Multiple choice questions

1. With regard to medication adherence:
   a the 12-month relapse rate in depressed people who are non-adherent is over 75%
   b the 12-month relapse rate in people with schizophrenia who are non-adherent is greater than 50%
   c up to 60% of people hospitalised with bipolar disorder were non-adherent with medication in the month prior to admission
   d the prevalence of non-adherence in people with severe mental disorders has fallen in the past 20 years
   e people who are unintentional non-adherers are also known as 'intelligent non-adherers'.

2. Key components of the cognitive representation of illness are :
   a time-line
   b susceptibility
   c cure
   d identity
   e consequences.

3. Key beliefs that contribute the health belief model are :
   a perceived severity
   b perceived benefits of treatment
   c perceived threat
   d perceived susceptibility
   e perceived barriers to treatment.

4. Patients are more likely to be adherent to a treatment regime if:
   a it is acceptable
   b it is understandable
   c if it is manageable
   d there is coherence between patients' abstract ideas about the illness and their concrete experience of symptoms
   e there is coherence between their cognitive representation of the illness and the psychiatrist's instructions.

5. Techniques that have been shown to enhance medication adherence are:
   a behavioural reinforcement
   b having a 'straight talk' with patients about their non-adherence
   c identifying and challenging negative automatic thoughts about their illness
   d ensuring that the perceived benefits of adherence exceed the perceived barriers
   e reframing underlying beliefs.

MCQ answers

1	2	3	4	5
a T	a T	a T	a T	a T
b T	b F	b T	b T	b T
c T	c T	c T	c T	c T
d F	d T	d T	d T	d T
e F	e T	e T	e T	e T

Commentary

Amanda Harris

Professor Scott sums up the views of many of the Manic Depression Fellowship's (MDF) members when she advocates a shift in consultation style towards a collaborative approach to treatment planning.

A survey of the membership undertaken in association with the Sainsbury Centre for Mental Health (Hill *et al*, 1996) and our ongoing evaluation of our Self Management Programme have both highlighted this issue. We now have a good deal of

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information from our membership which supports the view that individuals wish to gain greater control over their illness, and medication is one area where people can feel that they lack this control.

The relationship that one has with one's health care professionals appears to be an important factor in the issue of non-compliance.

In a question concerned with the helpfulness of general practitioners (GPs) and psychiatrists, 24% of respondents believed their psychiatrist was either 'not very helpful' or 'not at all helpful'. Twenty-three per cent of people responded in this category with respect to their GP. Follow-up focus groups, aimed at exploring the issues in greater depth, suggested that the psychiatrist may be seen as unwilling to engage in meaningful debate. (I am speaking only of the cases where the individual had responded negatively to the question, of course.) On the whole, GPs were thought to be helpful but poorly informed about serious mood disorders. The majority of respondents (74%) reported that their medication was prescribed by their GP and just under a quarter (23%) by their psychiatrist.

The following comments are typical of those individuals who believe this to be the case.

> "I have had two psychiatrists, the difference was not knowledge but style. One was democratic, would give loads of information, thought the illness belonged to the person and tried to educate them. The other was very taciturn, would not speak to the patient. To ask a question or have a dialogue was meaningless to him."

> "All my psychiatrist wanted to know was whether I took my two lithium tablets and that was all. He didn't talk very much."

> "... I was given medication and left to get on with it."

This unwillingness (on the part of a minority of professionals) to engage in discussion with their patients was also an issue for carers in the focus group. They commonly reported an apparent reluctance on the part of psychiatrists to listen to their views even when they felt they had important information to add.

I believe that a greater willingness on the part of mental health professionals to really listen to their patients – tackling the issue of compliance from the individual's unique perspective –would go a long way towards addressing this important issue. The information obtained from the evaluation of our Self Management Programme is helpful in understanding why individuals may intentionally not adhere to the medication prescribed. (Incidentally, Professor Scott provided extremely useful advice on drafts of our self-management booklets). A relatively high number of participants have admitted to intentional non-compliance and the programme has provided a useful forum for debate around these issues. We are currently undertaking an analysis of the data which will, as one component of the research, explore people's attitudes towards their medication before and after the programme. This follow-up will go on for a year following their attendance.

I have outlined below the key issues raised by those individuals who have knowingly not adhered to their medication programme.

(a) Lack of proper understanding and/or explanation of the medication and believing it may cause more harm than good. Even if discussed initially, it may be at a time when the individual feels particularly depressed or high, and repetition of the information would help.

(b) Unwillingness to take up too much of the doctor's time, or perceived reluctance on the part of the professional to engage in debate and answer questions. This is around the amount of time that they believe the doctor has available for them.

(c) A nervousness or reluctance in tackling doctors about medication issues because the perception is that they know best.

(d) A need to disassociate oneself with the diagnosis when one feels well again and medication is a very obvious reminder of this.

(e) Some individuals have self-medicated effectively without the knowledge of their GP and have found this regime more effective than that prescribed by their doctor. Obviously this is not a practice which MDF condones, but the atmosphere of the programme, which encourages open discussion, brings these issues to light.

(f) Individuals who believe they are on the wrong medication (and/or experiencing intolerable side-effects) do not always receive a sympathetic ear when this is explained. Some people then decide simply to stop taking the medication.

(g) Individuals may hear or read of an alternative medication, do a great deal of background research into it, but find that their doctor is unwilling to discuss a possible change in medication. This can have the effect of making the individual disillusioned with their present medication, whether or not this is justified.

(h) People who where incorrectly diagnosed and given the wrong medication find that it takes some time to build up trust after this experience. One survey respondent commented: "It took the psychiatrists from 1972 to 1990 to get my diagnosis right... I first went into hospital in 1968 and was told I was a hypochondriac... I was lost in a system and it took until 1993 for a locum to tell me what I already knew."

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I would suggest that compliance is more likely when the individual receives the correct diagnosis and the appropriate medication at a very early stage in the illness, and would not want this important factor to be overlooked in the debate surrounding non-compliance. In addition to implementing the strategies that Professor Scott suggests, there may also be a need for additional development of the professional in terms of their knowledge of severe mental illness. I am thinking particularly with respect to GPs.

The strategies that Professor Scott suggests would, I believe, go a long way towards addressing the issues raised by our members. As she comments, it is important to understand the reasons for non-adherence from the individual's perspective. The reasons differ greatly from one person to the next and the blanket use of any one method of improving compliance will be of limited effectiveness. I believe that improved communication, a greater degree of openness, willingness to meet as equal partners to agree the medication options, and the opportunity to spend time discussing the issues from the patient's perspective, would be very much welcomed by our members. The increasing use of the term 'concordance' rather than 'compliance' would seem to describe this approach better, aiming to empower rather than control.

Reference

Hill, R. G., Hardy, P. & Shepherd, G. (1996) *Perspectives on Manic Depression: A National Survey of the Manic Depression Fellowship*. London: Sainsbury Centre for Mental Health.

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