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Regional Update

Consensus statements on adherence issues in schizophrenia for Hong Kong

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ABSTRACT

Aim: In view of the clinical importance of the adherence issues in schizophrenia management, a consensus group of experienced local psychiatrists and nurse specialists gathered to outline a number of consensus statements for clinicians to consider enhancing adherence in their patients.
Process: Prior to the consensus group meeting, three core members drafted eight statements on the issue of adherence in schizophrenia. Using a modified Delphi method, published literature and published guidelines regarding the management of schizophrenia were reviewed by the full panel during the group meeting. After discussion and reflection from each individual member of the consensus group, the eight statements were reworded and electronically voted on anonymously in two steps: acceptance on quality of evidence and practicability in implementation.
Results: After modifications of the original statements, there was very high overall level of agreement and acceptance (reaching international standard) on all the five areas of adherence within the eight statements of the finalised statement.
Conclusions: The present consensus statements are the first in Hong Kong to address systematically adherence issues in schizophrenia management. They include areas on adherence assessment and definition, treatment strategies in enhancing adherence, and treatment considerations at specific phases of schizophrenia. They are tailored to be of practical utility in the local Hong Kong setting.
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1. Introduction

Adherence to treatment is essential for patients with schizophrenia to achieve clinical remission. Despite the availability of new drugs with improved efficacy and safety profiles, poor adherence remains a major issue in schizophrenia (Masand et al., 2009). Studies have shown that up to 20–40% of patients with schizophrenia fail to adhere to treatment (Chen et al., 2010; Valenstein et al., 2006), and poor adherence may have significant impact on the clinical outcome of patients, leading to psychiatric complications, treatment resistance, and increased risk of relapse, comorbidities or even suicide (Masand et al., 2009). As a result, adherence should be assessed accurately and regularly so that measures can be readily implemented in case of lack of adherence.

In Hong Kong, clinicians often fail to detect non-adherence (Hui et al., 2006). There is no standardised procedure for the regular assessment of patient adherence. Standardised treatment regimens in enhancing adherence are also lacking. In view of this, a consensus meeting was organised in Hong Kong as an attempt to develop a local consensus to enhance adherence in the treatment of schizophrenia, including proper clinical assessment, use of long-acting injectable antipsychotics (LAIs), and various psychosocial interventions. The essence of the consensus statements is to provide a review of current knowledge and opinions concerning

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the management of schizophrenia. The foundation of the statements is evidence-based medicine, but interpretive comments from the consensus group based on their expertise were provided to back up the statements in case of inadequate or contradictory evidence (Couetil et al., 2007). Comments from the consensus group on the statements are also key to identify research gaps to guide future research.

2. Methods

A meeting was held on 23rd July 2013 in Hong Kong, and the consensus group included council members of the Hong Kong Association of Psychosocial Rehabilitation and local clinical healthcare professionals experienced in the management of schizophrenia. Prior to the meeting, three core members of the consensus group, based on clinical experience on the issue and literature search, drafted 8 consensus statements. Five areas were identified as important and relevant, viz.: (1) adherence assessment; (2) defining adherence; (3) pharmacological interventions; (4) psychosocial interventions; and (5) treatment considerations at specific phases of illness. The literature search was performed using the PUBMED database with the following keywords: 'schizophrenia and adherence', 'atypical antipsychotics and adherence', and 'psychosocial intervention and adherence'. Only those papers published after 2000 were included, and reports that specifically address the adherence issue in schizophrenia were included.

The modified Delphi method (Leung et al., 2013; Linstone and Turoff, 2002) was abbreviated and employed for the formal face-to-face expert focus 'consensus group' meeting. First, the core members took turns to present the statements along with the associated research evidence. After a comprehensive review and free discussion, all (eleven) members of the consensus group voted anonymously on each statement using electronic voting devices. With reference to the methodology used by Ooi et al. (2010), each statement was rated according to both (1) classification of recommendation (based on good, fair or poor scientific evidence to support or refute the statement), and (2) practicability of recommendation in Hong Kong (accept or reject with or without reservation). A consensus statement was only accepted if at least 80% of the participants voted "A" or "B" for classification of recommendation, and at least 65% voted "A" or "B" for practicability (Table 1).

3. Results

After discussion, all eight consensus statements were finalised and accepted by the consensus group. The statements were categorised into five major parts. The first two parts (statements 1–4) focused on the predictors, assessment and definition of adherence, laying a foundation before addressing pharmacological and psychosocial interventions for adherence in Parts 3 and 4 (statements 5–7). Part 5 (statement 8) addresses treatment strategies at different phases of the course to enhance adherence and clinical outcome of schizophrenia.

3.1. Adherence assessment

3.1.1. Statement 1: Patients with multiple complex predictors should be identified as having a risky profile for non-adherence

Voting on

1. Classification of recommendation: A-55%, B-45%, C-0%, D-0%, E-0%
2. Practicability of recommendation: A-36%, B-55%, C-9%, D-0%, E-0%

After reviewing the various major references (Hui et al., 2006; Oehl et al., 2000; Valenstein et al., 2006; Velligan et al., 2009), it was agreed that 'medication adherence' is associated with four main factors, which may be characterised as patient-, physician-, treatment-, and environment-related (Oehl et al., 2000). Patient-related factors mainly refer to demographic parameters. For instance, patients of young age and male gender, patients with comorbidities such as substance abuse and mood symptoms, and patients with lack of formal education and poor illness insights are more likely to be non-adherent (Hui et al., 2006; Valenstein et al., 2006; Velligan et al., 2009). Health beliefs in terms of patients' perceptions towards antipsychotic medication, subjective wellbeing and quality of life are also correlated with adherence (Oehl et al., 2000; Velligan et al., 2009). Physician-related factors including therapeutic alliance and having a well-structured treatment plan have an important impact on adherence; whereas treatment-related factors including the benefit/risk ratio of medication and route of administration, and environment-related factors such as the level of family/social support are also associated with the level of adherence (Oehl et al., 2000; Velligan et al., 2009).

In Hong Kong, previous local studies exploring antipsychotic adherence in patients with schizophrenia concluded that predictors of non-adherence included awareness of illness, attitudes towards treatment, perceived benefits of medication, younger age, prescription with clozapine, and symptom severity (Bressington et al., 2013a). It is therefore important that healthcare professionals be advised to take note of patients' medical history and their clinical/emotional status throughout the course of illness, as well as supervise their treatment

Table 1
The grading system for each consensus statement during the voting session.

Quality of evidence	Classification of recommendation	Practicability of recommendation
I: Evidence obtained from at least 1 randomised controlled trial	A: There is good evidence to support the statement	A: Accept completely
II-1: Evidence obtained from well-designed control trials without randomisation	B: There is fair evidence to support the statement	B: Accept with some reservation
II-2: Evidence obtained from well-designed cohort or case–control study	C: There is poor evidence to support the statement but recommendation made on other ground	C: Accept with major reservation
II-3: Evidence obtained from comparison between time or places with or without intervention	D: There is fair evidence to refute the statement	D: Reject with reservation
III: Opinion of respected authorities, based on clinical experience and expert committees	E: There is good evidence to refute the statement	E: Reject completely

Modified from the Canadian Task Force on the Periodic Health Examination [Barkun], Ooi et al. (2010).

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