Treatment Adherence

Physician Monograph

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Introduction

A variety of terms including compliance and adherence have been used to describe the phenomena of patient follow through with treatment. Many healthcare practitioners and patients prefer the term adherence because it connotes a collaborative agreement regarding a treatment plan that has been established in the context of a therapeutic alliance between patient and provider.

The impact of adherence in schizophrenia and other serious mental disorders on morbidity, function and service use has been well established. Long-term studies have reported that non-adherence accounts for 33%-73% of all instances of rehospitalization.[1] Weiden and Olfson[2] report that, when discharged patients stop their medication, relapse rates go up from about 3.4% a month to about 12% a month. They estimate that non-adherence accounts for at least 40% of all episodes of relapse and subsequent readmission to a psychiatric facility. In fact, while medication gaps for antipsychotic use of greater than 3 months is associated with increased rates of hospitalization for individuals with schizophrenia, gaps as small as 10 days have been shown to double hospitalization rates.[3] Missing or stopping antipsychotic medications is also associated with increased emergency room visits and homelessness.

Non-adherence to second generation antipsychotic (SGAs) or atypical antipsychotic agents continues to be a major problem for 40-50% of patients with schizophrenia suggesting that improvement of side effects has not had the impact many people expected.[4] By self-report, 20% of patients with schizophrenia reported missing one week or more of oral antipsychotic medications during the first three months after hospital discharge.[5] Another study found non-adherence following discharge from inpatient care to be at least 50% after 1 year and as high as 75% at 2 years.[6] The finding of the CATIE study of a 74% all-cause treatment discontinuation even with SGAs further emphasizes this point.[7]

Clinicians generally overestimate their own ability to identify and quantify non-adherence among their patients, highlighting the importance of objective and validated approaches to measurement[8]. A study found that clinicians' best estimate of the proportion of their outpatients who missed 30 percent or more of their medication was approximately 6% whereas an electronic device in the cap of the medication bottle suggested that approximately 60% of the same patients met this threshold for non-adherence.[9.] While this electronic device is quite accurate, the medication possession ratio (MPR) is a more practical and cost effective method for assessing adherence in large populations10. The MPR is derived from the number of days' supply of medication a patient has received divided by

the number of days' supply needed if the patient was taking the medication continuously.

The Physician's Role in Maximizing Adherence

The physician is a key figure in maximizing treatment adherence. Central to the physician's sphere of influence is the relationship with the patient. The physician, however, can impact other important factors including engagement of both the family and the treatment team (e.g. case managers) around the principles of adherence. As the team leader, the physician can work to improve understanding principles of successful treatment and recovery. Family education and involvement can also be a very important asset in the patient adhering to treatment.

Challenges

The provider-patient relationship has been suggested by some to impart the greatest value in influencing treatment adherence. In surveys of patients, a number of important provider qualities were identified including good listening skills, empathy, and expertise in prescribing. This can be particularly challenging as the goals of the psychiatric encounter have shifted over time and now focuses on assessment of symptom severity, education, negotiating a treatment plan, providing psychopharmacological treatment, and coordinating treatment provided by multiple caregivers. These data gathering functions must be balanced with development of a trusting, caring and participatory relationship with the patient. This changed role is consistent with the paradigm shift observed in mental health services where there is a focus on disease management and recovery. Therefore, it is critical for the practitioner to have mastered psychotherapy and communication skills, knowledge of pharmacology and recovery principles to be maximally effective. The physician must understand the patient's wishes and allow participation in discussions about therapy.

Techniques to Improve Adherence

Cognitive Behavioral Therapy

The goal of cognitive behavioral therapy (CBT) is to improve insight into illness, increase adherence to medication, ameliorate the severity of symptoms and mitigate other negative consequences of schizophrenia. There are a variety of CBT interventions. In general they share several common features. The first is addressing distorted beliefs about illness and developing cues to support adherence behavior. The second is improving

the ability to recognize that clinical symptoms help to make patients more aware of their ongoing need for maintenance treatment and more appreciative of the benefits of medication. The third is linking the positive effects of medications to the patient's personal goals and desires for better functioning and quality of life. CBT has been shown to be effective in reducing residual psychotic symptoms, which is indirectly linked to improved medication adherence. [11-12]

Motivational Interviewing

Motivational interviewing is a CBT technique that involves helping people articulate goals and explores how medication may aid in achieving those goals.[13] Motivational interviewing techniques must be customized for application in psychotic disorders as negative symptoms and passivity can undermine motivation for change and ability to develop goals. Successful MI begins with the expression of empathy. When a patient feels understood, this serves to enhance self-esteem and facilitate change. In addition, there must be a continuous theme that the patient is responsible for choosing and carrying out change (self-efficacy). The next step is to develop discrepancy between a patient's present behavior and their expressed goals and values. The patient, in effect, is guided to present the arguments for change. During this process, resistance is expected. The clinician should not directly oppose this resistance or argue for change but instead offer alternative perspectives. Ultimately the patient needs to be the primary resource in finding answers and solutions. Throughout the process, the clinician should support self-efficacy through his or her own belief that the patient can change.[14-15]

Behavioral Strategies

There are a variety of practical behavioral interventions based on the assumption that adherence is modified by frequent repetition and behavioral modeling. Common strategies include providing patients with detailed instructions and concrete problem-solving strategies such as reminders (pill boxes, calendars, electronic reminders, reminder phone call), self-monitoring tools (medication logs), cues (placement of medications), and reinforcements (phone calls). Behavioral tailoring involves development of strategies for incorporating medication into daily routine (environmental cues) or simplifying the medication regimen. Comparison studies have shown behavioral therapy to be superior to psycho-education. [16]

Psycho-Education

Psycho-education is a therapeutic approach to reduce relapse and re-hospitalization rates of SMI patients. It is supposed that, through increased knowledge and insight, people with schizophrenia will cope in a more effective way with their illness, thereby improving prognosis. Patient education is aimed at improving knowl-

edge about both illness and treatment with the hope that a more developed rationale for treatment will be developed and adherence will be improved. Social skills training involves teaching people skills to improve interactions with prescribers, such as how to discuss medication side effects. While psycho-education by itself is largely ineffective in improving adherence with antipsychotic medications, it has been shown to increase a patient's knowledge base. Psycho-education should be accompanied by behavioral components and supportive services.

Practical Tips In Communicating With Your Patient About Adherence[17]

- Express your understanding of the patient (empathy).
- Emphasize the value of the regimen and the benefits of adherence (self-efficacy).
- Provide simple, clear instructions and simplify the regimen to the extent possible.
- Listen to the patient, and customize the regimen in accordance with the patient's wishes.
- Elicit patient's feelings about his/her ability to follow the plan. If necessary, help patient design supports to promote adherence.
- Reinforce desirable behavior and results when appropriate.
- Encourage patients to express reservations or concerns about medications.
- "Roll with resistance" and avoid direct confrontation. Utilize principles of motivational interviewing to help patient develop solutions and answers.

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