

Non-Compliance in Pharmacotherapy

Medical compliance has been defined as “the extent to which the patient’s behavior coincides with medical or health advice.” The antiquity of non-adherence gets documented in Hippocrates’ statement that “the physician should keep aware that patients often lie when they state that they have taken certain medicines.” Non-adherence is described when a patient misses his dose more than 30% of the days in a month.

Pharmacotherapy carves itself a revolutionary milestone, dissent withstanding, in the history of management of psychiatric disorders. Medications did help in (for a great number of patients) symptomatic relief – delusions, hallucinations, motor excitement, and aggression to be more specific. And relief is significant and measurable. Medicines helped in opening the gates to symptomatic recovery and thereby to functional recovery, the two essential requirements for social reintegration. The asylums became less in demand, one important reason being symptomatic relief. Thanks to antipsychotics, antidepressants, and lithium essentially. Common sense dictates that it is easier, possibly earlier, for somebody without hyperactivity and aggression, and without suspicions to return to premorbid functioning status. The stigma of mental illness is palpably lesser. Cure may be a distant dream (distinct reality!), but process of healing has begun, in a significant majority, thanks to pharmacotherapy.

It is said that it takes about 15 years and costs about \$1 billion to bring an effective new drug into the market. But the manifest efficacy of drug trials is not getting translated into effectiveness in the day-to-day clinical practice. One important reason is poor compliance, others being debatable methodology of drug trials, agreement on efficacy end points, etc.

The annual risk of relapse for patients with good compliance was 35% in comparison to 75% for those with non-compliance.^[1]

And so compliance constitutes a very important factor in successful patient management. But patient, the consumer, does not seem to be convinced. He is not willing to be on medication and his reluctance to pharmacotherapy can be frustrating to the clinician. The non-compliance rate for first episode patients within the first year of treatment was found to be as high as 59%.^[2] Cramer and Rosenheck have shown in 1998 that for chronic physical disorders, drug compliance was 75% in comparison with antidepressants at 60% and antipsychotics at 50%.^[3] Somewhat reassuring to the psychopharmacotherapist!

The proportion of patients with non-adherence has not changed since 1950 to the present day is a fact of pessimism, but a matter of monumental future challenge. Compliance (the word is looked down as a “remnant of outdated paternalistic medicine”)/concordance/adherence/collaborative care is a multidimensional issue influenced by a multitude of factors^[4] such as:

1. Physician related
 - Relationship with trust is the critical first step
 - Major reason for compliance (54%) with antipsychotic medication was the relationship with, and trust in the doctor^[5]
 - Positive therapeutic relationship and open communication channel is the key
 - Trusting relationship is a process and not a onetime affair
 - Negative therapeutic alliance is an important negative factor in poor compliance.
2. Patient related
 - The most important factor apparently is the gap between the attitude of the patient and relative about the cause of the illness that does not concur with the belief of the treating clinician. Routine Psychoeducation does not seem to change these beliefs considerably
 - In an interesting report, Rottenbacher *et al.* have shown that about 70% (only) of psychiatrists and about 35% of nonmedical professionals reported a willingness to take antipsychotic medication if they were to suffer from schizophrenia^[6]
 - Patients dislike the idea of controlling their moods by medicines, and having a chronic disease management plan
 - Misinformed and faulty risk/benefit conclusions.

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3. Illness related

- Absence of laboratory supporting evidence to confirm diagnosis, indicate relapse/worsening of illness
- Poor insight
- Comorbidity, substance abuse
- Correctness of and long-term (in)consistency of psychiatric diagnosis – shuffling of diagnosis from schizophrenia to depression or bipolar or OCD or adjustment problem and vice versa! Not very infrequently branded as pseudoscientific by our non-psychiatric medical colleagues who play a significant role in dismissing psychosis as “stress related and can be self-managed with more will power.”

4. Treatment related

- Efficacy of pharmacotherapy – “skepticism” of a few and “overenthusiasm” of many psychiatrists
- Delay in therapeutic effect
- Medication regimen: Monotherapy, polypharmacy, number of times of dosing, route of administration
- Significant, serious, and subsyndromal adverse events
- Fear of side effect rather than the side effect is a significant factor
- Nocebo effect
- Whether the individual patient finds the proposed medication regime – Acceptable? Understandable? Manageable?
- The “health belief” model provides a useful perspective
- Psychoeducation about treatments to “get you well” and also to “keep you well” are to be emphasized^[7]
- Rating scales can be used to quantify the compliance

In chronic physical disorders like Diabetes Mellitus and hypertension, missing a dose may result in immediate manifestation of signs/symptoms (rise in blood sugar/blood pressure), which may not be the case in psychiatric illnesses. The asymptomatic period sometimes may extend for a few weeks or months as in mood disorders, which may lead to complacency and poor compliance.

5. Caregiver related

- The role of caretaker in the Indian setting is of utmost importance unlike in the west. Patient’s visit to psychiatrist is almost always with a relative accompanying him/her
- Psychoeducation to the caregiver goes a long way in improving the compliance. The key lies in emphasizing the extended suffering the caregiver has to bear when his relative relapses.

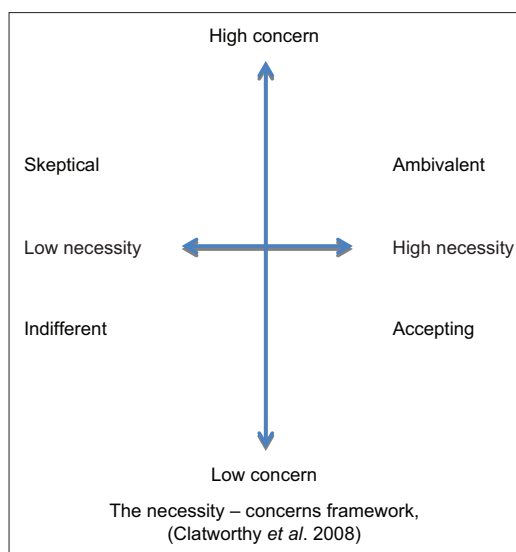


Figure 1: Necessity – concerns frame work

6. Socioeconomic related

- Cost of treatment – Ranks very high in the reasons for non-adherence in India and other developing countries
- No insurance support, economic status of majority of population, burden on the family
- Social surroundings and social rank of the disorder

We need to understand that adherence is a dynamic process. It is not a static all or nothing phenomenon, and in a majority of patients, it is a matter of partial compliance. For example, in the management of depression, the compliance can be halfhearted in the first 3 weeks before the onset of response, followed by very good compliance after remission of the suffering from depression. After a few weeks or months, intentional non-compliance with occasional skipping of daily dosage begins to check whether they really need long-term medication.

Assessment of an individual patient along with the caregiver for their attitude regarding necessity of pharmacotherapy with an attempt to address their concerns toward medication may go a long way in improving the adherence.

The goal to improve adherence should focus on creating an attitude of “high necessity” and “low concern” in patients and caregivers [Figure 1].^[8]

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