08 - Enhancing medication adherence

Enhancing medication adherence

Prescribing psychotropics CHAPTER 14 Monitoring adherence and assessing attitudes to medication Psychiatrists generally prefer to use direct questioning over the use of more intrusive/ objective and elaborate methods of assessing adherence. Partly as a result non-adherence may go undetected.34 NICE recommends that the patient should be asked in a non- judgemental way if they have missed any doses over a specific time period such as the previous week.35 Issues of forgetfulness aside, whether the patient takes medication or not will be, to a significant extent, determined by their views about medication and its perceived effect on their life and condition. Rating scales and checklists can help the clinician to guide and structure a discussion of what the patient thinks and feels about medication. The most widely used is the Drug Attitude Inventory (DAI),36 which consists of a mix of positive and negative statements about medication; 30 statements in its full form and 10 in its short form. The patient completes it by simply agreeing or disagreeing with each statement. The total score is an indicator of the patient's overall perception of the balance between the benefits and harms associated with taking medication, and therefore likely adherence. Attitudes to medication as measured in this way have been shown to be a useful predictor of adherence over time.37 Other checklists include the Rating of Medication Influences (ROMI) scale,38 the Beliefs about Medicines Questionnaire39 and the Medication Adherence Rating Scale (MARS).19 Enhancing medication adherence Adherence to medication requires collaboration between the patient and the prescriber. NICE recommends that, as long as the patient has capacity to consent, their right not to take medication should be respected. If the prescriber considers that this decision may lead to harm, the reasons for the patient's decision and the prescriber's concerns should be recorded. Adherence is a complex behaviour that is influenced by malleable underlying factors. Consequently, determinants of non-adherence can be modified through patient-specific and factor-focused interventions (Table 14.3). However, most adherence-enhancing interventions are not based on a sound theoretical framework and lack methodological rigour.40 Low-quality studies and their outcomes are often not duplicated in different settings. This phenomenon was also highlighted by the most recent Cochrane review of adherence interventions when they reported that only 11 studies out of 182 included papers had the lowest risk of bias.41 Strategies for improving adherence Systematic reviews suggest that patient-specific interventions are more

likely to enhance adherence in patients with serious mental disorders.42 NICE has reviewed the evidence for adherence over a range of health conditions and concluded that no specific intervention can be recommended for all patients. Note that few studies in this area specifically recruited non-adherent patients (the refusal rate in such patients is likely to be high) and the specific barriers to adherence are rarely identified. The small effect size seen in many studies may simply be a consequence of this unfocused approach. An intervention mapping framework43 provides a way to connect determinants of non-adherence to evidence-based interventions.

932 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 14 Medication-taking aids ‘Compliance aids’ are boxes that contain compartments that can accommodate up to four doses of multiple medicines each day. These may be helpful in patients who are clearly motivated to take medication but who are disorganised or who have cognitive deficits. But only 10% of non-adherent patients say that they simply forgot to take medication, so medication-taking aids are not a substitute for lack of insight or lack of motivation. Moreover, some medicines are unstable when removed from blister packaging and placed in a compliance aid. These include oro-dispersible formulations which are often prescribed for non-adherent patients. In addition, medication-taking aids are labour-intensive (expensive) to fill, it can be difficult to change prescriptions at short notice and the process of filling of these devices is particularly error-prone.46 More sophisticated programmes of practical support, both electronic and in-person, have been shown to be effective.47 Depot/long-acting antipsychotics Meta-analyses of clinical trials have shown that the relative and absolute risks of relapse with depot maintenance treatment were 30% and 10% lower, respectively, than with oral treatment.48,49 NICE recommends that depots are an option in patients who are known to be non-adherent to oral treatment and/or those who prefer this method of administration. However, it is worth remembering that switching a non- adherent patient from oral antipsychotics to a long-acting injectable formulation does not address the underlying reasons driving that non-adherence. This has been highlighted by a recent systematic review that reported a rate of discontinuation of above 50% in those who had been prescribed second-generation depots.50 So long-acting antipsychotics do not stop non-adherence but they do prevent sudden cessation of medication and its consequences (all depots provide a slow decline in plasma levels). Table 14.3 Interventions for non-adherence.44 Intentional non-adherence Unintentional non--adherence Psychoeducation is the foundation for all adherence interventions, but without behaviour-changing components it is not overwhelmingly effective. Provides both verbal and written information. Motivational interviewing for goal-setting Adherence therapy for exploring dysfunctional beliefs about medication or the illness, providing information and goal setting. It requires more time and multiple sessions. Cognitive behavioural therapy to eradicate or control the residual symptoms that prevent adherence. To address dysfunctional beliefs about treatment. Cognitive remediation to help with cognitive deficit in psychotic patients and thought disorder Mindfulness to help with symptoms Monitor adverse effects regularly and periodically Therapeutic alliance – a non-judgemental clinician allows patients to honestly disclose their thoughts and beliefs about medication Family intervention – psychoeducation and family therapy Simplify dose regimen – reduce number of medications and/or frequency of administration Dispensing interventions – medication-taking aids EAM (electronic adherence monitoring) – evidence for this is weak45 Pairing-up medication – taking with a daily activity (e.g. having breakfast, brushing teeth or before bedtime) Use technology – messaging service, email and telephone reminders Pharmacy interventions for those with physical impairment (e.g. opening bottles)

Prescribing psychotropics CHAPTER 14 Their use can also provide certainty about the level of adherence (the injection is either given or it is not). Depots are probably underused, for example a US study found that depot preparations were prescribed for fewer than one in five patients with a recent episode of non-adherence.51 An alternative to depots is the use of long-acting oral antipsychotics such as penfluridol, which can be given weekly.52 Supervised administration obviates the need for injections but does not provide the same level of certainty over compliance given the facility that patients have demonstrated for disguising the taking of oral medication. In the USA, Abilify MyCite is approved for use.53 This is a version of aripiprazole with a transmitting sensor embedded in the formulation which is able to confirm that a tablet has been taken. Evidence for its effectiveness is slim.54 Financial incentives Controlled trials in a number of disease areas support the offer of financial incentives to enhance medication adherence. Paying people to take their medication is extremely controversial, though some clinicians have found this strategy to be effective. The effect could not be maintained in a randomised controlled trial (RCT) at 6- and 24-month follow-up after payments were stopped, and complete adherence was achieved in only 28% of patients receiving the incentives.55 Other RCTs also have demonstrated a significant increase in adherence during the trial and a decline at follow-up when payments had stopped.56 Offering financial incentives did not reduce patients' motivation for treatment.57 A systematic review of acceptability of financial incentives for health- related behaviours has raised concerns about the validity and reliability of these interventions given their methodological limitations.58 Psychological interventions In physical medicine, medication adherence has been found to be associated with health beliefs and psychological variables, such as self-efficacy and locus of control.59 Family support is also positively related to medication adherence. It is likely to be the same in psychiatry – but what can be done? One such intervention – called, at the time, 'compliance therapy' – was evaluated at the Maudsley Hospital.60 This was a pilot of a mixed intervention, consisting of active listening, cognitive behavioural techniques, motivational interviewing and the provision of information and explanation. This showed promising results in terms of increased adherence and reduced admission rates over the next 6 months. However, training for staff and supervision render it time-consuming. A subsequent replication did not show the same improvements,61 but also did not appear to have incorporated a training or supervisory element for those delivering the therapy. However, a trial of training in compliance therapy did seem to have an effect on the junior doctors involved, who felt that they were more aware of the drivers of non-adherence and of the importance of empathic listening and more able to understand why a patient might not take medication.62 One prerequisite for successful adherence to a treatment regimen should be that the patient understands the objectives of treatment, the options on offer and the rationale behind them. However, many – perhaps most – doctors have had no specific training in how to convey information and understanding to patients. Difficulties have been noted

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