TAKING ISSUE

Who Receives Long-Acting Antipsychotic Medications?

In my psychiatric rotation in medical school in 1972, I quickly learned that depot fluphenazine was used for "noncompliant" patients. In 1978, I found, to my consternation, that my mental health center prescribed this medication significantly more often to African-American patients than to Caucasians. Similar prescribing practices were found in other settings. In 2006 psychiatrists have two other long-acting injectable medications to choose from, and we consider the term "noncompliant" to be pejorative and prefer "nonadherent." But we still believe that these agents are for nonadherent patients. We have not made much progress over the past 30 years.

In this issue Shi and colleagues report on a large three-year, prospective observational study of patients treated for schizophrenia. Although the study, funded by Eli Lilly and Company (for which I am a consultant and speaker), was not designed to identify why clinicians choose depot antipsychotics, it is the most comprehensive one to characterize the patients receiving these medications. The authors report that patients treated with a first-generation depot medication were more likely than those receiving oral medications to be younger, male, African American, less educated, and more clinically and socially dysfunctional. Over the one-year follow-up period adherence improved while these patients received depot medications.

The study would suggest that nonadherence is not the only indication for depot antipsychotics. However, if nonadherence is a reasonable indication for these medications, then we are not coming close to meeting that need. The low point prevalence of use of these agents in the United States (10%–15%) hardly matches the estimated rate of nonadherence (>50%) in the population treated. So what, exactly, is the indication for depot antipsychotics?

Little evidence supports the characteristics noted in the study as predictors of nonadherent behavior. And common sense tells us that this small subgroup of patients is not the only one to benefit from long-acting antipsychotics. So what has happened? For reasons that are too complex to discuss here, we seem to relegate the use of depot medications to uninsured, substance-abusing patients who belong to racial and ethnic minority groups or have criminal histories.

Shi and colleagues' findings indicate a need for a deeper understanding of our prescribing behavior with depot antipsychotics. We seem to prescribe these medications with erroneous assumptions that reveal some prejudices—such as prescribing them on the basis of race or predicted dangerousness rather than problematic adherence. We must explore why U.S. clinicians, compared with many non-U.S. clinicians, resist using long-acting antipsychotics. We need to look at cultural forces that may drive what, I fear, is a punitive attitude in our prescription of depot medications.—WILLIAM M. GLAZER, M.D., *President, Glazer Medical Solutions*

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