Medication Management in the Coordinated Specialty Care (CSC) Model for First Episode Psychosis

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July 7th, 2022

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

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Acknowledgment

Presented in 2022 by the Mental Health Technology Transfer Center (MHTTC) Network.

This presentation was prepared for the New England Mental Health Technology Transfer Center (MHTTC) Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA).

At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

The opinions expressed herein are the view of TTC Network and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

This work is supported by grants #1H79SM081775 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Presented 2022

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhtcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

1. What is *most important* for new providers to know about medication management for psychosis?

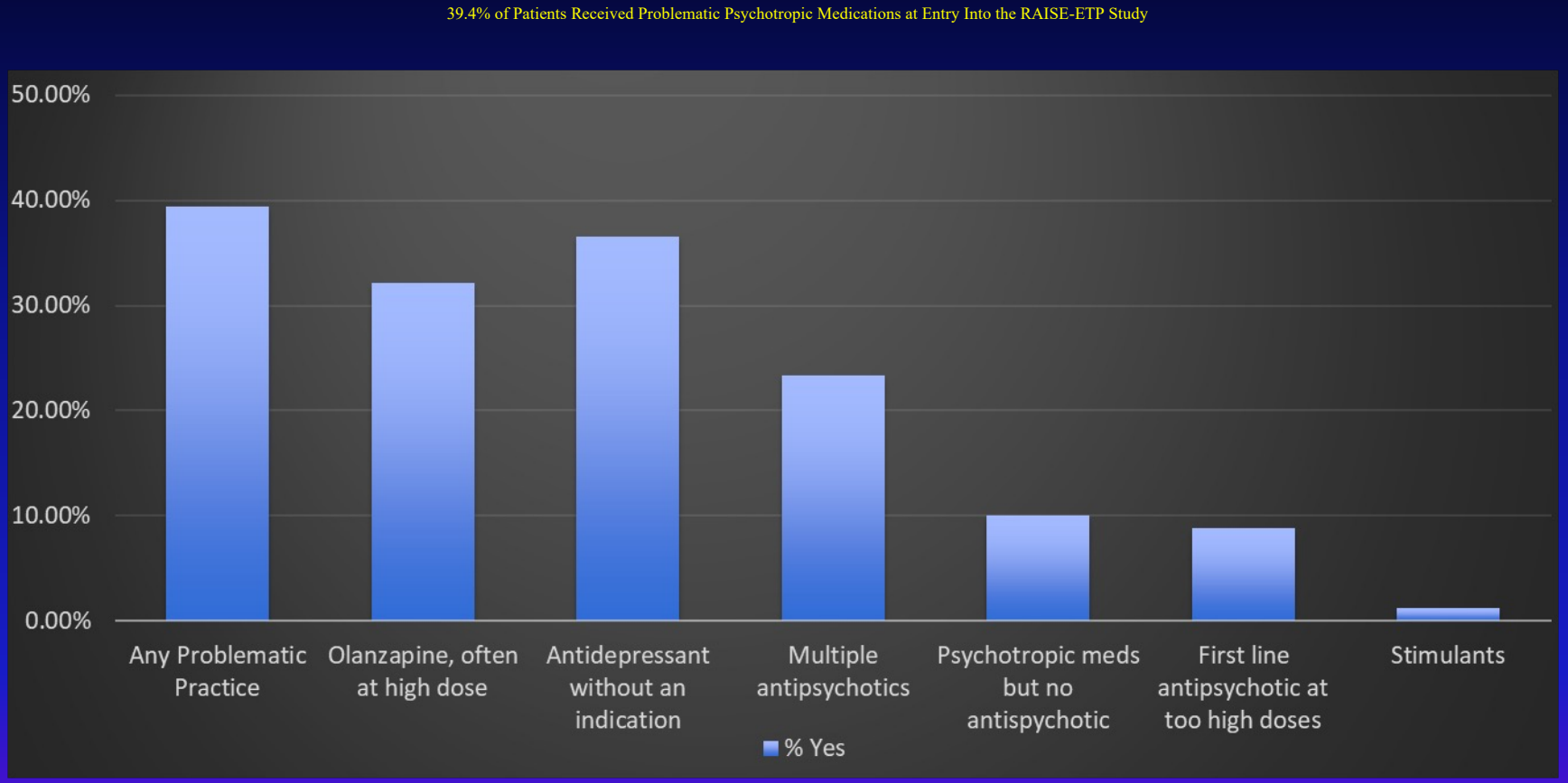
2. What have your previous prescribers (nurse practitioner or psychiatrist) done that *did not* work well?

3. What have your previous prescribers done that *was* helpful?

4. What are your thoughts about shared decision making with your prescriber? (i.e., making choices based on the need to manage symptoms while also minimizing side effects?)

5. Is there anything else about your own recovery journey that you would like to share in order to teach new providers about how to promote recovery?

Prescribing practices in management of early course psychotic disorders



Some patients received more than one problematic prescription

Robinson et al. American Journal of Psychiatry, 2015

Ms. M

- This 28 year old woman with a diagnosis of schizophrenia had been stable, and symptom free for the last 6 months on risperidone 4 mg per day. She is seen for a routine “med-check”. She is beginning to hear voices over the last 2 months, and is growing increasingly mistrustful towards her husband. She denies medication side effects. She has been taking her medications regularly. She denied any recent stresses.

- Your next step:

A. Increase her dose to 6 mg

B. Add a second antipsychotic

C. Consider clozapine

D. refer her to the therapist to to explore marital/family issues

- At the end of the med-check, Mrs. M. asked if she could another quick question. During the next 30 minutes that followed, she admitted to being worried about a diminished sexual desire. Upon further inquiry she reported her periods being irregular, and also bone pains. She had gone to her PCP who started her on some new medications about 3 months ago.

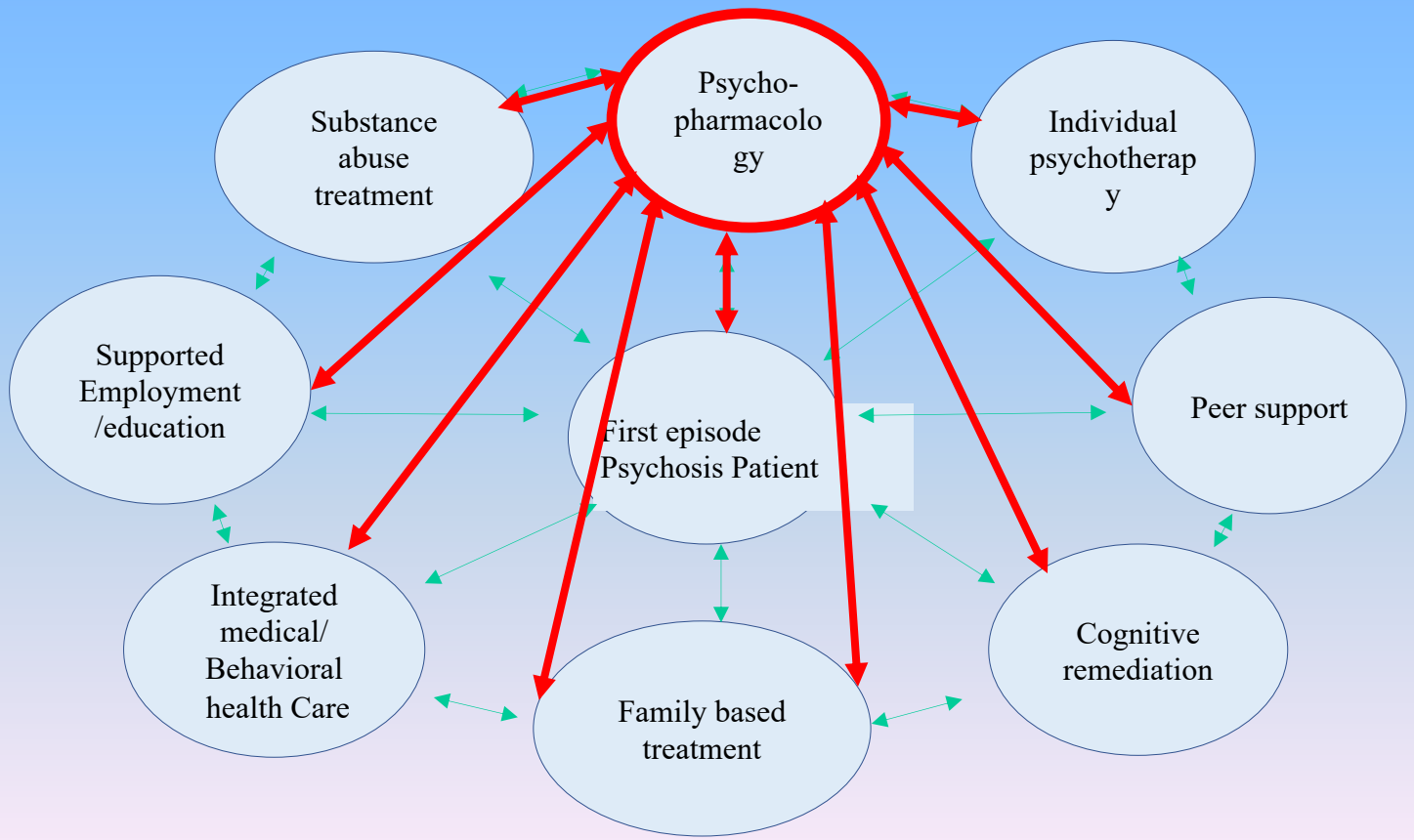
Your next step?

Talked to the PCP. Her prolactin level was 110 ng/ml. Unbeknown to the psychiatrist, she had been treated with bromocriptine 2.5 mg per day (a dopamine agonist) for hyperprolactinemia

The Ten commandments of good prescribing.

- Coordinated (team-based) treatment plan.
- Connecting and consent.
- Comprehensive assessment.
- Correct choice of medications.
- Correct dose and duration.
- Compliance (or better, adherence/ alliance
-).
- Collaborative decision making
- Comorbidity.
- Check (and prevent) side effects
- Consult (whenever in doubt)

1. Coordinated care.



Patients do not care how much you know until they know how much you

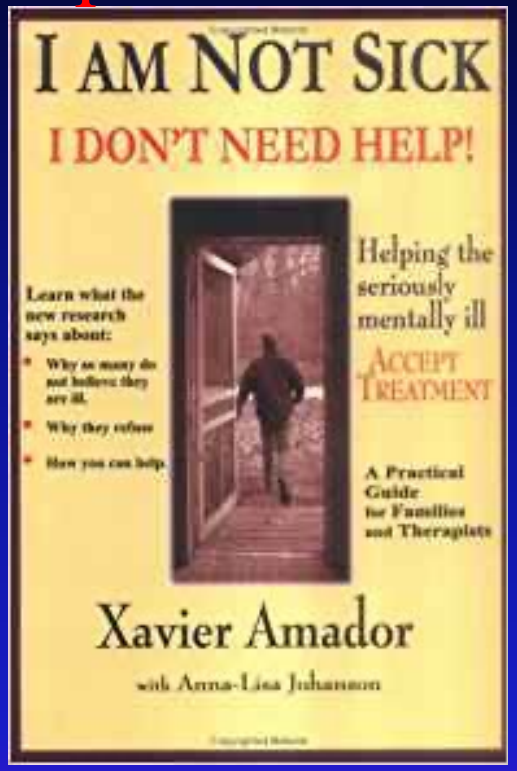
Scherger JE. What patients want. J Family Practice 2001

2. Connecting and engaging with the patient.

- Use terms that patient can understand
- Tailor education to individual
- Involve family members early;
- Correct mis-information
- Teach pathophysiology (e.g. dopamine imbalance)
- Emphasize risk- liability models (e.g. asthma, high blood pressure)

The LEAP principle

Listen
Empathize
Agree
Partner



The Role of the Therapeutic Alliance in the Treatment of Schizophrenia Relationship to Course and Outcome

Arlene F. Frank, PhD; John G. Gunderson, MD ***Arch Gen Psychiatry*** **1990;47(3):228-236**

3. Comprehensive assessment

- Diagnosis , antecedent/ comorbid medical
- illness including metabolic status

- Attitudes to medications

- Prior treatment response,
- and side effects

- Clarify compliance/adherence.

- Over-the-counter or “alternative”
- medicines

- Lab results as needed (e.g. liver and kidney function; glucose and lipid profile

Spend time with the patient!

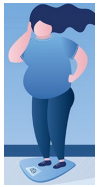
4. Choosing the right treatment.

- Aim for overall remission, not just symptom improvement
- Choose medicine with a favorable side effect profile
- Start low, go slow
- Monitor side effects— first episode
- patients more sensitive to side effects
- Use measurement based care
- (use Patient self rating scales)
- Make one change at a time

Advantages and disadvantages of APDs

	ADVANTAGES	DISADVANTAGES
Typical APDs **(e.g., haloperidol, fluphenazine, thiothixene)**	Effective with positive symptoms Relatively low risk of weight gain/ metabolic syndrome Haloperidol useful in delirium, pregnancy	**Extrapyramidal syndromes (EPS)** **Prolactin elevation**
Atypical APDs **(aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone, Lurasidone)**	Effective with positive symptoms, Relatively low EPS potential[1] Relatively less prolactin elevation[2]	Weight gain[3] Increased risk of metabolic syndrome (though not all atypical APDs) Expensive

Choosing Antipsychotics

GOAL	AVOID	CONSIDER
 • Avoid Extrapyramidal side effects	• Haloperidol, fluphenazine, risperidone	• Olanzapine, quetiapine, Aripiprazole, ziprasidone, lurasidone, cariprazine, brexpiprazole
 • Avoid Weight gain, metabolic	• Clozapine, olanzapine, quetiapine, risperidone	• Aripiprazole, ziprasidone, lurasidone, cariprazine, brexpiprazole
 • Avoid Sedation	• Clozapine, olanzapine, quetiapine	• Lurasidone, cariprazine
 • Fast acting		• haloperidol IM, Fluphenazine, Risperidone M-Tab, ziprasidone IM, asenapine
 • Treatment resistance		• Clozapine
 • Adherence issues		• LAI Haloperidol, fluphenazine, risperidone, paliperidone, olanzapine
		• Haloperidol, fluphenazine, risperidone

MEDICATIONS TO TRY FIRST

- In RAISE-ETP, it is recommended that chlorpromazine and haloperidol should be second line agents due to side effects and, for haloperidol, questions about maintenance efficacy

- RAISE-ETP first line agents are the remaining medications with relevant data: aripiprazole, quetiapine, risperidone, ziprasidone

Courtesy: Delbert Robinson MD

5. Correct duration and dose of medication trials

- First episode patients may respond to sufficiently long mono-therapy trials of antipsychotics
- Antipsychotics doses that are at 50-60% of what is used in more chronic patients are often sufficient to obtain a treatment response. Higher doses often are associated with a greater side effect burden
- The Preventing Morbidity study treated first episode patients with olanzapine or risperidone for 16 weeks
- Cumulative response rates increased steadily every study week until the end of trial
- The cumulative response rate was 40% by week 8; 54% by week 12 and 65% by week 16

J Clin Psychiatry. 2011 December ; 72(12): 1691–1696. doi:10.4088/JCP.10m06349.

Time to treatment response in first episode schizophrenia: should acute treatment trials last several months?

Juan A. Gallego, MD[a], Delbert G. Robinson, MD[a,b,c], Serge M. Sevy, MD[a,c], Barbara Napolitano, MA[d], Joanne McCormack, LCSW[a], Martin L. Lesser, Ph.D[b,c,e], and John M. Kane, MD[a,b,c]

Courtesy: Delbert Robinson MD

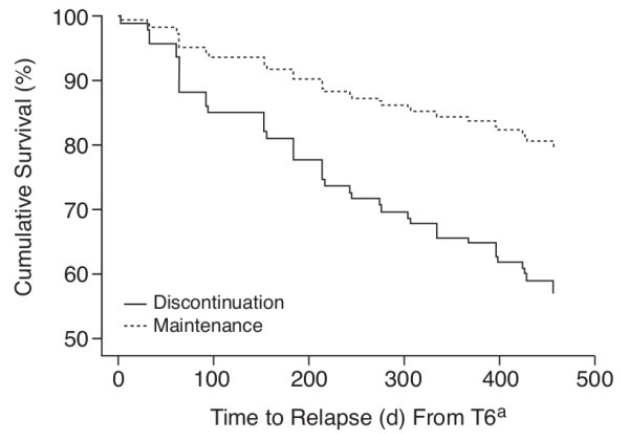
6. Enhancing compliance with treatment.

Results: Twice as many relapses occurred with the discontinuation strategy (43% vs. 21%, p = .011). Of patients who received the strategy, approximately 20% were successfully discontinued. Recurrent symptoms caused another approximately 30% to restart antipsychotic treatment, while in the remaining patients discontinuation was not feasible at all. There were no advantages of the discontinuation strategy regarding functional outcome.

Guided Discontinuation Versus Maintenance Treatment in Remitted First-Episode Psychosis: Relapse Rates and Functional Outcome

Lex Wunderink, M.D., Ph.D.; Fokko J. Nienhuis, M.A.; Sjoerd Sytema, Ph.D.; Cees J. Slooff, M.D., Ph.D.; Rikus Knegtering, M.D., Ph.D.; and Durk Wiersma, Ph.D.

Figure 2. Relapse Rates for the Discontinuation Strategy vs. Maintenance Treatment (survival function)



[a]T6 = start of trial (6 months after first treatment response).

- Antipsychotic discontinuation during the first years of illness is associated with increased relapse risk
- A few patients do not relapse after antipsychotic discontinuation , but we do not know how to predict relapse
- Using minimum effective doses is associated with better long term outcome at 7 years

J Clin Psychiatry 2007

Poor adherence and its management

• Patient who refuses meds	• Improve therapeutic alliance; rapid acting meds; involuntary meds as last resort
• Patient non-adherent because meds not working	• Dosage adjustment; consider medication switch, clozapine
• Patient non-adherent because of • side effects	• Dosage adjustment; consider medication switch; monitor & educate re. Side effects
• Patient does not show up for first appointment	• Improve hospital to clinic continuity; make care more accessible and patient friendly
• Patient who frequently misses/forgets meds/appts	• Cues to remember; memory aids such as pillboxes and alarm watches; phone call reminders; Long acting injectables
• Patient who believes he/she does not need meds	• Motivational interviewing; continuing psychoeducation; cognitive remediation

7. Check (and prevent/ Manage) side effects

- Prevent side effects by careful history, and appropriate choice
- Early monitoring, and psychoeducation
- “start low- go slow” strategy
- Reduce dose if possible
- Consider switching antipsychotics versus adding side effect medications

Mary

- **Mary is a 28 year-old single unemployed woman with schizophrenia been stable till about 3 months ago when she had been briefly hospitalized for a psychotic relapse. Her previous medications that she had been very compliant with i.e. clozapine 300 mg twice a day, amitriptyline 75 mg at night and lithium carbonate 300 mg three times a day were continued. Perphenazine 32 mg at night, benztropine 1 milligram twice a day and clonazepam 1 mg twice a day had been added during the hospitalization.**

One day, Mary did not show up for her regular clinic appointment that day. By the afternoon neighbors were concerned because children were crying loudly inside the house and Mary was not answering the door.

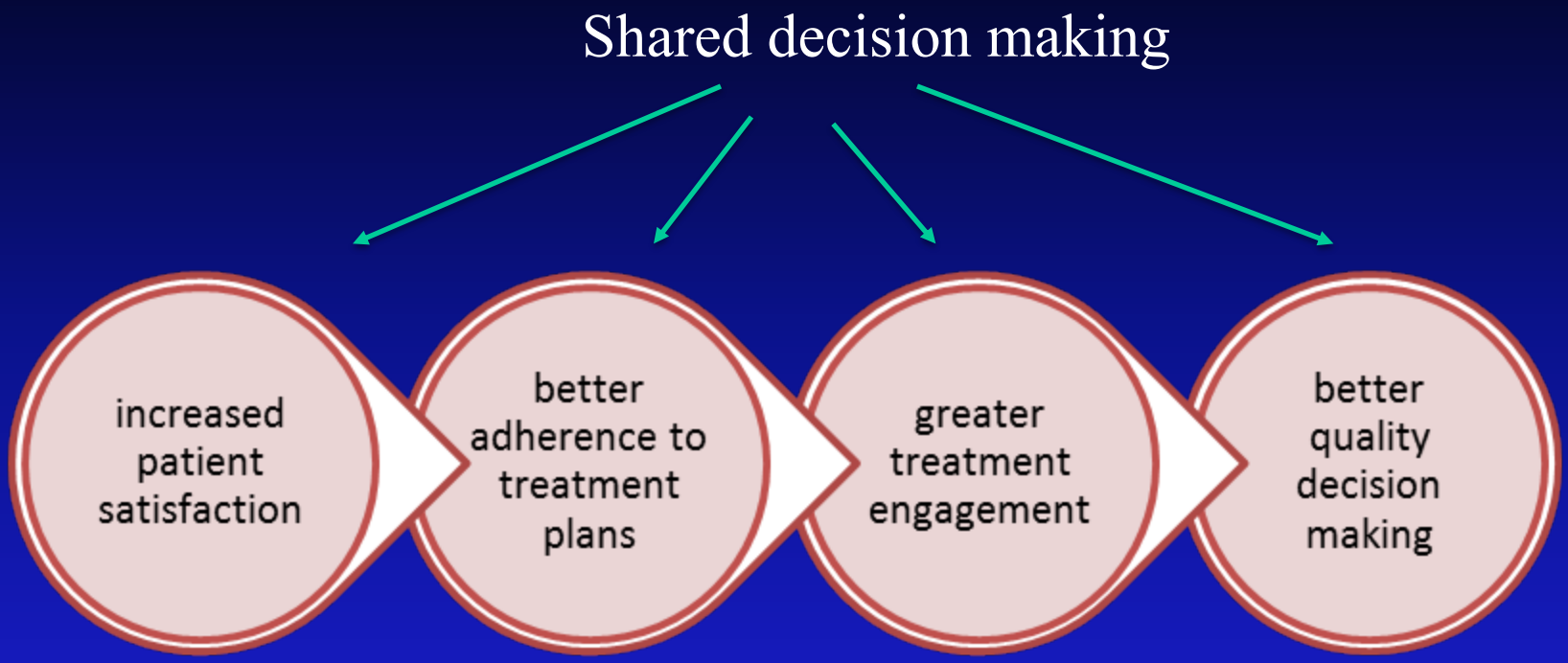
What might account for Mary's situation?

A. Substance abuse
B. Overdose
C. Drug interactions
D. Severe negative symptoms

The police were called and they entered the house to find that Mary had been deep asleep.

When she woke up, Mary admitted to having been very groggy and said she may have taken the morning medicines again because she "forgot"

8. Collaborative (Shared) decision making



There is increasing evidence for SDM to improve outcomes

Drake et al 2015

- Jane, 28, is treated in an outpatient clinic for schizophrenia. She has had recurrent relapses and hospitalizations despite treatment with 3 atypical antipsychotics (risperidone, quetiapine and aripiprazole). Over the last year, her delusions and hallucinations have responded well to clozapine (300 mg/ day), though she is troubled by the excessive sedation. Jane now wants to discontinue clozapine, as she is afraid she may lose custody of her 3 children (aged 2-8).

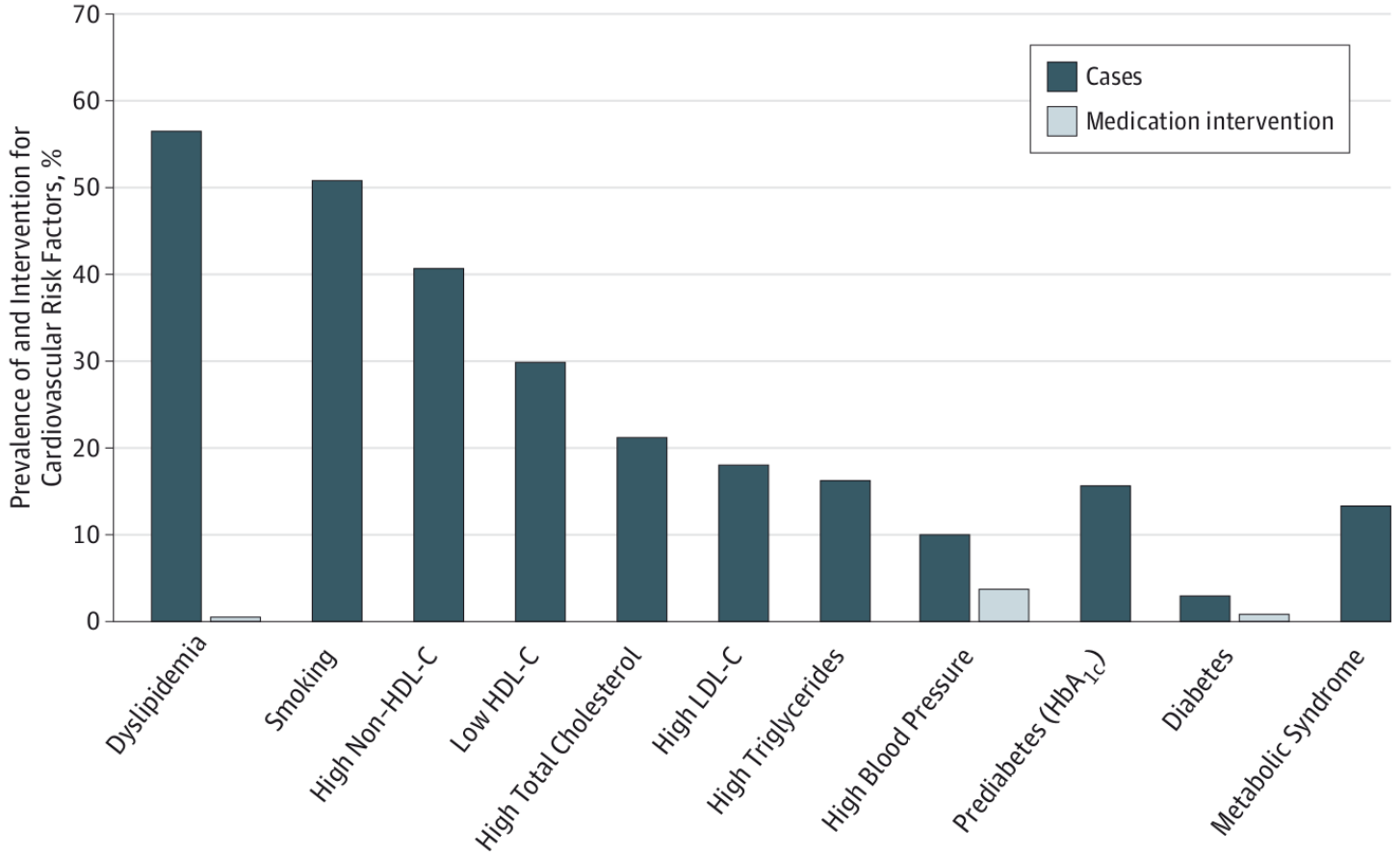
Example of SDM: Ms. M

Your options:

- A. Strongly recommend continuing clozapine
- B. Discontinue clozapine and start back previous medications
- C. Discuss with Jane the Pros and Cons of discontinuing clozapine, and present her the options of a) continuing clozapine plus modafinil (an alerting medicine) vs b) a trial of an alternative antipsychotic with less sedating effects (lurasidone).

9. Co-Morbidities Are Common in FEP

Figure 2. Prevalence of Smoking, Lipid Abnormalities, Hypertension, Diabetes, and Metabolic Syndrome and Respective Medication Treatment for the Conditions



Correll et al JAMA Psychiatry 2014

Schizophrenia: Comorbid Conditions

High rate of psychiatric and other medical comorbidities

- Substance abuse: 20%-40%
- Cigarette smoking: 60%-90%
- Mood disorders: 10%-20%
- COPD, diabetes, hepatitis B and C, HIV, and cardiovascular disease
- Frequent underdiagnosis and undertreatment

Psychopharmacology of early course psychoses: Summary.

- Coordinated (team-based) treatment plan.
- Connecting and consent.
- Comprehensive assessment.
- Correct choice of medications.
- Correct dose and duration.
- Compliance (or better, adherence/ alliance
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Thank you!