

How can clinicians help patients to take their psychotropic medication?

INVITED COMMENTARY ON ... WHY DON'T PATIENTS TAKE THEIR MEDICINE?[†]

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Abstract Enhancing a patient's adherence to psychotropic medication regimens is one of the challenges facing all mental health professionals. Medication is part of an overall care package that often depends on patients' engagement with the clinician or service. The therapeutic alliance might be improved by more active listening to patients. A reduced capacity may limit a patient's ability to make a treatment choice. This can be improved by provision of more time and information. If these techniques are insufficient, closer monitoring may be achieved by working with relatives and carers, or more frequent visiting. Strategies to avoid covert non-adherence could include checking for picked up prescriptions and the use of depot preparations. Finally, the use of compulsory powers may be appropriate, with attention to preserving or rebuilding the therapeutic alliance.

Mitchell & Selmes (2007, this issue) have provided a comprehensive account of the reasons that lead people with a wide range of mental disorders to miss their medications. They have illustrated many factors that such individuals share with patients with physical disorders, and also those more specific to people with mental disorders, for example illness beliefs and capacity. The challenge is to use this information to directly influence clinical practice to help psychiatrists and non-medical case coordinators to optimise their patients' adherence to prescribed medications and improve overall outcomes. This commentary will focus on four main areas: engagement, the therapeutic alliance, information and capacity, and the use of more assertive and compulsory strategies.

Engagement

Before concentrating on specific medication issues it is important to remember that medication is not the sole focus of a mental health intervention. For people with severe and enduring mental health problems, it is necessary to attempt to help the patient improve

their quality of life by finding meaningful occupation, helping family relationships and extending social networks. In addition, the care plan may focus on help or liaison with agencies providing support with utilities, benefits, housing and debt advice. These can be seen as a means of engaging with patients and also creating an environment of therapeutic trust and hope, conditions that may help the patient to see the value of taking their medication.

The therapeutic alliance

It should not be forgotten that the problem of inadequate adherence may be the responsibility of the clinician rather than the patient. For example, Johnson & Rasmussen (1997) found that clinicians often recommended inadequate periods of maintenance antipsychotic treatment for people with schizophrenia. More likely, as Mitchell & Selmes illustrate in their review, treatment adherence problems are related to the interaction between the mental health professional and the patient – the therapeutic alliance. At the most basic level, a poor therapeutic alliance may result from genuine problems in the relationship between the care coordinator or psychiatrist and a patient. This can lead to poor treatment adherence, which in turn may

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engender frustration and negative attitudes among mental health professionals, further worsening the situation. Such difficulties should be acknowledged and discussed within team supervision. A change of professional might be considered if the difficulties within a therapeutic relationship cannot be accommodated.

Specific problems with the therapeutic alliance include doctors failing to acknowledge patients' concerns, an example of which is the failure to respond to patients who talk about their auditory hallucinations in schizophrenia (McCabe *et al*, 2002). Furthermore, doctors appear not to appreciate the degree of distress caused by certain antipsychotic side-effects (Day *et al*, 1998). There is therefore a need to listen more effectively to patients and elicit their particular concerns about their illness and its treatment.

There are few data from research aimed at improving the therapeutic alliance. However, a current controlled, multicentred European study is looking into the effects of improving the therapeutic alliance by providing regular assessment of patient needs, treatment satisfaction and quality of life (Priebe *et al*, 2002).

Many relatively straightforward approaches to enhancing treatment adherence are regularly adopted by psychiatrists themselves (Chaplin *et al*, 2007). These include checking with general practitioners (GPs) about collected prescriptions, working with families and carers to administer or monitor tablets, checking the strategies of how people remember to take their pills and the routine practice of copying to patients letters written to their GPs. In addition, psychiatrists participating in Chaplin *et al*'s study stated that they put into place many of the practical aspects of compliance therapy (Kemp *et al*, 1996) such as exploring ambivalence to taking medication, addressing the experience of stigma and promoting medication as a means of self-efficacy or a coping mechanism.

Information and capacity

One of the greatest problems in treating people with severe mental illness relates to capacity. Indeed many patients with long-term mental illness lack capacity but still remain adherent to their medication. A possible explanation is that insight may not be the only predictor of engagement or adherence. For example, Tait *et al* (2003) showed that, regardless of their insight, patients with an integrative recovery style had better engagement with services. Patients should be presented with information about their treatment on more than one occasion, in a form they can understand. Since it is difficult to judge how much information to impart, this could be augmented

with the use of information leaflets. Research has shown that people with schizophrenia can achieve enhanced capacity to consent to a research study by such interventions (Carpenter *et al*, 2000).

Assertive and compulsory strategies

Mitchell & Selmes provide a framework for improving adherence that encompasses patient-centred practice and more intrusive methods of assessing adherence such as pill counts and checking whether prescriptions have been collected. In most situations the aim is to facilitate the patient's autonomy, but there are times when more intrusive practices are unavoidable and these may threaten the therapeutic alliance. For certain individuals at specific periods, closer supervision may be required. This may be achieved by more regular contact with the community mental health team, referral to a crisis or home treatment team, or to an assertive outreach team if close supervision is needed on a long-term basis. The use of depot antipsychotic medication, or orodispersible forms of antipsychotic drugs administered by carers or professionals, helps reduce covert non-adherence, but these preparations may of course be refused.

If these techniques do not enable the individual to achieve adherence and they cannot be managed in a less restrictive manner, psychiatrists are required to consider the use of compulsion (if the legal criteria are met) to ensure engagement with services so that treatment can be offered. Although supervised discharge orders (SDOs) in England and Wales specifically prohibit the compulsory administration of medication, they may provide a framework within which the patient engages with a service and attends to receive treatment, with the option of refusing it. Pinfold *et al* (2001) found that the majority of a selective group of patients who were subject to SDOs had complied with the specified conditions. Supervised discharge orders also appeared to be effective in achieving adherence with medication despite the absence of any formal legal power to enforce treatment.

There is a small literature on the use of compulsory treatment in the community and it shows mixed results. In England, Sensky *et al* (1991) found improved outcome in terms of time spent in hospital and treatment adherence for patients given extended leave from section 3 of the Mental Health Act 1983 when compared with matched controls. However, in Australia, Preston *et al* (2002) demonstrated no advantages in clinical outcomes over matched controls for patients treated under compulsory community treatment orders. Compulsory management, of whatever type, can

be discontinued once the individual's condition has stabilised. Compulsory treatment may be achieved in many instances without permanent damage to the therapeutic alliance.

Conclusions

Adherence to prescribed medication is unlikely to be achieved in patients with severe mental illness who are not well engaged with psychiatric services and who are not experiencing good therapeutic relationships. Clinicians need to examine their own roles in the formation of the therapeutic alliance, including their attitudes, their ability to listen and respond to patients' concerns (and beliefs about medication), and the quality and quantity of information they give. However, with some people at specific times of their illness, more assertive and, infrequently, restrictive practices might be the only ways to ensure that they receive care and treatment.

Declaration of interest

None.

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