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Psychiatry and Addictions Case Conference

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MANAGEMENT OF PSYCHOSIS IN PRIMARY CARE

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UW Medicine
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Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

SPEAKER DISCLOSURES

✓ None

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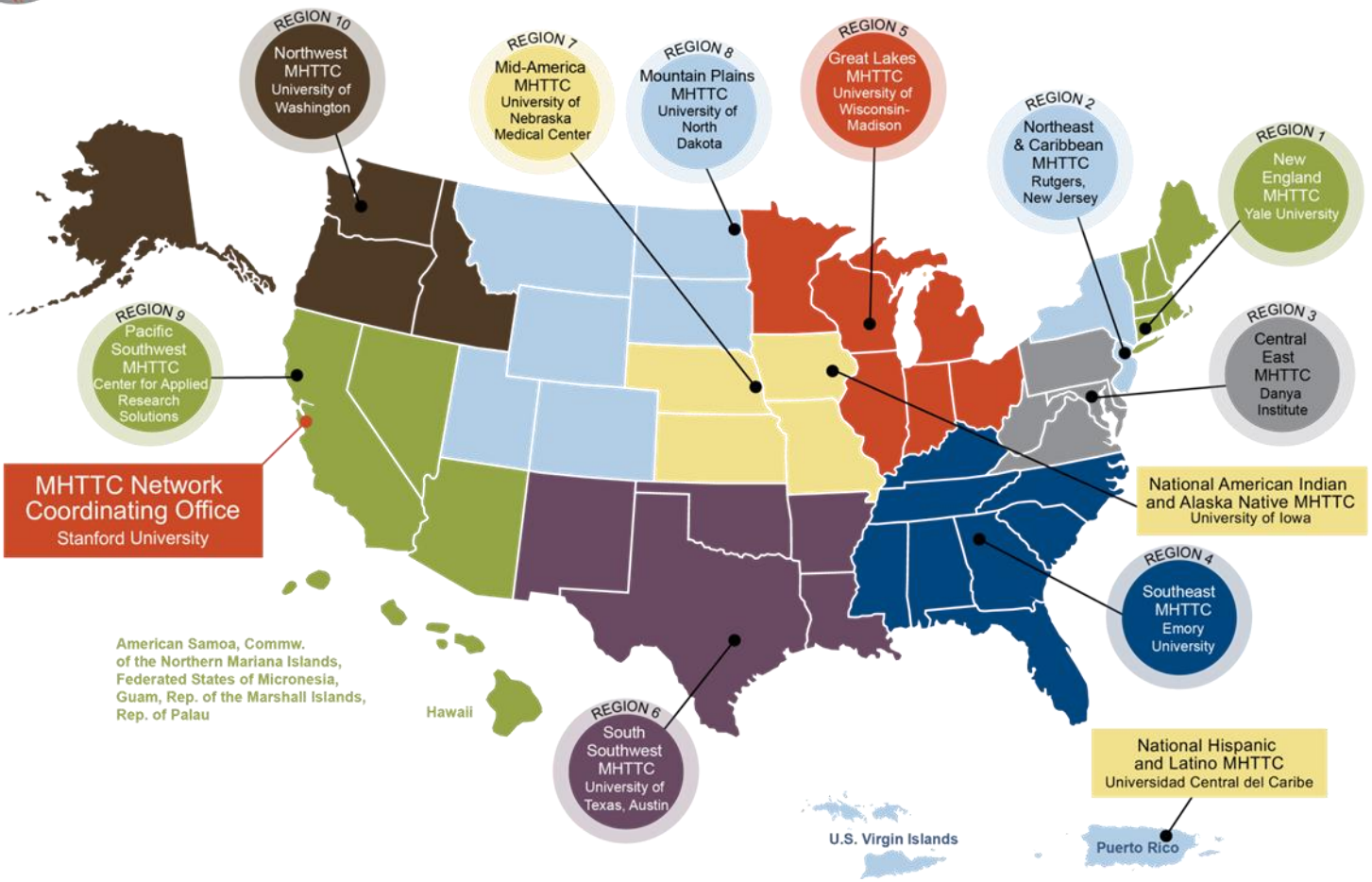
SPEAKER DISCLOSURES

✓ No conflicts of interest

MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



SAMHSA
Substance Abuse and Mental Health Services Administration

This work is supported by grant SM 081721 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

OVERVIEW: TWO SESSIONS ON 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 but involve loss of contact with reality

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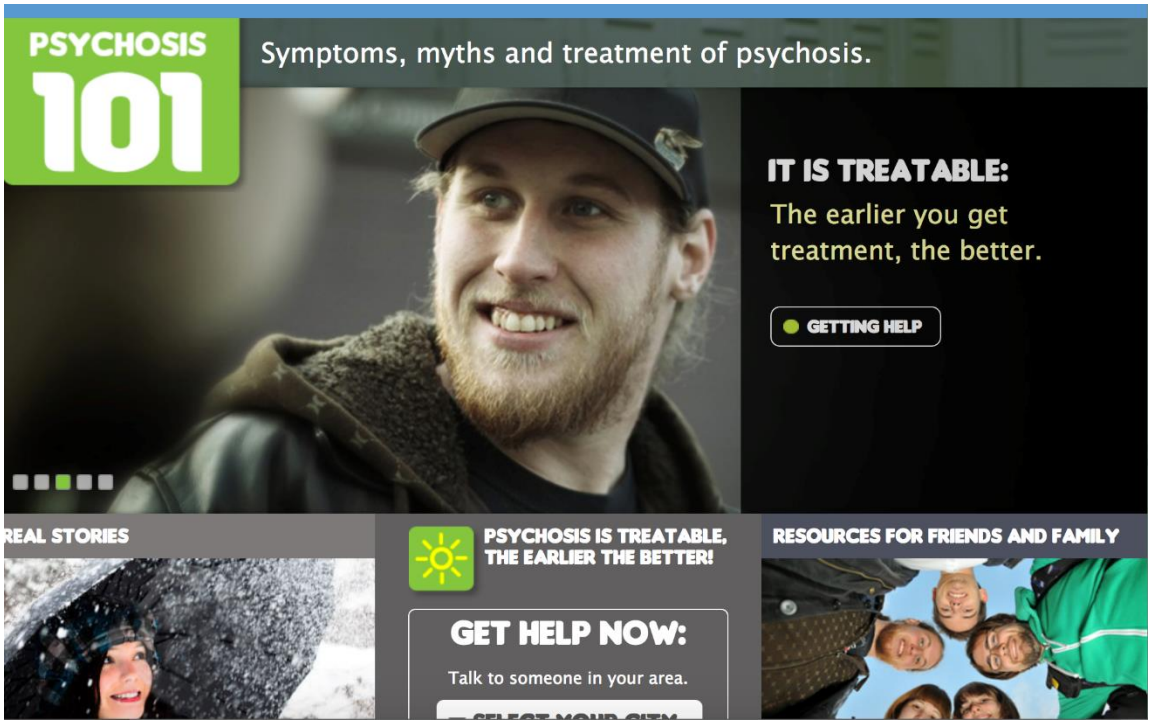
PSYCHOSIS IS TREATABLE



- Diagnosis
- Medical management
- Therapeutic style
- Health and healthcare disparities

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MEDICAL MANAGEMENT OF PSYCHOSIS

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OBJECTIVES

By the end of this session, participants will

1. Understand the 5 principles that guide safe prescribing of antipsychotic medication
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 patients treated with antipsychotic medications

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CHECKPOINT

Think about the last prescription you wrote for an antipsychotic medication…

- What was the indication for the medication you selected?
- Is the patient part of a population that is at increased risk from antipsychotic medications?
- What did you do to monitor the treatment?

QUALITY OF CARE

- 5.2 million adults in the US receive prescription for antipsychotic medication each year[1]
- People treated with antipsychotic medications, on average, are treated with 2.3 more prescription medications[1]
- More than 30% of antipsychotic medications are prescribed by nonpsychiatric prescribers[2]
- 38% of people with schizophrenia receive poor quality medication management[3]

[1]Dennis JA, BMC Psychiatry 2020; 20:483; [2]Olfson M et al, J Clin Psychiatry. 2015 Oct;76(10):1346-53; [3] Young AS et al, Arch Gen Psychiatry. 1998;55(7):611-617

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”WISE” PRESCRIBING

Choosing Wisely®

1. Don’t routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults.
2. Don’t routinely use antipsychotics as first choice to treat behavioral symptoms of dementia.
3. Don’t routinely prescribe an antipsychotic medication to treat behavioral and emotional symptoms of childhood mental disorders in the absence of approved or evidence supported indications
4. Don’t prescribe antipsychotic medications for any indication without initial evaluation and ongoing monitoring.
5. Don’t routinely prescribe two or more antipsychotic medications concurrently

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1. MEDICATION MANAGEMENT IN ELDERLY

- Increased mortality among elderly with dementia

Medication	Schizophrenia
Aripiprazole	15-30 mg
Clozapine	50-150 mg
Olanzapine	10-20 mg
Paliperidone	3-12 mg
Quetiapine	200-300 mg
Risperidone	2-3 mg

- APA practice guidelines https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426807

Garen P et a; Clin Interv Aging 2014; 9: 1363-1373

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1. INDICATIONS FOR AP MEDS

AHRQ, 2012

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

Aripiprazole, Asenapine, Clozapine, Iloperidone, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone

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2. MEDICATION MANAGEMENT IN ELDERLY

- Schizophrenia: Reduce dose

Medication	Dose in elderly
Aripiprazole	15-30 mg
Clozapine	50-150 mg
Olanzapine	10-20 mg
Paliperidone	3-12 mg
Quetiapine	200-300 mg
Risperidone	2-3 mg

- Agitation in dementia: increased mortality
- 2015 APA practice guidelines https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426807

Maust DT, JAMA Psychiatry 2015; 72(5): 438-445

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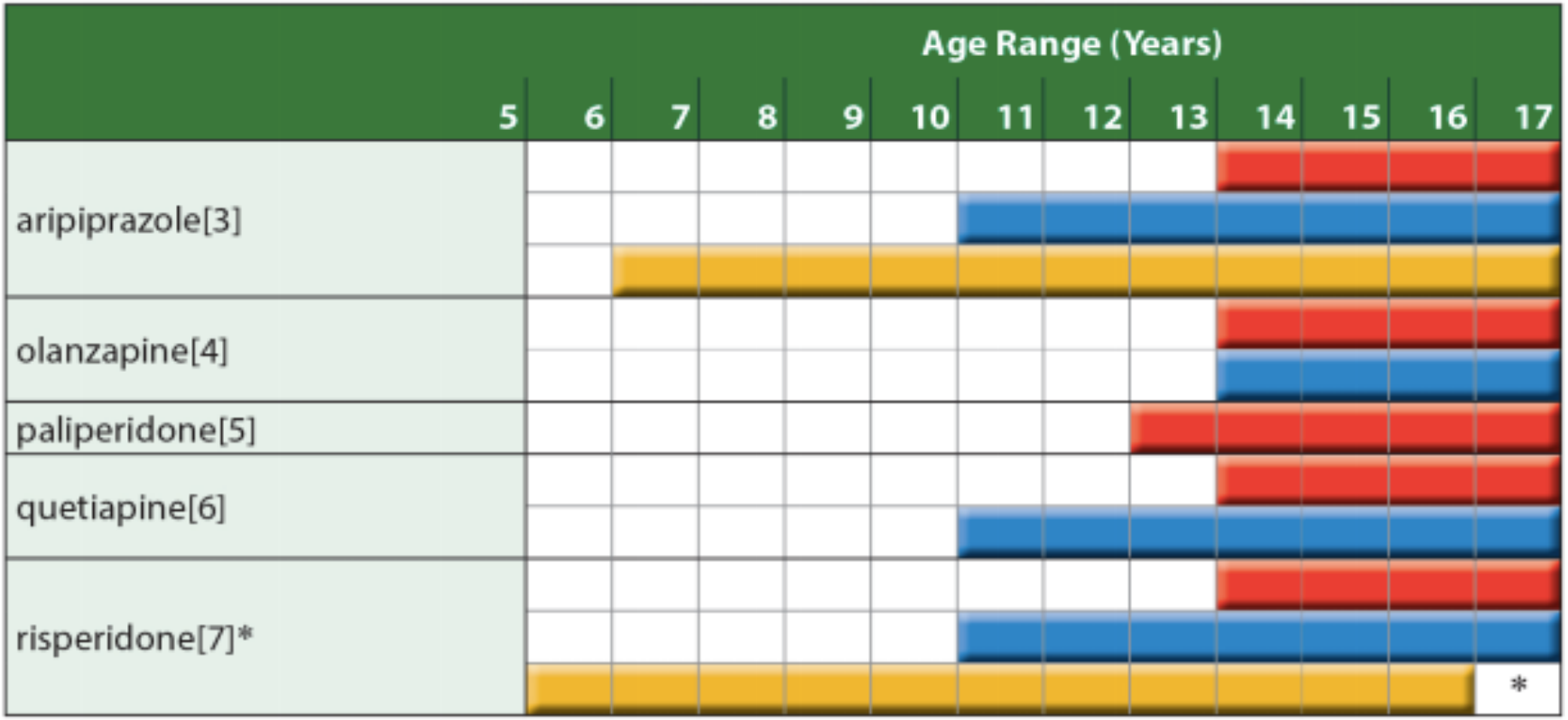
3. ANTIPSYCHOTIC MEDICATIONS IN CHILDREN

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



*Risperidone should not be used by patients older than age 16 who have been diagnosed with irritability with autistic disorder.

4. INITIAL (MEDICAL) EVALUATION

- Physical exam, emphasis on neurologic exam
- History: travel, occupational exposure
- Urine drug screen
- Labs: ESR, ANA, TSH, Vitamin B12, Ceruloplasmin
  - HIV, FTA-ABS
- MRI if neuro exam abnormal
- Suicide Risk assessment

FIRST LINE FOR FIRST EPISODE PSYCHOSIS

Generic	Brand	Target range	Max dose
Risperidone	Risperdal	3-4 mg daily	8 mg daily
Aripiprazole	Abilify	10-30 mg daily	30 mg daily
Ziprasidone	Geodon	80-120 mg daily	160 mg daily

LONG-ACTING INJECTABLE MEDICATIONS

First Line	Other
Palperidone Sustenna 39-117 mg q 4 weeks	Haloperidol (Haldol decanoate)
Paliperidone Trinza 273-819 q 12 weeks	Fluphenazine (Prolixin)
Risperidone Consta 25-50 mg q 2 weeks	Olanzapine (ZypAdhera)
Aripiprazole (Aristada) 441-882 mg q 4 weeks	Abilify Maintena

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5. AVOID POLYPHARMACY

- Very common: 19.6% of patients on AP meds are on more than 1
- 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

Gallego JA et al, Schizophr Res. 2012 Jun; 138(1): 18–28.

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MONITORING: MOST COMMON SIDE EFFECTS

- Weight gain
- Other metabolic side effects (lipid and glucose dysregulation)
- Prolactin elevation
- Motor side effects
- Sedation

https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424841

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Problem	Are You experiencing this?		Questions for Psychiatrist
Daytime sedation/ drowsiness	Yes	No	
Problems with memory or concentration	Yes	No	
Changes in appetite or weight	Yes	No	
Muscles being tense or stiff, or trembling or shaking	Yes	No	
Blurry vision, dry mouth, constipation, urinary retention	Yes	No	
Changes in sexual function	Yes	No	
Menstrual or breast problems	Yes	No	
Feeling unlike my usual self	Yes	No	
other	Yes	No	

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ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS.

MOVEMENT RATINGS: RATE HIGHEST SEVERITY OBSERVED, RATE MOVEMENTS THAT OCCUR UPON ACTIVATION ONE LESS THAN THOSE OBSERVED SPONTANEOUSLY.

CODE 0 = NONE 1 = MINIMAL, MAY BE EXTREME NORMAL
2 = MILD 3 = MODERATE 4 = SEVERE

EXAMINATION PROCEDURE

EITHER BEFORE OR AFTER COMPLETING THE EXAMINATION PROCEDURE OBSERVE THE PATIENT UNOBTRUSIVELY AT REST (E.G., IN WAITING ROOM). THE CHAIR TO BE USED IN THIS EXAMINATION SHOULD BE A HARD, FIRM ONE WITHOUT ARMS.

1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT.
2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH/DENTURES BOTHER PATIENT NOW?
3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE, HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES.
4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES LEGS SLIGHTLY APART AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION)
5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS; IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES (OBSERVE HANDS AND OTHER BODY AREAS.)
6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH,) DO THIS TWICE.
7. ASK PATIENT TO PROTRUDE TONGUE, OBSERVE ABNORMALITIES OF TONGUE MOVEMENT. DO THIS TWICE.
*8. ASK PATIENT TO TAP THUMB, WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10-15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.)
9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME). (NOTE ANY RIGIDITY AND RATE ON DOTES.)
10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN. HIPS INCLUDED.)
*11. ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS, AND MOUTH.)
*12. HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT) DO THIS TWICE.

** ACTIVATED MOVEMENTS

FACIAL AND ORAL MOVEMENTS:	1.	MUSCLES OF FACIAL EXPRESSION E.G., MOVEMENTS OP FOREHEAD, EYEBROWS, PERIORBITAL AREA, CHEEKS; INCLUDE FROWNING, BLINKING, SMILING, GRIMACING	0	1	2	3	4
	2.	LIPS AND PERIORAL AREA E.G.. PUCKERING POUTING, SMACKING	0	1	2	3	4
	3.	JAW E.G., BITING CLENCHING, CHEWING, MOUTH OPENING, LATERAL MOVEMENT	0	1	2	3	4
	4.	TONGUE RATE ONLY INCREASE IN MOVEMENT BOTH IN AND OUT OF MOUTH. NOT INABILITY TO SUSTAIN MOVEMENT	0	1	2	3	4
EXTREMITY MOVEMENTS:	5.	UPPER (ARMS, WRISTS HANDS FINGERS INCLUDE CHOREIC MOVEMENTS (I.E., RAPID, OBJECTIVELY PURPOSELESS, IRREGULAR SPONTANEOUS) ATHETOID MOVEMENTS (I.E., SLOW IRREGULAR, COMPLEX SERPENTINE). DO NOT INCLUDE TREMOR (I.E., REPETITIVE, REGULAR, RHYTHMIC)	0	1	2	3	4
	6.	LOWER (LEGS, KNEES, ANKLES, TOES) E.G., LATERAL KNEE MOVEMENT, FOOT TAPPING, HEEL DROPPING, FOOT SQUIRMING, INVERSION AND EVERSION OF FOOT	0	1	2	3	4
TRUNK MOVEMENTS:	7	NECK, SHOULDERS, HIPS E.G., ROCKING. TWISTING, SQUIRMING PELVIC GYRATIONS	0	1	2	3	4
GLOBAL JUDGMENTS:	8	SEVERITY OF ABNORMAL ACTION	0	1	2	3	4
	9	INCAPACITATION DUE TO ABNORMAL MOVEMENTS	0	1	2	3	4
	10.	PATIENT'S AWARENESS OF ABNORMAL MOVEMENTS	0	1	2	3	4
DENTAL STATUS:	11	CURRENT PROBLEMS	0	1	2	3	4
	12	DOES PATIENT USUALLY WEAR DENTURES?	0	1	2	3	4

❑ NOT APPLICABLE: PATIENT HAS NO HISTORY OF TREATMENT WITH NEUROLEPTICS FOR ONE MONTH OR MORE.

❑ EXAMINATION COMPLETED

PHYSICIAN'S SIGNATURE..... DATE OF EXAMINATION.....

REVISED 03/20/97

Monitoring for all atypical antipsychotics: AIMS exam at baseline and ~Q6months due to risk of tardive dyskinesia. Warn of dystonia risk. Weight checks, fasting glucose/lipid panel ~Q6months at minimum.

METABOLIC MONITORING GUIDELINES

	entry	4 weeks	8 weeks	12 weeks	monthly	annual
PMH / Family History	X					X
Weight (BMI)	X	X	X	X	X	X
Waist Circumference	X					X
Blood Pressure	X	X	X	X	X	X
Hemoglobin A1c	X			X		X
Lipid panel	X			X		X
Smoking Status	X	X	X	X	X	X
Physical activity	X	X	X	X	X	X

ADA-APA workgroup. Diabetes Care 2004; 27: 596-601.

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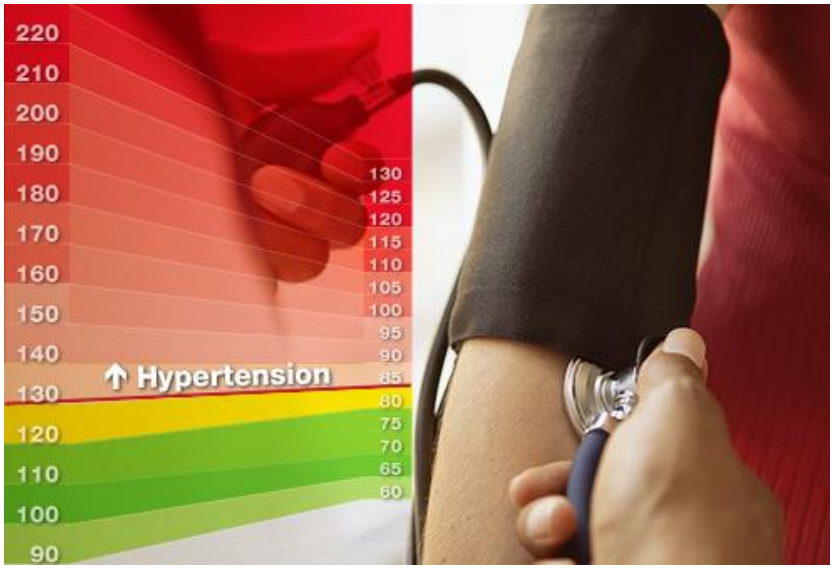
CHECKPOINT

DON'T JUST SCREEN…
…INTERVENE

CVD HEALTH DISPARITIES

- The average life expectancy for people with schizophrenia is 64.7 years (59.9 years for men)
- Risk factors twice as common
  - Obesity (52%)
  - Elevated BP (51%)
  - Dyslipidemia (35%)
  - Impaired fasting glucose (33%)



Olfson M et al. JAMA Psychiatry. 2015;72(12):1172-1181
Correll CU et al Psychiatr Services 2010; 61: 892-898

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EVIDENCE-BASED PRACTICES

Pharmacologic Treatment	Behavioral Strategies	Environmental Changes
• Antipsychotic meds • FDA-approved meds for weight loss	• Brief Counseling • Lifestyle programs	• Education: Family or Residential staff • CMHC setting • Community

AHRQ Publication No. 13-EHC063-EF April 2013
Gierisch JM, et al. J Clin Psychiatry. 2014 May;75(5):e424-40.
McGinty EE et al. Schizophr Bull. 2016 Jan;42(1):96-124

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RISK OF ANTIPSYCHOTIC MEDICATIONS

Low risk	Moderate risk	High risk
Aripiprazole	Asenapine	Clozapine
Lurasidone	Iloperidone	Olanzapine
Ziprasidone	Paliperidone	
	Quetiapine	
	Risperidone	

Werneke U, Taylor D, Sanders TA. Curr Psychiatry Rep; 2013; 15: 347
Kessing L et al. Brisish Journal of Psychiatry 2010; 197(4): 266-271

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SWITCHING ANTIPSYCHOTIC MEDICATIONS

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

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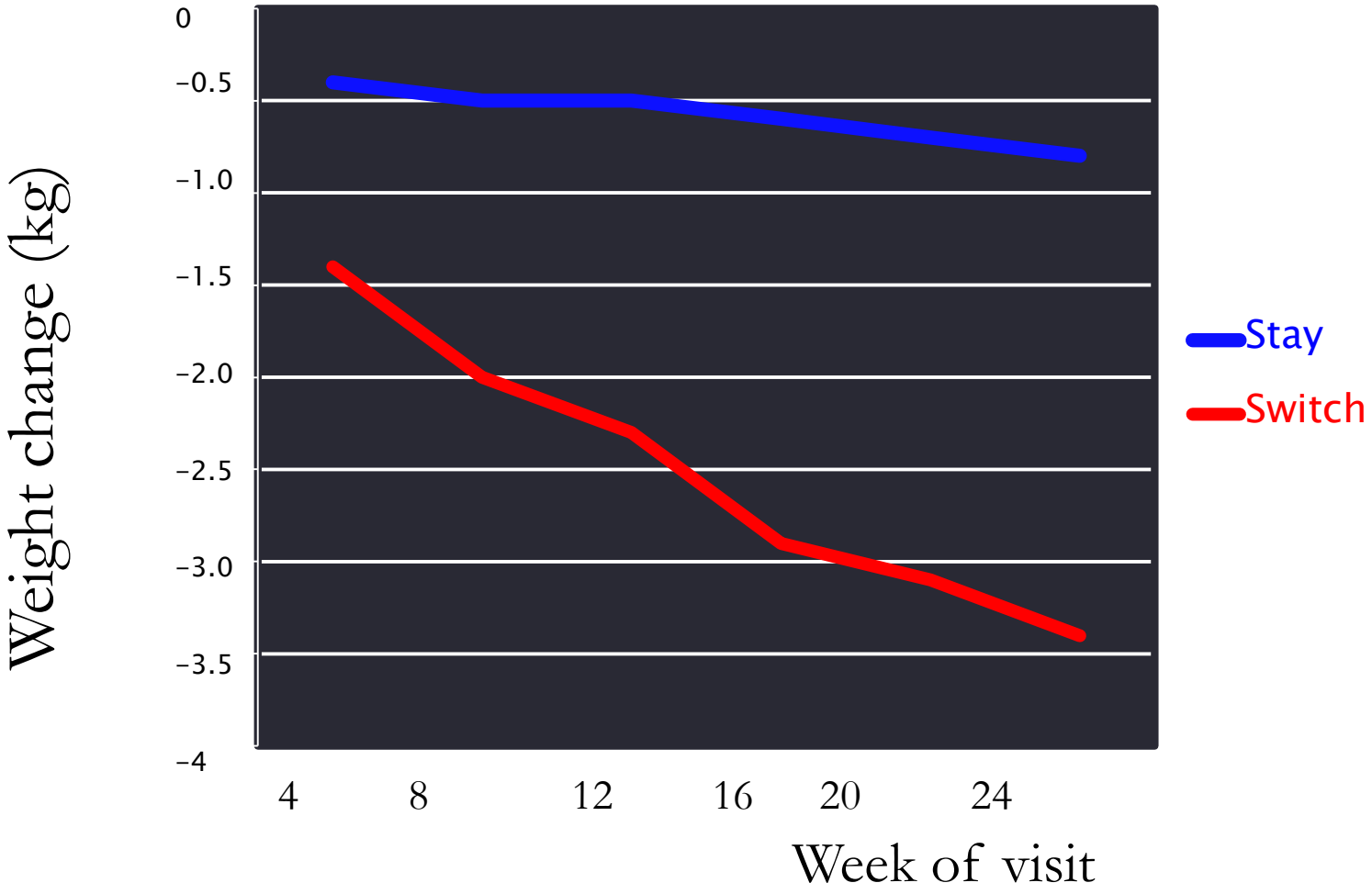
WHY SWITCH?



Stroup TS, et al. Am J Psychiatry 2011; 168: 947-956

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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

Takeuchi H, et al. Schizophr Res. 2018 Mar;193:29-36

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FDA-APPROVED FOR WEIGHT LOSS

Medication	Mechanism
Orlistat (Xenical)	↓ Fat absorption in gut
Phenteramine-Topiramate (Osymia)	↓ appetite
Lorcaserin (Belviq)	↑ satiety
Naltrexone-bupropion (Contrave)	↓ appetite
Liraglutide (Saxenda)	↑ satiety

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

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METFORMIN FOR WEIGHT LOSS

- Not FDA approved for this indication
- 16-week clinical trial in (n= 148) with schizophrenia
  - 3 kg weight loss in 16 weeks[1]
- 500 mg daily up to 2000 mg daily
- B12 malabsorption—check annually

[1] *Jarskog LF, Hamer RM, Catellier DJ, et al. Am J Psychiatry. 2013; 170(9): 1032–40.*

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QUALITY OF DIABETES CARE

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

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

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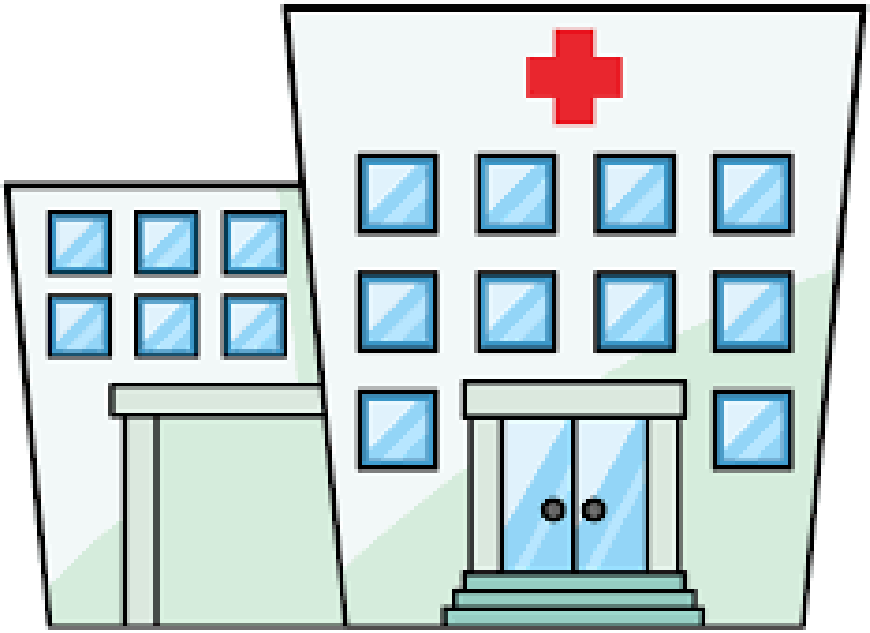
IMPACT OF SCHIZOPHRENIA ON DIABETES

- 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

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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.

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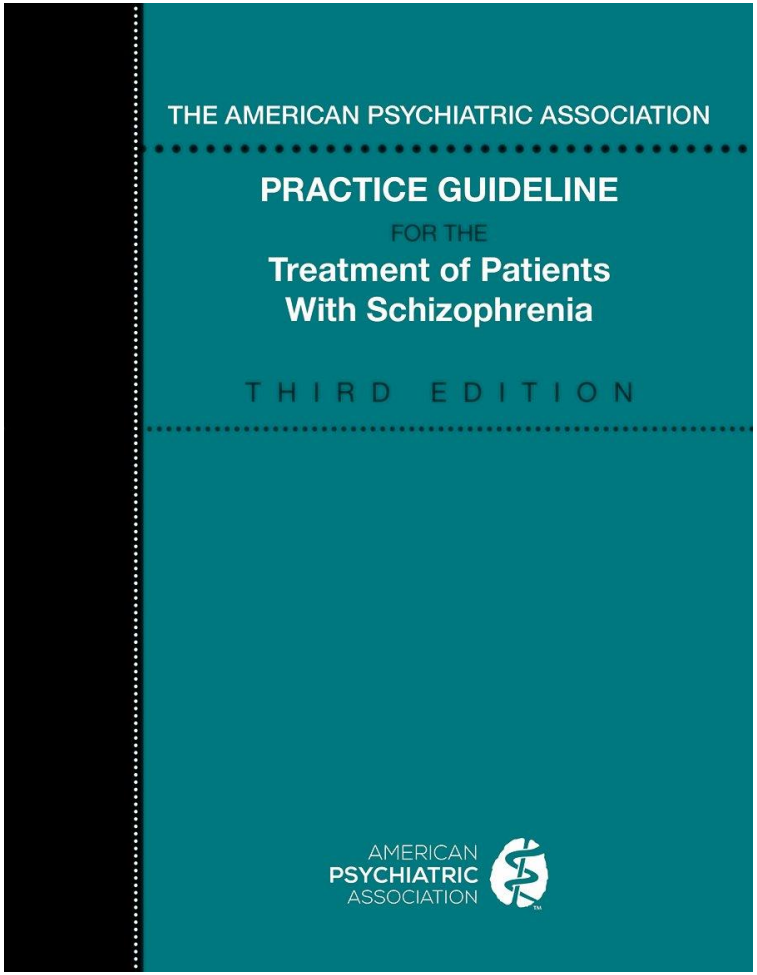
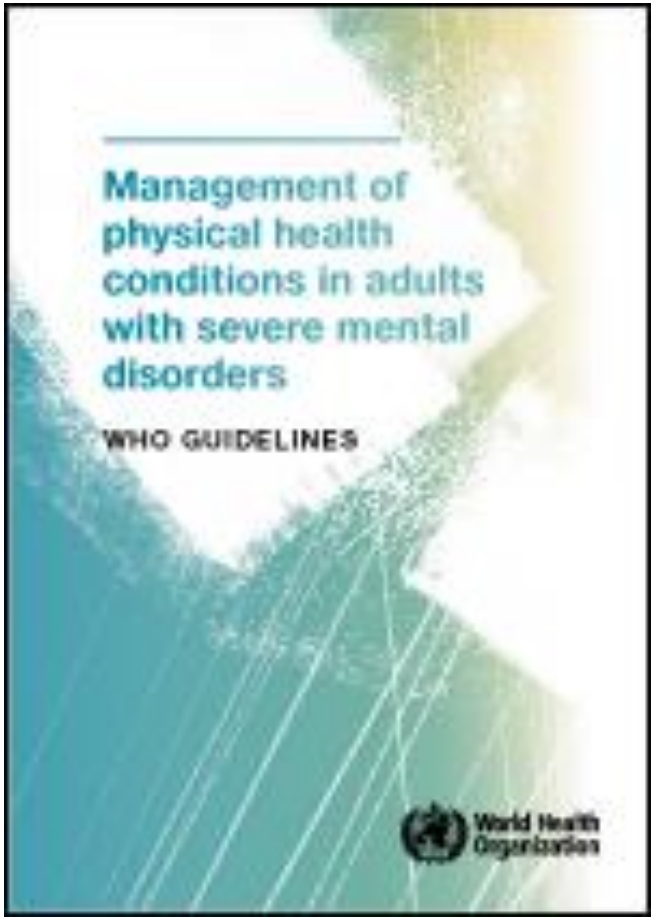
RESOURCES





http://www.choosingwisely.org/wp-content/uploads/2015/02/APA-Choosing-Wisely-List.pdf

AHRQ 2012: https://www.ncbi.nlm.nih.gov/books/NBK84656/

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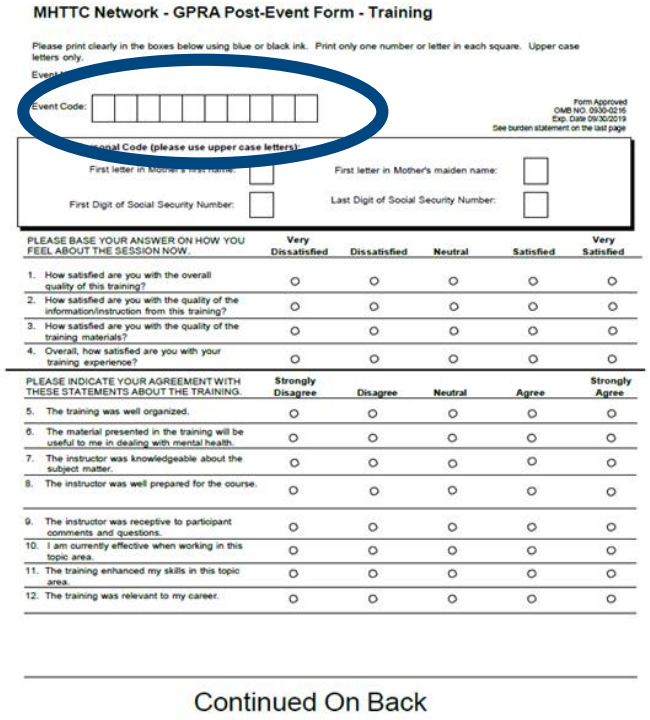
LET US KNOW WHAT YOU THINK!

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!



MHTTC Network - GPRA Post-Event Form - Training

Please print clearly in the boxes below using blue or black ink. Print only one number or letter in each square. Upper case letters only.

Event Code:

Form Approved
OMB NO. 0930-0216
Exp. Date 09/30/2019
See burden statement on the last page

First letter in Mother's maiden name:

First Digit of Social Security Number:

Last Digit of Social Security Number:

PLEASE BASE YOUR ANSWER ON HOW YOU FEEL ABOUT THE SESSION NOW.	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1. How satisfied are you with the overall quality of this training?	o	o	o	o	o
2. How satisfied are you with the quality of the information/instruction from this training?	o	o	o	o	o
3. How satisfied are you with the quality of the training materials?	o	o	o	o	o
4. Overall, how satisfied are you with your training experience?	o	o	o	o	o

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE TRAINING.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. The training was well organized.	o	o	o	o	o
6. The material presented in the training will be useful to me in dealing with mental health.	o	o	o	o	o
7. The instructor was knowledgeable about the subject matter.	o	o	o	o	o
8. The instructor was well prepared for the course.	o	o	o	o	o
9. The instructor was receptive to participant comments and questions.	o	o	o	o	o
10. I am currently effective when working in this topic area.	o	o	o	o	o
11. The training enhanced my skills in this topic area.	o	o	o	o	o
12. The training was relevant to my career.	o	o	o	o	o

Continued On Back

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

We greatly appreciate your feedback!