Expanded Uses of Long-Acting Injectibles Antipsychotic Medications for Community-Level Schizophrenia Management

ANNUAL CONVENTION & SCIENTIFIC ASSEMBLY
Psychiatry Section

TUESDAY
August 4, 2015
7:00 – 11:00 AM
Room: 320
MORNING SESSION
Expanded Uses of Long-Acting Injectables Antipsychotic Medications for Community-Level Schizophrenia Management

Needs Assessment:
Individuals with co-morbid chronic medical conditions and psychiatric illness are a costly and complex patient population, at high risk for poor outcomes. For individuals with severe mental illness such as bipolar disorder or schizophrenia, life expectancy may be up to 20 years shorter. And individuals with major depression die, on average, 5 to 10 years before their age-matched counterparts. Because the majority of this premature mortality is due to cardiovascular risks and diseases, there is a critical need to engage physicians around the integrative care of chronic mental and medical illnesses. The five most common serious mental illnesses (SMI) and medical co-morbidities were identified as hyperlipidemia (45%), hypertension (44%), asthma (28%), arthritis (22%), and diabetes (21%). Controlling for age, study site, and Medicaid status, racial/ethnic minorities with SMI were almost twice as likely as Caucasians to be diagnosed with hypertension and diabetes; women were almost twice as likely as men to be diagnosed with diabetes; and people with schizophrenia were around half as likely as those with other disorders to be diagnosed with hypertension and arthritis. Age was positively related to all conditions except asthma. Treatment prevalence was below 70% for approximately half of ongoing conditions. These results suggest a high level of medical vulnerability and need for coordination of health and mental health services in this at-risk patient populations.

Promoting educational opportunities related to prophylactic work between psychiatry and the general practice therapeutic areas may be beneficial in diminishing negative indicators for physical conditions such as cardiovascular disease, diabetes mellitus and overweight in patients with mental disorders. Research finds that physician contact for patients' co-occurring physical diseases and mental disorders was almost evenly divided between public or private psychiatry (46%-91%) and general practice (41%-93%). Patients being treated by psychiatrist with medical conditions and patients treated by primary care physicians (PCPs) with mental health disorders each had poorer clinical outcomes than their counterparts.

The session is based on reviewing mental illnesses and medical conditions reciprocally for joint clinical and medication strategies to deliver comprehensive mental and medical care for patients served in both psychiatric specialty or primary care settings. The CCEM intervention will review ways to redesign and adapt the care model by reviewing new schizophrenia clinical guidelines/protocols related to the role of long-acting injectable antipsychotics (LAIAs) in community settings. The CCEM strategy should heighten the diagnostic and treatment proficiencies of psychiatrists and PCPs thereby enhancing patient quality of life while improving health outcomes for a range of mental/medical health conditions across patient populations and practice settings. The live session is designed to: 1) meet educational needs for advanced level schizophrenia management of psychiatric specialists, 2) synchronized psychiatrist and PCP session with basic schizophrenia information on managing schizophrenia patients in primary care settings with special emphasis on managing antipsychotic medications and appropriate referral indications while giving the psychiatrist the opportunity to hone their skills by serving as mentors for the PCPs during the session interactive events; and 3) ensure structured but informal opportunities for open discussions between the attendees, faculty, and facilitators on office based use of antipsychotic medications and the importance of adverse event management in this process.

The session is designed for psychiatrists and includes presentations reviewing clinical guidelines and medication regimes related to more complex schizophrenia therapeutic issues related to diagnosis and management. The quandaries between the over diagnosis of Blacks with schizophrenia while there continue to be treatment deficiencies are serious but when coupled with the number of patients also affected by other co-morbid medical conditions treatment accuracy in schizophrenia management becomes crucial and possibility life-threatening. To overcome this dilemma it is essential for physicians that treat AA and other minority patients with schizophrenia to have information on proper uses of new diagnosis, treatment medication options. Another important variable for this continuing medical education course is that it focuses on reinforcing patient accessibility to quality improvements by enhancing the treatment efficiencies of the physicians' current treating these patients. There have been advancements in the medication management for schizophrenia, particularly LAIAs. The symposium will use the CCEM educational approach to review the new proposed uses for LAIAs medications at the community-level and the guidelines on which these options are based.

The session will focus on the reasons for poor adherence to oral antipsychotics which is the most common cause of treatment relapse. The discontinuation rate for oral antipsychotics in schizophrenia ranges from 26% to 44%, and as many as two-thirds of patients are at least partially non-adherent, resulting in increased risk of hospitalization and re-hospitalization. A very helpful approach to improve adherence in schizophrenia is the use of LAIAs, although only a minority of patients receive these. Reasons for underutilization may include negative attitudes, perceptions, and beliefs of both patients and health care professionals. Research shows, however, significant improvements in adherence with LAIAs compared with oral drugs, and this is accompanied by lower rates of discontinuation, relapse and hospitalization. In addition, LAIAs are associated with better functioning, quality of life and patient satisfaction. The educational scenario should encourage broader LAIAs use at the community-level especially among patients with a history of non-adherence with oral antipsychotics.

Schizophrenia is a relapsing and evolving condition, which requires treatment continuity. Increasing evidence shows that antipsychotic discontinuation is associated with relapse in most patients, and that early interventions have a positive impact on long-term outcomes. Considerable effort has been made toward improving adherence, including the development of LAIAs. Long-acting injectable antipsychotic have traditionally been reserved for repeated non-adherence patients; currently, several misconceptions prevent their more widespread use. The recent introduction of LAIAs formulations of atypical antipsychotics and the encouraging results in terms of the reduction in relapse rates and avoidance of hospitalization warrant a reassessment of the role of LAIAs in the management of schizophrenia. There is the need to change the attitude of providers and patients toward LAIAs--no longer a treatment of last resort, but a component of multimodal strategies leading patients to remission and rehabilitation. It is to that end, the session with the psychiatrists will be based on assisting to examine the value and clinical efficacy of community-level uses of LAIAs.

Learning Objectives:
1. Describe the new medication treatments currently used in community settings to treat schizophrenia patients.
2. Identify reasons for selecting certain medication strategies to treat patients with schizophrenia in community settings.
3. Assess the latest efficacy and safety data on current and emerging antipsychotic therapies for schizophrenia.
4. Distinguish the different optimal medication treatments for first-episode patients and those with multi-episode schizophrenia.
5. Appraise the long-term benefits of using antipsychotic treatments as maintenance therapy to address issue of relapse prevention with antipsychotic drugs.
6. Outline the guideline related to the use of LAIAs in community-level practice settings.

Core Competencies:
Patient-centered care, Interdisciplinary teams, Quality Improvement, and Informatics
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<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker/Lead Facilitators</th>
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<tbody>
<tr>
<td>1:30 – 1:50</td>
<td>Schizophrenia New Paradigms “First-Episode” and “Community Treatment”: Using Long-Acting Injectable Antipsychotic Medications to Reduce Relapse and Hospitalizations</td>
<td>William B. Lawson, MD, PhD, DLFAPA, Associate Dean of Health Disparities, Dell Medical School, University of Texas at Austin and Huston-Tillotson University, Austin, Texas</td>
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<td>1:50 – 2:00</td>
<td>Questions and Answers</td>
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<td>2:00 – 2:20</td>
<td>Assessing Schizophrenia Medications: Review of Benefits and Risks for Managing Long-Acting Injectable Antipsychotics in Community Practices</td>
<td>Rahn Kennedy Bailey, MD, DFAPA, DFAPA, Chairman, Psychiatry and Behavioral Medicine, Professor, Psychiatry and Behavioral Medicine, Maya Angelou Center for Health Equity, Wake Forest School of Medicine, Winston-Salem, North Carolina</td>
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<td>2:20 – 2:30</td>
<td>Questions and Answers</td>
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<td>2:30 – 2:50</td>
<td>Implementation of New Guidelines: Customizing Patient Treatment Plans to Address Mental and Medical Comorbidity and Medication Adverse Events</td>
<td>Annelle B. Primm, M.D., MPH, Department of Psychiatry, John Hopkins School of Medicine, Baltimore, Maryland</td>
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<td>2:50 – 3:00</td>
<td>Questions and Answers</td>
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<td>3:00 – 3:15</td>
<td>Audience Response (A/R) Session, Post-Test with Q&amp;A</td>
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<td>3:15 – 4:00</td>
<td>Panel Case Vignettes and Problem-Solving Exercises</td>
<td>Lead Facilitators: Diane Buckingham, M.D., Private Practice, Overland Park, Kansas, and Mikki Barker, D.O., Medical Director, Wendell Street Psychiatric, LLC, Fairbanks, Alaska</td>
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<td>4:00 –</td>
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William D. Richie, M.D., DFAPA is a board certified Forensic and General Psychiatrist who has provided psychiatric and forensic services in a wide variety of settings. After receiving a combined B.A/M.D degree from the University of Missouri in 1983, Dr. Richie completed his psychiatry residency training at Howard University in 1990. As a psychiatrist for the USAF and then entering a private practice with Howard University Hospital, (as Assistant Professor of Psychiatry and the director of the in-patient psychiatry service) he sought and developed teaching opportunities. He went on to obtain a fellowship in Forensic Psychiatry at the Louisiana State University Medical Center, (New Orleans), in 1998, (under Dr. Rahn Kennedy Bailey). He was accepted as a Fellow of the American Psychiatric Association in December of 2009. In additional to clinical duties, Dr. Richie has publications, national and international lectures and seminars, has media appearances and provided expert testimony in both civil and criminal forensic cases throughout the United States.

While the Lead Psychiatrist for the Center for Forensic Services at Western State Hospital in Tacoma, Washington, Dr. Bill Richie was recruited in January, 2012 (by the President-Elect of the NMA and Meharry Medical College Chairman of Psychiatry, Dr. Bailey), to join the faculty of the Department of Psychiatry and Behavioral Sciences as the Externship Program Director and Associate Director of Residency Training. In July 2012 he was appointed Residency Training Director. In August of 2012 Dr. Richie was elected as the Chair (Elect) of the Psychiatry section of the National Medical Association. In December 2012 Dr. Richie was appointed as a Distinguished Fellow of the American Psychiatric Association and was honored in May of 2013 in a ceremony during the annual meeting of the APA. Dr. Richie is now Interim Co-Chairman of the Department of Psychiatry and the Behavioral Sciences at Meharry Medical College. William D. Richie is a competent, dedicated physician-executive, an educator, mentor and a motivator. He is committed to providing high quality mental health services to the community and to the training aspiring psychiatrists and other life-long learning devotees.
Dr. Lawson is currently Associate Dean for Health Disparities at the Dell Medical School University of Texas at Austin and Huston-Tillotson University in Austin, Texas. He was past Professor and Chairman of the Department of Psychiatry and Behavioral Sciences at Howard University Health Sciences, Washington, DC. He is also a professor in the graduate faculties of psychology and pharmacology. He is President of the DC chapter of Mental Health America, Past President of the Washington Psychiatric Society, a Distinguished Life Fellow of the American Psychiatric Association and a member of the American College of Psychiatrists. He is past Chair of the Section of Psychiatry and Behavioral Sciences of the National Medical Association, and past president of the Black Psychiatrists of America. He received the American Psychiatric Foundation Award for Advancing Minority Mental Health, and was given the 2014 Solomon Carter Fuller Award by the American Psychiatric Association, which honors a Black citizen who has pioneered in an area which has significantly benefited the quality of life for Black people. He was inducted in Sigma XI the scientific honor society and Alpha Omega Alpha, the medical honor society. National Alliance for the Mentally Ill Exemplary Psychiatrist Award and the National Alliance for the Mentally Ill, Outstanding Psychologist Award. He was twice named one of “America’s Leading Black Doctors” by Black Enterprise Magazine, A “Super Doctor” by the Washington Post many times, and Top Doctor by US news and World Report multiple times. He was the Andrea Delgado Honoree and Lecturer for the Black Psychiatrists of America, received the Jeanne Spurlock Award from the American Psychiatric Association, received the E.Y. Williams Clinical Scholar of Distinction Award from the Psychiatry and Behavioral Sciences Section of the National Medical Association, a Multicultural Workplace Award from the Veterans Administration for his outstanding contributions to the advancement of diversity and multicultural understanding. He received the Howard University College of Medicine Research Award, the Faculty Senate Creativity and Research Award, and Profiles in Courage Award. He has over 180 publications and has received federal, industry, and foundation funding to study and treat severe mental illness, substance abuse, and AIDs.
William B. Lawson, M.D., Ph.D., D.L F.A.P.A

Slide 1
Schizophrenia New Paradigms: "First-Episode" and "Community Treatment": Using Long-Acting Injectable Antipsychotic Medications to Reduce Relapse and Hospitalizations

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Slide 2
Speaker Disclosure of Financial Relationship

Grants: Elixirx, Associates, Companion DX, Health Analytics
Speaker Bureau: Orlando

Discussion of off-label or investigational use: yes

Slide 3
The Problem

Slide 4
Treatment Received

Slide 5
Psychosis

- A loss of contact with reality, usually including false beliefs about what is taking place or who one is (delusions) and seeing or hearing things that aren't there (hallucinations).

Slide 6
What Is Schizophrenia?

- Schizophrenia is a chronic thought disorder that manifests itself through various symptoms during the course of the disease.
- Early in the course of schizophrenia, positive symptoms tend to dominate.
- Later in the course of the illness, negative, depressive, and cognitive symptoms may be more important, often interspersed with episodes of elevated positive symptoms.
Schizophrenia

- "The worst disease affecting mankind" as it primarily attacks the human properties considered most precious and distinguishing.
- Affects 1% of the world's population or 100 million people.
- Most chronic and debilitating illness.
- Victims become ill in their late teens and early 20s - lost opportunities.
- Patients exhibit a bizarre spectrum of symptoms.
- Social toll includes emotional and financial costs to families.

*Carpenter, NEJM 1994.

The Cost of Schizophrenia

- 1% prevalence; 2.5% of all health care costs.
- 22% of all mental health costs.
- 33% of all mental health beds.
- 25% of all hospital beds.
- 40% of all long term care days.
- 20% of all Social Security benefit days.
- <10% work.
- 33% of the homeless.
- Two thirds of costs public sector.

The Indirect Costs of Schizophrenia

- Morbidity.
- Affects 1% of population.
- Commonly strikes in teens/early 20s.
- Patients are often unable to work, require public assistance.
- Mortality.
- Mortality rate 4X general population.
- Shortened lifespan of a decade or more.
- Approximately 10% of patients with schizophrenia commit suicide.
- Often indifferent to health maintenance.
- Poor health habits.

Disparities in mental disorders: are they related?

- Depression thought to be rare among ethnic minorities.
- Bipolar disorder thought to be unknown.
- Schizophrenia believed to be far more common.
- Anxiety disorders seldom diagnosed.

Schizophrenia More Common in African Americans?

[Image of a person walking in a corridor, perhaps indicating a common setting for mental health patients.]

Problem: Schizophrenia Over-Diagnosed in African Americans

[Graph showing percentage of diagnoses by race.]

- African American (n = 56):
- White (n = 115):

[Legend includes categories such as Schizophrenia, Bipolar Disorder, Major Depression, Other.]

[Graph data source details at the bottom.]
Expanded Uses of Long-Acting Injectables Antipsychotic Medications for Community-Level Schizophrenia Management
**Slide 19**

![Genome-wide association study (GWAS).](image)

- Genetic material, or DNA, is made up of a sequence of molecular pairs, thousands of which string together to form genes. The GWAS involves tallying known common mutations in these pairs, in people with and without a condition. Variants that show up significantly more often in people with the condition are said to be “associated” with it.
- 128 gene variants have been found to be associated with schizophrenia, in 108 distinct locations in the human genome.

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**Slide 20**

![Immigration](image)

- “The increased incidence of schizophrenia in first-generation and second-generation immigrants is now a highly replicated finding” (Selten, 2015).
- “Research suggests that both first- and second-generation migrants are up to five times more likely to be diagnosed with schizophrenia in the UK than white British people. Racial discrimination within society is no blunder” (Harvey, 2011).

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**Slide 21**

![Time Line of Biologic Treatments for Psychotic Disorders](image)

**Slide 22**

![Percentage of Individuals Meeting Diagnostic Criteria for Schizophreniform Disorder at Age 26](image)

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**Slide 23**

**Recent Approvals**

- Ziprasidone
- Aripiprazole
- Paliperidone
- Iloperidone
- Asenapine
Expanded Uses of Long-Acting Injectibles Antipsychotic Medications for Community-Level Schizophrenia Management
Ziprasidone in Black Patients

**Objective:** To better understand the efficacy and tolerability of atypical antipsychotics among racial groups, we reviewed data from four short-term (4-6 weeks), fixed-dose, placebo-controlled trials of ziprasidone for black, white, and overall schizophrenic populations was compared to placebo using standard efficacy measures (Positive and Negative Syndrome Scale [PANSS] total, PANSS negative, Brief Psychiatric Rating Scale [BPRS], Clinical Global Impression-Severity [CGI-S], CGI-Improvement [CGI-I]).

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Test helps doctors select personalized medication for depression, PTSD at forefront

- Finding the right medicine to treat depression is largely trial and error, but now doctors can better choose medicines that are personally proven to work best on each patient.
- A personalized medicine company built around gene-profiling technology has tools that analyze how a person’s genome might affect their body’s response to medicine commonly prescribed to treat depression, posttraumatic stress disorder (PTSD), anxiety, bipolar disease, schizophrenia or other behavioral health conditions.
- The results of these tests tell doctors what medicines appear to not interfere with their patients genetic profile, medicines with the potential to interfere with it and those that are inescapable with a patient’s genetic makeup. While there’s no guarantee the medicine will always work, the test is clinically proven to double the chances that it will.

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Atypical Depot

- Risperidone
- Olanzapine pamoate
- Paliperidone palmitate
- Aripiprazole

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Schizophrenia Don’t Improve

- **DSM-III conceptualization (1980)**
  - “...a complete return to premorbid levels of functioning in individuals diagnosed with schizophrenia is so rare as to cast doubt upon the accuracy of the diagnosis”

- **Clinician’s illusion (1984)**
  - Recovering patients are seen infrequently or not at all, causing the majority of a clinician’s caseload to be those with the most severe illnesses.
Chestnut Lodge Follow-Up Study

- 187 patients were followed for an average of 19 years. Records from an index admission were used to categorize patients as having positive or negative symptoms.
- Patients with prominent negative symptoms had a worse course with more disability.
- Positive symptoms were related to the number of hospitalizations but not strongly related to functioning.

Vocation Rehabilitation in Serious and Persisting Psychiatric Illness

- Surveys indicate most psychiatric patients would like to work (60%-70%), but few do (10%-20%).
- Implicit acknowledgement of value of instrumental activity in the past (asylums, state hospitals)
  - Assigned tasks (farming, cleaning houses of staff)
- De-institutionalization movement and Americans With Disabilities Act prompted greater interest in helping persons with serious and persisting psychiatric illnesses obtain jobs in the community.

Cognitive Training: Effects on Employment Rate

Vocational Rehabilitation

- 3 approaches
  - Traditional brokerage (DVR)
  - Shelter/training (train and place)
  - Supported employment (place and train).
New Freedom’s* Definition of Recovery

Recuperation refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery.

*The New Freedom Coalition was established in 2002 to study the US mental health service delivery system and advise the President on methods to improve the system.

Three-decade-long study by the World Health Organization

- People with schizophrenia, a deadly illness characterized by hallucinations, disorganized thinking and social withdrawal, typically did far better in poorer nations such as India, Nigeria and Colombia than in Denmark, England and the United States.

Care and Remission

Most patients with schizophrenia in India are cared for by relatives and other social networks. The United States, by contrast, relies much more on medical and public infrastructure.
Social Policy (Vermont Study)

- Hope
- Rehabilitation
- Belief that each person, regardless of the severity of their condition, was capable of living a full and independent life in the community
Rahn Kennedy Bailey, MD, DFAPA, is Professor and Chair Department of Psychiatry and Behavioral Medicine and Executive Director Behavioral Medicine at Wake Forest Baptist Health in Winston-Salem, NC. In addition to his academic positions, Dr. Bailey is a member of Alpha Omega Alpha Honor Medical Society and has served as deputy representative to the American Psychiatric Association Assembly (APA) from the Black Caucus of the APA and as Board of Trustee Rutgers State University, New Jersey. He has interest in academic, research and forensic psychiatry. As a Yale University trained, board certified forensic psychiatrist his specialties include: determination of legal competency, sex offender assessments, criminal work in capital Punishment and civil work in personal injury. His passions and research interests have always been eliminating disparities, removing stigma, and enabling access as it relates to a person’s social context. This includes the wide range of individual, cultural, socioeconomic and political factors that influence health outcomes.

Dr. Bailey formerly served as 113th President of NMA (2012-2013), and Speaker of the House of Delegates of NMA (2009-2011). He is a recipient of Isaac Slaughter Memorial Leadership Award in 2010. Dr. Bailey was named as Region V Physician of the Year by the NMA (2006) for his exemplary efforts in coordinating medical care for victims of Hurricane Katrina. He received the NMA Postgraduate Physician Award in 1998.

Dr. Bailey was the principal investigator for HIV, COPE, PRIDE, and the Treatment Access Project II for the homeless at Elam Mental Health Treatment Center. Grants under his leadership reached over $3 million in 2012. Adult Continuum Care Grant, SISTER (Supported Intensive System of Treatment Empowerment and Recover) program, Rainbow Unit Grant, Adolescent and Family Treatment Program, Adolescent Day Treatment Grant, Substance Abuse Initiative Grant and many others. He has 45 peer-reviewed articles, 11 invited articles, 1 book and 4 book chapters published. He has given 45 academic Grand Rounds and 15 Hospital Grand Rounds lectures. Dr. Bailey is a member of several professional medical societies. He was named Outstanding Faculty by the University of Texas Medical School in Houston (2000). He has received a variety of academic awards and honors, including the Chester M. Pierce, MD, ScD, Resident Research Award (1995).
Objectives of this Presentation

- Review the Diagnostic Criteria as per the DSM V and also some of the key characteristics
- Compare the characteristics, side effects, and mechanisms of actions of atypicals and typicals antipsychotics
- Examine the data as to whether long acting injectable antipsychotics are beneficial in the treatment of schizophrenia.

Discipline

NO financial relationships with commercial interests to disclose.

Genetics

- The risk is highest for an identical twin of a person with schizophrenia, they have a 40-65% chance of developing the disorder.
- It occurs in 10% of people who have a first-degree relative with the disorder, such as a parent, brother, or sister.
- The lifetime prevalence of schizophrenia has been estimated to be approximately 1% in the U.S. (Bhugra, 2005).

Epidemiology

- The lifetime prevalence of schizophrenia has been estimated to be approximately 1% in the U.S. (Bhugra, 2005).
- The onset of schizophrenia usually occurs between the late teens and the mid 30s. (Usually appears earlier in males than females.)
- For males, the peak age of onset for the first psychotic episode is in the early to middle 20s; for females, it is in the late 20s.
Epidemiology (Continued)

- The first 5-10 years of the illness can be stormy, but this initial period is usually followed by decades of relative stability (though a return to baseline is unusual).
- Positive symptoms are more likely to remit than are cognitive and negative symptoms (see signs and symptoms).
- Although some variation by race or ethnicity has been reported, no racial differences in the prevalence of schizophrenia have been positively identified.

http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml

Signs and Symptoms

- Positive symptoms - Psychotic symptoms, hallucination are things a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. "Voices" are the most common type of hallucination in schizophrenia.
- Delusions are false beliefs that are not part of the person's culture and do not change. The person believes delusions even after other people prove that the beliefs are not true or logical.

Signs and Symptoms (continued)

- Thought disorder symptoms - are unusual or dysfunctional ways of thinking.
- One form is called "disorganized thinking," which is when a person has trouble organizing his or her thoughts or connecting them logically.
- Another form is called "thought blocking." This is when a person stops speaking abruptly in the middle of a thought.

Signs and Symptoms (Continued)

- Cognitive symptoms are subtle and may be difficult to recognize as part of the disorder. Often, they are detected only when other tests are performed.
- Cognitive symptoms include the following:
  - Poor "executive functioning" (the ability to understand information and use it to make decisions)
  - Trouble focusing or paying attention
  - Problems with "working memory" (the ability to use information immediately after learning it).
  - Cognitive symptoms often make it hard to lead a normal life and earn a living. They can cause great emotional distress.
  - Negative symptoms are associated with distortions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions.
Signs and Symptoms (continued)

- "Flat affect" (a person's face does not move or he or she talks in a dull or monotonous voice)
- Anhedonia (Lack of pleasure in everyday life)
- Inability to begin and sustain planned activities
- Speaking little, even when forced to interact

DSM-V Diagnostic Criteria for Schizophrenia

- Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
  - delusions
  - hallucinations
  - disorganized speech (e.g., frequent derailment or incoherence)
  - grossly disorganized or catatonic behavior

DSM-V Diagnostic Criteria for Schizophrenia (continued)

- Negative symptoms, i.e., is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behavior or thoughts, or two or more voices conversing with each other. Affective flattening, alogia or avolition

- Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behavior or thoughts, or two or more voices conversing with each other.

DSM-V Diagnostic Criteria for Schizophrenia (continued)

- During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

- Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no major depressive episode or manic episode has occurred concurrently with the active-phase symptoms;

- or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

- Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
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**Treatment of Schizophrenia**

- Antipsychotic medications have been available since the mid-1950’s.
- The older types are called conventional or “typical” antipsychotics, and the most commonly medications include Chlorpromazine, Haloperidol, Perphenazine, and Fluphenazine.
- A newer class of antipsychotics called atypical antipsychotics were also developed. Examples include: Risperidone, Olanzapine, Quetiapine, Ziprasidone, Aripiprazole, and Paliperidone.

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**Medication Side Effects**

- Atypical antipsychotic medications can cause major weight gain and changes in a person’s metabolism.
- This may increase a person’s risk of getting diabetes and high cholesterol.
- Typical antipsychotic medications can cause side effects related to physical movement, such as rigidity, persistent muscle spasms tremors, and restlessness.

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Side effects of atypical antipsychotic drugs

- Cataracts
- Sexual side effects
- Diabetes Mellitus
- Hypertension
- Ejaculatory dysfunction
- Sexual dysfunction
- Hyperprolactinemia
- Myocarditis
- Extrapyramidal symptoms
- Prolongation of QTC interval

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**Relative Adverse Effect Incidence of Antipsychotics**

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**Slide 23**

**Medication Side Effects**

- Long-term use of typical antipsychotic medications may lead to a condition called tardive dyskinesia (TD) which causes muscle movements a person can’t control.
- These movements commonly happen around the mouth and can range from mild to severe, and in some people the problem cannot be cured.

**Slide 24**

**Antipsychotics & Tardive Dyskinesia**

- Chronic blockade of D2 receptors leads them to up-regulate.
- Tardive dyskinesia is characterized by involuntary movements, tongue thrusts, lip smacking, eye blinking.
- Potentially permanent!
Mechanism of Typical Antipsychotics

- As the image below shows, first-generation antipsychotics are D2 antagonists. As a result, they reduce dopaminergic neurotransmission in the four dopamine pathways-mesocortical, nigrostriatal, mesolimbic, and tuberoinfundibular pathways.

Mechanism of action of Atypical Antipsychotics

- The mechanisms of atypical antipsychotics in the treatment of mood disorders remain unclear. These agents not only are antagonists of dopamine D2 receptors (as with the typical antipsychotics), but also block types 2 serotonin (5-HT2) receptors, particularly 5-HT2A and 5-HT2C receptors (Markowitz et al., 1999).

- Blockade of 5-HT2A receptors is a mechanism of action of certain antidepressants, particularly trazodone and nefazodone.

- The contribution of 5-HT2A/2C blockade to the antidepressant actions of atypical antipsychotics is unclear, but may involve their effect on forebrain norepinephrine and dopamine neurotransmission (Zhang et al., 2009).

Mechanism of action of Atypical Antipsychotics

- Additionally, aripiprazole, ziprasidone, and asenapine are 5-HT1A receptor partial agonists, which have also been shown to enhance the release of norepinephrine and dopamine (Ghanbari et al., 2009).

- Although the exact mechanism remains elusive, the apparent superior efficacy of these drugs to conventional antipsychotics as mood-stabilizing agents suggests that this effect occurs through actions beyond a D2 receptor antagonistic action (Blier and Szabo, 2005).
**Reasons for taking a Long Acting Injectable Antipsychotic (LAIA)**

- People have many different reasons for stopping their medications.
- Some people might have difficulty remembering to take their medications or problems obtaining—or paying—for them.
- Others people may not want to take their medications and will stop them out of choice (Llorca, 2008).

**Reasons to take a Long Acting Injectable Antipsychotic (LAIA) (continued)**

- Still other people may not think that there is any need for them to take medications and will simply stop their antipsychotics because they have limited insight into the nature of their illness.
- The discontinuation of antipsychotics in patients with first-episode schizophrenia or schizoaffective disorder increases the risk of relapse by approximately five times (Lieberman, 2002).
- The rate of medication discontinuation in individuals with first-episode psychosis ranges from 26% to 4% (Vemmos, 2000).
- Whatever the reason is for treatment cessation, one of the most common reasons for symptom relapse and rehospitalization for people living with environmental illness is medication discontinuation (who caused medication non-compliance and medication non-adherence) (Hogarty, 1979).

**Reasons to take a Long Acting Injectable Antipsychotic (LAIA) (continued)**

- Many individuals will elect for treatment with long-acting injectable antipsychotic medications (LAIs).
- In the U.S., a number of LAIs exist and are often referred to as “depot formulations.”
- These include haloperidol, fluphenazine, risperidone, olanzapine, paliperidone and Aripiprazole.
- Stopping one’s medications can be particularly dangerous when it is done rapidly or without the

**Indications for LAIAs in Schizophrenia**

- Patients who respond well to a specific oral antipsychotic medication but they have experienced a dose dependent side effect such as an extrapyramidal symptom or sexual dysfunction.
- Patients who stop taking an antipsychotic and become symptomatic with behaviors leading to adverse consequences such as an arrest, assault, self harm, loss of employment or housing.

**Benefits in Using LAIAs**

- People who elect for treatment with LAIs are more likely to continue their medications than people who take their medications on a daily basis by mouth.
- This may be because some people find it easier to remember to go to an appointment to receive a shot (once or twice each month) than remembering to take a pill (once or twice each day).
- Multiple large scientific studies have shown that people who elect for treatment with LAIs are less likely to be hospitalized for their illness (Haddad, 2008).
Benefits in Using LAIAs (continued)

- This is likely because people who are on a stable antipsychotic medication regimen are less likely to experience symptom relapse.

- When individuals are taking oral medication, nonadherence is difficult to detect; the first indication might be a worsening of the patient’s condition, which can be too late to prevent further deterioration (Kane, 2013).

- In addition, given the pharmacokinetic properties of LAIs, blood levels do not decline as quickly after a missed injection as they would after missing a dose of oral medication.

Benefits in Using LAIAs (continued)

- This gives all interested parties time to intervene before an exacerbation is likely.

- With these medications there is a low risk of overdose and suicide to those patients who are suicidal and have a chronic mental illness.

- Quality of Life (QoL) is an important parameter in assessing the overall benefit of a specific treatment, particularly for chronic conditions. Studies of patients switched from oral to LAI antipsychotics or those initiated on LAIs reported significant improvements in schizophrenia symptom control, QoL, satisfaction, and functioning (Lloyd, 2010).

LAIAs use in early stages of schizophrenia

- There is general reluctance in using LAI antipsychotics in routine clinical practice in first-episode patients.

- This reluctance may be present even when patients are considered poorly adherent (West, 2008).

- More than 60% of patients are not offered the option of LAI antipsychotics (Jaeger, 2010); and less than 30% of patients are prescribed LAIs in preference to oral antipsychotics (Heres, 2011).

- A recent study conducted in Germany found that clinicians were reluctant to prescribe LAIs even when, by their own assessment, they suspected or anticipated non-adherence (Hannemann, 2014).

LAIAs use in early stages of schizophrenia (continued)

- In the case of first-episode patients, a survey conducted in the UK reported that even though 50% of the psychiatrists considered LAIAs as an option, less than 15% went on to prescribe LAIAs (Jaeger, 2010).

- Results from surveys of clinician attitudes conducted in 2007 and 2011 revealed that psychiatrists believe that patients with first-episode schizophrenia will probably decline LAIAs (Jaeger, 2010).

- However, 73% of first-episode patients participating in a prospective trial accepted the recommendation to receive retentionsal LAIAs (RAs).

LAIAs use in 1st episodes schizophrenia (continued)

- The evidence on the use of LAIAs in first-episode or recent onset schizophrenia is inconclusive as available studies have methodological limitations, particularly single-arm designs not comparing oral antipsychotics with LAIs, the lack of differentiation between first and second generation LAIs, and confounding factors such as patient selection bias.

- Kim and colleagues compared relapse rates in patients diagnosed with first-episode schizophrenia and treated in an open label design either with RLAI (n = 22) or oral risperidone (n = 28) (Kim 2008).
LAIAs use in 1st episodes schizophrenia (continued)

- At 1-2 years of follow-up, patients on RLAI had significantly lower relapse rates associated with longer periods of adherence and higher rates of adherence than patients on oral risperidone (68% vs. 32%).

- Additional benefits in the RLAI treated patients included greater reduction in the total Positive and Negative Syndrome Scale (PANSS) (10% vs. 2%; p = 0.001), and in the Clinical Global Impression-Severity (CGI-S) scale (10% vs. 2.5%; p = 0.001) and greater functional improvement as measured by the General Assessment of Functioning (GAF) scale, with patients on oral risperidone experiencing a 0.6% improvement (n = 
  
  
  
  
  
  
  

LAIAs use in 1st episodes schizophrenia (continued)

- Another recent randomised controlled trial enrolled subjects in the early phase of the disease (schizophrenia diagnosis ≤ 3 years before study entry) who were either medication naive or had been taking SGA (oral risperidone, olanzapine or quetiapine), and started maintenance treatment after stabilization (Mattila, 2013).

- There were no differences in the CGI-S scores, PANSS total and positive symptoms subscale scores between patients randomised to RLAI (n = 42) or continuing on oral SGA (n = 35).

- However, the posthoc analysis on the change in PANSS negative symptom subscale scores showed differences between groups over time. Negative symptom scores decreased between baseline and study endpoint for both groups.

\[
\text{LAIAs use in 1st episodes schizophrenia (continued)}
\]

Contraindications and Reasons to Not Use LAIAs

- Difficulty taking an injectable medication because lack of access.

- Haloperidol-LAI and fluphenazine-LAI are contraindicated in severe central nervous system depression and coma.

- Haloperidol-LAI is also contraindicated in Parkinson’s disease, subcortical brain damage, blood dyscrasias, and hepatic disease for fluphenazine-LAI.

Reasons LAIAs are not used often in treatment (continued)

- High treatment cost (Heron, 2006).

- Psychiatrists survey of physician attitudes toward the use of LAIAs found that 50% had decreased their use over the past 5 years, despite acknowledging better adherence than with oral antipsychotics (Peters, 2010).

- The main disadvantage of LAIs relates to the slow dose titration and the long time required to achieve steady state levels (Agid et al., 2010).

- This disadvantage is most evident in acutely ill individuals, whom would need rapid dose titration within days of initiating treatment.

- During this time oral antipsychotic supplementation may be necessary, adding to the complexity of the titration process.

Reasons LAIAs are not used often in treatment (continued)

- It is also more difficult to make sensible dose adjustments because attainment of steady state plasma levels may take more than 4 months after a dose change.

- For these reasons, the initiation of LAIs has generally been confined to those periods when a patient is at least partially stabilized on their existing treatment.

- With some newer LAIAs, such as paliperidone palmitate, rapid therapeutic levels can be attained by means of a loading dose protocol, allowing for its use in patients with moderate symptoms, and bringing about a rapid onset of action with no need for oral supplementation (Civis and Naashafah, 2013).

- Psychiatrists survey of physician attitudes toward the use of LAIAs found that 50% had decreased their use over the past 5 years, despite acknowledging a high treatment cost (Heron, 2006).
Reasons LAIA are not used often in treatment (continued)

- Among the beliefs were that LAIs are less effective for first episodes of psychosis (38%) and that patients always preferred oral antipsychotics (35%).

- In another study, psychiatrists in the US were surveyed about nonadherence in patients with schizophrenia and their use of LAIs (West, 2008).

- In another study, psychiatrists (n=360) were surveyed about their reluctance to prescribe LAIs for schizophrenia or schizoaffective disorder (Heres, 2006)

Conclusions

- It is necessary to improve the availability of additional LAIs and to develop more reliable methods of antipsychotic delivery.

- There needs to be a radical change in the attitude among care providers and patients so LAIs are seen as a 1st step to ensure treatment continuity and maximize clinical remission.

- Oral medications are not successful in preventing relapse so hopefully new medications will have better long-term delivery systems to address the issues of relapse and nonadherence in all phase of schizophrenia.

Resources


- Rahn Kennedy Bailey, MD, DFAPA

Resources Continued


- http://www.asp.org/ (American Society for Psychosomatic Research)

- http://www.psychopharmacology.org/ (International Society for Psychopharmacology)

- http://www.acaap.org/ (American College of Clinical Pharmacology)

- http://www.americanpsychological.org/ (American Psychological Association)

- http://www.asp organization.org/ (American Society for Psychosomatic Research)

- http://www.psychopharmacology.org/ (International Society for Psychopharmacology)

- http://www.acaap.org/ (American College of Clinical Pharmacology)

- http://www.americanpsychological.org/ (American Psychological Association)
Annelle B. Primm, M.D., MPH, is a community psychiatrist currently serving as the Medical Director of the Paving the Way Multi Service Institute in Washington, DC and Senior Psychiatrist Advisor for several organizations in the Baltimore-Washington area. Dr. Primm held the position of Deputy Medical Director of the American Psychiatric Association (APA) from 2009 until March 2015. In addition, she served as Co-Director of the Recovery-Oriented Care in Psychiatry Curriculum during her tenure as the leader of APA’s Division of Diversity and Health Equity from 2004-2014. Prior to her service at the APA, Dr. Primm was Medical Director of the Johns Hopkins Hospital Community Psychiatry Program where she oversaw a variety of mental health services for adults. She is an adjunct Associate Professor of Psychiatry at Howard University College of Medicine and the Johns Hopkins School of Medicine.
Annelle B. Primm, M.D., MPH

Slide 1
Managing Common Medical Comorbidities in People with Schizophrenia:

National Medical Association
Psychiatry Section
August 4, 2015

Annette B. Primm, M.D., MPH
Medical Director
Paving the Way Multi Service Institute
Washington, D.C.

Slide 2
Disclosures

No disclosures to report

Slide 3
Outline

Schizophrenia
- Description
- Epidemiology
- DSM-5 changes in diagnosis
- Disparities and African Americans
- Integration of physical and mental health care
- Assessment and monitoring
- Strategies and approaches

Slide 4
Schizophrenia
- Positive symptoms (delusions, hallucinations, disorganized thought and behavior) and negative symptoms (apathy, lack of motivation)*
- Affects approximately 1% of the population
- Treatment with antipsychotic medications, 1st and 2nd generation, rehabilitation and psychosocial interventions


Slide 5
Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia
- Elimination of special treatment of bizarre delusions and "special" hallucinations in Criterion A (characteristic symptoms)
- At least one of two required symptoms to meet Criterion A must be delusions, hallucinations, or disorganized speech
- Deletion of subtypes

Slide 6
Schizophrenia Spectrum and Other Psychotic Disorders

Catatonia now exists as a specifier for neurodevelopmental, psychotic, mood and other mental disorders; as well as for other medical disorders (catatonia due to another medical condition)
African Americans and Schizophrenia

- African Americans receive higher rates of diagnoses of schizophrenia and lower rates of depression diagnoses than Whites
- Higher rates of psychosis and similar rates of mood symptoms compared to Whites
- Clinicians overvalue psychotic symptoms
- Discrimination and healthy paranoia may contribute to misinterpretation of symptoms

Gara et al. 2012

People with serious mental illnesses die decades earlier than the general population

Modifiable risk factors include:

- Smoking and other substance use
- Obesity
- Inactivity
- Inadequate access to medical care

Psychiatrists’ Role: Building a Partnership for Change

- Sharing information and decision making
- Attentive to all aspects of well being and quality of life
- Emphasize the individual’s role in managing health

Screening and Monitoring

- Blood pressure and pulse
- Height and weight
- Waist circumference and BMI
- Review of diet and activity level
- Medication reviews

Coordination with Primary Care

- Chronic pain/headache
- Diabetes
- Hyperlipidemia
- Hypertension
- Smoking Cessation
- Medication effects
Collaborative Care
- Importance of integrated care and collaborative care between primary care and behavioral health in patient-centered medical homes:
  - 70% of individuals with significant MH/SUD had at least 1 chronic health condition, 45% have 2, and almost 30% have 3 or more
  - Ethnically and racially diverse populations have high rates of chronic disease and premature death

Common medical problems seen in people receiving mental health services
- Obesity
- Heart disease
- Diabetes
- COPD, asthma
- Hepatitis
- Hypertension
- Pain
- Metabolic syndrome

Metabolic Syndrome
<table>
<thead>
<tr>
<th>At least 3:</th>
<th>Men: Equal to or greater than 40 inches (102 cm)</th>
<th>Women: Equal to or greater than 35 inches (88 cm)</th>
</tr>
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<tbody>
<tr>
<td>Large waist circumference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevated triglycerides</td>
<td>Equal to or greater than 150 mg/dL</td>
<td></td>
</tr>
<tr>
<td>Reduced HDL (good) cholesterol</td>
<td>Men: Less than 40 mg/dL</td>
<td>Women: Less than 50 mg/dL</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>Equal to or greater than 130/85 mm Hg</td>
<td></td>
</tr>
<tr>
<td>Elevated fasting glucose</td>
<td>Equal to or greater than 100 mg/dL</td>
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</tr>
</tbody>
</table>

Other medications can contribute to medical problems
<table>
<thead>
<tr>
<th>These Medications:</th>
<th>May contribute to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitors</td>
<td>Hyperglycemia</td>
</tr>
<tr>
<td>HMG-CoA reductase inhibitors (statins)</td>
<td></td>
</tr>
<tr>
<td>Dapakote</td>
<td>Weight gain</td>
</tr>
<tr>
<td>Antihistamines</td>
<td></td>
</tr>
<tr>
<td>Beta-adrenergic blocking agents</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Fluoroquinolone antibiotics</td>
<td></td>
</tr>
</tbody>
</table>

Obesity: A National Problem
Even more common among people with mental illness

Age-adjusted prevalence of obesity among adults aged 20 and over by sex and race/ethnicity: United States, 2015

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
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</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>32%</td>
<td>25.4%</td>
</tr>
<tr>
<td>White</td>
<td>30.4%</td>
<td>29.4%</td>
</tr>
<tr>
<td>Black</td>
<td>43.1%</td>
<td>30.4%</td>
</tr>
</tbody>
</table>
Slide 19

**Obesity in People with Schizophrenia**

Possible contributing factors:

- Sedentary lifestyle
- Limited financial resources
- Reliance on inexpensive and convenient food choices
- Disturbance of the sleep-wake cycle which can stimulate appetite
- Some prescription medications

Mindshare, 2012; Kraus and Vogt, 2012

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Slide 20

**Medications**

- Educate and Advise
- Focus on patient goals
- Monitor closely as risk increases
- Make adjustments when side effects emerge

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Slide 21

**Addressing Obesity**

- Understand perspective
- Provide information on risks
- Help individuals become more aware
- Discuss activity level
- Consider support groups, walking groups
- Talk therapy

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Slide 22

**Small Changes**

**Diet**

- Drink water instead of soda sometimes!
- Increasing fruits and vegetables
- Keep healthy snacks handy
- Small portions throughout the day!

**Exercise**

- Dance
- Take the stairs
- Stretch
- Walk 15 minutes a day
- Yoga, Tai Chi

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Slide 23

**Smoking**

More common among people with psychiatric disorders; account for 40% cigarette sales

![Bar chart showing smoking rates for different groups](chart)


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Slide 24

**Smoking, by race/ethnicity: United States, 2013**

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Current smoking</th>
<th>Lifetime smoking</th>
<th>Past Month mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>39.2</td>
<td>65.0</td>
<td>82.0</td>
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<tr>
<td>White</td>
<td>48.7</td>
<td>73.0</td>
<td>90.0</td>
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<tr>
<td>Black</td>
<td>51.0</td>
<td>65.0</td>
<td>85.0</td>
</tr>
</tbody>
</table>

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Helping a Smoker
- Inquire regularly about smoking habits
- Offer support through:
  - Nicotine replacement
  - Other smoking cessation medications
  - Develop smoking cessation plans
  - Support groups
  - Hotline
  - Stress management training

Chronic Sleep Problems

People eat more when they sleep less.

Slide 27

Improving Sleep

Sleep hygiene
- Go to bed at the same time every night
- Avoid napping
- Avoid caffeine altogether, or at least in PM
- Exercise during day

Medication
- Give potentially sedating medications in evening
- Avoid prescribing medications for chronic sleep difficulty

Slide 28

Diabetes

- Screen and refer to primary care physician
- Reinforce value of adherence to treatment
- Help plan lifestyle changes
  - Dietary changes
  - Physical activity
  - Stress management training
- Avoid medications which make it worse

Slide 29

Advocating
- Don’t assume the primary care physician is monitoring everything—ask!
- Help the individual to better advocate for himself/herself
- Advocate for the person who may not be able to advocate well for himself/herself

Support Small Steps
- Confronting a health problem not recognized before
- Making small lifestyle changes (diet, exercise, sleep)
- Maintaining the changes
- Self monitoring for triggers or stressful events
- Abstinence from alcohol or drug misuse/abuse
Slide 31

Summary

- Monitor for common health conditions
- Change the variables you can control
- Incorporate health and wellness in planning and treatment
- Coach and support individuals in understanding and managing the variables they can control

Slide 32

Resources/References

- Mobile apps may be useful tools for individuals to include:
  - Meditation apps (e.g., Headspace
  - Track food and nutrition
  - Track and help provide motivation for exercise
  - Maintain easily accessible personal health records

- Metabolic Syndrome Monitoring Form from the Center for Quality Assessment and Improvement: www.cqai.org


Slide 33

References


Slide 34

References


Slide 35

THANK YOU
**Dr. U. Diane Buckingham** began her career in medicine as a registered nurse, and decided to train as a physician to be able to respond to the psychiatric needs of her patients, especially children and adolescents. She is in private practice.

Although she experienced discrimination as she launched her career, Dr. Buckingham benefited from the support of mentors and her own drive to have more direct involvement with patients. She is especially proud of her role in empowering patients to demand better health care. Areas of Dr. Buckingham's current private practice focus on children and adolescents with ADHD, Tourette's syndrome, autism and obsessive-compulsive disorder. She is a nationally recognized expert in providing psychiatric care to African Americans and multicultural children, and travels the country giving speeches to educate parents, teachers and health professionals about culturally correct assessments tools and treatment options, not only with ADHD, but other behavioral and mental health diagnosis. Dr. Buckingham is committed to raising awareness of the benefits of behavioral health treatment in communities of color. In that way, she says, "patients will no longer avoid mental health treatment because of its stigma."

Dr. Buckingham served as Chair of the National Medical Association from July 2007 to July 2009. In July 2008, she was awarded one of the largest unrestricted educational grants in the history of the psychiatry section. She has received numerous awards including the Black Psychiatrists of America award for Outstanding Psychiatric Resident in the Cause of African American Families and Children in 1994 and a Presidential Scholar Award in 1991 from the American Academy of Child and Adolescent Psychiatry. She has also served as an officer of the local chapter of the NAACP. She was recognized in the Black Enterprise Magazine.
Mikki King Barker, DO, is currently the Medical Director at Wendell Street Psychiatric Services, LLC in Fairbanks, Alaska. Prior to this she served as Medical Director at Fairbanks Community Health Center and Psychiatric Director at Bartlett Hospital in Juneau Alaska. She worked at Wabash Valley Hospital in W Lafayette, IN, and Apogee INC, and Lakeside Alternatives in Orlando, Florida and New Horizons of the Treasure Coast in Ft Pierce, FL. She has worked at Riverside County, and Orange County Mental Health in California. She trained in Psychiatry at King-Drew Medical Center- Augustus Hawkins Mental Health and completed her medical training at Western University- COMP. Dr. Barker is a general psychiatrist with extensive experience in Addiction Medicine, Community Mental Health, Child/Adolescent and Geropsychiatry, as well as Forensics. Licensed in Alaska, California, Indiana and Florida.

She is the past President of NOMA 2004-2006, An active member of the NMA, and serves on the CAFA Committee as well as the representative from Psychiatry to the House of Delegates. She is the current Treasurer of Region 6 of National Medical Association.
Expanded Uses of Long-Acting Injectibles Antipsychotic Medications for Community-Level Schizophrenia Management

TUESDAY
August 4, 2015
7:00 – 11:00 AM
Room: 320
MORNING SESSION