

CATIE and the Value of Atypical Antipsychotics in the Context of Creating a Recovery-Oriented Behavioral Health System

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Abstract This paper discusses the implications of CATIE findings within the context of an active recovery-oriented systems transformation effort of the Philadelphia behavioral health system. The authors argue that atypical antipsychotics should maintain an important role in a transformed system, but that symptom reduction and medication compliance should not remain the cornerstones of treatment services. The findings suggest that we need to better understand and positively influence the therapeutic relationship between consumers and providers as they relate to treatment participation and engagement. Psychotropic medications need to be discussed within the context of developing positive, empowering therapeutic relationships and offering psychosocial rehabilitation supports that together can enhance functional outcomes that individuals most desire. Examples of specific efforts to develop a CATIE-informed, recovery-oriented systems transformation are offered.

Keywords Mental health policy · Systems transformation · Recovery · Medication compliance

Introduction

A 17-year lag has been found between published treatment advances and their adoption into routine clinical care (IOM, 2003). However, every once in awhile a groundbreaking study is published that gains immediate recognition, generates significant discussion, and quickly germinates seeds of action. The clinical antipsychotic trials of intervention effectiveness (CATIE) study (Lieberman et al., 2005) is emerging as a study that may have such an immediate impact. CATIE investigators examined the relative clinical effectiveness of first-generation (i.e., perphenazine) and second-generation antipsychotics and have thus far reported, among many other findings, that 74% of all patients discontinued the study medication before 18 months primarily due to ineffectiveness or intolerable side effects with only modest differences in efficacy and marked differences in side effects found among perphenazine and the second-generation antipsychotics.

The initial response to the CATIE findings has been vigorous, partly due to the implicit cost-effectiveness issues that are raised in a period of increasing pharmacology costs and flat or shrinking mental health care budgets. Two CATIE investigators have admitted “surprise” at the general lack of efficacy differences between the second-generation medications and the much less expensive first-generation medication and conclude it indicates that first-generation antipsychotic medications remain useful and should not be discarded (Lieberman & Hsiao, 2006). However, they also point out that it does not logically follow that the older, less expensive medications can replace the more expensive, newer antipsychotics. In fact, they contend that the CATIE findings should lead policymakers to increase

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medication options and reduce formulary restrictions in order to allow prescribers to identify the medication option that produces the most favorable results for each individual.

Luchins, in this journal (2006a), raises serious questions about what the CATIE findings mean for policymakers and mental health administrators in the context of \$8.5 Billion dollars being spent annually on antipsychotics, much of it spent on the much more expensive second-generation medications. Elsewhere, Luchins (2006b) offers his real-life dilemma as the clinical director of the Illinois Mental Health Authority of having to deal with flat budgets and rising second-generation antipsychotic drug costs that led to the decision to reduce funding for other services, presumably psychosocial interventions. This zero-sum situation, expensive medications versus psychosocial interventions, where medications usually win out, occurs in real-world Departments of Mental Health across the country. This reality seems to underlie Luchins plea for pharmacoeconomic studies that take psychopharmacology out of a vacuum and places them fully within a context in which psychosocial, evidenced-based practices are also present. Ragins (2005) suggests that the CATIE should be a “wake-up call” for researchers who he claims fail to pay attention to the interplay between psychopharmacology effectiveness and doctor-patient relationships, psychosocial interventions, and system orientation (i.e., adoption of recovery orientation). Lieberman and Hsiao (2006) respond that functional outcome differences and receipt of rehabilitative services were assessed and will be reported in future papers.

The aforementioned dialogue about the initial CATIE findings for mental health system administrators is occurring in the midst of three significant, highly interrelated policy realities—health care finance pressures and rising pharmacology costs, pressure to adopt evidence-based practices, and simultaneous proclamations for systems transformation and adoption of a recovery orientation (i.e., New Freedom Commission on Mental Health, 2003). Mental health care financing discussions have been a constant concern of policymakers and administrators and the current momentum to adopt evidence-based practices represents a continuation of best practices efforts begun in the 1990s. It is interesting to note that the epiphany-like excitement about moving towards a recovery orientated service philosophy was raised by mental health consumers (e.g., Campbell and Shraiber, 1989; Chamberlin, 1978; Chamberlin & Rogers, 1990) and others (e.g., Anthony, 1993) many years ago. The enthusiasm and steps toward adopting this vision is consistent with the pre-

viously mentioned lag discussed by the Institute of Medicine (2003).

In this paper we discuss the value of the CATIE findings and atypical antipsychotics, but do so in the context of describing an active recovery-oriented system transformation effort in the Philadelphia Behavioral Health System. The description of this systems transformation effort, one that is fully informed by the CATIE study, offers an alternative to policy responses involving simple formulary restrictions on the use of atypical antipsychotics or equally simple services responses to enhance medication compliance through any means possible, including coercive means. The former response is clearly not justified solely on the CATIE findings, as argued by Lieberman and Hsiao (2006), and the latter response is unlikely to achieve their objectives and furthers the misguided perspective of the person in services as an object to be “treated” rather than as a full participant and director of the process. Descriptions of transformation efforts in the context of CATIE findings can spur additional policy discussions and inspire transformation efforts elsewhere.

The Philadelphia behavioral health system transformation involves a number of initiatives that incorporate technology and culturally competent service delivery, including an emphasis on consumer-provider communication, in an effort to ensure that individuals receive the medications that work best for them, that will ultimately increase adherence. It also includes steps toward adopting and implementing psychosocial best practices that, in combination with medication, is expected to maximize community integration and recovery. This paper will focus on four sets of efforts of most relevance in the context of the CATIE dialogue: (1) Application of technology and creating a data-driven system for effective and equitable service delivery; (2) Culturally competent service delivery and targeting consumer-provider communications; (3) Altering the configuration of day treatment programs; and (4) Developing new initiatives to increase peer support and self-determination.

Technology to Improve Service Delivery and Ensure Equity

The Philadelphia Department of Behavioral Health is moving toward becoming a more data-driven system that integrates information into policy planning, development, and implementation. An integrated management information system (MIS) involving mental health, substance use, criminal justice, child welfare, homeless services, and crisis services is being designed. Current efforts are underway to incorporate

client-level psychosocial outcomes data into the system to complement the individual-level service use data. One particularly innovative component of this system may be the inclusion of data whereby prescriptions can be examined in real-time and the potential of linking this system to pharmacies to monitor whether or not prescriptions are being filled. A demonstration study of such a prescription monitoring system is currently being conducted in partnership with the University of Pennsylvania School of Medicine. Reports will be produced and actively incorporated into the decision-making process. One goal of these efforts is to ensure the equitable distribution of behavioral health services to limit any disparities that may exist. The MIS will allow policymakers to undertake a four-pronged initiative to assess for potential disparities in access, retention, services profile, and effectiveness.

The prescription monitoring system is particularly relevant in the context of the CATIE findings. At a system level it can be useful to understand atypical antipsychotic prescribing patterns, estimate potential pharmacology costs in real-time, and examine medications in relationship to the delivery of psychosocial interventions. At an individual consumer level it could be useful in ensuring continuity of care in prescribing from outpatient to inpatient settings. It could also offer an organized, longitudinal picture of medications prescribed to a particular individual in order to enhance a clinician's ability to identify medications that may have been helpful, or unhelpful, to the individual in the past, including a better understanding of side effect profiles. Finally, better linkages to pharmacies can lead to earlier intervention in cases when prescriptions are not refilled to potentially prevent relapse and hospitalizations.

Culturally Competent Service Delivery

Eliminating disparities in service delivery and ensuring that services are family- and person-centered will be partly accomplished by initiatives to ensure that the system is culturally competent and meets the needs of all Philadelphia residents. This will be achieved by systematically addressing identified behavioral health disparities through a broad-based, data-driven process. This process will also foster enhanced partnerships with religious organizations and community groups, to ensure that the behavioral health needs of specific community members are addressed. Moreover, increased training and technical assistance will be utilized to ensure that services are fully accessible, responsive to individual needs, and effective for the various cultural groups that receive services in the treatment system.

Consumer-provider communication is obviously a key factor in providing culturally competent services. A significant amount of attention has been paid to training the provider to improve their communication, and similar efforts are occurring in Philadelphia. Of particular relevance to the CATIE study is that enhanced training of case managers, psychiatrists, nurses, and others will focus on biases that may lead to disparities and communications regarding medications and especially how to improve the therapeutic alliance that has been discussed as critical for improving treatment adherence (Blackwell, 1997). CATIE results further suggest that training for consumers is also critical. One unique approach being taken in another demonstration study is to educate and motivate consumers in order to alter the treatment relationships. Patient distrust of non-rationally concordant providers may lead to poorer communication and disengagement from treatment (Cooper-Patrick et al., 1999, 2003) that likely affects both the quality of care received, including treatment disparities, and treatment adherence. Whites might be more trusting and engaged in treatment compared to African-Americans and, therefore, might be more inclined to express concerns about medication effectiveness and side effects. This could result in Whites receiving more effective medications and experiencing fewer side effects, with greater likelihood of adherence. A brief, telephone-based intervention, modeled on a similar previous effort for enhancing adherence (Salzer, Tunner, & Charney, 2004), is being tested with persons diagnosed with schizophrenia and depression with the goal of enhancing trust of their provider, motivation to be more engaged in treatment decision-making, and improved communication. This low-cost intervention could prove to be a powerful tool for addressing some of the issues raised by the CATIE study about the need to prescribe medications that is most effective with the least disruptive side effects at a tailored dose for each individual. The introduction of medication algorithms and similar techniques are other strategies for reducing disparities by promoting a systematic and consistent approach to the administration of medication.

Reconfiguring Day Treatment Services

The old maintenance-oriented system paradigm that focuses on symptom reduction and stabilization put psychopharmacology at the core of mental health services. The recovery-oriented system perspective focuses on enhanced community integration, well-being, and recovery. From this perspective symptom reduction and stabilization are seen as, at most, a means to

an end, and possibly even independent of recovery, based on the idea that people with mental illnesses can live satisfying and fulfilling lives (Anthony, 1993) with or without psychiatric symptoms. From this perspective, medications obviously play an important role in such a system, but not the central role.

Efforts are underway to create a continuum of supports that enhance community integration, defined as the opportunity to live in the community like everyone else, and ultimately facilitate recovery. The continuum includes a decreased emphasis on facility-based services and increased investment in service supports that meaningfully engage people out in the community. These services will be designed to increase opportunities for employment, education, leisure activity, spirituality, development of social relationships, and other life domains. These are the types of supports that, when combined with effective prescribing and solid therapeutic relationships, lead to enhanced community tenure and high quality lives in the community that are not dominated by the distress caused by residual symptoms. We imagine that this is an approach that is consistent with the system perceived of by Ragins (2005).

Peer Support and Self-Determination Initiatives

A prime focus of the Philadelphia system transformation is to ensure that it is consumer- and family driven. Philadelphia has long supported consumer-operated services that are viewed as a best practice (Salzer & MHASP Best Practices Team, 2002). These support programs are being integrated into the continuum of day treatment services available to individuals. These efforts are undertaken to promote self-management and self-determination skills, and increase responsibility for one's life, including heightened responsibility for being an active participant in treatment. As noted earlier, more active engagement should result in more effective prescribing, fewer side effects, and ultimately enhanced community integration and recovery. Other initiatives underway include a widespread promotion of Wellness Recovery Action Plans (WRAP) and a peer support specialist training program and creation of new peer support specialist positions within community mental health agencies.

Conclusion

The initial CATIE findings need to be seriously considered by mental health policymakers and adminis-

trators. One response to CATIE could be to undervalue atypical antipsychotics and limit formularies. Luchins (2006b) described being part of a difficult decision to cut other programs in favor of allowing unfettered prescribing of second-generation medications and now calls this decision a mistake. However, this scenario suggests that policymakers are only faced with simple cost tradeoffs (i.e., medications for psychosocial services) within a constrained budget. Another approach is to restructure a behavioral health system by holding the psychopharmacology budget constant, and maintaining a role for atypical antipsychotics as a valuable treatment option for consumers and providers, and altering the remaining service package, possibly using the same budget, to meet systems transformation goals and adoption of a recovery-oriented system. This is the approach being taken in the Philadelphia behavioral health system as described above. The goal is to create the kind of service setting that is implied as being critical in effective treatment by Ragins (i.e., good doctor–patient relationship; strong patient beliefs in medication efficacy; integration of important support services; and services provided in a recovery-oriented context) without necessarily restricting consumer and prescriber medication options. More light on the most cost-effective approach to be taken might be shed in the publication of additional CATIE results or in publications resulting from the publication of results from the types of cost-effectiveness studies requested by Luchins (2006a). The vigorous dialogue will likely continue while we await these results.

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