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Identifying and Managing Nonadherence to Antipsychotics in People with Schizophrenia

Announcer:
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Dr. Correll:
So hello, my name is Christoph Correll. I'm Professor of Psychiatry and Molecular Medicine at the Zucker School of Medicine at Hofstra Northwell in New York. Welcome to Roundtable: Identifying and Managing Nonadherence to Antipsychotics in People with Schizophrenia. I'm joined by my good friend and colleague.

Dr. Citrome:
Hi, I'm Dr. Leslie Citrome. I'm a Clinical Professor of Psychiatry and Behavioral Sciences at New York Medical College in Valhalla, New York.

Dr. Correll:
Well, we'll be talking about the difficulties of maintaining adherence, but also how we know as clinicians about it. So, what do we do? I mean, do we just ask patients and then they say yes, and we go our merry way?

Dr. Citrome:
Well, I don't think we can guess. And I don't think patients can accurately tell us if we just ask it, do you take your medicine? Because the natural answer is, ‘Of course, I take my medicine, doctor, why wouldn't I take my medicine?’ So, I try to humanize it, make it part of what, you know, this can happen in everyday life, that people don't take their medicine. I say, like, ‘Everyone misses their medicine from time to time. Even I do that with my antihypertensives. I need to know approximately how often this happens to you? I don't need an exact number, just a ballpark figure, how often during the week could it possibly happen?’ Then I will get a more honest answer. But even then, patients have limited insight very often, and they don't actually remember all that well. So, if we guess, we're going to guess wrong. If they guess, they’re going to guess wrong. And if family members guess, they're going to guess wrong. And we know that from all sorts of studies that used these pill bottles that actually measured the number of times that pill bottle was open and closed. And it turned out by using that research we can actually say that we miss the identification of adherence almost all of the time.

So, perhaps a better way, if we don't have access to those special pill bottles that measure the time you open and close them, is plasma levels of medicines. And barring that, if we're really not sure if they're taking their medicine and getting a benefit from medicine, why not consider a long-acting injectable as a trial? And that will rule out something we call pseudo resistance. Patient’s not getting better, not because the medicine doesn't work, but because they're not taking it.

Dr. Correll:
Yeah, so you said a couple of very important things. First, you need to normalize nonadherence and maybe ask not how many times have you taken your medication, but how many times have you not taken it. So, assuming that this is part of the game, and that people don't feel stigmatized by not taking the medication, undermining the doctor's role or anything, but then also, to be sure, maybe a long-

acting injectable is the only way that we know the day, the hour, the minute when a person becomes nonadherent. And actually, when they do, they still have blood levels available because the medication goes out of the system much, much more slowly. And the question then is, why are we relying so much on just asking a patient, are you taking a medication? Or not even asking that?

Dr. Citrome:
So, it's human nature too to assume that our patients are perfect, that they're doing what we tell them to do. And it's always, 'Oh, it's the other guys' patients that don't take their medicine, my patients are always adherent.' Nah, it's human nature to feel that way. But the truth is, when we ask ourselves, how many times have we completed a full course of antibiotic medicine? Well, then, you know, the truth is there, we actually don't. People with hypertension and diabetes and asthma actually have rates of adherence that are similar to those with schizophrenia, but half are kind of reasonably adherent. The other half are not. So, this is a common problem. And I think the more we admit that this is a possibility in one's practice, the more likely we are to actually ask the right questions in a tactful way and get the answers we need.

Dr. Correll:
Now, there's also a possibility to have family members check on the medication. But that can cause a lot of conflict, basically. So maybe it's better to agree that a long-acting injectable can free up time and reduce also the conflict that people may have, so that they can then achieve their goals better.

Dr. Citrome:
Well, I'm very fond of saying, you know, we can take out that stressor at home of: Did you take your medicine? Did you take your medicine? Did you take your medicine? It's enough to drive anybody crazy, frankly, to be badgered like that. Well, we can eliminate that conversation with the guaranteed delivery system of a long-acting injectable. And then no one has to ask.

And for us, as clinicians, we don't have to guess, are they taking their medicine or not? We know that they are because they came for their injection. Now if it doesn't work, well, then we can address other issues to explain why it's not working. Maybe it's a matter of dosing. Maybe it's the wrong medicine. Maybe there's a psychosocial stressor that we have not identified. Maybe there's comorbid substance use that we have not identified.

Dr. Correll:
Well, that's a very important point. When it doesn't work, you take out of the equation, the nonadherence, because how often have we doubled the dose, added another medication, maybe given up on something that could have worked, because we thought, 'Oh, biologically, this medication is just not the right thing for that patient.' But it wasn't biological, it was behavioral. And we cannot know that unless patients are on a long-acting injectable. Plus, ambivalence is part of schizophrenia: Should I? Should I not? Am I sick or not? And actually, I've had patients who are relieved by not having to decide that every single day, 'No, I'm staying the course, I'm going once a month, every other month, whatever it is, and I get my shot, and then I deal with my life,' it makes it also easier for them.

Dr. Citrome:
Absolutely. So, it's simplicity itself to be able to deliver something once every 2 weeks, every month, every 6 weeks, every 2 months, every 2 months. And now actually, every 6 months is also a possibility.

Dr. Correll:
So basically, we can only ask clinicians to not assume patients will say no, because I think that's the biggest barrier, what research is showing. It's not the patient saying no, is the clinician thinking the patient will say no.

Dr. Citrome:
So, we need to offer long-acting injectables to more people and actually earlier on in their illness, which we didn't really get into. But you know, if we intervene early enough, maybe we'll have an impact on the trajectory of their illness.

Dr. Correll:
Especially earlier is better, because the people who are in the early phase have the most to gain and the most to lose, are closest to friends, family, and also educational and vocational areas. And when you're really chronically ill, it's harder, even when you're stable, to then make this jump out of the chronicity role. So hopefully, more LAI use can also help patients re-engage with life and have more agency.

Alright, well, we thank you all for listening and watching this video and roundtable, and hope that you can consider more long-acting injectable treatment offerings to patients and discussing it in a way that it's not stigmatizing and that you're not assuming that patients will say no, because research shows very often they might actually agree with it and have a good outcome.

So, thank you very much.

Announcer:
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