SPEAKER NOTES

Medications Used for Treatment of Mental Illness

Summarized by Thomas T. Thomas

Every few years we update members on the current medications used in treating mental illness. At our speaker meeting on November 19, we heard from **Douglas Dell Paggio, PharmD, MPA,** Director of Pharmacy Services for Alameda County Behavioral Health Care Services and an associate clinical professor at the University of California-San Francisco's (UCSF) College of Pharmacy.

DOUGLAS DEL PAGGIO, PHARMD, MPA

Del Paggio said that he valued talking with NAMI groups, because it was good to get the perspectives and opinions of family members and friends of people with mental illness. The Mental Health Services Act, Proposition 63, has created many new programs in Alameda County—12 to 15 in the last year alone, he said—and although some of them are still small, they are growing.

"One of the new programs is for Prevention and Early Intervention [P&EI]," he said, "which tries to identify people with mental illness before they have their first crisis. Other countries, including Australia and Canada, do a much better job in this area, with better outreach programs. Experience has shown that if you intervene early, you have much better outcomes."

Another program Del Paggio mentioned was the Co-Occurring Disorder Initiative, addressing clients who have both a mental illness and an alcohol or substance abuse problem. "There's a huge initiative this year to bring all the services on board to treat these disorders."

A third initiative is for Tobacco Cessation. He noted that smoking and mental illness seem to go hand-in-hand, but a number of psychiatrists in the county have had success helping clients quit smoking, and now the county has funded a program to support this, headed by Oakland pediatrician Dr. Cathy McDonald.

Del Paggio himself is working on an initiative to redefine the relationship between the clinician and the client and family members. "I was schooled in the old school, where you do what the doctor says. But we've come to understand that people who are chronically mentally ill often don't understand their medications. About 50 % of clients don't take them, and then they become disabled, their symptoms return, and they may need hospitalization, which is disruptive." A new model, called shared decision making, looks at this process in a different way and

tries to get information to the client and the family so they can share in the decisions about medications. Del Paggio is working on a number of decision aids to support this. Most of the information available to clients, he said, is long and hard to understand, like the pages of tiny type that follow a drug company ad in a magazine. He is trying to make it easier to understand and compare different medications for different qualities like side effects, compatibility with alcohol consumption, response time, and interactions.

"Everyone has a different set of values," he said. "For instance, I may not want to gain weight and some of the newer medications are linked to weight gain. Others may want to avoid the movement disorders associated with the older medications. Still others want to know about drug interactions." Del Paggio is working on simple sheets that compare medications in these areas, sometimes using color coding and smiling or frowning faces to show the medication's effects.

He noted that there have only been three studies of medication effectiveness that were not done by drug companies. The largest, the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) in the U.S. followed 1,460 patients with chronic schizophrenia who stayed with a particular medication for up to 18 months. Another, the Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS) in the UK, tested the hypothesis that people with schizophrenia requiring a change in treatment had an improved quality of life with second-generation or atypical antipsychotic medications after one year, compared with the first-generation medications. A third study, Comparison of Atypicals for First-Episode Psychosis (CAFE), tracked patients in the U.S. and Canada who were experiencing their first psychotic episode to see whether any of the antipsychotic medications were particularly helpful for this group.

Del Paggio said the CATIE study looked at the newer antipsychotic medications and compared them with the older generation in terms of efficacy, adverse effects, patient compliance, and cost. They found that all the drugs were about equally effective; that the newer drugs had different but not fewer side effects; and that the main reason patients stopped taking a medication was that it was not helping their symptoms. These studies were conducted by the National Institute of Mental Health to compare different medications—"something individual drug companies don't do, because they want their drug to appear to be the best," Del Paggio said.

In support of his initiative for shared decision making, he asked NAMI members in the audience to fill out a survey he had prepared that tested their preferences in various areas of the treatment process, either as family members or as clients. The questions offered choices or write-in responses on questions like concerns about seeking treatment, information sources when deciding on a medication, things they valued with considering a medication, and factors that would influence the decision to take an antipsychotic medication.

Del Paggio also discussed the current state of Medicare Part D, the program that subsidizes the cost of prescription drugs. "Things have gotten more complex," he said. The period of open enrollment for 2009, November 15 to

December 31 of this year, is also when the California benchmark1 plans are changed. Last year, there were nine such plans, while this year there will only be six. These plans are also reducing the options available to clients. Two years ago, their formularies covered 98% of the most prescribed psychotropic medications; last year, only 85%; and in the latest revision, the most any plan covers is 63%. The plans also impose dosing limits, usually based on the FDA-approved dosage, whereas many patients require a higher dosage for efficacy. Alameda County will try to cover its clients for full dosage, in order to avoid them going off their medications, leading to hospitalization and possible loss of housing. Some plans also require "step therapy," in which patients must try medication A or B before receiving the one they actually need. Other plans require prior authorization. Del Paggio urged members to check out the Medicare website (www.medicare.gov) to see whether the medications their family members were taking are still covered and at the appropriate dosage.

Douglas Del Paggio also took members' questions during the course of his presentation.

Q. What is the standard dosage of Zyprexa (or Olanzapine)? The maximum? And is there a minimum?

A. The maximum is usually 30 milligrams (mg), but some people take up to 45 mg. There is no minimum, but you want to start with the lowest dose possible. But there have not been enough studies done yet with different populations, or even with women vs. men, to establish a dosage pattern.

Q. Can you evaluate the efficacy of an antipsychotic medication with a blood test?

A. No. Blood tests are required with Clozaril (or Clozapine) because it affects the white cell count. The only medication that can be evaluated by measuring the amount in the blood is the mood stabilizer and bipolar medication lithium.

Q. Have there been any long-term studies of drug side effects?

A. Not by the drug companies, because they have no incentive. The CATIE study went for two years. Generally, there has been a dearth of long-term studies, and many of these illnesses, including schizophrenia, are lifetime disorders.

Q. Should you take only one medication at a time?

A. The experts are pretty clear that most people should only be on one *antipsychotic* drug at a time, and not more than one. Other psychotropic medications are different. Some physicians prescribe more than one antipsychotic because they aren't sure the client is taking even one of them. That's the importance of our work on share decision making.

[1] Of the more than 200 plans available in California, the benchmark plans are those with the lowest premiums and co-pays for qualifying clients, usually those with "dual eligibility" under Medicare and MediCal.