Compliance

Table 1: Core Components of Understanding Compliance

Core Component	Key Concept
Definition	• No single definition of noncompliance; ranges from any deviation from doctor's advice (partial compliance) to complete cessation of medication. • Many prefer "nonadherence" to "noncompliance" to stress the collaborative rather than authoritarian role of the physician
Efficacy	• Noncompliance needs to be addressed at the onset of the treatment relationship between patient and prescriber, even before it is clear if a medication is effective.
Therapeutic Alliance	• Relationship with clinician is one of the most important predictors of compliance • Address compliance while building an alliance • A collaborative relationship facilitates compliance
Assessment	• Partial or noncompliance is common and anticipated clearly not in the patient's best interest. Clinicians underestimate noncompliance • Patient self-report of compliance may be unreliable • Assess both behavior and attitude • Use multiple sources of information • Always start with the patient's perspective
Intervention	• Use the therapeutic alliance as much as possible • Address concerns about compliance from the patient's perspective • Base your intervention on maximizing perceived benefits and minimizing perceived costs • Providing patients with concrete instructions and problem-solving strategies, such as reminders, self-monitoring tools, cues, and reinforcements, is useful (Zygmunt et al. 2202). • Distress from side effects is more relevant than severity of side-effects. • Once a day medication may be superior to more frequent drug regiments (Diaz et al. 2004) • Depot preparations should be considered if partial or noncompliance persists.

Keep in mind that *attitude* is not the same as *behavior*.

The tables shown below highlight some of methods for conducting focused interviews to assess compliance *behavior* and compliance *attitudes.*

Table 2: Assessing Compliance Behavior
• Every medication visit should have a brief screening question about compliance asked in a nonthreatening and uncritical manner • A focused assessment is indicated when there is an inadequate response or unexpected loss of efficacy, but noncompliance should not be assumed • Assessment should use focused, nonjudgmental questioning that normalize medication noncompliance, keeping in mind that the patient may not want to disclose noncompliance • Whenever possible, the compliance interview should be supplemented by interviewing other informants, checking pharmacy records or plasma drug levels

Table 3: Assessing Compliance Attitudes
• Attitudes about medication should be routinely assessed, regardless of the patient's actual compliance behavior. • Any discussion about compliance concerns should start with the patient's point of view rather than the doctor's point of view. • The attitudinal assessment should review both the reasons influencing compliance and reasons influencing noncompliance . • The doctor should be aware that it is the patient's subjective beliefs rather than the objective medical reality that is what ultimately influences compliance behavior. • The doctor should withhold responding to the patient's opinions until the patient has discussed all of the issues that influence continued compliance and noncompliance.

The use of long acting IM medication for the non-compliant patients is discussed in Node 2A.(4).on non-compliance under Critical Initial and Emergent Issues that impact management and choice of drugs.

References

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Zygmunt A. Olfson M. Boyer CA. Mechanic D. Interventions to improve medication adherence in schizophrenia. American Journal of Psychiatry. 159(10):1653-64, 2002