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Long-Term Management of Schizophrenia: Preventing Relapse and Promoting Recovery

Ms. Baker:
This is *NeuroFrontiers* on ReachMD, and I'm psychiatric nurse practitioner Ashley Baker. Here with me today to share strategies for the long-term management of schizophrenia is Dr. Rakesh Jain. Dr. Jain is a Clinical Professor in the Department of Psychiatry at Texas Tech University School of Medicine in Permian Basin, Texas. Dr. Jain, welcome to the program.

Dr. Jain:
I'm so happy to be with you, Ashley. And what a great topic we're going to be discussing. This is great.

Ms. Baker:
Yes. So why don't we start then by focusing on relapse prevention. For some background, how common are relapses among patients with schizophrenia?

Dr. Jain:
Relapses are as common as the fact that the sun will rise in the east tomorrow morning. I don't think there's even such a thing as schizophrenia that does not relapse. So I sort of make the assumption that relapses are part of the DNA of this disorder. And when I start treatment, Ashley, I immediately start planning and doing my very best to prevent that relapse but also be prepared should one happen, how do I address it.

Ms. Baker:
With that prevalence in mind, what have you found to be the most effective approaches for preventing relapse?

Dr. Jain:
So first things first, if I can, I offer very good psychoeducation to the family and to the patient, obviously. As best as I can, I wraparound services that are outside of medications around the patient's care, so social services might be very important. For example, vocational retraining might be very important. But when it comes to the choice of pharmacotherapy, if I'm very worried about adherence, which is not true with every patient, but if I'm particularly worried, then I'm using a long-acting injectable as soon as possible.

The other thing I tend to do is make sure that the patient's mind/body needs for the medication are aligned with the medication choice I have. So if a patient is experiencing a lot of sedation and insomnia already, if I add a medication that further adds to it, there's a higher chance they won't be adherent. So it really is my role as a matchmaker; when I say that, what I mean is I know my medications well, and I now need to get to know my patient as well as I can. Then I'll try and do my very best to merge the abilities and disabilities of a particular medication with the patient. And it's quite interesting when you have that thoughtful approach how often we can land at the right treatment option or options.

Ms. Baker:
Now if we move on from relapse, what factors might impact a patient's adherence to treatment? And how do you address this challenge?

Dr. Jain:
Adherence is such a problem, Ashley, isn't it, in our poor patients who are afflicted with schizophrenia for a variety of reasons and we need to address them. The first is lack of awareness of their own disease state. Factor number two is lack of motivation, which is a slightly different problem than awareness. And factor three is side effects. Those tend to be the three biggest challenges my poor

patients have in terms of adherence.

So let's look at solutions for 1, 2, and 3. So when there is lack of insight, I use not just myself as a tool—because at the end of the day, patients who are actively psychotic aren't fully able to comprehend what is happening, at least for the time being—I use peer support groups because often hearing a fellow patient describe what the disorder is and what to do about it is perhaps more powerful.

The second thing I do when it comes to motivation is to see if I can come up with a support system that could administer them the medication. Sometimes I'm quite successful with that. Or use a long-acting injectable if that's simply the right thing to do.

But it's the third thing that I think we should focus our conversation on is the side effect burden. So far, what we are seeing from data coming from NAMI and from DBSA, weight gain and sleepiness appear to be the two single greatest challenges that lead to low adherence and then no adherence to medications. So as a result, I try and do my very best to reduce the sleepiness potential or the weight gain potential of medications. So for example, if I do choose something like olanzapine because it's such an efficacious medication, I might consider combining olanzapine with samidorphan, which I still get all the benefits of one medication but still reduce the side effects. I was just using that as an example. Or I might use a low weight-gain potential medication such as cariprazine or lumateperone. Do you see my thinking evolves around that? I even have patients who will receive a medication that helps them with weight loss, so I sometimes will use metformin or some of the newer medications to reduce the burden of weight gain.

So I'm almost like a tailor in some ways in that I'll try to customize my treatment options to patients, and I stay dynamic. Because what their needs are today—and I've done my job perfectly well, so today I've solved it—but that doesn't mean if the situation changes tomorrow, I'm not dynamic enough to stay with the patient and change my approach to help them.

Ms. Baker:
For those just joining us, this is *NeuroFrontiers* on ReachMD. I'm psychiatric nurse pactitioner Ashley Baker, and I'm speaking with Dr. Rakesh Jain about the long-term management of schizophrenia.

So, Rakesh, let's look at one last aspect of long-term management. How can we promote functional recovery in our patients with schizophrenia?

Dr. Jain:
Functional recovery is our North Star. So let's never, ever forget the goal of treatment of schizophrenia is not just to treat it like it's an academic problem. The whole goal of this exercise is functional recovery, and function is defined by the patient and the patient's system.

So I would say goal number one is to minimize or eliminate the positive symptoms, and same is true with negative symptoms. Same is true with the cognitive symptoms of this disorder. It's hard to get to functional recovery without absolutely doing our best to control these symptoms. So that's the first conversation we need to have. Do your very best to reduce the symptomatology of the disorder.

Point number two about functional recovery is don't forget the body. Just don't. Ninety-five percent of the human being is below the neck. That's valuable. That's important. Let's do our very best to manage weight gain. Let's do our very best to manage prolactin elevation. Let's do our very best to minimize sexual dysfunction.

The third thing is never, ever make the mistake I made earlier in my career, that the treatment of schizophrenia is just pharmacotherapy. It is so much more than that. There's a reason, perhaps, Ashley, that recovery rates for schizophrenia in many parts of the world are 100 percent better than they are in North America. But the medications don't change in Asia as compared to the United States. So what's the difference? I think part of the difference is the social fabric is stronger there. The support systems are better. And there's a deep focus on, quote unquote, "getting you back to the business of life." So appropriate patients who need disability help absolutely should get it. But just because a patient needs disability help, we should not condemn the patient, in our minds, to a permanent state of disability. Very many patients can be quite protective members of their families, of society, etc. And keeping that holistic positive attitude in mind is perhaps the call to action for today's clinician who's helping patients with schizophrenia.

Ms. Baker:
As a quick follow-up to that, can you provide some examples of the community resources or support systems that you would recommend to patients to help them in their recovery?

Dr. Jain:
Yes, so first-episode psychosis programs are proliferating around the country. As much as you can, get linked up to it or link your patient up to it. Even though they're called first-episode psychosis, they are never limited to first episode. They are limited to earlier onset. The reason why I'm such a strong proponent of them is because they keep the focus on exactly what I was saying: choosing the right medication, having an optimistic attitude, and finding wraparound services for the patient and the family, not just the patient. So that's

option one, if available, take advantage of it.

The second is join an organization like NAMI. NAMI is profoundly positive in its orientation, but also resource rich.

The third thing to do, perhaps, is to not assume that, as prescribers, you and I, Ashley, are part of a treatment team and are not necessarily the only members of the treatment team. So as much as we can broaden this village to raise this individual with schizophrenia, that's what we should do.

And perhaps the fourth thing to keep in mind is should you not get optimum outcomes from a medication, don't stay stuck to it. Feel free to change medications. There's no shame in medication changes. The only shame would be to stay with a treatment option that's evidently not working.

Ms. Baker:
Lastly, Rakesh, are there any other strategies or considerations for the long-term management of schizophrenia you'd like to share with us today?

Dr. Jain:
Yes. Schizophrenia used to be considered literally a death sentence. And perhaps one of the greatest strategies we should all follow is never lose sight of the fact that inside this lockbox that is schizophrenia lives a human being with passions and drives and hopes and desires, is someone's son, someone's daughter. And to keep that hopeful attitude and maintain that energy. If you're not seeing all that the patient needs, maintain that energy to think bigger and broader. What am I missing here? Have I connected them to enough social services? Have I made sure that their adherence is adequate? Have I made sure that I haven't forgotten the body as I'm treating their brain? How do I use motivational interviewing to not just connect with the patient, but also motivate them to change in a non-conflicted fashion? If they're smoking, how do I find a way to maybe eliminate that? If they're using substances, how do I work with them on that? If they are not socializing, what can I do to gently move them towards that direction? All of this sounds like a lot of work, and you might say, 'I only have 15 minutes, how do I do it?' But here's the good thing: our patients are with us for an extended period of time; we don't have to solve every problem today, it's actually not even feasible to do that. But the quality of the relationship with the patients is such a strong motivator of change. Let's not forget this at all, that we ourselves are medicine. The relationship itself is therapeutic, and paying a lot of attention to that ultimately benefits the patient-clinician dyad.

Ms. Baker:
That's a great way to round out our discussion on this subject. And I want to thank my guest, Dr. Rakesh Jain, for joining me to discuss how we can approach the long-term management of schizophrenia. Rakesh, it was great having you on the program.

Dr. Jain:
I was so delighted to have this heart-to-heart conversation with you and our colleagues, Ashley. Thank you.

Ms. Baker:
For ReachMD, I'm psychiatric nurse practitioner Ashley Baker. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD, where you can Be Part of the Knowledge. Thanks for listening.