SECTION 5, CHAPTER 11, POLICY 002-I

ATTACHMENT I – SPECIFIC PHARMACOTHERAPY TREATMENT STRATEGIES FOR MENTAL HEALTH DISORDERS (APA PRACTICE GUIDELINES)

A. Purpose

1. The American Psychiatric Association (APA) publishes guidelines that are part of a database of treatment guidelines established by the Agency for Healthcare Research and Quality (AHRQ), that provide information on the use of atypical antipsychotics in adults and recommended, evidence-based treatment options for a variety of mental health disorders.

B. Treating Autism Spectrum Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD)

1. No specific pharmacologic interventions can be recommended as efficacious in preventing the development of ASD or PTSD in at-risk individuals.

2. For ASD, SSRIs and other antidepressants are reasonable clinical interventions.

3. For PTSD, SSRIs are recommended as first-line medication treatment.

4. TCAs and MAOIs may also be beneficial.

5. Benzodiazepines may be useful in reducing anxiety and improving sleep.

6. Anticonvulsant medications may have benefit for treating symptoms of re-experiencing the trauma.

7. Second generation antipsychotic medications may be helpful in individual clients and for clients with comorbid psychotic disorders, or when first-line approaches have been ineffective in controlling symptoms.

8. Alpha2-adrenergic agonists and Beta-adrenergic blockers may be helpful in treating specific symptom clusters.

C. Treating Alzheimer's Disease and Other Dementias

1. Non-pharmacological approaches should be used first for non-emergency situations, and avoid polypharmacy when possible.

2. In general, use low starting doses, small dose increases, and long intervals between dose changes.

3. Be cautious about medication side effects (e.g., anticholinergic effects, orthostasis, and sedation) that may pose particular problems for elderly clients and those with dementia, such increased risk of falls, respiratory depression, over sedation, and worsening cognitive impairment.

D. Treating Bipolar Disorder

1. For severe acute manic or mixed episodes, initiate lithium in combination with an antipsychotic or valproate in combination with an antipsychotic.

   For less severe episode, monotherapy with lithium, valproate, or an antipsychotic such as olanzapine may be sufficient.

2. For mixed episodes, valproate may be preferred over lithium.

3. Second generation (atypical) antipsychotics are preferred over first generation (typical) antipsychotics because of their generally more tolerable side effects.

4. Treatments depends on illness severity, associated features such as rapid cycling and psychosis, and client preference, when possible.

5. For clients with a "breakthrough" manic or mixed episode while on maintenance treatment, optimize the medication dose.

6. If symptoms are inadequately controlled within 10 to 14 days of treatment with optimized doses of the first-line medication(s), add another first-line medication.

   Alternative treatment options include adding carbamazepine or oxcarbazepine in lieu of an additional first-line medication, adding an antipsychotic if not already prescribed, or changing from one antipsychotic to another.

   Clozapine may be effective in refractory illness.

7. For psychosis during a manic or mixed episode, treat with an antipsychotic medication.

8. For depressive episodes, initiate lithium or lamotrigine.

   As an alternative, consider initiating treatment with both lithium and an antidepressant

9. For clients with a "breakthrough" depressive episode while on maintenance treatment, optimize the medication dose. If the client fails to respond to optimized maintenance treatment, consider adding lamotrigine, bupropion, or paroxetine.

   Alternative next steps include adding another newer antidepressant or a MAOI; TCAs are not recommended.

10. For rapid cycling, identify and treat medical conditions such as hypothyroidism or drug or alcohol use that may contribute to cycling.

If possible, taper medications that may contribute to cycling, such as antidepressants.

11. For initial treatment of rapid cycling, use lithium or valproate; an alternative treatment is lamotrigine.

12. Treatment options for bipolar disorder with the best empirical support include lithium or valproate, and possible alternatives include lamotrigine, carbamazepine, or oxcarbazepine.

E. Treating Borderline Personality Disorder

1. Treatment is symptom specific, directed at particular behavioral dimensions. Medication should target both acute symptoms (e.g., anger treated with dopamine-blocking agents) and chronic vulnerabilities (e.g., temperamental impulsivity treated with serotonergic agents).

2. Treat affective dysregulation symptoms initially with a SSRI. A reasonable trial is at least 12 weeks.

3. Consider adding a benzodiazepine (especially clonazepam) when affective dysregulation presents as anxiety.

4. For severe behavioral dyscontrol, consider adding low-dose antipsychotics.

5. MAOIs and mood stabilizers are considered second-line treatment.

6. For impulsive-behavioral symptoms, SSRIs are the treatment of choice. If a serious threat to client's safety is present, consider adding a low-dose antipsychotic to the SSRI. If an SSRI is ineffective, consider another SSRI or another class of antidepressant. If the client shows partial response to SSRI, adding lithium may enhance the effectiveness of the SSRI.

7. For cognitive-perceptual symptoms, low-dose antipsychotics are the treatment of choice for psychotic-like symptoms.

8. Clozapine maybe warranted for clients who have failed other treatments or with severe, refractory psychotic-like symptoms.

F. Treating Eating Disorders

1. For clients with anorexia nervosa, use psychotropic medications in conjunction with psychosocial interventions, not as a sole or primary treatment. Whenever possible, defer making decisions about medications until after weight is restored.

2. Be aware of and manage general side effects, as malnourished and/or depressed clients are more prone to side effects.

3. Consider antidepressants to treat persistent depression or anxiety following weight restoration. SSRIs have the most evidence for efficacy and less adverse effects. SSRIs may also be useful in clients with bulimic or obsessive-compulsive symptoms.

4. Bupropion should be avoided in clients with eating disorders due to increased risk of seizures. TCAs and MAOIs should be avoided in underweight clients; their potential for lethality and toxicity in overdose should be considered.

5. Consider second generation and low potency antipsychotics for selected clients with severe symptoms.

6. Consider approaches to restore lost bone mineral density, such as calcium supplementation and vitamin D.

7. For clients with bulimia nervosa, consider an antidepressant to reduce the frequency of binge eating and vomiting, reduce associated symptoms such as depression and anxiety, and prevent relapse. It is recommended to continue the antidepressant for at least 9 months.

G. Treating Major Depressive Disorder

1. For clients with a major depressive episode, aim to induce remission and achieve a full return to the client's baselines level of functioning. Remission is defined as at least three (3) weeks of the absence of both sad mood and reduced interest and no more than three (3) remaining symptoms of the major depressive episode.

2. When selecting initial treatment modality, consider the following: severity of symptoms; presence of co-occurring disorder or psychosocial stressors; biopsychosocial factors; client preference; and prior treatment experiences.

3. The effectiveness of antidepressant medications is generally comparable between and within classes of medications, including SSRIs, SNRIs, TCAs, and MAOIs. Therefore, choose a medication largely based on the following: client preference; prior response to medication; safety, tolerability, and anticipated side effects; co-occurring psychiatric or general medical conditions; pharmacological properties of the medication; and cost.

4. For most clients, a SSRI, SNRI, mirtazapine, or bupropion is optimal.

5. In general, MAOIs should be restricted to clients who do not respond to other treatments.

6. If side effects occur, lowering the dose or changing to a different antidepressant should be considered.

7. If the medication is changed to or from an MAOI, a washout period is essential to prevent a potentially lethal interaction (serotonin syndrome).

8. Improvement may be observed as early as the first 1-2 weeks and continue for up to 12 weeks. Remind clients that full benefit at a given dose may not be achieved until 4-8 weeks.

9. Some antidepressants can be lethal in overdose. Early in treatment, it is prudent to dispense only small quantities of such medications and keep in mind the possibility of hoarding. In clients who are suicidal, it may be preferable to use a medication class that is safer in overdose, such as an SSRI.

10. If response is inadequate, optimizing the dose is a reasonable first step if side-effect burden is tolerable. Some clients may require doses higher than those approved by the FDA. In clients who have shown partial response, extending the antidepressant medication trial can be considered.

11. For clients who do not show at least a partial response to an initial antidepressant, a common strategy is to change to a different non-MAOI antidepressant in the same class or in a different class.

12. Pharmacotherapy combined with psychotherapy may offer advantages over either modality alone, particularly for clients with chronic, severe, or complex illness.

13. For clients treated with an antidepressant, augmentation strategies with modest evidence base include: adding another non-MAOI antidepressant, generally from a different class; adding lithium; adding thyroid hormone; and adding a second-generation antipsychotic.

14. For clients with treatment-resistant symptoms of depression, electroconvulsive therapy (ECT) is the most effective form of therapy.

15. For clients receiving an antidepressant, continue the medication for 4-9 months, generally at the same dose used during the acute phase to help achieve remission.

16. If pharmacotherapy is discontinued, clients should be advised not to discontinue medications before stressful events (e.g., holidays, weddings). The medication should be tapered over at least several weeks to allow for detection of recurring symptoms and facilitates a return to full treatment, if needed. Additionally, tapering can minimize discontinuation syndromes.

17. Advise the client about the potential for relapse and plan for resuming treatment if symptoms return. Risk of relapse is highest in the first two (2) months following discontinuation of treatment.

H. Treating Obsessive-Compulsive Disorder (OCD)

1. First-line treatments for OCD are cognitive-behavioral therapy (CBT) and serotonin reuptake inhibitors (SRIs). SRIs include clomipramine and all of the SSRIs. Clomipramine, fluoxetine, fluvoxamine, paroxetine, and sertraline are approved by the FDA for treatment of OCD.

2. CBT alone is recommended for a client who is not too depressed, anxious, or severely ill to cooperate with this treatment modality, or who prefers not to take medications.

3. An SRI alone is recommended for a client who has previously responded well to a given drug or who prefers treatment with an SRI alone.

4. Combined treatment (SRI and CBT) is more effective than monotherapy for some clients but is not necessary for all clients.

5. Initiate pharmacotherapy at the dose recommended by the manufacturer (for most clients) and titrate to a maximally tolerable dose. Continue pharmacotherapy for 8-12 weeks, including 4-6 weeks at a maximally tolerable dose.

6. Provide CBT at least once weekly for 13-20 weeks.

7. If a client continues to have an inadequate response to treatment, consider the following alternatives: combined SRI and CBT treatment; augmenting SRI with antipsychotic medication; switching to a different SRI; and switching to venlafaxine.

8. Continue treatment for most clients for 1-2 years before considering a gradual taper, as relapse is common.

I. Treating Panic Disorder

1. The use of SSRIs, SNRIs, TCAs, or CBT as the initial treatment for panic disorder is strongly supported by demonstrated efficacy in numerous randomized controlled trials. In the absence of a co-occurring mood disorder, monotherapy with a benzodiazepine is also an appropriate initial treatment.

2. SSRIs and SNRIs are considered the best initial pharmacotherapy choice for many clients with panic disorder due to relatively favorable safety and side-effect profiles. TCAs are also effective but their side effects and greater toxicity in overdose limit their clinical utility and acceptability to clients. SSRIs, SNRIs, and TCAs are all preferable to benzodiazepines as monotherapies for clients with co-occurring depression or substance use disorders.

3. MAOIs are generally reserved for clients who have failed to respond to several first-line treatments for panic disorder.

4. Because clients with panic disorder can be sensitive to medication side effects, low starting doses are recommended, and the low dose maintained for several days, then gradually increased to a full therapeutic dose over subsequent days and as tolerated by the client.

5. CBT and exposure therapy are also recommended psychotherapies to consider with pharmacotherapy.

6. If the client's response to a first-line treatment is unsatisfactory, first consider possible contributing factors (e.g., underlying untreated medical illness, inadequate treatment adherence, and presence of psychosocial stressors). If response remains unsatisfactory, despite an adequate trail, consider adding or switching to another first-line treatment.

7. If significant symptoms persist despite a lengthy course of a particular treatment, reassess the treatment plan and consider consultation with another qualified mental health professional.

8. When discontinuing an effective pharmacotherapy, taper the medication gradually over several weeks and monitor for recurrence; reinitiate the medication at a previously effective dose, if indicated.

J. Treating Schizophrenia

1. Initiate antipsychotic medication as soon as it is feasible. Assess baseline levels of signs, symptoms, and laboratory values relevant to monitoring effects of antipsychotic therapy.

2. Medication should be selected based upon prior degree of symptom response, past experience of side effects, client's preferences (including route of administration), and available formulations.

3. Second generation (atypical) antipsychotics are considered first-line medications because of the decreased risk for extrapyramidal symptoms (EPS) and tardive dyskinesia (TD).

4. Consider long-acting injectable (LAI) antipsychotic medication for clients with recurrent relapses related to medication non-compliance.

5. Titrate medication as quickly as tolerated to the target therapeutic dose and monitor clinical status for 2-4 weeks.

For first-generation antipsychotics, the optimal dose for most clients is the dose at which minimal rigidity is detectable on physical examination.

For second-generation antipsychotics, the target dose usually falls within the therapeutic dose range specified by the manufacturer and in the labeling approved by the FDA.

6. If the client is not improving, consider whether the lack of response is due to medication non-compliance, rapid medication metabolism, or poor absorption.

7. Adjunctive medications may be used to treat comorbid conditions or associated symptoms to address sleep disturbances, and to treat antipsychotic drug side effects.

8. ECT may be considered in addition to antipsychotic treatment for clients with schizophrenia or schizoaffective disorder who have persistent severe psychosis and/or suicidal ideation or behaviors and for whom prior treatments, including clozapine, have failed.

9. If the client achieves an adequate therapeutic response with minimal side effects, monitor the response to the same medication and dose for at least six (6) months.

10. Consider a trial of clozapine for a client who has had a clinically inadequate response to two (2) antipsychotics (at least one of which was a second-generation drug) and for a client with persistent suicidal ideation or behavior that has not responded to other treatments.

11. Assess the client for factors that may contribute to secondary negative symptoms.

If negative symptoms are secondary, treat their cause: antipsychotics for positive symptoms; antidepressants for depression; anxiolytics for anxiety disorders; antiparkinsonians or antipsychotic dose reduction for EPS.

If negative symptoms persist, they are presumed to be primary negative symptoms, and consider treatment with clozapine or other second-generation antipsychotics.

K. Treating Substance Use Disorders

1. For some clients, medications may be used to treat intoxication states; decrease or eliminate withdrawal symptoms in an effort to reduce craving and risk of relapse; decrease the reinforcing effects of abused substances; promote abstinence and prevent relapse; and treat co-occurring psychiatric conditions.

2. To decrease or eliminate withdrawal symptoms, substitute an agonist for the particular class of substance being used (e.g., methadone for opioids, benzodiazepines for alcohol). Also consider other medications that may decrease withdrawal symptoms (e.g., clonidine for opioid withdrawal).

3. To decrease the reinforcing effects of abused substances, consider medications that block the subjective and physiological effects (e.g., naltrexone to block effects of opioids).

4. To promote abstinence and prevent relapse, consider medications such as disulfiram naltrexone, acamprosate, and bupropion.

5. Address co-occurring psychiatric disorders to improve adherence and success with substance use disorder treatment.

L. Assessing and Treating Suicidal Behaviors

1. The use of antidepressants is supported by the strong association between depressive disorders and suicide.

2. Long-term maintenance treatment with lithium salts in clients with recurring bipolar disorder and major depressive disorder is associated with substantial reductions in risk of both suicide and suicide attempts.

3. Reductions in the rates of suicide attempts and suicide have been reported in specific studies of clients with schizophrenia treated with clozapine. Other first- and second-generation antipsychotics may also reduce suicide risk.

4. Because anxiety is a significant and modifiable risk factor for suicide, use of antianxiety agents may have the potential to decrease this risk. Benzodiazepines have the potential to disinhibit aggressive behaviors and enhance impulsivity, particularly in clients with borderline personality disorder.

5. ECT may reduce suicidal ideation in the short term.