Taking Care of Patients with Early Course Psychotic Disorders: the art and the science

Matcheri Keshavan, M.D.

New England MHTTC

December 14th, 2022

SAMHSA
Substance Abuse and Mental Health Services Administration

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

Housekeeping Information

Participant microphones will be muted at entry

If you have questions during the event, please use the chat

This session is being recorded and it will be available by the next business day.

If you have questions after this session, please e-mail: newengland@mhttcnetwork.org.

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://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Taking care of patients with early course psychotic disorders: The art and the science

Matcheri S Keshavan MD

•. 2017

Why early intervention in psychosis is important

- This population is *vastly undertreated*: a review of privately insured 16-30 year olds in U.S. found that in the year following index diagnosis of psychotic disorder, 61% filled no prescriptions and 41% received no psychotherapy (Schoenbaum et al., 2017)

- High treatment need: Nearly two-thirds (62%) of the cohort had at least one hospitalization and/or one emergency department visit during the initial year of care.

- *High all-cause mortality* due to suicide, overdose, accidents (Simon et al., 2018); *15-20 years shorter life expectancy* due to high rates of cardio-metabolic illnesses, low employment rates, and high rates of loneliness (SAMHSA)

-

Psychiatry is still more of an art than a science

My medical education had taught me plenty of facts, but little about the spaces that live between facts

- Siddhartha Mukherjee in:
- The laws of Medicine”

- Developing a therapeutic alliance
- Sharing the diagnosis and prognosis with patient and his/ her family
- Shared decision making
- The art of prescribing
- Tailoring treatment to phase of illness

THE ESSENTIAL IMPORTANCE OF THE THERAPEUTIC ALLIANCE

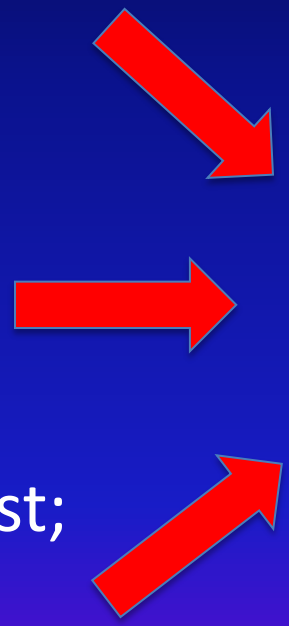
- Prescribing medications is a partnership between prescriber and recipient:
  - Prescriber: I know about the medications and doses;
  - Patient: I know how they make me feel (think, behave)
- Together, the two find their way through appropriate drug, dose, and side effects

Bordin's 3 main components (Bordin, 1979) :

Therapist-pt agreement on goals ¤

Therapist-pt agreement on interventions

The bond between pt and therapist; implies trust, respect, and acceptance



Therapeutic alliance

PHARMACO-THERAPEUTIC ALLIANCE

- In therapy (or in prescribing) *empathy* is the tool *par excellence*, which allows the creation of a relationship between patient and prescriber that can offer some hope of mitigating early self pathology.
- “pharmacotherapeutic alliance”: “an active collaboration with the patient involving shared inquiry, shared goals and mutual participation in both experiencing and observing the process of using medication”.

Kohut, 1968; Gutheil, 1993

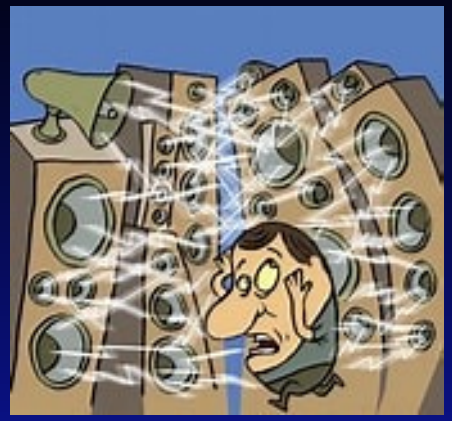
Building alliance when a patient believes she has no illness

- ***Lucy, a 22 year old woman had been brought to one of us (MSK) for gradual social withdrawal, talking to herself and beliefs that she is the messiah destined to eliminate poverty from the world. She had dropped out of electrical engineering in her sophomore college year because of failing grades and disinterest in attending classes. She had refused medications, and had only grudgingly agreed to see a psychiatrist.***

- ***In her first session, she denied all psychotic symptoms, but admitted to being unhappy about dropping out of college. When inquired about her experience in college, she said she liked the topic of her studies, but could not pay attention in classes because of her mind being "cluttered" because of "chatter" inside her head.***

What would be your approach?

Too much



Just right

Too little

LISTEN- EMPATHIZE- AGREE-PARTNER (LEAP PRINCIPLE)

I am not sick, I don’t need meds by Xavier Amador

Ms. T

- A 32 year old college lecturer was treated successfully for two psychotic episodes with paranoia and auditory hallucinations. Since she was symptom free for over three years, the risperidone dose was gradually reduced to 2 mg per day. She then moved to another state for a better job, and wanted to discontinue the medication. The clinician recommended a continued small maintenance dose, and follow-up with a treater in her new location. Ms. T was reluctant to do.

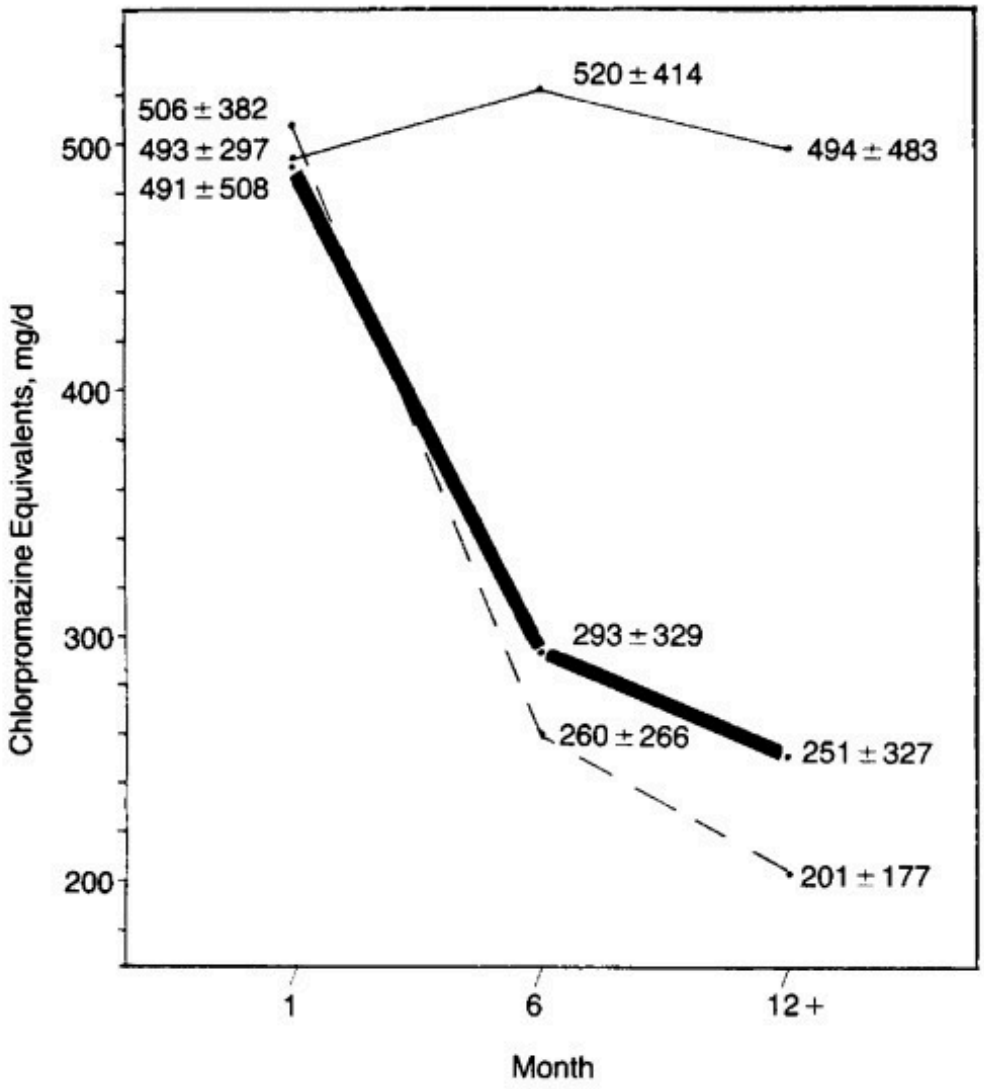
Your options:

- 1. Continue to , treat her long distance.
- 2. Discharge her and ask her to follow-up with a local psychiatrist.
- 3. Discharge as needed by her, connect her with a local psychiatrist, and also ask her to contact you if urgently needed.

Two years later,

- the clinician a call from Ms. T who was in an airport reporting that she had suddenly begun hearing voices from a nearly air conditioner. She wanted to get back on the risperidone as soon as possible. She was given a prescription and she promptly responded to the treatment.

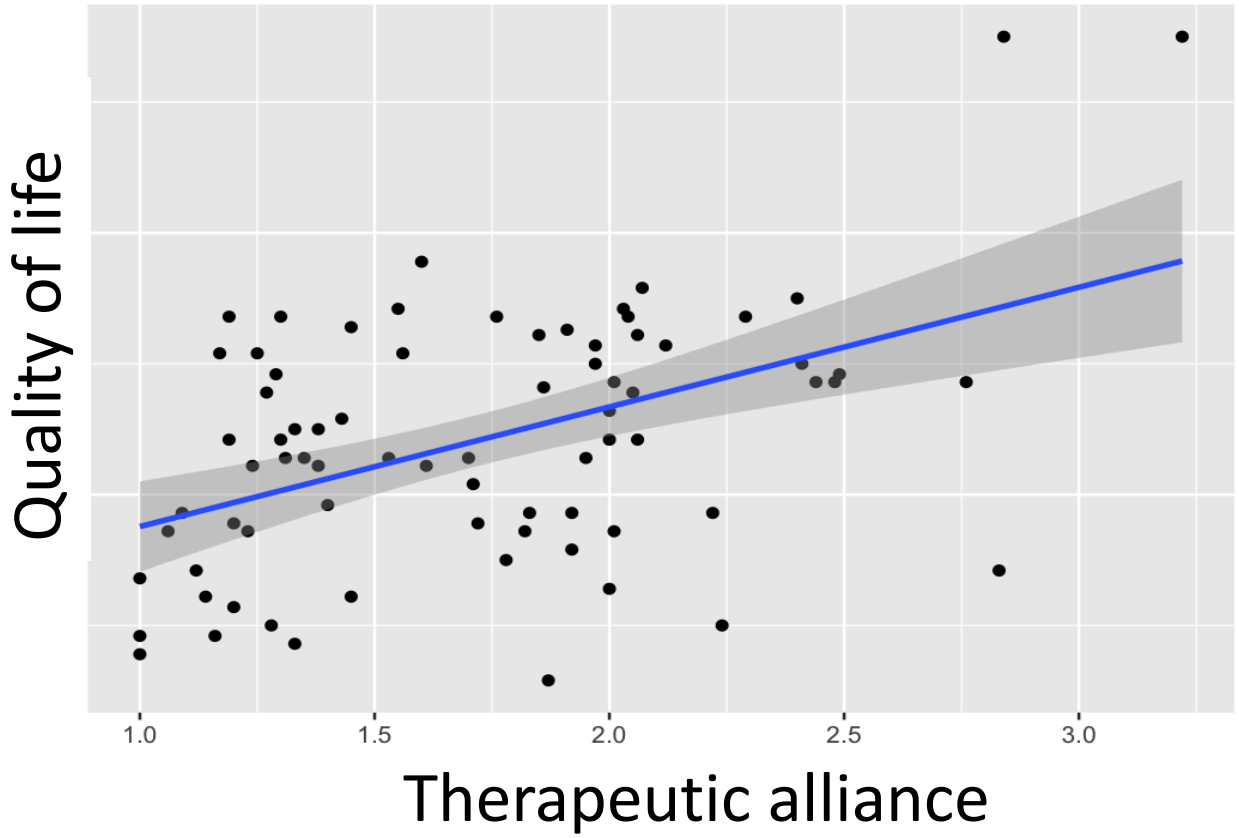
Maintaining therapeutic alliance has lasting benefits



Change over time in mean ± SD neuroleptic dosage for patients with good, fair, and poor alliances at 6 months. Heavy solid line indicates good alliance (n = 24); dashed line, fair alliance (n = 34); and light solid line, poor alliance (n = 13).

patients who formed good alliances with their therapists within the first 6 months of treatment were significantly more likely to remain in psychotherapy, comply with their prescribed medication regimens, and achieve better outcomes after 2 years, with less medication, than patients who did not.

Frank and Gunderson Arch Gen Psychiatry 1990



Therapeutic alliance is positively related to quality of life

Unpublished data from the Consumer advisory Board, MMHC

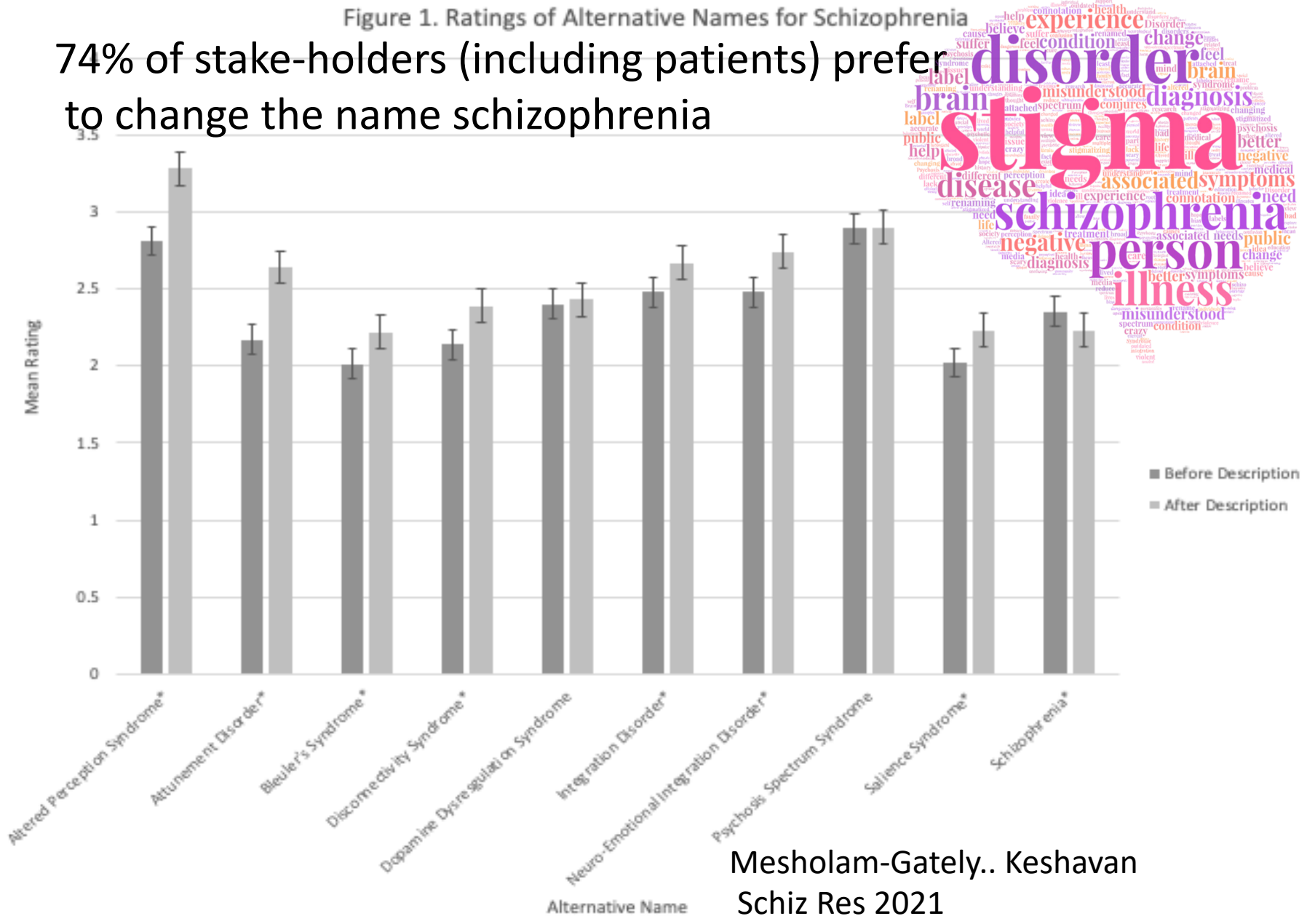
- How do we develop a therapeutic alliance?
- How do we share the diagnosis and the prognosis with our patient and his/ her family?
- How do we develop a shared decision making approach in the management of psychotic disorders?

Anything wrong with this?

- You are suffering from a chronic schizophrenic illness. This is a condition that is a medical term for what lay people consider "craziness".

Words matter

74% of stake-holders (including patients) prefer to change the name schizophrenia



Mesholam-Gately.. Keshavan
Schiz Res 2021

Use normalizing, hopeful language

- Clinician to patient
  - " you seem to be having paranoid thoughts".

It seems you have difficulty trusting people.

  - You may be unable to go back to work because of cognitive impairment.

You may have difficulty concentrating at work at this time.

  - You will have to be on meds for life

For now it would be good to continue meds for at least a year, to make sure you don't relapse. Let's revisit that in a year

- Individualized,
- Normalizing and non-stigmatizing,
- Setting-specific,
- Person-centered,
- Informational,
- Reassuring
- Empathetic and empowering\
- Strategy and next Steps

INSPIRES: an approach to sharing diagnosis

“What is the outlook, Doc? “ The art of inspiring HOPE

- Hope, honesty and humility
- **Options now and later.**
- **Person-centered and partnership focused.**
- **Empowerment.**

Talking to patients and families about prognosis: an account by a person with lived experience of schizophrenia

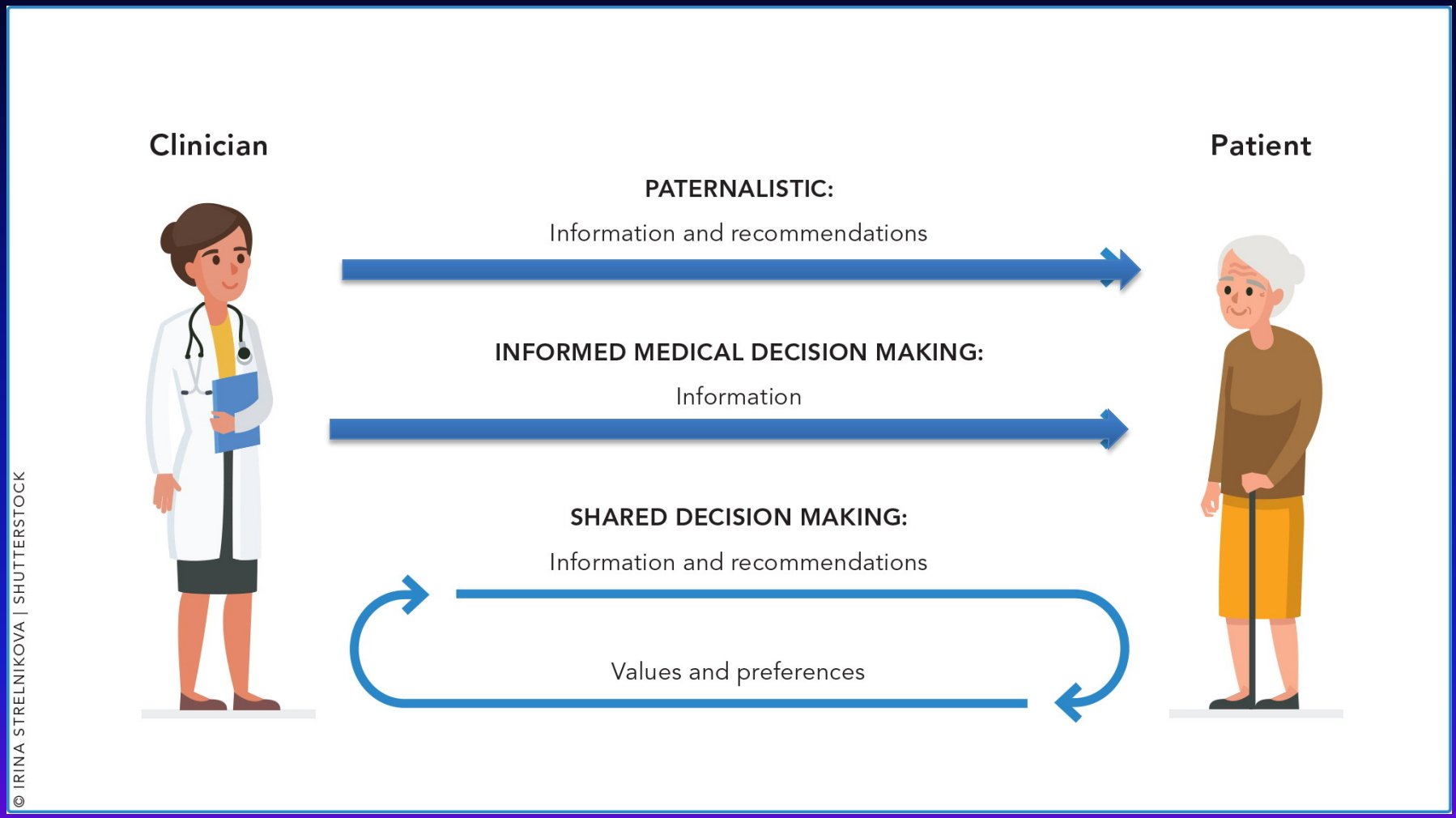
- " you have a disease called schizophrenia. Schizophrenia is a disease that is a lot like diabetes. Just like a diabetic has to take insulin for the rest of their lives, you'll have to take antipsychotic medication for the rest of your life." After discharge, the doctor said "your job was to avoid stress and take high dose antipsychotics religiously, in order to slow the progression of the disease. No romance. No school. Just avoid stress".

No one at the time told me boredom and meaninglessness are profoundly stressful.

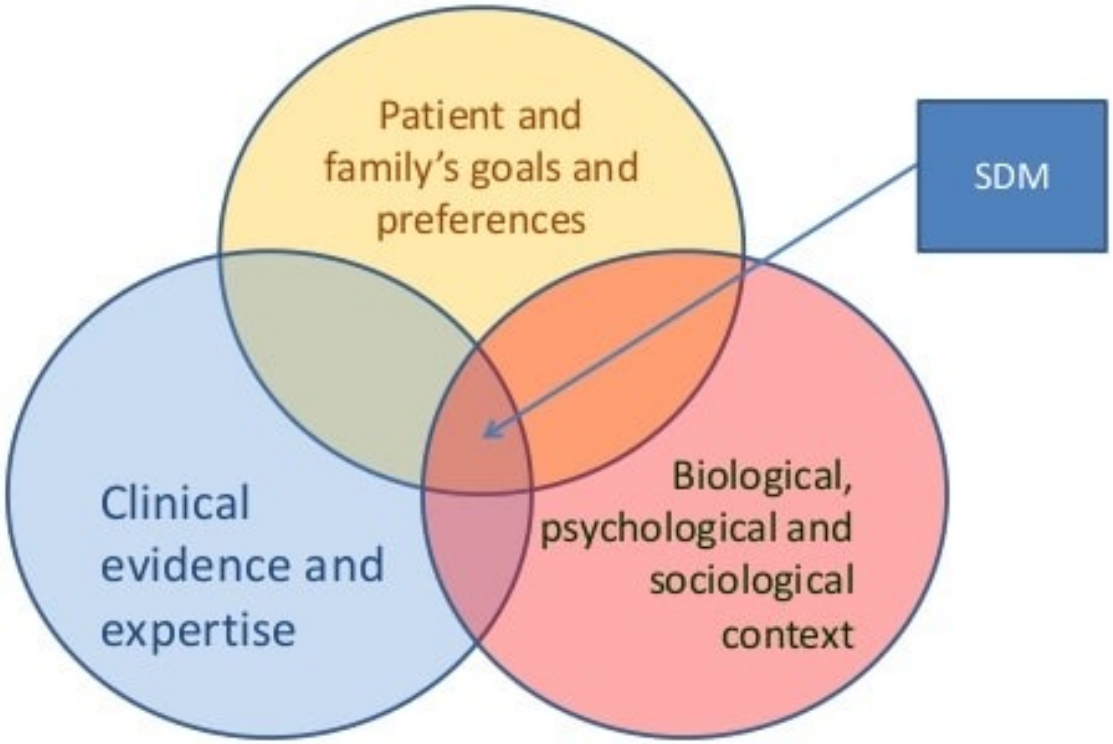
Pat Deegan Schizophrenia Research 2022

- How do we assess and arrive at a diagnosis in a patient with a recent onset psychosis?
- How do we share the diagnosis with our patient and his/ her family?
- How do we develop a shared decision making approach in the management of psychotic disorders?

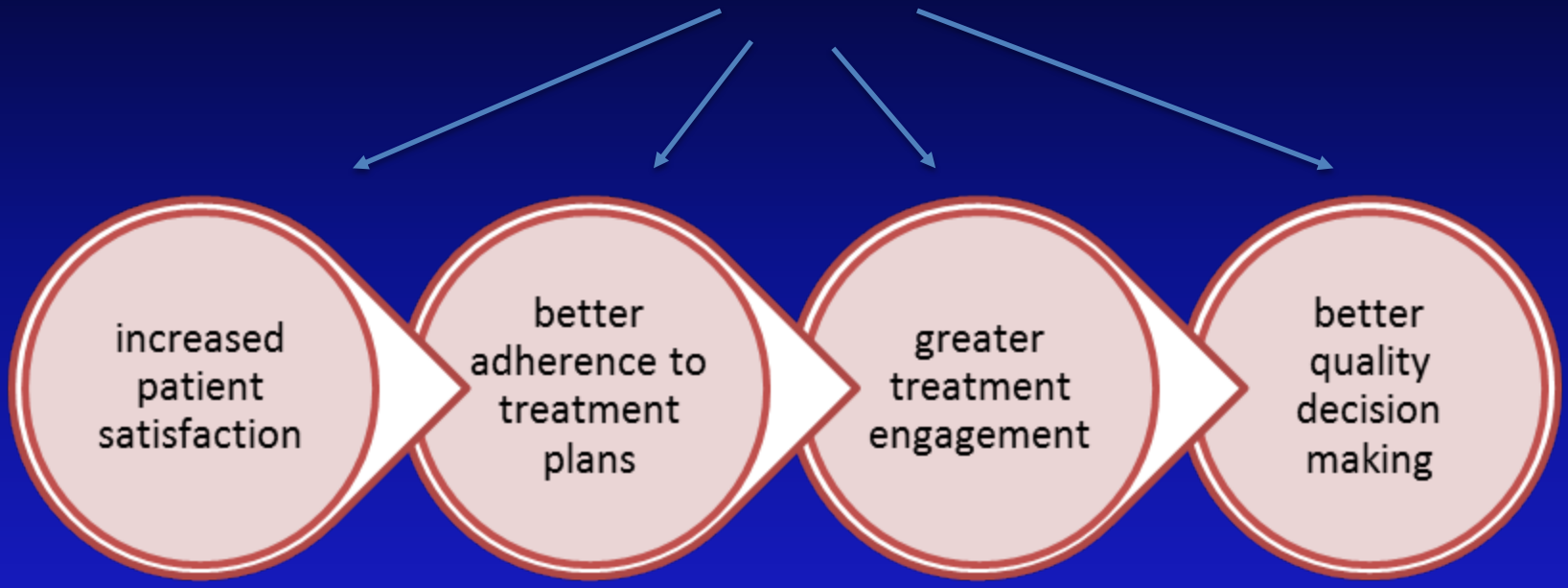
Principles of SDM



Decision-making process



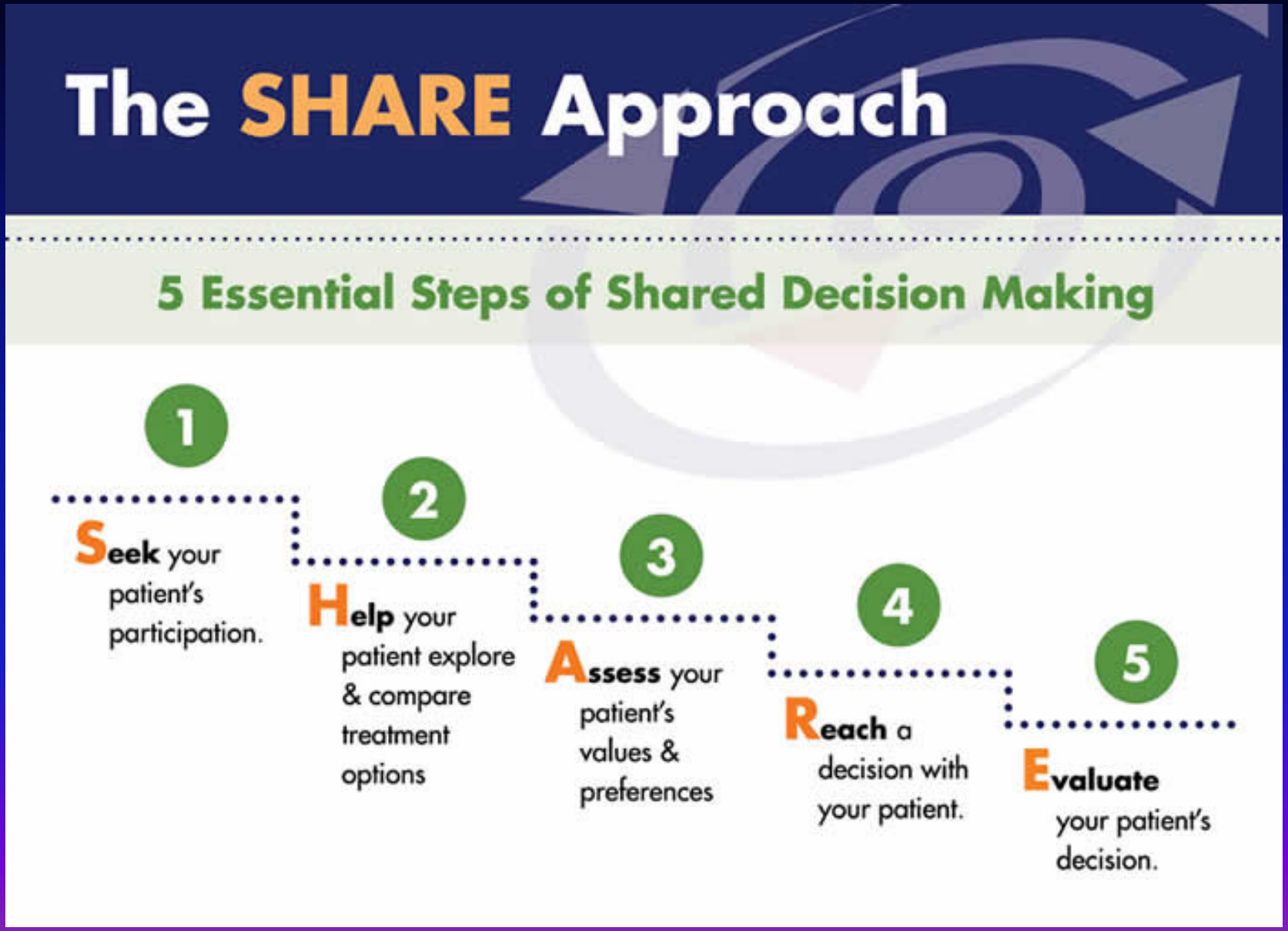
http://www.cincinnatichildrens.org/



There is increasing evidence for SDM to improve outcomes

Drake et al 2015

Approaches to SDM



Example of SDM: Ms. M

- Ms.M, A 38 year old single woman 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. Ms. M now wants to discontinue clozapine, as she is afraid she may lose custody of her 3 children (aged 2-8).

What is the best option for the prescribing clinician?

- A. Strongly recommend continuing clozapine since she has not responded well to 2 other antipsychotics
- B. Discontinue clozapine and start her back on her previous medications
- C. Discuss with Ms M 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).

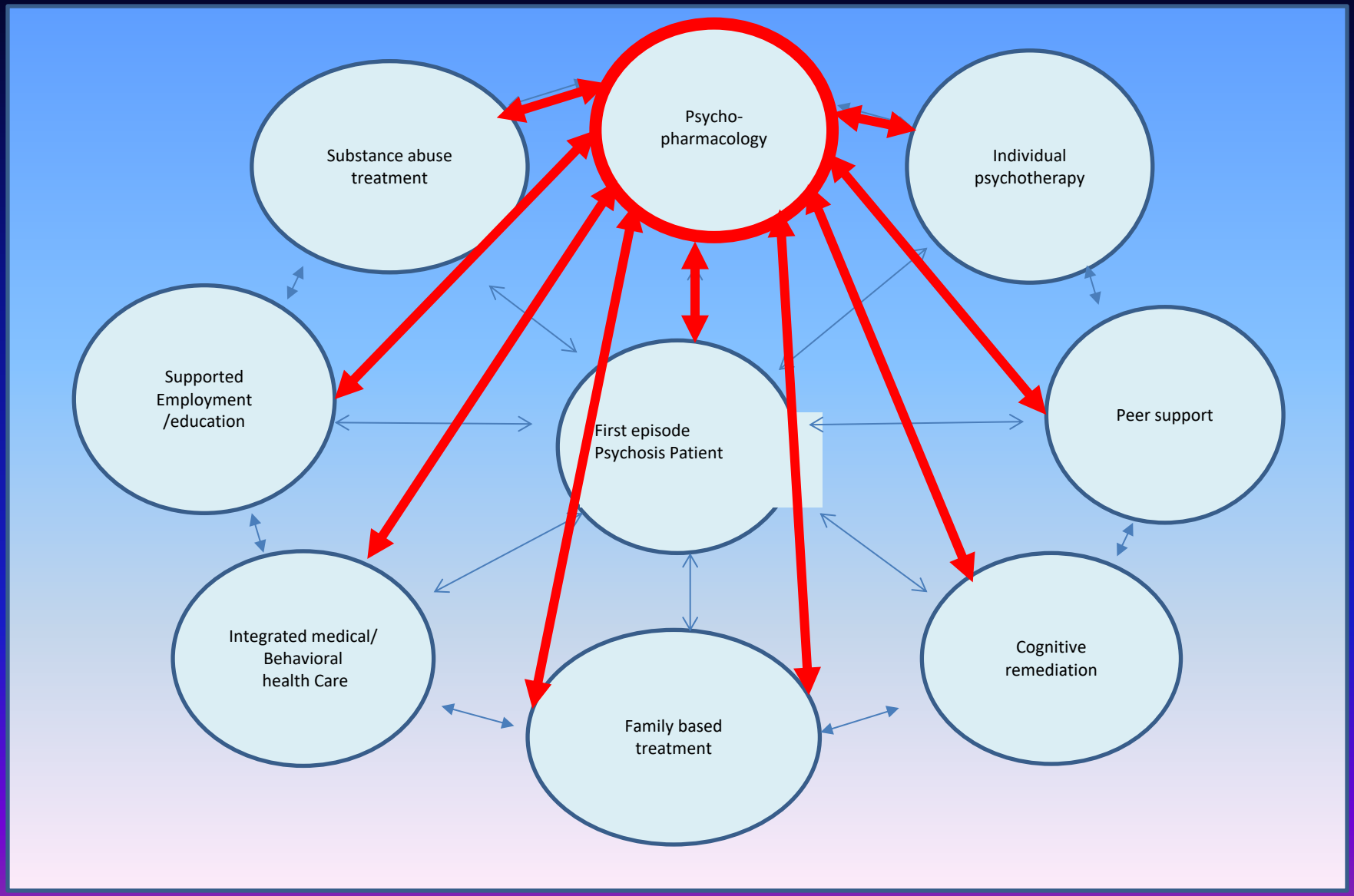
Questions

- The art of developing a therapeutic alliance
- The art of sharing the diagnosis and prognosis with our patient and his/ her family
- The art of shared decision making
- The art of prescribing

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

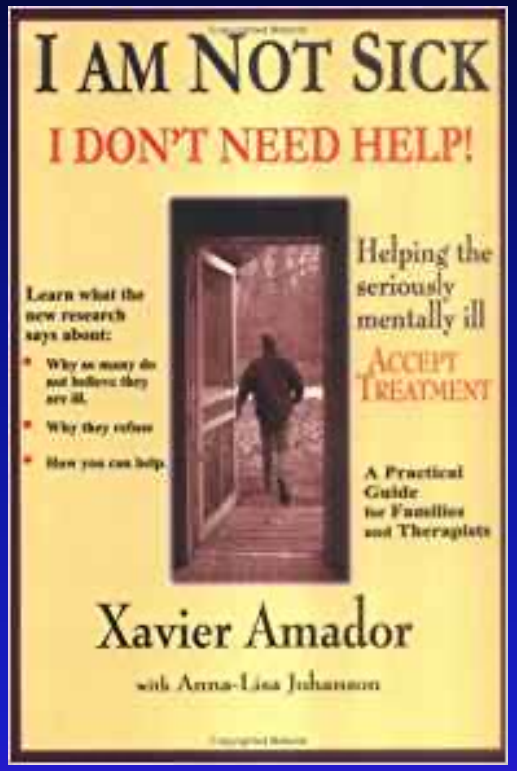


2. Connecting and engaging with the patient.

- Use terms that patient can understand “psychosis” rather than “schizophrenia” initially
- Tailor education to individual’s illness stage and ability to process
- Involve family members early; have them as part of your team and set up open communication
- Correct mis-information (e.g. that it is a split-mind disorder, that it is incurable, etc)
- Teach pathophysiology (e.g. dopamine imbalance) as connected to treatments (e.g. antipsychotic medications)
- Emphasize risk- liability models (e.g. asthma, high blood pressure)
- Some repetition is good; emphasize interaction

The LEAP principle

Listen
Empathize
Agree
Partner



Patients do not care how much you know until they know how much you care
Scherger JE. What patients want. J Family Practice 2001

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

- Comprehensive history and examination to arrive at an accurate diagnosis , and assess/rule out antecedent/ comorbid medical illness including metabolic status
- Get all possible records, but often the patient is the only source of vital information. Complete assessment may take months
- Involve family and other care-givers, assess patient and family attitudes to medications
- Inquire about prior treatment response, and side effects
- Clarify compliance: medication taken versus medication prescribed during prior treatment - they often/usually are different.
- Inquire about the use of over-the-counter or “alternative” medicines
- Obtain and review appropriate lab results as needed (e.g. liver and kidney function; glucose and lipid profile

4. Choosing the right treatment.

- Aim for overall remission, not just symptom improvement
- Choose an antipsychotic with a favorable side effect profile and give for up to 4 months, either as an oral or a long acting formulation
- Use doses around half of what is used with multi-episode schizophrenia
- Monitor side effects closely— first episode patients are also more sensitive to side effects
- Monitor closely for medical co-morbidities
- Use the patient self ratings and your ratings to get all the information needed to make the best decisions within a shared decision making process

Adapted from: Delbert Robinson MD

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**

Medications to Try First

- Guidelines differ but there is general agreement that olanzapine and clozapine should not be first line agents due to their side effect profiles
- 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
- Paliperidone does not have first episode dosing data but is closely related to risperidone

Courtesy: Delbert Robinson MD

5. Correct duration and dose of medication trials

- First episode patients may respond to 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.

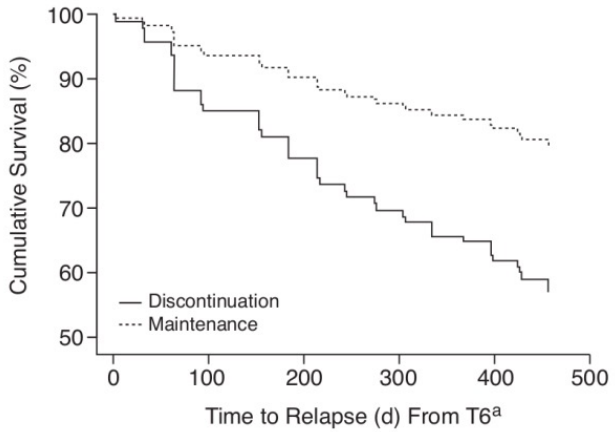
Guided Discontinuation Versus Maintenance Treatment in Remitted First-Episode Psychosis: Relapse Rates and Functional Outcome

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.

J Clin Psychiatry 2007

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.

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



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

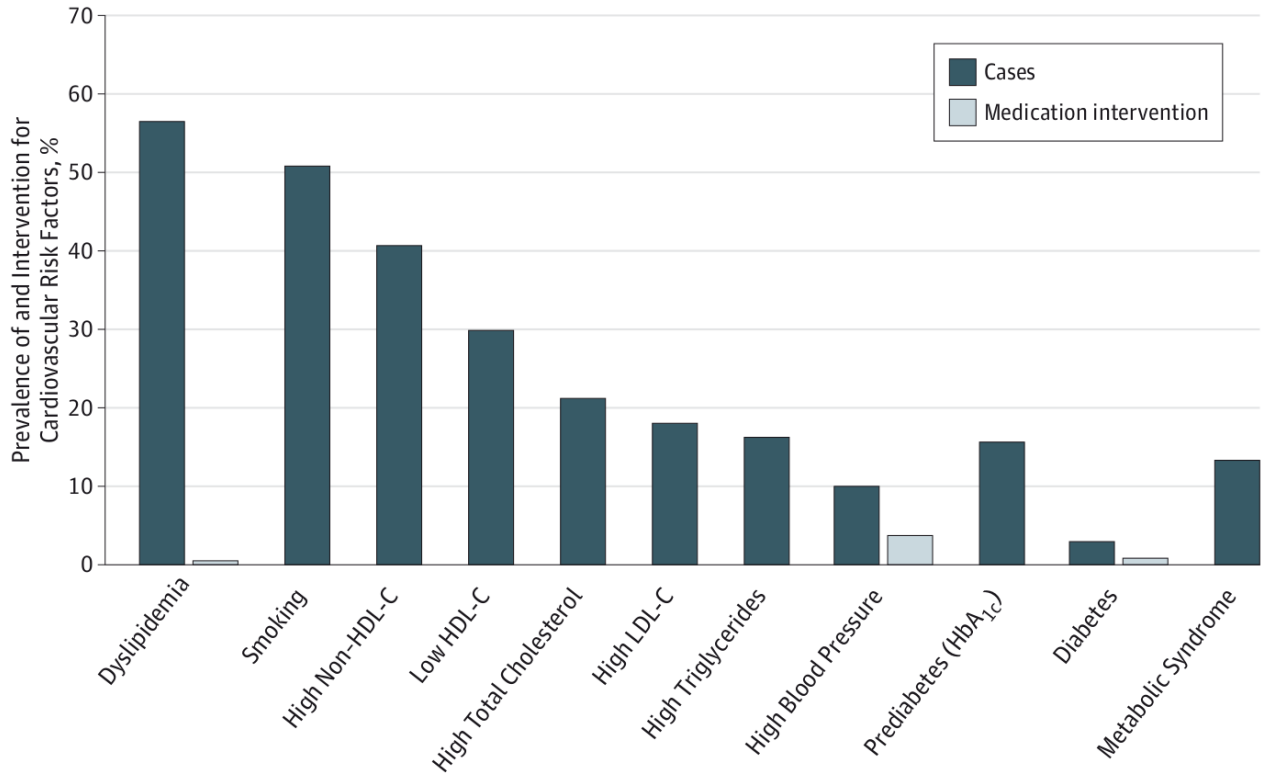
- Antipsychotic discontinuation during the first years of illness is associated with increased relapse risk (Wunderink et al 2007)
- A small number of patients do not relapse after antipsychotic discontinuation , but we do not know how to predict relapse
- Using minimum effective doses is associated with better long term outcome at 7 years (Wunderink et al 2013)
- Best strategy now is to prescribe continuous antipsychotic maintenance treatment using the lowest effective doses

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

8. 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

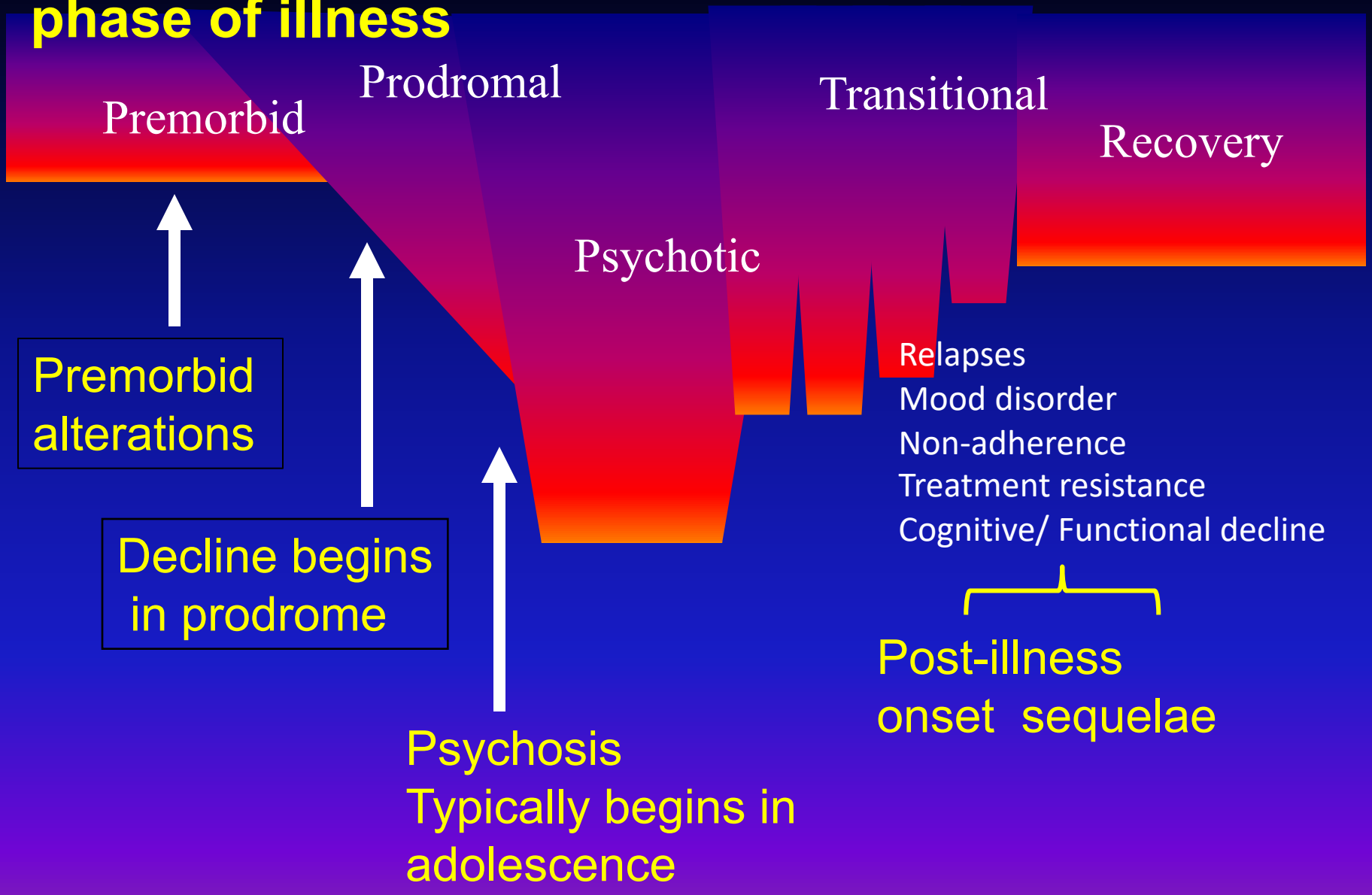


Correll et al JAMA Psychiatry 2014

Questions

- The art of developing a therapeutic alliance
- The art of sharing the diagnosis and prognosis with our patient and his/ her family
- The art of shared decision making
- The art of prescribing
- Tailoring treatment to the phase of illnes

Treatment of psychosis needs to be tailored to phase of illness



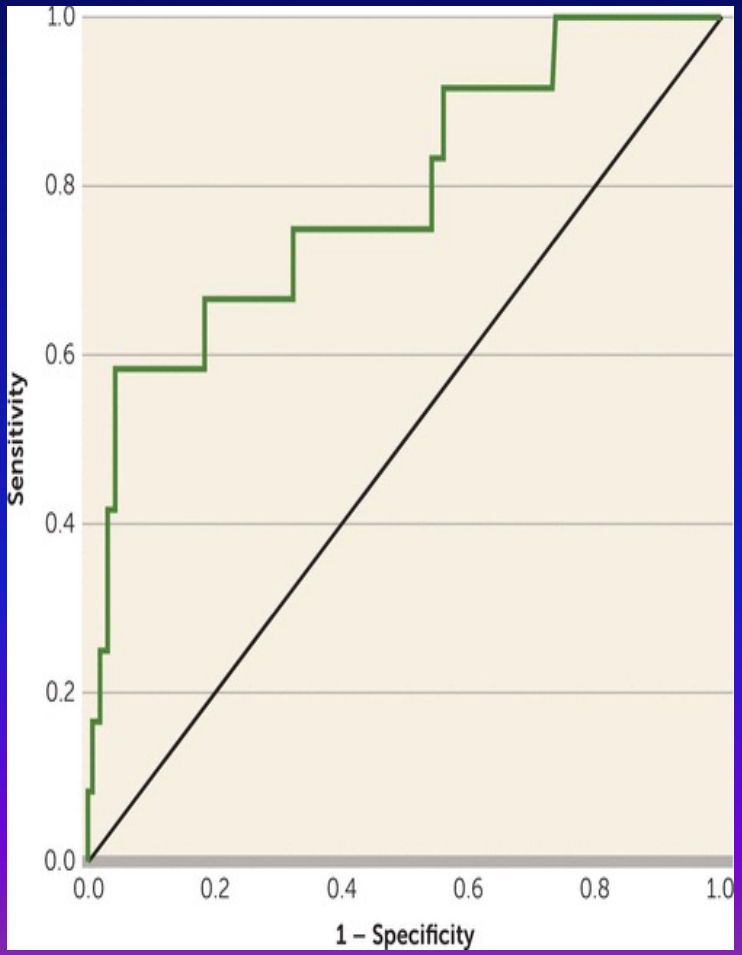
Psychosis is actually a "late" stage of schizophrenia!

The prodromal phase of psychotic illness

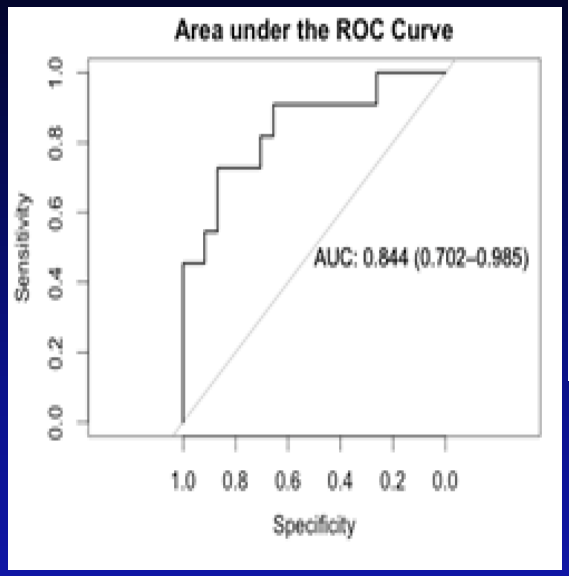
- ***Jeff's grades began to decline during high school and his grades were mostly Cs by his junior year. He had increasing anxiety and feelings that he had more important missions in life than just getting a college degree.. He withdrew socially, and began to post garbled political messages. on twitter***

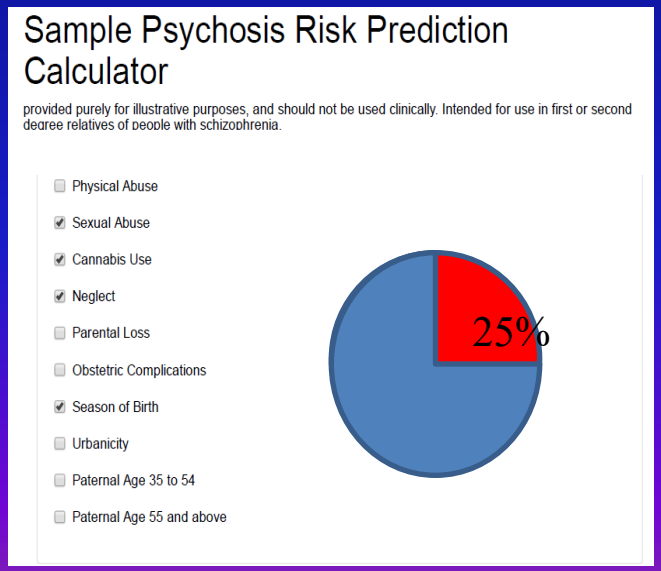
Prediction of risk in CHR and FHR

Risk calculator predicts conversion to psychosis in Clinical high risk individuals
Cannon et al 2016



Polyenvirome risk score predicts conversion to psychosis in Familial high risk individuals
Padmanabhan et al 2016





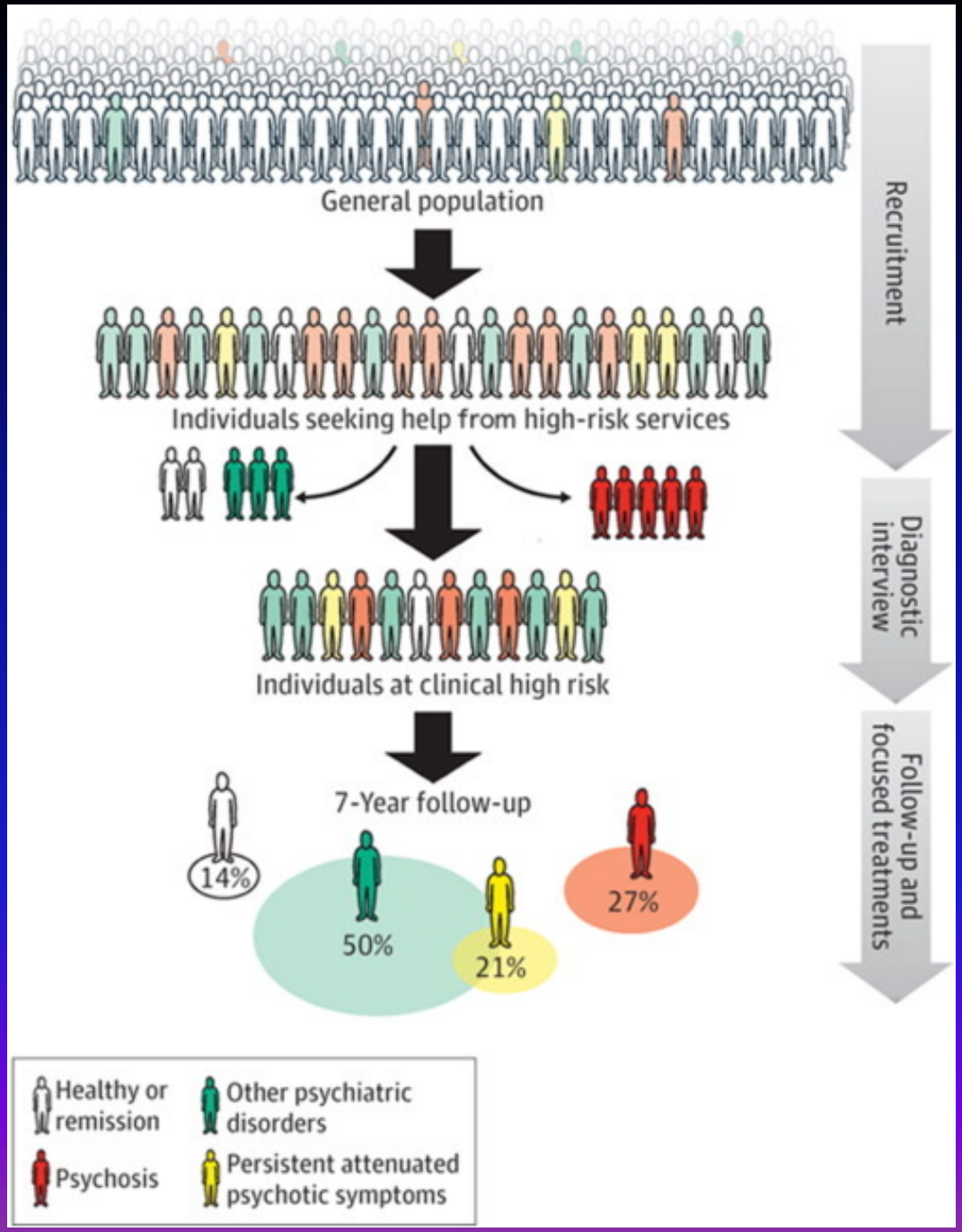
https://kesh-lab.shinyapps.io/PERS-calc

Atypical antipsychotics may reduce conversion to psychosis, but potential benefits are limited by side effects

Cognitive behavior therapy and family focused treatment have modest benefits to prevent conversion to psychosis

Cognitive remediation improved cognition and functioning, but no data yet on preventing psychosis

Devoe et al 2019 Early Interventions in Psychiatry

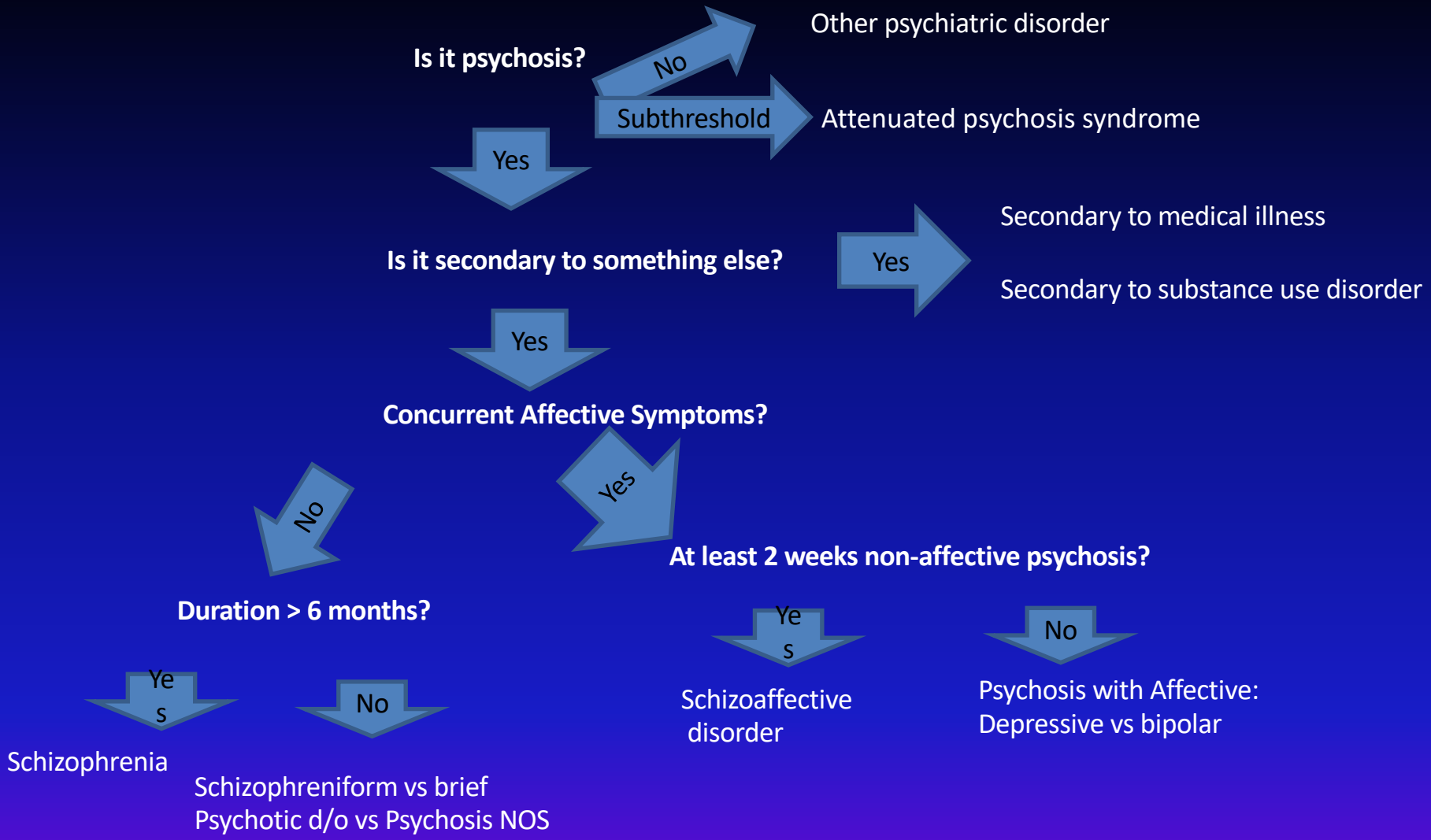


Psychotic phase

- ***During his second year of college, Jeffrey began believing that he is destined to become the President of the United States and that FBI and the CIA were"vetting him" to be groomed to the highest office. He was hearing voices commanding him to go to the white house and occupy the oval office***

Diagnostic questions to consider in every new onset patient with psychosis:

- Is this really a psychotic disorder?
- Is the presentation of the psychosis atypical?
- Is the medical condition or substance use temporally related to the psychosis?
- Is the psychosis Explainable as a direct physiological consequence of a medical illness or substance use?
- Is the psychosis not better explained by a primary psychotic disorder, or another mental disorder?
- Is a medical illness the cause, coincidental, or a consequence of the illness?



Psychosis Differential diagnosis

Recommended workup

- **A. First line assessments in every new patient with psychosis:**
  - Neuropsychiatric and medical History
  - Neurological /physical exam
  - Neuropsychological testing.
  - Laboratory Investigations: complete and differential blood count, erythrocyte sedimentation rate, glucose, electrolytes, thyroid function tests, liver function tests, urinary drug screen.

- **B. Second line assessments in patients with high index of suspicion**
  - Blood: Rapid Plasma Reagin (RPR) to rule out syphilis; HIV testing; serum heavy metals; copper and ceruloplasmin levels, Serum calcium levels, Autoantibody titres (e.g. antinuclear antibodies for lupus) ; B12, Folate levels; arylsulphatase –A levels
  - Karyotyping.
  - Urine: culture and toxicology; Urine drug screen; heavy metal screen
  - Imaging: MRI/CT/ PET/SPECT of the brain
  - Electrophysiological studies: EEG, Polysomnography; Evoked potentials
  - Cerebrospinal fluid analyses: Glucose, Protein, cultures; cryptococcal antigen

First-Generation Antipsychotics (FGAs)

Drug	Dose Range	Side Effects
HIGH-POTENCY		High selectivity for D_2
Haloperidol	6-20 mg/day	EPS
Fluphenazine	6-20 mg/day	EPS
MID-POTENCY		Medium selectivity for D_2
Perphenazine	8-64 mg/day	Moderate-high EPS, mild sedation
Loxapine	30-100 mg/day	Moderate EPS, moderate sedation
LOW-POTENCY		Low selectivity for D_2; H1, AChR, AR antagonism
Chlorpromazine	100-1000 mg/day	Sedation, anticholinergic side effects, hypotension

AChR=acetylcholine; AR=adrenergic; EPS=extrapyramidal symptoms; H1=histamine.

Buchanan RW, et al. *Schizophr Bull*. 2010;36(1):71-93.

Second-Generation Antipsychotics (SGAs)

Drug	Dose Range	Side Effects
Clozapine	25-900 mg/day	Sedation, weight gain, agranulocytosis
Olanzapine	5-20 mg/day	Sedation, weight gain, dyslipidemia
Risperidone	0.5-8 mg/day	Sedation, weight gain, hyperprolactinemia
Paliperidone	3-6 mg/day	Sedation, weight gain, hyperprolactinemia
Quetiapine	25-750 mg/day	Sedation, weight gain, postural hypotension
Asenapine	10-20 mg/day	Sedation, weight gain, EPS
Iloperidone	12-24 mg/day	Sedation, moderate weight gain
Ziprasidone	40-160 mg/day, with food	Akathisia, QTc prolongation, minimal weight gain
Lurasidone	40-160 mg/day, with food	Akathisia, EPS, minimal weight gain Procognitive?
Amisulpiride	**400- 800 mg/ day**	**Sedation, hyperprolactinemia**

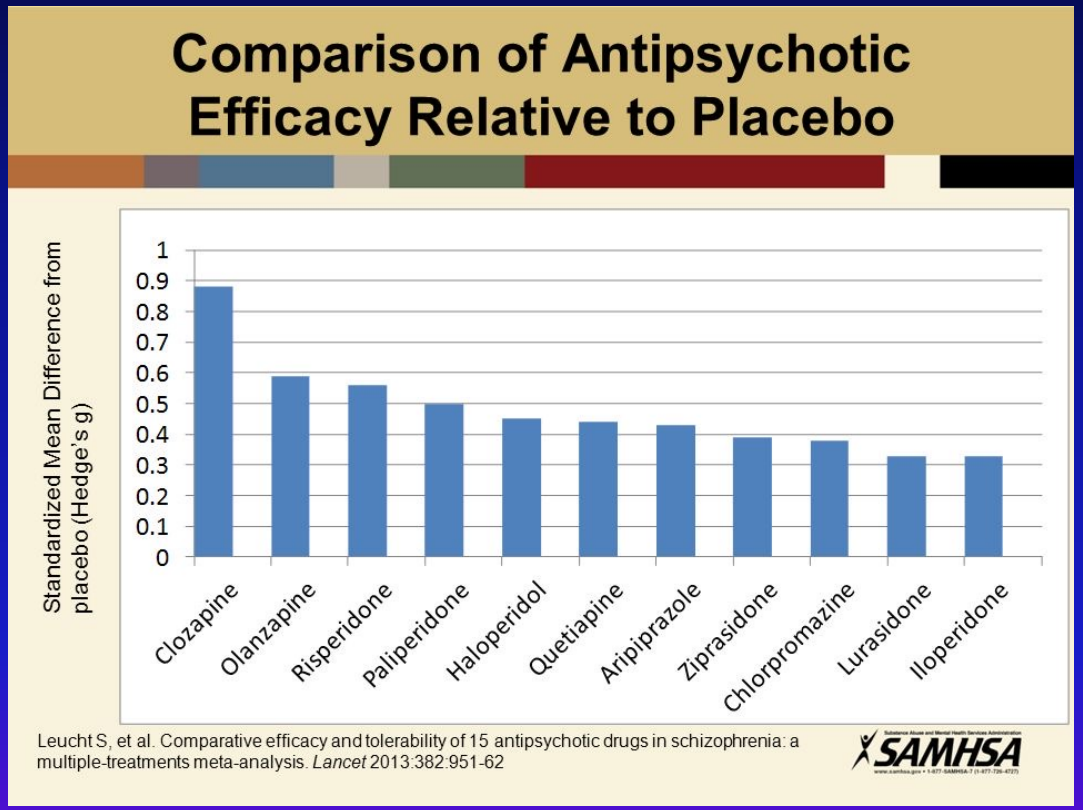
Partial Agonist/Antagonist Antipsychotics

Drug	Dose Range	Side effects
Aripiprazole partial agonist at presynaptic and post-synaptic D_2 receptors	10-30 mg/day	Akathisia, activation, some weight gain, tremor **Can reverse prolactin increases**
Brexpiprazole partial agonist activity at serotonin 5-HT_{1A} and dopamine D_2	2-4 mg/day	Akathisia, insomnia, minimal weight gain; **Has antidepressant effects**
Cariprazine partial agonist at the dopamine D3 and D2, 5HT2a and b-antagonist	3-6 mg/day	Akathisia, EPS, insomnia, tremor, minimal weight gain; **Good for Negative symptoms?**
Lumateperone serotonin, dopamine and glutamate	42 mg single daily dose	Akathisia, EPS, insomnia, tremor, minimal weight gain **Good for Negative symptoms?**

Kane JM, et al. *J Clin Psychiatry*. 2002;63:763-771; Kane JM, et al. *Schizophr Res*. 2016; 174:93-98; Citrome L. *Clin Schizophr Relat Psychoses*. 2016; 10:109-119; Corponi et al Europian Neuropsychopharmacology 2019

Treatment Selection with Antipsychotics

- All antipsychotics are effective against psychotic symptoms
- Clozapine more effective than other agents in otherwise treatment-refractory patients
- SGAs have lower risk of EPS and TD than FGAs
- Some SGAs (clozapine, olanzapine, Quetiapine have significant metabolic side effects
- FEP patients respond well to relatively low doses of antipsychotics

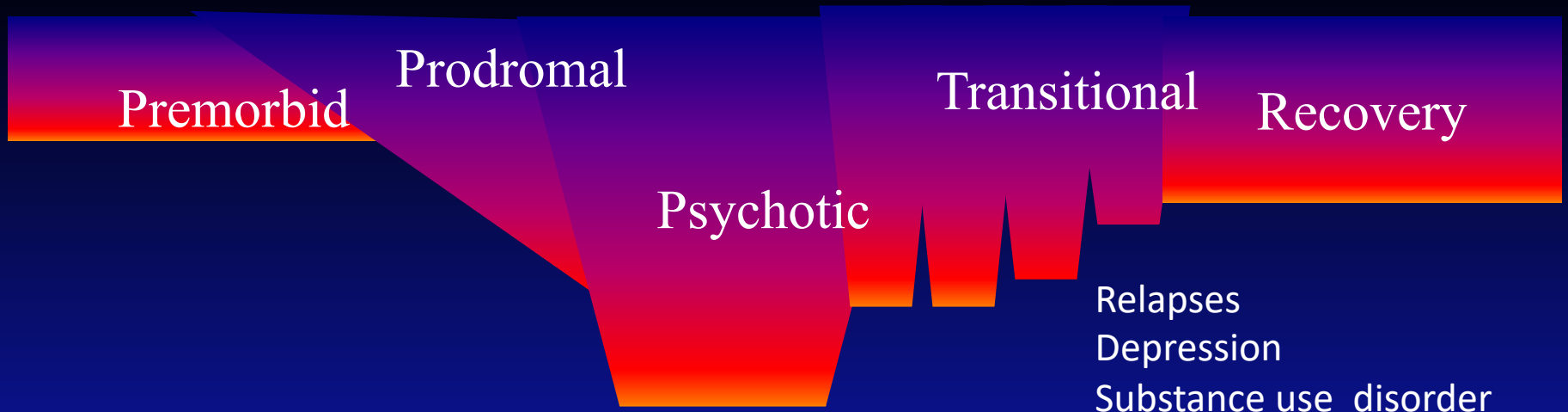


SGA=second-generation antipsychotic; FGA=first-generation antipsychotic; EPS=extrapyramidal symptoms; TD=tardive dyskinesia.

Bruijnzeel D, et al. *Asian J Psychiatr*. 2014;11:3-7.

Antipsychotic side effects

	EPS/TD	Dyslipidemia	Weight gain/T2DM	Elevated prolactin	Anticholinergic effects	Orthostatic hypotension	QTC prolongation
*First generation**							
chlorpromazine	+	+++	+++	++	+++	+++	+++
haloperidol	+++	+	+	+++	+/-	-	++ (+++ if IV)
fluphenazine	+++	+	+	+++	+/-	-	+/-
*Second generation**							
aripiprazole	+	-	+	-	-	-	+/-
asenapine	++	-	++	++	-	+	++
brexpiprazole	+	+	+	+/-	+/-	+/-	+/-
lurasidone	++	+/-	+/-	+/-	-	+	+/-
olanzapine	+	++++	++++	+	++	+	++
paliperidone	+++	+	+++	+++	-	++	++
pimavanserin	+/-	-	+	-	+	++	+
quetiapine	+/-	+++	+++	+/-	++	++	+++
risperidone	+++	+	+++	+++	+	+	++
ziprasidone	+	+/-	+/-	+	-	+	+++ (BBW!)
clozapine	+/-	++++	++++	+/-	+++	+++	++

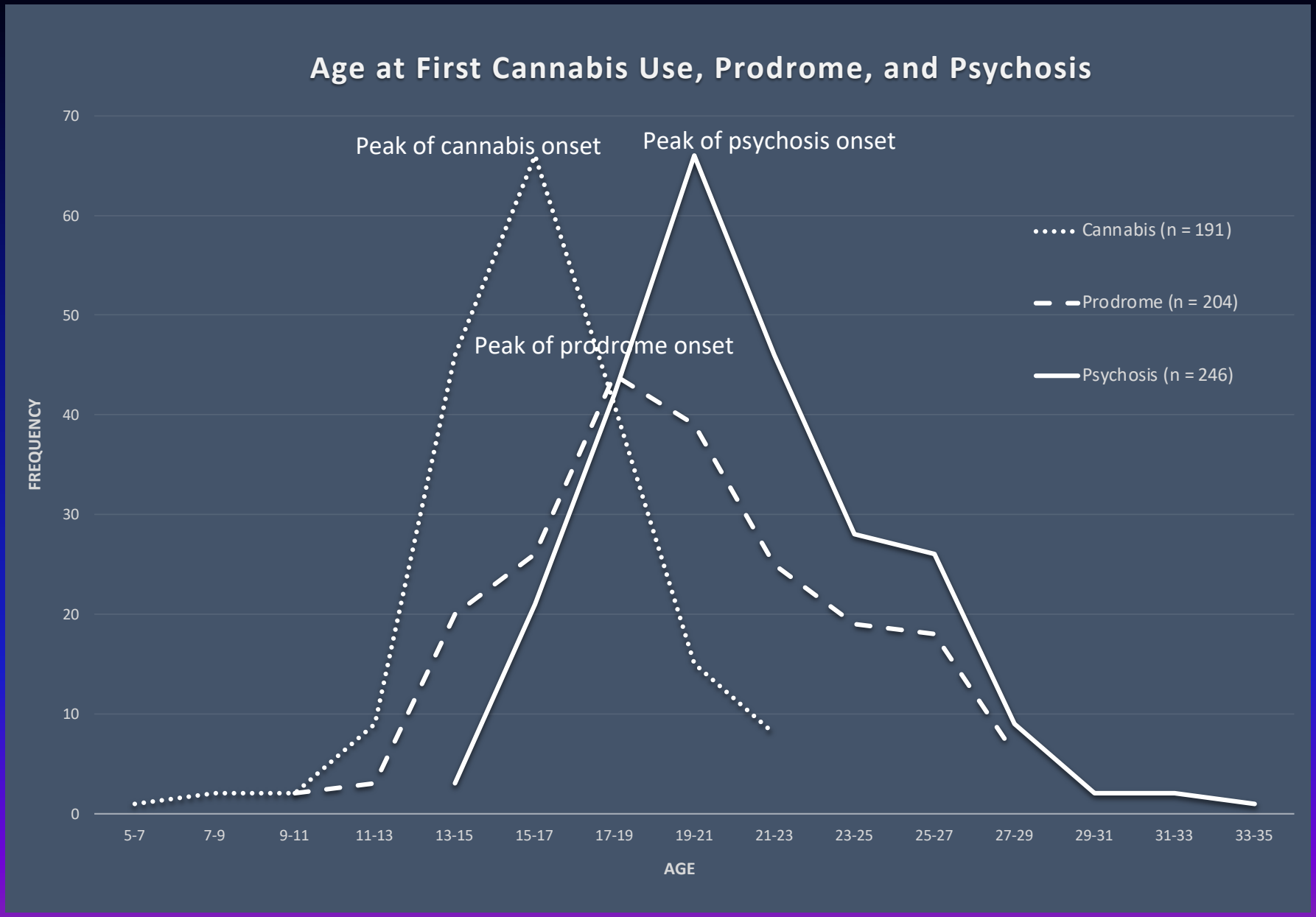


Jeffrey- continued

- ***Over the past 4 years, intermittently relapses because of poor adherence as well as forgetfulness. he has few significant friendships and has no steady job. He continues to be unmotivated, depressed, and continues to have "presidential" delusions.***

Cannabis and Psychosis

- Adolescent marijuana use is a risk factor for psychotic disorder
  - Early, frequent, high-potency
- THC is the psychoactive compound in marijuana plant and can maintain psychosis/interfere with medication effects among those with established psychosis ("THC sensitivity")
- Many (>40%) of our FEP patients have a current or past cannabis habit and nearly all (>80%) have some degree of exposure (Kline et al., under review)
- Given the high prevalence, often hard to tell whether psychosis is "caused by" vs. "comorbid with" cannabis



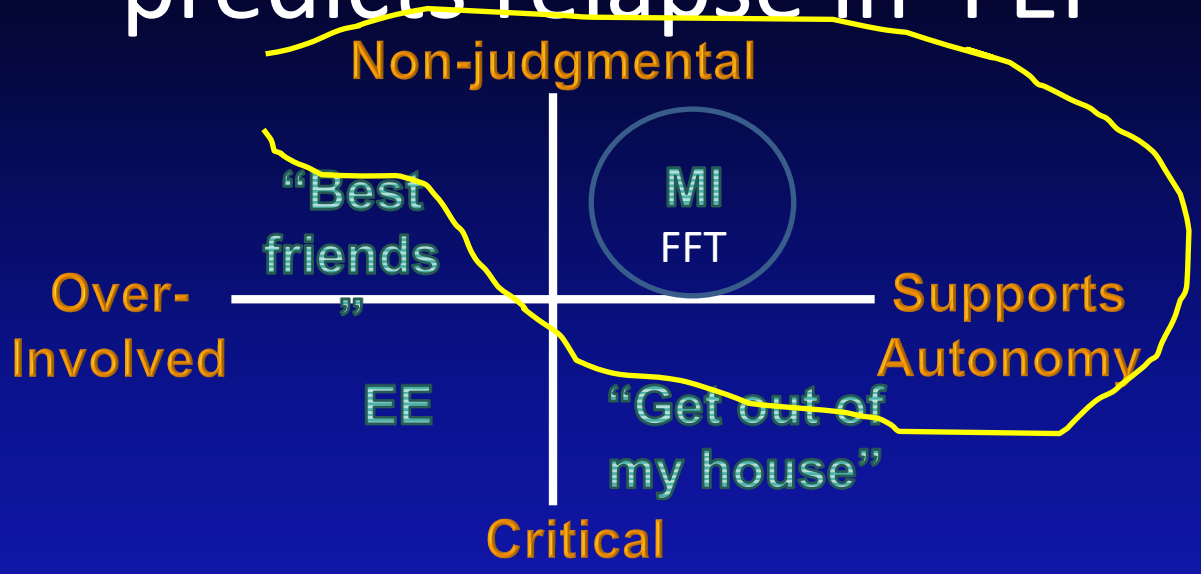
Kline et al., under review

Addressing Cannabis and other SUD in FEP

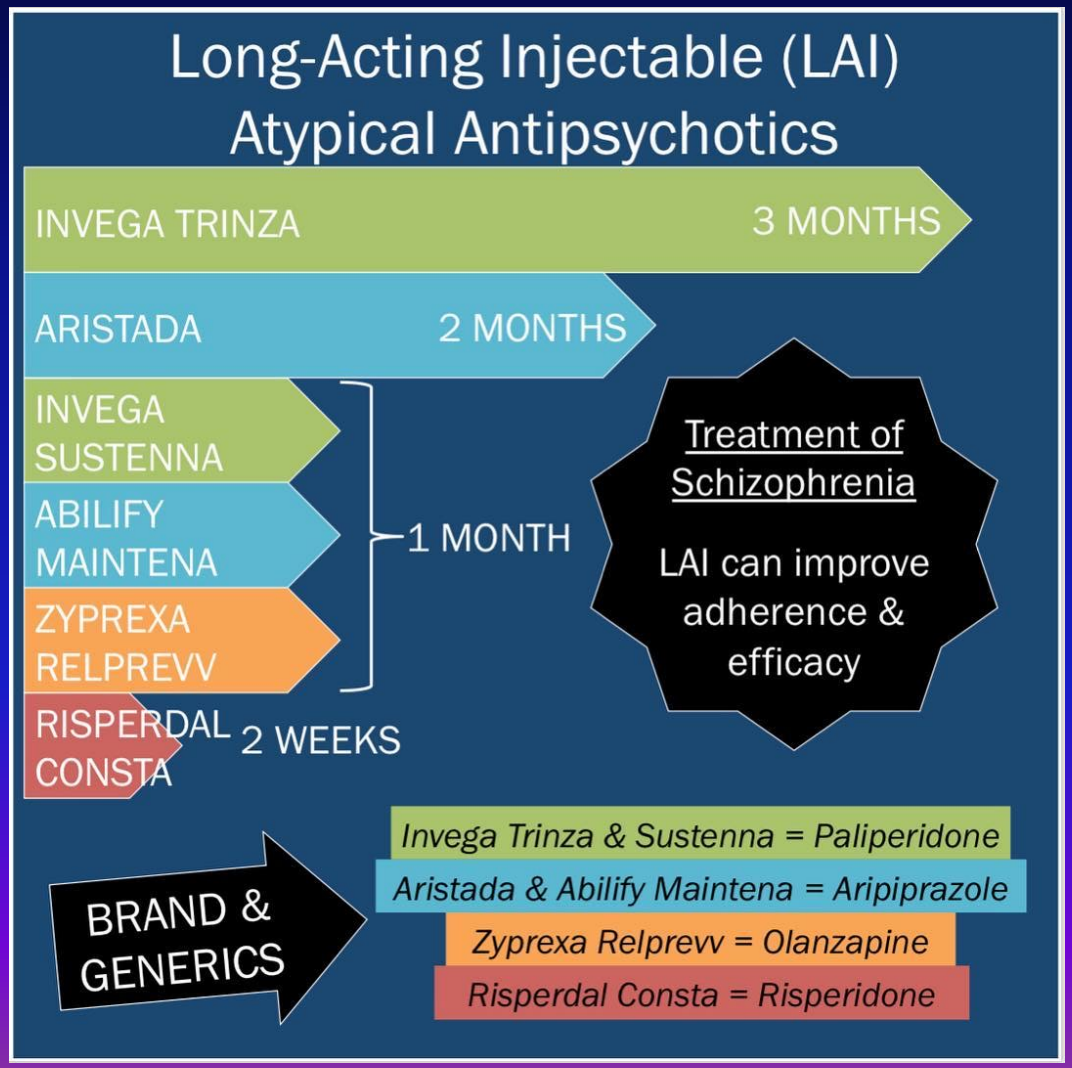
- Heavy cannabis users did worse in Navigate relative to TAU (??)
- Approaches to try: flexible, needs-based treatment; motivational interviewing; family involvement; contingency management
- Harm reduction ideas: use flower instead of extracted resins; avoid high-sativa strains; avoid keeping vape pen ever-present; try limited schedule of use; CBD is fine
- This may be an area for policy advocacy (e.g., establish THC potency limits; ban preparations that are attractive to children)

Expressed Emotion predicts relapse in FEP

- Got a bad rap – parent blaming
- Message to parents: it's not your fault, but you can have an impact – a message of HOPE without BLAME
- EE is often understood and assessed as a communication style/speech act
- Motivational Interviewing (emphasis on absolute worth & autonomy) is conceptual flip of EE (critical, controlling)



Non-adherence: Early introduction of long acting antipsychotics?



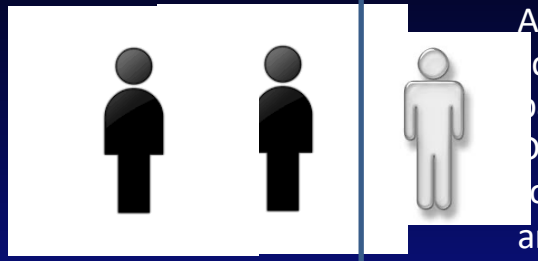
Lian et al Efficacy of long-acting injectable versus oral antipsychotic drugs in early psychosis: Early Interventions in Psychiatry 2019 :

Considering only RCTs revealed advantages of LAIs over OAPs in terms of hospitalization rates

INVEGA HAFYERA

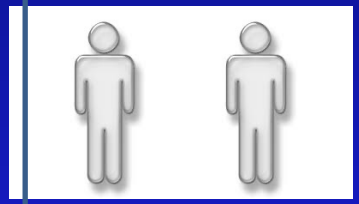
1092-1560 mg

TREATMENT RESISTANCE: CONSIDER CLOZAPINE EARLY



About a third of
chizophrenia
atients
o not respond
o conventional
antipsychotics
(typical or
atypical)

Treatment resistance



About a third of schizophrenia patients
Do not respond to clozapine

? ECT ?? Addition of D2 blocker
Psychotherapy

kane criteria for treatment resistant schizophrenia

Resistant Schizophrenia

Kane's criteria (Arch Gen psychiatry, 1988):

≥ 3 Antipsychotic Treatments, ≥ 2 Chemical classes, doses equiv 1000 mg/d chloropromazine, 6 weeks, without significant relief.

Before concluding that patient has Treatment resistance , verify:

- Correct diagnosis (of a psychotic disorder)?
- Continuing psychosocial stressors?
- Comorbid condition (such as depression or substance abuse)?.
- Compliance (Is patient is taking the meds?)
- Concentration (Is level within therapeutic limits?)

Summary

- Developing a positive therapeutic alliance is critical for successful management.
- **Sharing the diagnosis** with patients and caregivers is an important early step in management; consider the INSPIRES and HOPE approach.
- **Shared decision making** can enhance therapeutic alliance and improve outcomes.
- There is a science and an art to prescribing
- Tailor the treatment to the individual patient and to the phase of illness

National Institute of Mental Health

Mass DMH Department of Mental Health

Thank you!

DISCLOSURES
NIMH
NARSAD
Baer Foundation
Natalia Foundation
Massachusetts Department of Mental Health

Editor Schizophrenia Research

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals. Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

CONNECT WITH US

MHTTCnetwork.org

Sign-Up for Newsletter

MTTC News

SAMHSA

Substance Abuse and Mental Health Services Administration