MANAGEMENT OF PSYCHOSIS IN PRIMARY CARE

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GENERAL DISCLOSURES

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GENERAL DISCLOSURES

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NORTHWEST MENTAL HEALTH TECHNOLOGY TRANSFER CENTER

Our Role

Provide training and technical assistance (TA) in evidence-based practices (EBP) to behavioral health and primary care providers, and school and social service staff whose work has the potential to improve behavioral health outcomes for individuals with or at risk of developing serious mental illness in SAMHSA’s Region 10 (Alaska, Idaho, Oregon, and Washington).

Our Goals

– Heighten awareness, knowledge, and skills of the workforce addressing the needs of individuals with mental illness
– Accelerate adoption and implementation of mental health-related EBPs across Region 10
– Foster alliances among culturally diverse mental health providers, policy makers, family members, and clients
This work is supported by grant SM 081721 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
OVERVIEW OF SESSIONS

• Medical management
• Diagnosis
• Therapeutic style
• Addressing disparities in quality of care
MEDICAL MANAGEMENT OF PSYCHOSIS

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OBJECTIVES

By the end of this session, participants will:

1. Understand the 5 principles that guide evidence-based safe antipsychotic prescribing
2. Know the recommended first-line medications for treatment of psychosis
3. Identify two changes they can make in current practice to mitigate the metabolic risk among their patients who are treated with antipsychotic medications
PSYCHOSIS

• 3% of people in US experience an episode of psychosis in their lifetime
• A first episode usually occurs in teens or early adulthood
• Experience and symptoms vary greatly from person to person
CHECKPOINT

Think about the antipsychotic medications you prescribe for your patients...

• Is there an indication for a/the antipsychotic medication you have selected?
• Is the patient part of a population at increased risk?
• Which medications do you select for antipsychotic naive patients?
QUALITY OF CARE

• 1.1-2.2% of adults received AP med prescription in 2010;
• More than 30% were to nonpsychiatric prescribers
• For schizophrenia: 38% of patients receive poor quality mediation management

Young AS et al, Arch Gen Psychiatry. 1998;55(7):611-617
5 PRINCIPLES OF "WISE" PRESCRIBING

Don’t routinely prescribe antipsychotic medications ...
1. as a first-line intervention for insomnia in adults.
2. as first choice to treat behavioral symptoms of dementia.
3. to treat behavioral and emotional symptoms of childhood mental disorders unless there is an approved indication
4. for any indication without initial evaluation and ongoing monitoring.

AND

5. Don’t routinely prescribe two or more antipsychotic medications concurrently
# 1. INDICATIONS FOR AP MEDS

<table>
<thead>
<tr>
<th>Indication</th>
<th>Age</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Adults</td>
<td>ARI, ASE, ILO, OLZ, PAL, QUE, RIS, ZIP</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>13-17</td>
<td>ARI, ILO, OLZ, QUE, RIS</td>
</tr>
<tr>
<td>Schizoaffective</td>
<td>Adults</td>
<td>PAL</td>
</tr>
<tr>
<td>Treatment-resistant scz</td>
<td>Adults</td>
<td>CLZ</td>
</tr>
<tr>
<td>Reduce suicide in scz</td>
<td>Adults</td>
<td>CLZ</td>
</tr>
<tr>
<td>Bipolar</td>
<td>Adults</td>
<td>ARI, ASE, ILO, OLZ, QUE, RIS, ZIP</td>
</tr>
<tr>
<td>Bipolar</td>
<td>13-17</td>
<td>ILO, OLZ</td>
</tr>
<tr>
<td>Bipolar</td>
<td>10-17</td>
<td>ARI, QUE, RIS</td>
</tr>
<tr>
<td>Bipolar depression</td>
<td>Adults</td>
<td>QUE</td>
</tr>
<tr>
<td>Treatment-res MDD</td>
<td>Adults</td>
<td>OLZ</td>
</tr>
<tr>
<td>Adjunctive MDD</td>
<td>Adults</td>
<td>ARI, QUE</td>
</tr>
<tr>
<td>Acute agitation</td>
<td>Adults</td>
<td>ARI, OLZ, ZIP</td>
</tr>
<tr>
<td>Irritability in autism</td>
<td>6-17</td>
<td>ARI, RIS</td>
</tr>
</tbody>
</table>

Aripiprazole, Asenapine, Clozapine, Iloperidone, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone
MEDICAL DIAGNOSTIC WORK-UP

- Physical exam, emphasis on neuro
- History: travel, occupational exposure
- Urine drug screen
- Labs: ESR, ANA, TSH, Vitamin B12, Ceruloplasmin
  - HIV, FTA-ABS
- MRI if neuro exam abnormal
2. MEDICATION MANAGEMENT IN ELDERLY

- Increased mortality among elderly with dementia

<table>
<thead>
<tr>
<th>Medication</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td>15-30 mg</td>
</tr>
<tr>
<td>Clozapine</td>
<td>50-150 mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>10-20 mg</td>
</tr>
<tr>
<td>Paliperidone</td>
<td>3-12 mg</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>200-300 mg</td>
</tr>
<tr>
<td>Risperidone</td>
<td>2-3 mg</td>
</tr>
</tbody>
</table>

- APA practice guidelines
  

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144926/
3. ANTIPSYCHOTIC MEDICATIONS IN CHILDREN

Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Atypical Antipsychotics

- **Aripiprazole** [3]
- **Olanzapine** [4]
- **Paliperidone** [5]
- **Quetiapine** [6]
- **Risperidone** [7]*

Legend:
- **Red**: Schizophrenia
- **Blue**: Bipolar I disorder: manic or mixed
- **Yellow**: Irritability with autistic disorder

*Risperidone should not be used by patients older than age 16 who have been diagnosed with irritability with autistic disorder.
FIRST-LINE TREATMENT FOR EARLY PSYCHOSIS

NAVIGATE

• Risperidone (Risperdal) 3-4 mg
• Aripiprazole (Abilify) 10-30 mg
• Ziprasidone (Geodon) mean 100 mg
• Quetiapine (Seroquel) mean 500 mg

OnTrack NY https://www.ontrackny.org

• Risperidone (Risperdal)
• Aripiprazole (Abilify)
• Ziprasidone (Geodon)
4. Metabolic Monitoring Guidelines

<table>
<thead>
<tr>
<th></th>
<th>entry</th>
<th>4 weeks</th>
<th>8 weeks</th>
<th>12 weeks</th>
<th>monthly</th>
<th>annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMH / Family History</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hemoglobin A1c</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lipid panel</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physical activity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

PREMATURE MORTALITY

• The average life expectancy for people with schizophrenia is 64.7 years (59.9 years for men)

• Largest CVD health disparities of any group

Olsson M et al. JAMA Psychiatry. 2015;72(12):1172-1181
RISK FACTORS TWICE AS COMMON

- **Obesity**
  - 27% (BMI >25);
  - 52% were obese (BMI >30)
- **Elevated BP (51%)**
- **Dyslipidemia (35%)**
- **Impaired fasting glucose (33%)**

*Dickerson F, et.al,. Psychiatr Serv 2013; 64 (1): 44*  
*Correll CU et al Psychiatr Services 2010; 61: 892-898*
5. AVOID POLYPHARMACY

- Meta-analysis of 147 studies
- 19.6% receive APP
- Rate increased 34% between 1980s and 2000s in North America
- APP associated with increased
  - hospitalization rates and length of stay
  - Costs
  - adverse effects, including mortality
- Augmentation of clozapine may be the exception

CHECKPOINT

Think about your own practice...

Can you do more to mitigate metabolic risks in your own prescribing?
# EVIDENCE-BASED PRACTICES

<table>
<thead>
<tr>
<th>Pharmacologic Treatment</th>
<th>Behavioral Strategies</th>
<th>Environmental Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Antipsychotic meds</td>
<td>• Brief Counseling</td>
<td>• Education: Family or Residential staff</td>
</tr>
<tr>
<td>• FDA-approved meds for weight loss</td>
<td>• Lifestyle programs</td>
<td>• CMHC setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community</td>
</tr>
</tbody>
</table>

McGinty EE et al. Schizophr Bull. 2016 Jan;42(1):96-124*
### RISK OF ANTIPSYCHOTIC MEDICATIONS

<table>
<thead>
<tr>
<th>Low risk</th>
<th>Moderate risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td>Asenapine</td>
<td>Clozapine</td>
</tr>
<tr>
<td>Lurasidone</td>
<td>Iloperidone</td>
<td>Olanzapine</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>Paliperidone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quetiapine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risperidone</td>
<td></td>
</tr>
</tbody>
</table>

SWITCHING ANTIPSYCHOTIC MEDICATIONS

• Can switching improve metabolic outcomes?
• When should a switch be considered?
• What is the optimal strategy for switching?
WHY SWITCH?

WHEN SWITCH?

• Intolerable side effects
  – weight gain = 5-7% of body weight
  – Any magnitude of weight gain that leads to non-adherence with medication
  – New diagnosis of diabetes

https://www.psychiatrictimes.com/cme/switching-antipsychotics-why-when-and-how/page/0/2
HOW SWITCH?

• Options
  – Abrupt discontinuation and immediate initiation of second medication at clinically effective dose
  – Cross-taper (reduce 25-5-% every 4-5 days) with gradual initiation of new antipsychotic
  – Overlap and discontinuation: continue pre-switch med at full dose while starting and titrating new med

• No one strategy uniformly superior

# FDA-APPROVED FOR WEIGHT LOSS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orlistat (Xenical)</td>
<td>↓ Fat absorption in gut</td>
</tr>
<tr>
<td>Phenteramine-Topiramate (Osymia)</td>
<td>↓ appetite</td>
</tr>
<tr>
<td>Lorcaserin (Belviq)</td>
<td>↑ satiety</td>
</tr>
<tr>
<td>Naltrexone-bupropion (Contrave)</td>
<td>↓ appetite</td>
</tr>
<tr>
<td>Liraglutide (Saxenda)</td>
<td>↑ satiety</td>
</tr>
</tbody>
</table>

https://www.niddk.nih.gov/health-information/weight-management/prescription-medications-treat-overweight-obesity
CHECKPOINT

Think about your own practice...

• What additional challenges are there in the management of diabetes when my patient also has psychosis?

• Do my patients with psychosis receive the same quality of diabetes care as my other patients?
IMPACT OF SCHIZOPHRENIA ON DIABETES

• More diabetes-related hospitalizations\(^1\)
• More hospitalizations for ambulatory care sensitive conditions\(^2\)
• Increased risk of re-hospitalization for T2DM in 30 days\(^3\)
• Increased diabetes-specific mortality\(^1\)

\(^1\)Mai Q, et al. BMC Med 2011; 9:118;
\(^2\)Druss BG, et al. Med Care 2012; 50(5): 428-433
\(^3\)Chwastiak L, et. al. Psychosomatics 2014; 55(2): 134-143
### QUALITY OF DIABETES CARE

<table>
<thead>
<tr>
<th>HEDIS measure</th>
<th>Any MH Dx, %</th>
<th>No MH Dx, %</th>
<th>Adjusted OR</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>43.8%</td>
<td>47.0%</td>
<td>0.88 (0.86-0.89)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Eye exam</td>
<td>51.1</td>
<td>58.9</td>
<td>0.73 (0.72-0.74)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>LDL screening</td>
<td>24.4</td>
<td>26.9</td>
<td>0.88 (0.86-0.89)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Medical attention for nephropathy</td>
<td>12.0</td>
<td>12.4</td>
<td>0.96 (0.94-0.99)</td>
<td>0.0023</td>
</tr>
<tr>
<td>At least 2 HEDIS measures</td>
<td>38.4</td>
<td>42.8</td>
<td>0.83 (0.82-0.85)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

*Druss BG, et.al. Medical Care 2012; 50(5): 428-433*
CONCLUSIONS

• Safe antipsychotic management involves baseline evaluation and appropriate monitoring, and judicious selection of medication

• There is rarely a good reason to prescribe multiple antipsychotic medications

• All patients on second-generation antipsychotic medications are at increased risk of diabetes—children and adolescents are a particularly high risk

• Patients with psychosis generally receive poorer quality of medical care for chronic conditions—PCPs should monitor and address disparities.
Healthy Active Lives (HeAL)
Keeping the Body in Mind in Youth with Psychosis

Imagine a world where...

- Young people experiencing psychosis have the same life expectancy and expectations of life as their peers who have not experienced psychosis.
- Young people experiencing psychosis, their family, and supporters know how to, and are consistently supported to, maintain physical health and minimize risks associated with their treatment.
- Concerns expressed by young people experiencing psychosis, their family and supporters about the side effects from the medications used to treat psychosis are respected and inform treatment decisions.
- Healthcare professionals and their organizations work collaboratively to design interventions to protect and maintain the physical health of young people experiencing psychosis.
- Healthy active lives are promoted routinely from the start of treatment, focusing on healthy nutrition and diet, physical and psychosocial activity, and reduced tobacco use.

LET US KNOW WHAT YOU THINK!

Post-event surveys are critical to our work!

- Survey will be emailed to you
- Your personal code allows us to link your responses with follow-ups without knowing your identity
- You will be invited to participate in a follow-up survey in 30 days
- Respondents will receive a $5 gift card for filling out the follow-up survey!

Every survey we receive helps us to improve and develop our programming.

We greatly appreciate your feedback!
LONG ACTING INJECTABLE AP MEDICATIONS

Available LAI

• Haloperidol (Haldol decanoate),
• Fluphenazine (prolixin IM),
• Risperidone (Consta),
• Palperidone (Invega Sustenna, Invega Trinza),
• Aripiprazole (Maintena, Aristada),
• Olanzapine (ZypAdhera)

First-Line for FEP

• Palperidone Sustenna 39-117 mg q 4 weeks
• Risperidone Consta 25 mg q 2 weeks
• Aripiprazole IM (no dosing studies)