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Prescribing psychotropics CHAPTER 14 hospital. The only difference is that with the depot preparations, adherence is, for a while at least, assured (and known about) – something which cannot be said for oral medications. Improving adherence offers substantial possibilities for improving the outcomes from treatments. WHO comments that ‘increasing the effectiveness of adherence interventions may have far greater impact on the health of the population than any improvements in specific medical treatments’.1 We must also remember that medication is not the only effective treatment for psychosis. Although a meta-analysis24 and systematic review25 of such psychodynamic interventions (which included studies in unmedicated patients) confirmed the superiority of treatment with antipsychotics, the most recent systematic review of psychosocial interventions for psychotic patients (with no or low-dose antipsychotics) found the effect of such interventions to be equal to treatment with antipsychotics.26 Cognitive behavioural therapy (CBT) for psychosis has been demonstrated to reduce certain symptoms, although its effect on quality of life does not seem to be significant.27 So – we certainly need better drugs, but we need also to improve adherence. Factors affecting adherence7,28 Table 14.1 lists many of the factors that might affect adherence. Clearly, not all of these factors necessarily fit into a single category. For example, poor understanding by the patient can either be due to poor health literacy and/or numeracy or can be due to deficiencies in communication by the doctor. Assessing adherence29,30 Table 14.2 outlines methods of assessing medication adherence. For some antipsychotics such as clozapine, olanzapine, aripiprazole and risperidone, blood tests can be used to directly assess plasma levels. However, the plasma levels of these drugs attained with a fixed dose do vary, as do the therapeutic effects in individuals. It is therefore not possible to accurately determine partial non-adherence. That is to say, total non-adherence will be readily revealed (plasma level = zero) but partial and full adherence may be difficult to tell apart. Table 14.1 Factors affecting adherence. Illness-related Treatment-related Clinician-related Patient-related Environmental Lack of motivation Poor insight Grandiose delusions Cognitive deficit Thought disorder Forgetfulness Disorganisation Adverse effects Dysfunctional beliefs Inappropriate medication preparation or packaging Dosing schedules31,32 Poor therapeutic alliance Lack of follow-up Limited consultation time Poor provision of information and explanation Denial Poor insight Comorbidities Physical impairments Poor literacy Poor health literacy33 Poor understanding of treatment options Disorganised environment Family’s beliefs Religious beliefs Health beliefs

930 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 14 Table 14.2 Assessing adherence. Method Variables measured Advantages Disadvantages Direct Blood test Drug/metabolite plasma levels Accurate Invasive Costly Inter-individual variations (e.g. fast and slow metabolisers) Not reliable for all drugs (see text) Only a result of zero can be definitively interpreted Information only relevant for a very limited timeframe No information about the patterns of medication-taking behaviour, levels of adherence or factors that may change adherence Indirect Pill count Number of missing tablets/ missed prescriptions Simple to use (useful in clinical trials) Labour-intensive in clinical practice Substantial evidence that pill counts underestimate levels of non-adherence Electronic database: clinical/pharmacy records History of non-adherence (but generally with very little detail or formal assessment) Pharmacy dispensing and collection records (e.g. medication possession ratio – MPR) Readily accessible Easy to identify non-adherent patients Inexpensive Non-invasive Not reliable – only provides evidence for collection and possession of medication Self-report Validated assessment scales (questionnaires) (e.g. Medication Adherence Rating Scale – MARS) Easy to use Inexpensive Subject to reporting bias Tendency to please clinicians Massively overestimates adherence Subjective Electronic monitoring devices (e.g. Medication Event Monitoring System – MEMS) Number of times medication container has been opened and (assumed) percentage of doses removed Among the most accurate methods Objective Provides additional information on medication-taking behaviour Expensive Bulky containers Not evidence for ingestion of medication – only of container opening Patient feels under surveillance

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