Treatment Adherence Strategies in Behavioral Health

Shane W. Rau, MD, PhD, FAPA
Psychiatrist, Acute Unit
The Pavilion at Williamsburg Place
OVERVIEW

❖ Adherence to treatment is a pervasive issue across the house of medicine.

❖ Particularly in psychiatric illness, poor treatment adherence is known to play a large role in illness relapse which, in turn, leads to greater functional difficulties for our consumers and their loved ones.

❖ A variety of factors contribute to difficulties with adherence.

❖ The literature provides examples of efforts to understand these factors and to test techniques to
  ❖ improve treatment adherence,
  ❖ reduce symptom and illness severity and thereby
  ❖ improve lives.
PRESENTATION OBJECTIVES:

❖ Discuss the link between medication adherence and service utilization.

❖ Discuss factors that influence the level of medication adherence in persons with severe mental illness.

❖ Discuss strategies for improving medication adherence in persons with severe mental illness.
CASE 1

57yo Caucasian male, admitted due to grandiose delusions and aggressive behavior in the community. This is his third hospitalization for psychotic symptoms. When asked about his mental health history, he endorses, “I don’t have a mental problem, I am God’s messenger”.

This is his 5th hospital admission in the last 2 years. He endorses not taking medications outside the hospital because “God will take care of me”.

After speaking with his outpatient pharmacy, you learn he was filling his medication regularly until about 6 weeks ago when he got his last prescription.
Antipsychotic medications are effective in:

- the treatment of acute episodes of psychosis
- the prevention of relapse
- in reducing the risk of relapse for 1st episode AND chronic schizophrenia

“...nonadherence plays a significant role in psychotic relapse and each relapse contributes to accrued social toxicity and disability.”

--Freudenreich and Cather, 2012
Adherence and Service Utilization

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- the prevention of relapse
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--Freudenreich and Cather, 2012
Adherence and Service Utilization

Subotnik and colleagues (2011); in early course schizophrenia, even a mild degree of nonadherence robustly predicted psychotic symptom exacerbation.

Weiden and colleagues (2004) used medicaid pharmacy refill and medicaid claims data to demonstrate: partial adherence predicts rehospitalization risk in a dose dependent manner.

--Freudenreich and Cather, 2012
Poor Adherence is Highly Prevalent

Insufficient adherence to medications is a pervasive problem in ALL of medicine.

It is estimated that 41% of schizophrenia patients are nonadherent.

Jackevicius CA and colleagues (2002) performed a study looking at 2-year adherence to statins for secondary prevention of cardiac event: it was only 40% in a cohort of elderly patients following acute coronary syndrome.

--Freudenreich and Cather, 2012
Poor Adherence is Highly Prevalent

Even with 1\textsuperscript{st} episode patients:

In a study of 171 1\textsuperscript{st}-episode psychosis patients; 24\% of subjects were non-adherent at a 4 year follow-up (Kane JM, 2008)

--Freudenreich and Cather, 2012

The estimated cost of non-adherence across the US is $290 billion per year. $100 billion is due to re-hospitalization.

American Pharmacists Association, 2013
Adherence Defined?

In clinical practice, a working general definition of adequate adherence is:

…the minimum level of adherence (maintaining a level of treatment) required for a person to achieve adequate treatment response and avoid relapse that is mutually agreed upon by patient and provider.

--Velligan et al, 2010
How poor is “poor”?

A cutoff of < 75 – 80% of prescribed doses is often used, but is not empirically based.

Docherty et al (2003) provided some evidence that there is a dose response relationship between increasing percentage of missed doses and level of active symptomatology…

No “gold standard” seems to exist; for any one individual; the level of non-adherence that becomes “clinically relevant” is difficult to predict and is highly variable from person to person.
Can we measure it?

Oh…let us count the ways!

A 2010 medication adherence e-survey by the Healthcare Intelligence Network (HIN) categorized methods used by health care organizations.

65% of programs surveyed had programs designed to improve medication adherence

--Healthcare Intelligence Network, 2013.
Can we measure it?

- Self-report
- Pharmacy refill records
  - Medication Possession Ratio (MPR): proportion of days on which medication is available in a defined time period
- Biomarker / Drug Levels
- Medication Event Monitoring System (MEMS)
  - Bottle with an electronic recorder that is activated as bottle opens
- Direct Observed Therapy
- Patient Questionnaires
- Patient Diaries / Clinic Pill Counts
- “Smart Pills”

--American Pharmacists Association, 2013
Can we measure it?

--American Pharmacists Association, 2013
Can we measure it?

Questionnaires

➢ Beliefs About Medicines Questionnaire (BMQ)
  ➢ Most common and well-validated
  ➢ 11 items; Two scales:
    ➢ 5 items: Necessity Scale; need for the medication
    ➢ 6 items: Concerns Scale; appraising concerns about adverse effects.

➢ Morisky Medication Adherence Scale
  ➢ 8 item self-report scale: informal; normalizing questions

➢ Medication Adherence Report Scale
  ➢ 5 item self-report scale for schizophrenia; also validated for other disorders

➢ Drug Attitude Inventory.
  ➢ Self-report; true/false assessment of attitudes toward antipsychotics

—American Pharmacists Association, 2013
MMAS-8: Yes or no questions

1. Do you sometimes forget to take your medication?
2. During the previous 2 weeks, were there any days when you did not take your medication?
3. Have you ever cut back or stopped taking your medication without telling your physician because you felt worse when you took it?
4. When you travel or leave home, do you sometimes forget to bring along your medications?
5. Did you take your medication yesterday?
6. When you feel like your depression is under control, do you sometimes stop taking your medication?
7. Taking medication every day is a real inconvenience for some people. Do you ever feel hassled about sticking to your antidepressant treatment plan?
8. How often do you have difficulty remembering to take your medication (never/rarely, once in a while, sometimes, usually, or all the time)?
Drug Attitude Inventory: True or false statements

- For me, the good things about medication outweigh the bad.
- I feel strange, “doped up,” on medication.
- I take medications of my own free choice.
- Medications make me feel more relaxed.
- Medication makes me feel tired and sluggish.
- I take medication only when I feel ill.
- I feel more normal on medication.
- It is unnatural for my mind and body to be controlled by medications.
- My thoughts are clearer on medication.
- Taking medication will prevent me from having a breakdown.

—American Pharmacists Association, 2013
Risk Factors for Poor Med Adherence

A. Patient Related Factors
1. Poor insight
2. Negative attitude toward medication
3. Negative attitude toward condition
4. Relationships
5. Cognitive deficits
6. Physical conditions
7. Negative subjective response to medication
8. Previous nonadherence
9. Substance abuse
10. Shorter illness duration

--Lacro JP et al, 2002
--American Pharmacy Association, 2013)
Risk Factors for Poor Med Adherence

B. Treatment Related Factors
1. Inadequate treatment environment
2. Poor therapeutic alliance.
3. Dosing regimen
4. Adverse drug reactions

C. Health-system and provider factors; awareness of adherence issues often lacking amongst clinicians.

C. Condition-related issues; cognitive deficits, metabolic syndrome, physical disabilities, etc.

--Lacro JP et al, 2002
--American Pharmacy Association, 2013)
C. Cultural Influences

- Nearly 60% of Chinese Americans in one survey reported it would be shameful to seek help from a Western trained clinician for a mental health issue.

- Nonadherence higher amongst African-Americans and Mexican Americans vs. Caucasian Americans

--Lacro JP et al, 2002
--American Pharmacy Association, 2013
Drug Attitude: correlates with adherence; refers to patient’s overall appraisal of the risks and benefits associated with a particular medication.

Measurable: Drug Attitude Inventory
   Originally a 30-item true / false scale
   Available also as 10-item version

   --Freudenreich and Cather, 2012

No differences found in drug attitude for those taking 1st-generation antipsychotics vs. 2nd generation
(Freudenreich O et al, 2004)
The DAI-10 was derived by means of stepwise discriminant analyses applied to the responses of 150 schizophrenia patients to the DAI-30 (Awad, 1993).

The DAI-10 contains six items that a patient who is fully adherent to prescribed medication would answer as ‘True’, and four they would rate as ‘False’.

Scores are allocated to each answer and the total score is calculated in the same way as for the DAI-30. Similarly, a positive total score indicates a positive subjective response (adherent) and a negative total score indicates a negative subjective response (non-adherent).
# Negative Drug Attitude

## DAI-10 questionnaire

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer (True/False)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. For me, the good things about medication outweigh the bad</td>
<td>T / F</td>
</tr>
<tr>
<td>2. I feel strange, &quot;doped up&quot;, on medication</td>
<td>T / F</td>
</tr>
<tr>
<td>3. I take medications of my own free choice</td>
<td>T / F</td>
</tr>
<tr>
<td>4. Medications make me feel more relaxed</td>
<td>T / F</td>
</tr>
<tr>
<td>5. Medication makes me feel tired and sluggish</td>
<td>T / F</td>
</tr>
<tr>
<td>6. I take medication only when I feel ill</td>
<td>T / F</td>
</tr>
<tr>
<td>7. I feel more normal on medication</td>
<td>T / F</td>
</tr>
<tr>
<td>8. It is unnatural for my mind and body to be controlled by medications</td>
<td>T / F</td>
</tr>
<tr>
<td>9. My thoughts are clearer on medication</td>
<td>T / F</td>
</tr>
<tr>
<td>10. Taking medication will prevent me from having a breakdown</td>
<td>T / F</td>
</tr>
</tbody>
</table>

If you have any further comments about medication or this questionnaire, please write them below.

T = True, F = False

*Answers shown in **bold** are scored +1; answers in normal font are scored -1
**Negative Drug Attitude**

**BEMIB**
BRIEF EVALUATION OF MEDICATION INFLUENCES AND BELIEFS

Instructions: Below is a list of statements that describe how people sometimes feel about their medication. Please read each one carefully and circle the number to the right that best describes the extent to which you agree or disagree with the statement. Circle only one number for each statement and do not skip any items.

**My antipsychotic medication(s):** *(Please circle all that apply)*
Abilify / Zyprexa / Risperdal / Geodon / Seroquel / Clozapine / Saphris / Fanapt / perphenazine / haloperidol / thioridazine / Not Sure / None

<table>
<thead>
<tr>
<th>Statement</th>
<th>Completely Disagree</th>
<th>Generally Disagree</th>
<th>Undecided</th>
<th>Generally Agree</th>
<th>Completely Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Taking my antipsychotic medication makes me feel better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Taking my antipsychotic medication helps prevent getting hospitalized.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Side effects from my antipsychotic medication bother me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I have a system that helps me remember to take my antipsychotic medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Taking my antipsychotic medication is difficult to remember every day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Getting my antipsychotic medication from the hospital or pharmacy is not a problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I am supported by my family, friends and doctors to take my antipsychotic medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I have a psychiatric disorder that antipsychotic medication improves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
EUFEST (Gaebel E et al, 2010) demonstrated that, in the first episode / early psychosis population, drug attitude was the STRONGEST predictor of later drug discontinuation; sexual side effects and high psychopathology score also predicted nonadherence.

--Freudenreich and Cather, 2012
Lack of Insight

Identified by WHO as a pathognomonic, core symptom of schizophrenia (Carpenter WT, 1973)

--Freudenreich and Cather, 2012
Lack of Insight

Insight is a multidimensional construct:

➢ Awareness of symptoms: capacity to re-label inner experiences as pathological symptoms
➢ Recognition of mental illness: attributing symptoms to a psychiatric illness
➢ Acceptance of need for treatment
➢ Sociocultural dimension: ...the end-result of an intersubjective construction of meaning...clinician and patient bring assumptions, opinions, etc. to the table based on culture, experience and training

--Freudenreich and Cather, 2012
Tranulis and colleagues (2009):

--Posited that insight is developed through a combination of abstract reasoning and introspection as well as concrete interpersonal interactions and actual experiences of illness and treatment.

--Freudenreich and Cather, 2012
Lack of insight has been shown to be associated with treatment discontinuation and poor outcomes (Pijnenborg GH et al, 2011).

Poor insight can be indicative of a stable, anosognosia-like neurocognitive deficit (Arango C, et al, 2011).

Partial insight also exists and can create difficulties.

--Freudenreich and Cather, 2012
25yo African American female admitted with depression and significant paranoia. She does not wish to speak to you because “you are part of the system and you just want to sell me some meds”.

She is obese and has type 2 diabetes. During a previous hospitalization, she was given Haldol and had a significant dystonic reaction.

She is unemployed, uninsured, and there is no psychiatrist within 50 miles of her home.
1st Step: RECOGNITION!!

Clinicians and patients are NOT good at this!

In one prospective trial of 52 outpatients dx’d with schizophrenia, pill counts and electronic monitoring were strong correlated; however pills counts were only weakly correlated with both patient self-report and clinician estimate (Velligan DI et al, 2007)

--Freudenreich and Cather, 2012
## Remedies?

Velligan and colleagues (2010): 3-tiered approach

<table>
<thead>
<tr>
<th>Adherence Targeted Group</th>
<th>Examples of Appropriate Adherence-Enhancing Interventions</th>
</tr>
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<tbody>
<tr>
<td>Universal (all patients)</td>
<td>psychoeducation, provider training in provider-patient communications, all systems-based interventions</td>
</tr>
<tr>
<td>Selected (high risk for nonadherence)</td>
<td>reminder, pill boxes, regular monitoring, family interventions</td>
</tr>
<tr>
<td>Indicated (currently nonadherent)</td>
<td>motivational interviewing, electronic monitoring, directly observed therapy</td>
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Remedy: Improved Therapeutic Alliance

Perceived clinician or physician support is a powerful predictor of adherence

Sample of 228 patients w/ psychotic disorder: negative treatment attitudes were predicted by less positive relationship with prescriber, perceived coercion during admission and low insight (Day JC et al, 2005)

Most critical question here: does the patient see the role of psychiatric treatment as at least potentially beneficial

--Freudenreich and Cather, 2012
Remedy:
Improved Attitude Toward Treatment

Beck and colleagues demonstrated that targeting treatment-related attitudes lead to more robust changes in adherence than trying to increase global insight (2011).

Shared decision-making known to be effective.

It is helpful to work to improve “subjective well-being under neuroleptic treatment” (SWN): target lowest effective doses, show flexibility in altering dosing times or switching medication (Naber D et al, 2005).

--Freudenreich and Cather, 2012
Remedy: Directly Observed Therapy (DOT)

As it sounds…directly observe and verify that the patient is adherent to treatment

Farooq and colleagues (2011): randomized 110 patients to family-supervised med administration vs. TAU:
   67.3% adherent in intervention group
   45.5% in TAU

Spaniel and colleagues (2008): piloted cell-phone based telemonitoring system to detect non-adherence and signs of early relapse in 45 patients.
   Reduced hospitalizations by 60% compared with same time period prior to participation

--Freudenreich and Cather, 2012
Remedy: Compliance Therapy (CT)

CT is rooted in CBT and motivational interviewing…attempts to help patients weigh risks and benefits from treatment, similar to how patients would approach their treatment for hypertension or diabetes”

In particular: assists the patient in viewing discrepancies between his or her goals and values and his or her current state of function in light of possible benefits from treatment adherence.

--Freudenreich and Cather, 2012

“The investigator helped each participant tailor his prescribed regimen so that it was better adapted to his personal habits and routines.”

By:

Identifying a highly visible location for the placement of medications

Pairing the daily medication intake with specific routine

For their particular trial: each participant was given a self-monitoring spiral calendar, which featured a dated slip of paper for each dose of the neuroleptic. The participant was instructed to keep the calendar near his medications and tear off a slip each time he took a pill…”
Remedy: Long-Acting Injectables (LAIs)

LAIs are effective medications, however there is no significant proof that they are superior to oral medications, overall, regarding hospitalization rates, symptom improvement or quality of life.

Caveat: Difficult to study in that those willing to enter a trial comparing injectable vs. oral medication may be more likely to be adherent in the first place

--Freudenreich and Cather, 2012
Remedy: Cognition Adaptation Training (CAT)

Velligan and colleagues (2008): designed a multi-pronged intervention called CAT

9 month intervention: tailored environmental support and compensatory strategies
Lead to significant improvement in adherence vs treatment as usual (TAU)
Benefit extended beyond treatment period (longer term follow-ups needed!)

--Freudenreich and Cather, 2012
Paying patients to take meds—can be effective!!

Pilot study in Netherlands: 5 patients; acceptance of injections increased from 44% - 100% and resulted in 10-fold reduction in days spent in the hospital (Staring AB et al, 2010).

FIAT currently underway in Britain: Financial Incentives for Adherence Trial (FIAT)

--Freudenreich and Cather, 2012
CASE 3

60 yo Caucasian female is being seen for routine follow-up for treatment of chronic schizoaffective disorder. Her speech is pressured and she has great difficulty maintaining concentration in your office.

She is prescribed prolixin and lithium. She “thinks” she takes her medications. Her pharmacy endorses consistent medication fills for lithium, but not prolixin.

She asks, “why am I supposed to take these meds, my family tells me to “leave them alone” as they may hurt me.
Velligan and colleagues (2010): 3-tiered approach

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Velligan and colleagues (2010): Intervene!

**Table 3** Qualities of an Ideal Adherence-Enhancement Intervention

- patient-centered, fostering empowerment and self-management
- incorporates consideration of illness type and severity, cognitive status and relevant clinical variables
- tailored to the individual’s **current attitudes** toward treatment
- longer-term as opposed to one-time intervention, recognizing that adherence is a process/may change over time
- incorporates culture-, gender-, age-specific issues regarding adherence
- considers both barriers and facilitators to adherence
- may blend multiple types of approaches (behavior+care system+ memory aid)
- incorporates both quantitative and qualitative assessments as appropriate
| For intended nonadherence | Poor therapeutic alliance | Optimize overall care experience  
Minimize perceived coercion |
|---------------------------|--------------------------|-------------------------------|
|                           | Negative drug attitude  | Persist in trying to achieve good efficacy  
Increase “subjective well-being under neuroleptics” |
|                           | Poor insight c          | Consider long-acting injectable (LAI) antipsychotic  
Consider directly observed therapy (DOT)  
Incentivize taking antipsychotics (e.g., financial)  
Use motivational principles (e.g. Compliance Therapy) |
| For unintended nonadherence | Cognitive difficulties  | Consider Cognitive Adaptation Training (CAT)  
Consider LAI  
Consider DOT |

---Freudenreich and Cather, 2012

a Risk factors are not mutually exclusive  
b Then interventions are not specific for just one risk factor. For example, DOT would also be appropriate for patients with a poor therapeutic alliance or negative drug attitude  
c In some patients insight per se might not be amenable to change
Quickie Adherence Survey

Sent a survey out to 102 staff and clinicians of the UNC Center for Excellence in Community Mental Health.

Received 47 responses = 46.1% response rate.

Asked about perceived adherence of our patient population, ways in which our clinicians encourage or enhance adherence and about ways in which we might measure adherence.
1. One common benchmark for saying that someone is “adherent” to treatment is that they take or participate in AT LEAST 70% of their primary treatment. That is, 70% of their primary medication, or 70% of their scheduled therapy / support appointments.

With this in mind, in your estimation, to what extent are your patients adherent with treatment:

a. All (100%) of my patients are adherent
b. Most (about 75%) of my patients are adherent
c. About half (50%) of my patients are adherent
d. About one quarter (25%) of my patients are adherent
e. Almost none (0%) of my patients are adherent
## Quickie Adherence Survey

<table>
<thead>
<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All (100%) of my patients are adherent</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>2</td>
<td>Most (about 75%) of my patients are adherent</td>
<td>29</td>
<td>66%</td>
</tr>
<tr>
<td>3</td>
<td>About half (50%) of my patients are adherent</td>
<td>7</td>
<td>16%</td>
</tr>
<tr>
<td>4</td>
<td>About one quarter (25%) of my patients are adherent</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>5</td>
<td>Almost none (0%) of my patients are adherent</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>44</td>
<td>100%</td>
</tr>
</tbody>
</table>
1. Please check what you believe are the TOP THREE reasons your patients do not adhere to treatment (please check ONLY three boxes):

[ ] Poor insight into their psychiatric illness
[ ] Poor insight into the effectiveness of treatment
[ ] Negative attitudes toward medication / treatment
[ ] Negative subjective response to medication
[ ] Poor therapeutic alliance
[ ] Poor effectiveness of medication / treatment (i.e.; the treatments aren’t working)
[ ] Disorganization and / or cognitive deficits
[ ] Cultural belief / negative attitude toward psychiatry / mental health professionals
[ ] Other - I believe this reason, not listed above is in the TOP THREE reasons:
# Quickie Adherence Survey

<table>
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<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Poor insight into their psychiatric illness</td>
<td>29</td>
<td>64%</td>
</tr>
<tr>
<td>2</td>
<td>Poor insight into the effectiveness of treatment</td>
<td>21</td>
<td>47%</td>
</tr>
<tr>
<td>3</td>
<td>Negative attitudes toward medication / treatment</td>
<td>24</td>
<td>53%</td>
</tr>
<tr>
<td>4</td>
<td>Negative subjective response to medication</td>
<td>16</td>
<td>36%</td>
</tr>
<tr>
<td>5</td>
<td>Poor therapeutic alliance</td>
<td>4</td>
<td>9%</td>
</tr>
<tr>
<td>6</td>
<td>Poor effectiveness of medication / treatment (i.e.; the treatments aren’t working)</td>
<td>9</td>
<td>20%</td>
</tr>
<tr>
<td>7</td>
<td>Disorganization and / or cognitive deficits</td>
<td>16</td>
<td>36%</td>
</tr>
<tr>
<td>8</td>
<td>Cultural belief / negative attitude toward psychiatry / mental health professionals</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>9</td>
<td>Other – I believe this reason, not listed above is in the TOP THREE reasons:</td>
<td>7</td>
<td>16%</td>
</tr>
</tbody>
</table>
Quickie Adherence Survey

➢ > 80% of respondents felt the following were common reasons for poor adherence:

➢ Poor Insight
➢ Negative attitude toward meds / treatment

➢ Only 29% agreed that Poor Therapeutic Alliance was a common reason for poor adherence
1. Please check any of the following interventions you utilize (that is, to specifically address treatment adherence) to assist your patients with adherence to their treatment (check all that apply):

[ ] Motivational Interviewing
[ ] Acceptance and Commitment Therapy
[ ] Cognitive Behavioral Therapy (including compliance therapy)
[ ] Directly Observed Therapy ((enlisting family, friends, living facility staff, treatment team members, yourself, etc) to establish a way of directly observing the patient take medication or come to appointments)
[ ] Use of a long-acting injectable
[ ] Financial Incentives
[ ] Shared-Decision Making
[ ] Psychoeducation
[ ] IMR Module on Using Medication Effectively
[ ] Other -- Please name the technique you use: _________________________
[ ] I don’t discuss adherence with my patients
### Quickie Adherence Survey

<table>
<thead>
<tr>
<th>#</th>
<th>Answer</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Motivational Interviewing</td>
<td>33</td>
<td>73%</td>
</tr>
<tr>
<td>2</td>
<td>Acceptance and Commitment Therapy</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>3</td>
<td>Cognitive Behavioral Therapy (including, but not limited to, compliance therapy)</td>
<td>18</td>
<td>40%</td>
</tr>
<tr>
<td>4</td>
<td>Directly Observed Therapy ((enlisting family, friends, living facility staff, treatment team members, yourself, etc) to establish a way of directly observing the patient take medication or come to appointments)</td>
<td>26</td>
<td>58%</td>
</tr>
<tr>
<td>5</td>
<td>Use of a long-acting injectable</td>
<td>23</td>
<td>51%</td>
</tr>
<tr>
<td>6</td>
<td>Financial Incentives</td>
<td>2</td>
<td>4%</td>
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<tr>
<td>7</td>
<td>Shared-Decision Making</td>
<td>35</td>
<td>78%</td>
</tr>
<tr>
<td>8</td>
<td>Psychoeducation</td>
<td>39</td>
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</tr>
<tr>
<td>9</td>
<td>IMR Module on Using Medication Effectively</td>
<td>4</td>
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<tr>
<td>10</td>
<td>Other -- Please name the technique you use:</td>
<td>3</td>
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</tr>
<tr>
<td>11</td>
<td>I don't discuss adherence with my patients</td>
<td>0</td>
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References


Hogarty et al. (1979). *Arch Gen Psychiatry*. 36: 1283-94.


