Compliance Therapy in Severe Mental Illness

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Adherence in general clinical practice is poor

- Antipsychotics (3–24 months) (24 studies)
- Antidepressants (1.5–12 months) (10 studies)
- Non-psychiatric (0.25–10 months) (12 studies)

Wide range of estimates across studies may reflect difficulty of assessing covert non-adherence

Data shown are mean and range

“Place under your tongue and swallow. Then spit it out when no one’s looking.”
Relapse rates of multi-episode antipsychotic-responsive patients*

*Assumes constant optimal antipsychotic dose relapse rate of 3.5% per month, constant medication non-adherence rate of 7.6% per month, and constant non-adherence relapse rate of 11% per month

The 3 Components of Insight

- Awareness of illness
- Ability to re-label symptoms
- Compliance

Relapse in 1\textsuperscript{st} episode patients over 1 year: according to compliance

Novak-Grubic & Tavcar P. \textit{Eur Psychiatry} 2002;17:148-54
Predictors of non-compliance: First-episode schizophrenia

Novak-Grubic & Tavcar P. Eur Psychiatry 2002;17:148-54
Risk Factors for Nonadherence in Schizophrenia

- Insight/ Attitude toward medication
  - Poor alliance with therapist/ Less OP contact
  - Poor aftercare environment
  - Substance abuse
  - Previous nonadherence
  - Duration of symptoms

- Cognitive impairment
- Regimen complexity /Route
- Family involvement
- Symptom severity

- Mood symptoms
- Dosage
- Age/ Gender/ Ethnicity/ Education level

Consistently associated with adherence

Not Consistently assoc. with adherence/inadequate data

From Compliance to Concordance

Compliance model

Concordance model
Concordance training: therapeutic toolkit

- Sorting out practical issues essential
- Looking back essential
- Examining negative treatment experiences discretionary
- Exploring ambivalence essential
- Target symptoms discretionary
- Normalising rationales discretionary
- Discussing beliefs and concerns about medication essential
- How would things be different if… discretionary
- Medication problem solving discretionary
- Looking forward essential

Adapted from R. Gray et al, 2004
Three phases of CT:

1. Eliciting the patient’s stance towards treatment;
2. Exploration of ambivalence;
3. Working towards treatment maintenance.
RCT of Compliance Therapy
Effect on Insight

Effect of ‘Compliance Therapy’ versus non-specific counselling on adherence

Maudsley Hosp study – acute in-patients

Impact of compliance therapy training on trainee psychiatrists’ confidence in their skills

Impact of consultants’ views of importance of clinical skills

Referral and exclusions for QUATRO Study:

- Referred by clinicians as meeting criteria, n=1218
- Total Excluded n= 809
  - Not IGC schizophrenia n=52
  - Not meeting other inclusion criteria n=249
  - Refused to participate n=366
  - Other reasons n=142

Randomised n=409

Adherence therapy:
- n=204
  - Completed therapy n=182
  - Did not complete therapy n=22
  - 1 year follow-up n=178
  - Not followed up n=26

Health Education:
- n=205
  - Completed therapy n=173
  - Did not complete therapy n=32
  - 1 year follow-up n=194
  - Not followed-up n=11

Adherence Therapy: “QUATRO”* Study

No significant effect of Adherence Therapy

*Multicentre EU study of OP maintenance Rx
Health Educ. (Control), n=171
Adherence Ther., n=156

QUATRO Study

- No significant effect of Adherence Therapy
  - Subgroups may be identified who benefit more
  - Baseline levels of adherence were fair - ceiling effect
  - Patients enrolling for clinical trial are ‘compliant’
  - Intervention may have more effect post acute relapse (cf Kemp et al) rather than in maintenance phase
Factors that affect treatment adherence

**Increase**
- Acceptance of illness
- Perception of severity/susceptibility
- Level of support
- Family stability
- Positive therapeutic alliance
- Formulation/delivery

**Decrease**
- Side effects
- Poor symptom control
- Complex regimen
- Substance abuse
- Impaired judgement
- Poor doctor–patient relationship
- Poor communication
Depot conventionals versus oral conventionals: meta-analysis of RCTs

Relapse rates: summary

Total n=846 (RR 0.96) (0.80–1.14)

Rates of relapse (%)

Depot (n=146/420) 36%
Oral (n=153/428) 35%

Depot versus oral conventionals: meta-analysis of RCTs

Global improvement

Total n=127 RR 0.68 (CI=0.54–0.86)

- Oral (n=12/62)
- Depot (n=30/65)

RR = risk ratio
CI = confidence interval

**Risk of Rehospitalisation by medication – best results with depot**

*Adjusted for sex, year, length of follow-up, duration of 1st admission.

Depot or oral?
Patient preference according to current formulation

Coercion: depot vs oral

- More CMHT patients on depot felt people try to force them to take medication
  - 30% vs 2%, p<0.001

- More CMHT patients on oral felt no-one tried to force them to take medication
  - 90% vs 65%, p=0.01

“I medicate first and ask questions later.”
## CTOs: How do we use them?

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<th>Conditions</th>
<th>N</th>
<th>(%)</th>
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<tr>
<td>Attendance at Appts</td>
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<tr>
<td>Medication adherence</td>
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<td>23.7</td>
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<td>Depots</td>
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<td>53.8</td>
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<tr>
<td>Clozapine</td>
<td>23</td>
<td>11.8</td>
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FIAT: Financial incentives to improve adherence to antipsychotic maintenance medication in non-adherent patients - a cluster randomised controlled trial

Trial Registration: Current controlled trials ISRCTN77769281.

BMC Psychiatry
Study protocol

Stefan Priebe, Alexandra Burton, Deborah Ashby, Richard Ashcroft, Tom Burns, Anthony David, Sandra Eldridge, Mike Firn, Martin Knapp and Rose McCabe.

Will be reporting this year....

http://www.biomedcentral.com/1471-244X/9/61
Conclusions

- Partial adherence is a major problem in medicine, but especially schizophrenia; it is the major cause of relapse
- Pharmacological and Psycho-social approaches may improve adherence and insight:
  - CBT Approaches – based on collaboration
  - Formulation e.g. depots (?associated with coercion)
  - Compulsion
  - Incentives?
FACE YOUR DEMONS.

TAKE A PILL.

GOOD SHRINK, BAD SHRINK
On disagreements with players, the late maverick English football manager Brian Clough said:

“I ask him which way he thinks it should be done, we get down to it, we talk about it for 20 minutes, and then we decide I was right”. 