



# Discussion Topics: Challenges to Early and Effective Treatment of Schizophrenia

*As part of the meeting, several questions and areas of discussion were raised. The following summary represents some of the key issues and comments from the attendees.*

## How does psychiatric treatment differ from medical treatment?

First, there may be differences in treatment strategy. In cancer treatment, for example, the strategy may be either to start with the “big gun”

(the highest-efficacy drug)—even if it has a high adverse effect burden—and then back off when the patient is through the critical, acute phase of treatment; or, alternatively, to start with the medication that has the most benign adverse effect profile and, if the response is inadequate, to escalate

quickly to the big gun. In contrast, psychiatric treatment usually does not employ the big gun (eg, clozapine in schizophrenia) until multiple other medications have been tried.

Second, there are differences in insurance coverage. Traditionally, insurance provides less coverage for mental health than for physical health. Although mental health parity has been a reality for government benefits for some time, that mandate has only recently been extended to private insurance (with a number of significant loopholes).

Third, there are differences in societal attitude; stigma is still an issue, and can make it more difficult for patients to accept and follow through with treatment. Fortunately, stigma, although still considerable, is decreasing. This is not so much because people are seeing schizophrenia as a brain disorder (as opposed to a mental illness); people still do

“People with schizophrenia have more chronic medical illness. They’re actually more likely to die of chronic medical illness than they are of suicide or accidental death. They’re more likely to be obese, more likely to be diabetic, more likely to have heart conditions. Some of this is a result of the illness itself, it appears. Some of it is a result of the medications we use to treat, packing on pounds. And some of it is the access to medical care and the stigmatization. You go into the ER, and if you’re on Thorazine, they’ll call a psychiatrist first even though you may be having a cardiac event.”

*Joseph Parks*



not view schizophrenia in the same way that they view, say, diabetes or heart failure. The reduced stigma is probably more the result of an increasing perception of treatability; people stigmatize that which makes them feel helpless. Perceived treatability of psychiatric illness took a leap forward when selective serotonin reuptake inhibitors were introduced, and another leap with the advent of atypical antipsychotics, which helped to reduce the neurologic side effects that contributed to stigmatization of patients with schizophrenia.

While some psychiatric disorders, such as major depression, have become relatively mainstream, there is still considerable stigmatization and disenfranchisement of patients with schizophrenia, even within the health-care system; and this can result in sub-optimal treatment. There may still be a willingness to emphasize cost over benefit—for example, in choosing between a generic conventional antipsychotic versus a branded atypical agent, in some instances the generic agent may be prescribed, not because it happens to be the best drug for that patient, but because it is less expensive—overlooking, for example, the higher risk of tardive dyskinesia. This approach would not be tolerated in the treatment of a medical condition such as hypertension—for example, if hydrochlorothiazide were associated with a similar risk of tardive dyskinesia, no one would put patients on it just because it is generic.

Stigma may also affect the way patients with schizophrenia are treated for medical conditions. Schizophrenia is associated with high rates of medical comorbidity; it could almost be considered a marker for having multiple chronic medical conditions, including cardiovascular disease. Yet, when a patient with schizophrenia presents at the emergency department, often a psychiatrist is called first, although the patient is having a cardiac event. Emergency department staff may need to be educated about this problem.

“We have very fragmented care.... We have the kidney doctor separate from the internist separate from the psychiatrist, and that’s our business model. We don’t do it because it’s good to have 3 different clinical records; we do it because it’s more convenient to set up and pay for services that way.”

*Joseph Parks*

“I still think there is somewhat of a stigma and somewhat of a disenfranchisement on schizophrenics, and I do think that affects treatment.”

*Robert L. Dufresne*

### **Do benefit managers and medical directors work collaboratively to optimize cost associated with disease state management—so that consideration is given to concurrent management of medical and psychiatric disease?**

Collaborative management occurs infrequently; healthcare is still very fragmented. Healthcare is compartmentalized into medical versus psychiatric versus pharmacy domains, with each domain or “silo” managed and budgeted separately. Medical and pharmacy directors are each challenged to reduce costs; however, each silo lacks access to integrated data that would permit evaluation of the big picture—nor is there any incentive to manage the whole patient. This often results in different services working at cross-purposes to each other. For example, use of less expensive (but less effective) medications may increase rates of hospitalization and other medical interventions. This not only compromises patient outcomes, but may also increase total costs.

Integrated systems can provide the data needed to measure out-

comes across domains. The Veterans Administration (VA) is an example of such a system. The VA maintains a large national database that tracks individual patients, wherever they are located. Such a database should make it possible to look at gaps in care, to analyze what is and is not working. However, even in the VA system, there is still a silo approach, a disconnect between the different domains and overall treatment outcomes.

Although the silo approach fails to improve outcomes and reduce costs, it persists, at least in part because it is administratively convenient for payers. It also appears to be a cultural problem: people are used to having separate compartments, we’re conditioned to think that way.

### **What can be done to minimize or eliminate barriers of access to care that may be particularly challenging for patients with cognitive impairments and low frustration thresholds?**

As mentioned earlier, people with schizophrenia have high rates of medical comorbidity. However,



“We go back to the much more conservative treatment methods that have been around forever, and cut the ones that have demonstrated value in the last few years. And family therapy is one, and training family members and close friends of patients with schizophrenia how to interact with them and how to see the early signs of them deteriorating. To try to have an intervention before they’re required to have a hospitalization, clearly, pays for itself. But that’s one of the kinds of services that frequently, in a contracting budget period, ends up being cut.”

*Doug Noordsy*

these patients often get “lost” between psychiatry and primary care. One simple thing that can be done to improve access is to have psychiatric and primary care services available to them in the same location, on the same day. If patients do not have to keep different appointments on multiple days, they can navigate through the system more easily.

As budgets contract, the most patient-friendly interventions are often the first to be cut because they’re perceived as “fluffy”—for example, medication monitoring in the home; family therapy; teaching family members and friends how to interact with the patient and how to recognize early signs of deterioration. Yet these interventions have been demonstrated to reduce relapse rates and cost of care. Overall, the way to eliminate access barriers is

to integrate systems, to bridge the “disconnects” between silos so that decision makers are aware of total costs.

### **How should clinicians and payers apply the concept of early and effective treatment? What benefits would this have for patients, and what are the challenges in applying these principles?**

There is a call for “best practices” (ie, evidence-based guidelines for schizophrenia treatment) to avoid trial-and-error prescribing. One of the challenges to developing and using such guidelines is that many clinicians misunderstand the concept of evidence-based medicine (EBM) as

a “cookbook” approach that relies solely on clinical trial results, to the exclusion of clinical experience and judgment. EBM—what it is, what it isn’t, and how clinicians can use it to benefit their patients—will be discussed in an upcoming newsletter, the second of this 3-part series.

There is also a need for consistent use of outcomes measurement in clinical psychiatry. Unlike the situation with nonpsychiatric medical disorders, there are few objective measures in psychiatry. We use rating scales such as PANSS and BPRS in clinical trials, but we do not use them routinely in clinical practice. Instead, psychiatrists are accustomed to using global, subjective judgment to guide treatment decisions, and there is little motivation to change this practice. Clinicians often feel that they do not have time to use quantitative measures such as rating scales. However, psychiatric rating scales do not have to be time-consuming and cumbersome; there are short instruments that are reliable and valid.

To increase the motivation to use such instruments, it is critically important not only to educate clinicians about their use, but also to reimburse time and resources spent using them. If necessary, *Current Procedural Terminology (CPT)* code definitions could be amended to include a requirement for documenting quantitative measurement of symptom change over time; payers could then deny claims that do not include such documentation.

Another challenge to early and effective treatment is the need to get first-episode patients and their support systems on board with the idea that schizophrenia is a significant illness that needs aggressive treatment. To do this, clinicians need to spend a lot of time with first-episode patients and their families—time which, again, is not well reimbursed. Perhaps also, better resources are needed to educate patients and their families, and to

“There’s no more powerful reinforcement than people getting better and tolerating the treatment. I think that’s a really good argument for early and aggressive treatment, because if they have a favorable response and their adverse effects are dealt with quickly, that’s going to make them more likely to be adherent in the future. It’s a good upward spiral.”

*Lawrence J. Cohen*



motivate them for what is a very challenging battle, parallel to that of a cancer diagnosis.

**Studies have shown that, over an 8-week course of treatment, early responders have lower total treatment costs than early nonresponders. What message or insight can payers take away from this?**

First, it's counterproductive to set up systems where it takes 8 weeks to get an appointment with the psychiatrist. It is critical for patients to have rapid access to a psychiatrist—or, alternatively, for primary care to manage antipsychotic medication until the patient can get a psychiatry appointment.

Second, it is important to provide access to all of the antipsychotic drugs; if any authorization is required, it should be flexible, rapid, and responsive. There are various ways of structuring formularies to provide access while controlling costs. Formulary considerations will be discussed in the third newsletter of this series.

Third, it's an argument for putting patients into case management sooner rather than later. First-episode patients are the ones most in need of a case manager to help them to manage their illness, to see whether they need a treatment change and help them navigate the system to obtain it. Yet

“About the depot issue: I've actually had fairly good success with not trying to convince the person to take it now, but 'I'd like to talk to you about this medication. And if you'd like it now, that would be fine. Or, if you again stop the medication, that's telling me that you really should think about this the next time you come in.' And when they come back, they very frequently say, 'Yeah, we can talk about starting that other medication that I can take by a shot.'”

*Stephen Saklad*

case management is typically reserved for chronic patients, thereby missing an opportunity to influence the critical early trajectory of the illness.

**How do you rate the importance of adherence to drug therapy?**

A drug can be effective only if it's being taken.

One way to improve adherence is to use depot injections. Depot formulations have been shown to be effective. But although nonadherence rates are high among first-episode patients, depots are generally reserved for patients who have already repeatedly stopped taking their medications and had multiple relapses. One possible reason for this has to do with access barriers: to minimize the costs associated with administering injections, some formularies are set up to require nonadherence before depots can be

prescribed. Another possible reason has to do with stigma: patients may see depots as a punishment for not taking their medicine, rather than a convenience that makes it possible not to have to take pills every day. Also, it may actually not be convenient to go to the provider who gives the injection; it's often much easier to take pills that come in the mail or that can be picked up at the pharmacy. One way around this is to have the injections administered at the pharmacy, by pharmacists who are trained to do so, by a more conveniently located primary care physician/nurse practitioner, or even in the home by a visiting nurse.

However, there is no more powerful reinforcement for patients than getting better. Rather than wait for failure, the focus should be shifted to early and aggressive treatment (including early use of depots, if desired)—because a rapid and sustained favorable response will increase the likelihood of subsequent adherence.

The opinions expressed in the article do not necessarily reflect those of the publisher, editor, editorial board, or sponsor of this supplement.

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A204



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## DISCLOSURES

The faculty report the following disclosures:

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Consultant/Advisory board:  
AstraZeneca, Lilly, Wyeth;  
Honoraria: AstraZeneca, Forest, Lilly.

Robert L. Dufresne, PhD, PhD, BCPS, BCCP:  
Advisory board: Johnson & Johnson, Eli Lilly; Expert testimony: AstraZeneca; Lecturer: Johnson & Johnson, Eli Lilly.

John M. Kane, MD:  
Consultant/Advisory board: Bristol-Myers Squibb, Janssen, Lilly, Otsuka, PGxHealth, Wyeth; Lecturer: Bristol-Myers Squibb, Janssen, Lilly, Otsuka; Stockholder: MedAvante.

Joseph Parks, MD:  
Consultant: Eli Lilly, Janssen, Solvay, Wyeth; Employee: Missouri Department of Mental Health; Pending grants: National Institute of Mental Health; Grants received: Substance Abuse & Mental Health Services Administration; Honoraria: National Alliance on Mental Illness Alabama.

Douglas L. Noordsy, MD:  
Consultant/Advisory board: Lilly; Grants: Janssen; Honoraria: AstraZeneca, Lilly, Pfizer.

Stephen Saklad, PharmD, BCPP:  
Advisory board: Lilly Academic PharmD Advisory Board; Honoraria: Dartmouth University; Speakers' bureau: Bristol-Myers Squibb, Pfizer.