Medication adherence and patient choice in mental health

Low adherence with prescribed treatment is common throughout medicine and is a substantial hurdle to achieving better outcomes for patients. It also has a profound impact on the clinical and economic burden for health services. The World Health Organization (2003) reports that adherence to long-term therapy averages 50% in developed countries and is even lower in developing nations. The impact of poor adherence grows as the burden of chronic disease increases worldwide but interestingly, the mentally ill are no worse (and may even be better) at adhering to long-term medications than others with long-term illnesses (Kreyenbuhl et al, 2010).

Adherence

Adherence may be defined as the extent to which a patient's behaviour (in terms of taking medication, following a diet, modifying habits or attending clinics) coincides with medical or health advice. Rates of non-adherence in mental health are difficult to summarize because they vary by setting, diagnosis and type of adherence difficulty. Rates are reported as 40–60% for antipsychotics, 18–56% for mood stabilizers and 30–97% (median 63%) for antidepressants (Patel and David, 2007).

Non-adherence with medication accounts for 40% of rehospitalization costs within 2 years and has a predicted annual cost of £2500 per patient for inpatient services and over £5000 for total service use (Knapp et al, 2004). There are also clear personal costs to the individual patient. Non-adherent patients with schizophrenia are 3.5 times more likely than adherent patients to relapse within 2 years and in both schizophrenia and bipolar disorder the risk of suicide is significantly greater in patients not adhering to medication (Patel and David, 2007).

Causes of non-adherence can be broadly categorized as intentional and unintentional. The patient's ability to understand the purpose of medication and follow his/her medication regimen may be limited by intellectual deficits or symptoms of mental illness such as disorganization and lack of insight. Another factor implicated has been the lack of access to care and financial barriers in paying for treatment, particularly in relation to homelessness. Intentional non-adherence occurs when the patient decides not to follow treatment recommendations. This is best understood in terms of the beliefs and preferences that influence perceptions of treatment and motivation to commence and continue with it.

Factors affecting adherence vary between individuals. Systematic reviews of the literature highlight that sociodemographics such as age at illness onset, age at first hospitalization, sex, socioeconomic status, marital status and ethnicity are not consistently associated with differences in adherence. In chronic diseases generally, adherence usually declines over time, but in patients with first episode psychosis, non-adherence rates can be as high as 40% and beliefs about the need for medication appear particularly important.

Low insight predicts non-adherence and improvements in insight are often accompanied by improvements in adherence (Rittmannsberger et al, 2004). However, low insight may be linked to poorer cognitive function and one study suggests that during the first year of treatment, patients with poorer premorbid functioning are more likely to discontinue medication (Robinson et al, 2002).

Alcohol and substance misuse are strong predictors of non-adherence (Patel and David, 2007). Doctors contribute to patients' poor adherence by prescribing complex regimens, failing to explain the benefits and side effects of a medication adequately, not giving consideration to the patient's lifestyle or the cost of prescriptions, and having a poor therapeutic relationship with their patients.

The ability of clinicians to recognize non-adherence is poor and rates of non-adherence tend to be underestimated. Measuring non-adherence is not simple and various methods exist. These include direct methods such as directly observed pill taking or measurement of the level of medicine or metabolite in the blood and indirect measures such as patient questionnaires and self reports, pill counts and rates of prescription refill, assessment of clinical response and electronic medication monitors (Patel and David, 2007) (*Table 1*).

Many interventions have been tried to improve adherence. Psychoeducational methods including both individual and family or group-based interventions have been shown to be largely ineffective (Patel and David, 2007). Strategies to improve dosing frequency, the use of calendar packs and dosette boxes are more simple methods which can be used. Improved communication between clinician and patient and shared decision making has repeatedly shown positive results in improving adherence. In mental health the use of long-acting injections (depot) antipsychotics provides a means of the clinician knowing how much medication a patient is receiving and is generally felt to improve overall rates of adherence.

Given the multifactorial nature of non-adherence it is clear that one single approach that will not be successful with every patient and that a combination of strategies should be used. Roter et al (1998) published a meta-analysis of adherence-enhancing interventions which concluded that 'no single strategy or programmatic focus showed any clear advantage

Table 1. Top tips for developing a positive therapeutic alliance

Style: emotionally warm, welcoming, empathy, respect offered
Time: don't appear rushed, ask and listen
Participation: allow discussion, answer patient or family concerns
Collaboration: mutual understanding, mutual goal setting

adapted from Tacchi et al (2010)

Table 2. Top tips for promoting medication adherence in clinical practice

Simplify the medication regimen, e.g. no more than twice a day or all at night
Give written instruction and verbal summary
Provide or recommend a pillbox ('dosette box')
Link medication use to daily routine, e.g. brushing teeth or morning cup of tea
Engage family or carers for reinforcement and reminders

compared with another and that comprehensive interventions combining cognitive, behavioural and affective (motivational) components were more effective than single focus interventions' (*Table 2*).

Choice

According to Rankin (2005), '…making choices is a manifestation of the rights of and responsibilities of adulthood'. Patient-centred medicine emphasizes the point that patients should play a central role in decisions about their health care and choice of care is viewed as important to the modernization of health and social care services. The NHS Constitution emphasizes the rights of patients to be involved in discussions and decisions about health care and to be given information to enable this. The expectation is that increased choice will lead to increased patient satisfaction with services, by joining up what patients want and what services provide.

Mental health is a particularly challenging area to embrace fully the concept of patient choice as mental illness may affect an individual's capacity to make valid treatment decisions. The danger is that psychiatrists too readily assume the patient is not able to deal with information and choice (Samele et al, 2007). Hope (2002) suggests two methods to facilitate patient choice including giving good quality information and evidence about treatments to the patient and including the patient's values in the decision analysis, recognizing that the best intervention for one patient may not be the best for another in a similar situation.

Intuitively, improving patient choice would be expected to improve adherence and outcomes, but research examining the effect of patient choice on adherence or outcomes is lacking in mental health. Despite this, many clinical guidelines now endorse the concept of patient choice. Studies looking at the relationship between choice and adherence in other areas of medicine generally indicate that improving choice improves adherence with medication (Mendonca and Brehm, 1983).

Conclusions

Poor adherence to prescribed treatments is a pervasive problem across all medical specialties which results in a considerable burden to the individual, health-care system and national economy. Lack of treatment adherence should be recognized as a dynamic process that changes over time and is dependent on individual circumstances and beliefs. Review of the available literature indicates that there is no single intervention that is superior in improving adherence, and that more high quality research studies are needed to further evaluate strategies aiming to improve adherence.

Improving patient choice might intuitively be expected to improve adherence in mental health, but as yet this has not been scientifically investigated. Contrary to a stigmatized stereotype, however, the mentally ill are no different to (and possibly even better than) other individuals with long-term illness in terms of medication adherence (Kreyenbuhl et al, 2010). The shift away from a paternalistic model of psychiatry to one which embraces shared decision making, promotes the therapeutic alliance, and engenders autonomy and trust should be welcomed. BJHM

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Table 1 *is adapted from Tacchi et al (2010) by kind permission of the authors.*

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KEY POINTS

- The World Health Organization regards poor medication adherence as the greatest challenge facing long-term disease management.
- In mental health, the typical medication adherence rate is 50–60%, and 40% of rehospitalization costs are directly attributable to non-adherence.
- The mentally ill have similar medication adherence rates as other chronic disease sufferers.
- Low illness insight, impaired intellectual function and substance misuse are all associated with elevated non-adherence rates in mental health.
- Doctors contribute to low adherence rates via complex medication regimens and by neglecting the therapeutic rapport.
- Promoting patient choice may improve medication adherence, but in mental health this has not been scientifically studied.