The Canadian Journal of Psychiatry

Volume 58, Number 5 May 2013 Supplement 1

Guest Editorial

Why Are Canadians Complacent About Long-Acting Injectable Antipsychotic Therapies? Come on, Canada, You Can Do Better!

Peter J Weiden, MD[1]

[1]Professor of Psychiatry, Department of Psychiatry, University of Illinois at Chicago Medical Center, Chicago, Illinois.
Correspondence: UIC Medical Center (MC 913), 912 South Wood Street, Chicago, IL 60612–7327; pweiden@psych.uic.edu.

As a psychiatrist specializing in serious mental illness, I am appalled by the shortcomings of the US mental health care system. On bad days, when dealing with disaster after disaster because of lack of continuity of care, I look north to Canada with envy. In Canada, you are able to treat schizophrenia in the context of an integrated psychiatric service system. When I received Dr Ashok Malla's generous invitation to be the guest editor for this special issue on the state of long-acting treatments for schizophrenia in Canada, I accepted with enthusiasm. I assumed that the situation regarding the use of LAI therapies would have to be better in Canada than it is in the United States because the LAI lends itself to integrated mental health services. Now I am not so sure. When reviewing the manuscripts, I was saddened to learn that many Canadian mental health services do not routinely use LAI therapies. Also, based on the focus group results in this issue, many Canadian psychiatrists seem to be biased against, or at least uncomfortable with, routinely using LAI therapies.

This supplement in *The Canadian Journal of Psychiatry* is a very important step toward reconciling variations in experience, enthusiasm, and proper understanding of LAI therapies within the context of psychiatric treatment services in Canada.

One of the frustrating aspects of reviewing LAI therapies is the tremendous variation among clinician attitudes about LAI therapy, and variation in the results of research studies on the relative usefulness of this approach. Having said that, I would suggest that there are 2 issues in particular that stand out. One issue is the disconnect between senior clinicians and younger clinicians. I have found that senior clinicians experienced in schizophrenia treatment tend to be strong advocates of LAI therapies, whereas younger clinicians who trained in the 1990s or later are generally less enthusiastic. I believe that these generational differences are partly explained by the relative benefit of LAI therapies over oral, which is not immediately apparent and often happens over years. Another explanation is secular changes in psychiatric training. Senior clinicians trained during a time when so-called depot therapy was commonly used, and observed the benefits over time; younger psychiatrists are less likely to have been trained in using LAI therapies, and may be less comfortable with how and when to use LAIs in community practice.

The second explanation for underuse is the apparent inconsistency found in the research literature on the relative benefits of LAI therapies. Cohort studies of real-world treatment environments tend to show better outcomes with LAI therapies than with oral, even though patient selection differences would be biased toward the opposite finding.[1] In contrast, most prospective RCTs of the oral, compared with the LAI, route do not tend to show such benefits.[2] The question becomes, Which kind of study design is most informative? While RCTs are usually viewed as the gold standard, in this instance, I count myself as believing that the epidemiologic studies have better face validity. My clinical experience has convinced me that LAI therapies, when properly integrated into a larger context of care, can change the course of an illness.[3,4] My frustration with the debate on the effectiveness of LAI therapies seems shared by some of the authors of this supplement, where many of the leading schizophrenia experts in Canada have developed sensible clinical recommendations for using LAI therapies, while also being aware of some of the limitations in the research literature and in clinical use.

This supplement helps guide Canadian clinicians and policy makers about individualizing decisions and recommendations for LAI therapy. General treatment guidelines invoke LAI medication as the magic elixir for the nonadherent patient. That is not good enough because such

treatment guidelines convey very little useful information about how LAI medication may be useful for the individual patient. We see an example of the fallout from oversimplified reliance on current guidelines in the transcript of one psychiatrist who equates LAI with noncompliance.

> *Facilitator: What type of patients would you consider an injectable for?*
>
> *Doctor: . . . mostly noncompliant . . .*
>
> *Facilitator: Noncompliant? [unspoken]*
>
> *Doctor: . . . it would be the noncompliants.*

Unfortunately, that does not get us very far. What does that mean? Does this mean patients will voluntarily accept a LAI medication after stopping oral medication? Unlikely! At the very least, as is done in this issue, recommendations need to differentiate the use of LAI therapy as an adherence tracking method from being a direct adherence intervention.

The clinical benefits of LAI therapy are much easier to recognize when there is a good understanding of exactly what is being expected by the recommendation of LAI therapy for the individual patient. For experienced clinicians who have followed schizophrenia patients during many years and have witnessed the differences in outcome associated with LAI therapies, the matching of patient profile with expectations arise from experience but do not find their way into the usual guideline. This special issue is a big step in helping less experienced readers to better understand expectations regarding LAI therapy for specific patient profiles.

Why have a supplement specific for Canadian psychiatrists? We think of pharmacologic treatments as somehow divorced from the logistic chain that makes a given medication available for our patients. Assuming equivalent financial coverage, with few exceptions, getting a prescription for an oral drug is going to be roughly the same, no matter where you are in the United States, Canada, or the United Kingdom. In contrast, the benefits—or last thereof—of LAI APs is much more sensitive to context. Even a so-called simple difference in number of days or hours in which a person can come in for an injection may translate into differences in outcomes.

Consider, in this supplement, the implications of what is said by the patient who seemed to prefer LAI therapy but said,

> I've had to skip a lot of classes to get my injection, and when I prioritize too my education is extremely important to me but not as important as my health, so I'm forced to choose [between classes and getting my medication].

Likewise, there is a great deal of variation in access to giving injections. In some parts of Canada, physicians may say, "I can't get anybody to give injection to my patients." My guess is no Canadian physician would say,

> I can't get anybody in the pharmacy to dispense my prescription for oral APs.

So, why have this special issue for Canadian psychiatrists? This consortium of Canadian experts have made a great contribution to helping explain national and regional practices across Canada, and offers a great deal of guidance for Canadian clinicians, educators, and policy makers.

Come on, Canadian colleagues, you can do better than this!

Warm regards from your neighbouring country,

Peter J Weiden, MD

Acknowledgements

Information on funding and support appears on page 2S.

References

1. Tiihonen J, Haukka J, Taylor M, et al. A nationwide cohort study of oral and depot antipsychotics after first hospitalization for schizophrenia. Am J Psychiatry. 2011;168(6):603–609.
2. Rosenheck RA, Krystal JH, Lew R, et al. Long-acting risperidone and oral antipsychotics in unstable schizophrenia. N Engl J Med. 2011;364(9):842–851.
3. Weiden PJ, Solari H, Kim S, et al. Long-acting injectable antipsychotics and the management of nonadherence. Psychiatr Ann. 2011;41(5):271–278.
4. Hamann J, Mendel R, Heres S, et al. How much more effective do depot antipsychotics have to be compared to oral antipsychotics before they are prescribed? Eur Neuropsychopharmacol. 2010;20(4):276–279.