disorders

- Normalize…but don't minimize
  - Triggers?
  - Evoluationary perspective
  - "distress or impairment"
- Provide reassurance
  - Panic attacks vs cardiac vs. pulmonry
- Try non-medication options
  - Meditation
  - Exercise
  - Distraction
  - Mindfulness
  - Substance abuse tx

Medication Options

- Antidepressants
- Buspar
  - Useful for antidepressant sexual side effects
  - Generally two to three times a day dosing
- Gabapentin*
  - Useful for comorbid alcohol use disorder and chronic pain
  - Abuse potential
  - Drug of interest with DEA
- Clonidine/Guanfacine*
  - Useful comorbid opioid use disorder and/or trauma disorders
  - Dehydration/hypotension
- Propranolol*
- Antihistamines

Bipolar Disorder

Tx Pearls for Bipolar Disorder

- Confirm the diagnosis
- Get comfortable with ambiguity
  - Significant diagnostic overlap w/ personality disorders, ADHD and substance use
- Depakote and Lithium are considered first-line for mood stabilization…but with caveats
- Use of antidepressants is controversial
- Psychoeducation can be very useful

Mood stabilizers

- Lithium
  - Can be dosed once daily
    - Easier on the kidneys
    - Improves adherence
  - Hydration status is important*
  - Use caution if prescribing with diuretics, NSAIDs, metformin, ACE inhibitors…
  - Recommended to check EKG and thyroid before start
  - Epstein's anomaly not as common as once thought
- Valproate
  - Avoid in women of child-bearing age
  - Easier to dose and requires less monitoring than lithium
  - Good for individuals with anger/aggression/impulsivity

- Lamotrigine
  - Indicated only for bipolar depression
  - Poor evidence for management of mania
  - Requires very slow titration (25 mg/week)
  - Must restart at beginning if off med for more than 3 days
  - Valproate can double levels
- Carbamazepine/Oxcarbazapine
  - Agranulocytosis
  - Cytochrome inducer…beware with OCP use
- Second Generation Antipsychotics

Psychotic Disorders

Tx pearls for psychotic disorders

- Side effect profiles matter
  - FGA = increased risk of EPS and dyskinesia
  - SGA = metabolic risks and prolactin elevation
- All adherence isn't equal…so use long-acting injectables whenever possible*
- Treat early and "aggressively"
  - 5yr critical period
  - LAIs have evidence suggesting neuroprotection
- Be aware of impact on QTC
- Avoid antipsychotic polypharmacy
- DON'T use for sleep
- Titrate slowly to avoid side effects…and to gain alliance

Oral medications

- Ziprasidone/lurasidone
  - Requires 350 – 500 kCals for absorption
  - Ziprasidone = twice daily dosing
- Olanzapine
  - Very effective…but will likely cause weight gain
- Quetiapine
  - Useful for mood and psychosis
  - Weight gain is NOT dose dependant
  - Has "street value"

Oral and Long-acting medications

- Risperidone
  - Increased risk of EPS, hyperprolactinemia at higher doses (>6mg)
  - Long acting option = Q2weeks and Q4weeks
- Paliperiodone
  - Active metabolite of risperidone
  - If tolerated risperidone in past, will likely tolerate
  - Long acting option = Q 30days and Q 90days
- Aripiprazole
  - Useful with co-morbid mood symptoms
  - Long acting option = Q30 days and Q 60days
  - Can shorten QTc
  - Partial D2 agonist – helpful in hyperprolactinemia
- Haloperidol/fluphenazine
  - Long acting = Q2 to 4 weeks

Substance Use Disorders

Tx pearls for substance use disorders

- High association with other psychiatric illnesses
  - When in doubt err on the side of treating
  - But make diagnoses with caution in active substance use
  - Substance of choice can be diagnostically helpful
- Don't take being manipulated personally
- Relapse is part of the disease course
- Maintain non-judgmental stance
- Focus on strengths and troubleshooting
- Harm reduction!!!

Medication options

- Gabapentin
  - Evidence for use in alcohol use disorders alone or in combination with naltrexone
- Topamax
  - Evidence in alcohol use disorders
  - Can impact cognition (up to 25%)
- Naltrexone
  - Useful in alcohol and opioid use disorders
  - May be useful in behavioral addictions
- Clonidine/Guanfacine
  - Can be helpful in opioid use disorders
  - Potential role in minimizing stress-induced drug cravings
- N-acetylcysteine

Trauma Related Disorders

Tx pearls for trauma related disorders

- There's no magic pill
- Focus on the most distressing symptoms

Medication options

- Prazosin
  - Useful for trauma related nightmares
  - Slow titration
  - Monitor blood pressure and orthostasis
- Cyproheptadine
  - Also for trauma related nightmares
  - Appetite stimulant
  - Potential anxiolytic effect
- Clonidine
- Guanfacine
- N-Acetylcysteine*
- SSRIs

Insomnia

Tx pearls for insomnia

- No really good options…EVERYONE sleeps poorly
- Suggest earplugs
- Over the counter medications are probably just as effective as off label meds
  - Most generally rely on antihistamic side effect
- Dose potentially sedating meds at night
- Avoid medications with potential for abuse or physiologic dependence

Med options

- Antihistamines
- Trazodone
  - Buzzword side effect = priapism
  - Doses greater than 200mg aren't necessarily more effective
  - Can worsen nightmares
- Mirtazapine
  - Generally thought to be more sedating at lower end of dosing
- Ramelteon
  - Non-benzodiazepine receptor activity
  - Usually requires patient assistance – very expensive
- Melatonin
  - Over the counter supplement
  - Evidence suggests that it may reduce metabolic side effects related to SGA use

In summary….

- Be patient focused
- Therapeutic alliance is the key
- Even if patient declines treatment…keep seeing them and making the reccomendation
- Use what you've got
- Meet patients where they are
- Having a partner in crime helps
- Don't assume patients are adherent, even if they say they are

Questions?

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