

IMPROVING COMPLIANCE AND COMMUNICATION in psychiatric care

By NICOLA O'CONNELL

Treatment with certain antipsychotic medicines is often associated with poor patient compliance. This article examines the reasons for non-compliance, and discusses ways pharmacists can help patients adhere to their treatment plans

Poor patient compliance is common among people treated with certain antipsychotic medicines and it often occurs as a result of unwanted side effects. Non-compliance can lead to patients experiencing episodes of relapse and, in some cases, admittance to hospital.

However, there is evidence to demonstrate that better communication between health care professionals and patients, combined with effective treatment and a greater understanding of side effects, can result in improved patient compliance and enhance overall patient/carer satisfaction.

"We know that dissatisfaction with treatment can affect many areas of a patient's life, from lower quality of life, personal distress and burden on family, to relapse of symptoms and even suicide," says Dr Jonathan Hellewell, consultant psychiatrist at Trafford General Hospital, Manchester. "Evidence suggests that more than 50 per cent of people diagnosed with schizophrenia do not comply with treatment."

It is already known that patients with psychotic illness who do not engage with their care team during routine consultations can experience acute episodes more frequently and may be more socially impaired than those who are successfully engaged in services.¹ But it is less clear how these patients can best be encouraged to discuss their concerns more openly, how they may be prompted and which precise areas should be covered during discussion.

It is acknowledged that patients actively attempt to talk to their care teams about their symptoms. Yet there is often a breakdown in communication, which if addressed, might result in better engagement and lead to a more satisfactory

outcome, further strengthening the relationship between the patient and health care professionals.²

ROLE FOR PHARMACISTS

The potential role for engagement is certainly not restricted to psychiatrists. A recent survey of psychiatric pharmacists at the UK Psychiatric Pharmacy Group conference revealed that pharmacists are all too aware of the association between lack of understanding of the impact of therapy and poor compliance.

Over 90 per cent of pharmacists questioned considered that currently, patients do not have access to sufficient advice regarding their treatment. The majority of pharmacists indicated that the provision of advice and information to patients takes up less than 25 per cent of their time.

Not surprisingly, the need to juggle priorities was cited as a key challenge. Pharmacists said there is a distinct lack of allocated one-to-one support as a result of limited resources and time constraints placed on them.

"There is an opportunity for all health professionals who have contact with patients to look at the quality of communication between themselves and their patients," says Dr Hellewell. "There is no suggestion that communication between pharmacists and patients is going to be free of the problems affecting communication between patients and doctors or nurses, but there may be plenty of scope for pharmacists to look more systematically — and this is where communication tools and checklists may play a role.

"Furthermore, as experts in medication, pharmacists can be a resource on treatment alternatives and the management of any side effects. They might consider devoting more time to patients who need it, allowing others to have a more brief interaction.

COMMUNICATION TOOL

In conjunction with a number of colleagues, Dr Hellewell developed a communication tool called "2-COM", a simple patient-completed self-report instrument designed to facilitate patient-professional carer communication. The rationale behind the tool is to enable patients and health care professionals to address any unmet needs and help identify any problems of which the professional may be unaware. As Dr Hellewell explains: "The majority of clinicians work hard to understand their patients' point of view, but there are indications that we can do better and that patients will benefit."

The 2-COM tool is an example of how the communication between a patient and their psychiatrist can be made more effective. Dr Hellewell believes that a similar tool could be used by psychiatric pharmacists to enhance communication with their patients. This could encourage patients to discuss the side effects they experience with a health care professional who is not only knowledgeable about their current treatment, but is also aware of alternative treatment options.

Results of a study involving 243 patients with a clinical diagnosis of non-affective psychoses, such as schizophrenia, and their professional carers, reveal that such a tool could be valuable in the majority of cases.³ While in the waiting room before seeing the clinician, patients were asked to complete the 19-item questionnaire. This covered a wide number of areas from, "Are you having any problems with your medication?" to "Is the sexual part of your life satisfactory?" Patients also had an opportunity to indicate that they would like to discuss a particular need. Responses to the questionnaire enabled a more focused discussion between doctor and patient.

Over 50 per cent of carers and more than four-fifths of patients said they found 2-

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COM useful in at least one aspect. "We are continuing to conduct research into how the long term benefits of 2-COM persist and the fact that it leads to changes in behaviour by clinicians," says Dr Hellewell. "It doesn't just result in patients feeling more positive about communication; it also results in the clinician switching treatment where appropriate, which can help to reduce non-compliance. This means that the 2-COM has positive benefits for patients, not only in terms of their attitudes towards treatment, but also in that the clinician is more likely to change treatment in the light of a fuller discussion of the patient's problems."

It is not unreasonable to question the reliability of the subjective self-assessments provided by antipsychotic patients. But there is actually nothing to suggest that psychiatric illness makes people less reliable in the feelings and complaints they have. "There is now good evidence that patients are reliable in the reports they make about themselves and they are consistent over time," comments Dr Hellewell.

— TROUBLESOME SIDE EFFECTS

A careful review and discussion of treatment side effects is important, as these are so often cited by patients as a key prob-

lem area that can lead to non-compliance and relapse. The association of conventional agents with adverse side effects and extrapyramidal symptoms (EPS) can strongly compromise compliance and significantly affect overall positive response. Yet professional carers may not always appreciate the full impact of EPS and the impact that it has on the patient's life.

Patients' negative attitudes towards antipsychotic drugs are not only due to these side effects and lack of recognition of the beneficial effects of the drugs, but also objective side effects.⁴ In a study of 53 chronic schizophrenic outpatients receiving maintenance depot antipsychotic treatment, side effects, such as akathisia, dysphoria and emotional indifference were most often observed by patients.

"Clinicians tend to have preconceived ideas about which problems are the most important," says Dr Hellewell. "There is a great danger of making assumptions, even though side effects are very individual," says Dr Hellewell. "If side effects are not discussed, some patients may feel isolated and not necessarily even attribute the side effect to the treatment. In instances such as this, the trust between the patient and their care team is broken and this, in turn, can impact heavily on a patient's readiness to take their treatment."

The side effects of antipsychotics can be broken down into four key categories: extrapyramidal (tardive dyskinesia), cognitive (sedation), medical (cardiovascular systems) and sexual (sexual dysfunction, fertility). Research indicates that patients with schizophrenia are more concerned about sexual side effects than any others⁵ and Rethink (formerly the National Schizophrenia Fellowship) findings reveal that sexual side effects are the most troublesome. Endocrine side effects, however, tend not to be monitored by clinicians.

— HYPERPROLACTINAEMIA

The sexual complications associated with some antipsychotic treatments, including sexual dysfunction, fertility problems and metabolic problems, have one common aetiology: raised prolactin levels, or hyperprolactinaemia. The main action of prolactin, the lactogenic hormone, is to initiate and sustain lactation, and the level normally rises during pregnancy and breastfeeding. There are many neuroendocrine and physiologic factors involved in the control of prolactin release, which affect both men and women.⁶

Hyperprolactinaemia is the commonest biochemical disturbance of the pituitary gland. In women, the major effects of hyper-

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prolactinaemia are amenorrhoea, cessation of normal cyclic ovarian function and loss of libido. In men, the effects are impotence, loss of libido and hypospermatogenesis.⁷

Several studies have also reported a decrease in bone mineral density in men and women treated with typical antipsychotic medication, which may increase the risk of fractures.⁸ Emerging literature suggests that this condition may be more prevalent than currently believed.⁹

Hyperprolactinaemia was first associated with conventional antipsychotics in 1974.¹⁰ The drugs cause increased prolactin release by disinhibition due to dopaminergic receptor blockade.¹¹ Women treated with conventional antipsychotics have been reported to have greater elevations in prolactin than men.¹²

“All typical antipsychotics raise prolactin levels,” says Dr Veronica O’Keane, consultant psychiatrist and honorary senior lecturer at the Maudsley Hospital, London. “There is no elevation of prolactin levels in unmedicated schizophrenics.”

The mechanism of sexual dysfunction associated with antipsychotic drugs is generally poorly understood. In an attempt to shed light on it, Dr O’Keane and colleagues conducted a study to assess the frequency of sexual dysfunction and determine the possible underlying mechanisms.¹³ Sexual function was assessed in 101 patients taking

antipsychotic medication, 57 normal controls and 55 controls attending a sexual dysfunction clinic.

Results showed that sexual dysfunction was present in 45 per cent of patients taking antipsychotic medication, 17 per cent of normal controls and 61 per cent of controls attending a sexual dysfunction clinic. The study concluded that conventional antipsychotic medicines are associated with significant levels of sexual dysfunction, and that clinicians should ask routinely about sexual symptoms before prescribing medication and on follow-up.

— PROLACTIN-SPARING AGENTS

Until the launch of clozapine in 1975, the first atypical antipsychotic, it was believed that hyperprolactinaemia was the “cost” of antipsychotic therapy. Although it has yet to be proven, it is believed that lack of prolactin elevation in the newer antipsychotic agents is due to higher specificity.¹⁴ This results in fewer blockades of dopamine receptors in the turbo-infundibular system.

However, not all atypical agents are equal in terms of effect on prolactin. “Risperidone and amisulpiride are prolactin raising, while there is good evidence to show that olanzapine, clozapine and quetiapine are prolactin sparing,” says Dr O’Keane.

For instance, in one North American double-blind 335-patient trial, olanzapine was shown to have modest effects on prolactin compared with conventional antipsychotics and risperidone.¹² Although olanzapine was associated with prolactin elevation in a dose-dependent manner, the increase with all doses was not significantly greater than those observed with placebo. The study showed that rates of prolactin elevation with olanzapine are approximately one half to one third of those observed with haloperidol, and even at the highest dose range (15 ± 2.5 mg/day) olanzapine was not associated with persistent elevations of prolactin.

In recent studies comparing the newer antipsychotics with haloperidol, better effects have been observed with regard to negative symptoms and depression.⁴ In many cases, it is likely that patients did not link a number of side effects to their medication, and were unaware that a change of medication could make a significant difference. This is compounded by their lack of engagement during consultation.

“We know from our own surveys that a large proportion of patients do not tell their doctor about EPS, and an even greater number do not mention sexual dysfunction. We also know that typically, the only time the subject of sexual function is raised is when

patients initiate discussion," says Dr Hellewell.

It would appear that if patients were given the opportunity to discuss their concerns more openly with health care professionals, and alternative medication was considered where appropriate, the result could be a much higher level of patient satisfaction — and hence also compliance. Research shows that patients who were switched from their previous antipsychotic therapy to a prolactin-sparing antipsychotic treatment, in general, experienced a rapid and statistically significant reduction in serum prolactin.¹⁵

While greater discussion would entail a little more of the professional carer's time initially, it could involve a team approach, with pharmacists being in an ideal position to initiate discussion on suitable occasions. Such an approach could lead to an overall enhanced patient-carer relationship with the bonds of trust being strengthened, thus helping to avoid any subsequent ongoing problems, including the patient's decision to stop taking medication.

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