Adherence Therapy
One day workshop

Richard Gray
E: richard.gray@uwe.ac.uk
Dr Richard Gray

- Biography: am professor of Mental Health and Honorary Consultant at the University of the West of England. I trained at King’s College as a Mental Health Nurse and at the London School of Hygiene and Tropical Medicine in Public Health. I was awarded my PhD in 2001 from King’s College London and in the same year I was awarded a prestigious MRC research training fellowship. I lead a multidisciplinary research group with programmes of work in treatment adherence, co-morbid depression in long term conditions, physical health problems in severe mental illness, pain management, cancer, violence and aggression and mental health in older adults. I have published some interesting papers but most of them are dull and some starkly contradict each other! My current h-index is 18, ten years after my PhD. One of my papers has been cited over 100 times and five over twenty five.
Agenda

09:30   Introductions and setting aims
10:00   Why don’t people take their medication?
11:00   Coffee
11:30   What are the key elements adherence therapy?
12:30   Lunch
13:30   Assessment (importance confidence and satisfaction)
14:30   Tea
14:45   Working with beliefs about medication
15:45   From theory to evidence
16:00   Evaluation and close
At the end of the workshop you will…

• Explored your beliefs about medication
• Be aware of how common non-adherence is
• Understand why people don’t take medication
• Be able to assess peoples beliefs about medication
• Be able to work with peoples beliefs about medication
I believe...
Is continuous medication important in schizophrenia treatment?

Symptom control

Placebo-controlled clinical trials with APs in the acute phase of schizophrenia have consistently demonstrated the active drug to be significantly more effective.
The efficacy of APs in schizophrenia is not in doubt.

Relapse prevention

After 2 years of uninterrupted treatment with RLAI, 97% of remitted patients relapsed over 3 years following discontinuation.
AP discontinuation may not be in the best interest of the majority of patients.

Potential for neuroprotection

Poor outcome in patients with schizophrenia associated with extent of cortical thinning.
In a 5-year longitudinal study comparing patients with schizophrenia and healthy controls using brain MRI, higher cumulative intake of atypical APs associated with less pronounced cortical thinning.

Improved physical health

Long-term cumulative exposure (7-11 years) to any antipsychotic treatment was associated with lower mortality than was no drug use.
In patients with one or more filled prescription for an antipsychotic drug, an inverse relation between mortality and duration of cumulative use was observed.

Antipsychotics are good for you (if you have SMI)

11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study)

Jari Tiikinen, Jouko Lönnqvist, Kristian Wohlbeck, Timo Klaukka, Leo Niskanen, Antti Tanskanen, Jari Haukka

Lancet 2006; 374: 620-27
Published Online
July 13, 2009
DOI:10.1016/S0140-6736(09)60742-X

Figure 2: Risk of death from any cause versus cumulative use of any antipsychotic drug
*Mortality=unadjusted absolute risk per 1000 person-years. †No antipsychotic drug=patients (18 914) who had not used any antipsychotic drugs during follow-up.
Adherence

• Full adherence
  – Taking all medication as prescribed

• Partial adherence
  – Occasionally missing or questioning the need for medication

• Non-adherence
  – Complete cessation of medication
How common is non-adherence?
Extent and burden of non-adherence in treatment of chronic disorders

• In developed countries, only 50% of patients with chronic diseases adhere to treatment recommendations\(^1\)
  – Rates may be even lower in developing countries

• One-third of all prescriptions are never filled\(^3\)
  – More than half of filled prescriptions are associated with incorrect administration\(^3\)
  – Of those who do fill, approximately 50% discontinue therapy in the first 6 months (lack of medication persistency)\(^4\)

• 33–69% of all medication-related hospital admissions in the US are due to poor medication adherence\(^2\)
  – Costing approximately $100 billion/year
Adherence challenges affect almost all patients*

*Based on availability of medication in a 1-year naturalistic study; †'No therapy' defined as days in which medication was not available.

High percentages of patients receiving oral SGA and FGA treatment received no antipsychotic therapy for a substantial portion of study follow-up

*Based on availability of medication in a 1-year naturalistic study; †'No therapy' defined as days in which medication was not available. Patients were considered to be receiving therapy on days when medication was available and COULD have been taken.

FGA, first-generation antipsychotic; SGA, second-generation antipsychotic

What do patients think about antipsychotic medication?
What do patients think about their medication?

• 26 patients
• Early psychosis
• Prescribed antipsychotic medication

• Most striking observation
  – Patients had a mix of positive and negative views about antipsychotic medication
  – Discrepant with the “Noise”

Meek I. and Gray R. (in preparation)
What do patients think about their medication?

• Theme: There has to be something else
  – “It is the companies and the research; I was dead against them when I was first taking it because of how it made me feel. I started to accumulate reasons not to take it. I raged against the drug companies and their propaganda, making themselves the best option…” [P10, Male, 30]

• Theme: The drugs don’t work
  – “They keep people on these drugs for too long. I am no better than when I was not on them…” [P10, Female, 23]
  – “I get no effects from it. It does nothing to me. I don’t have a mental problem” [P4, Male, 27]

Meek I. and Gray R. (in preparation)
What do patients think of their medication?

• Ambivalence
  – “It doesn’t chill me out enough. It doesn’t quite relieve my symptoms” [P12, Male, 30]
  – “If doesn’t work as well as I hoped for. I still feel worried/paranoid and I still hear voices. I’m relying on something to help me get through, although feeling it was not necessary to take it” [P6, Male, 22]
  – “I wish my medication got rid of all my symptoms. My thoughts are less distressing but I still have them at times” [P20, Male, 27]
What do patients think of their medication?

• Theme: It does what it says on the tin
  – “The effectiveness of and the speed of it working for me. It worked within two weeks, it continued to be effective. I would recommend it as an effective antipsychotic drug” [P17, male, 28]
  – “They are doing what they are supposed to do with some thoughts. They are doing what they are supposed to do. That is the main factor [P18, Male, 28]
  – “I’m not so jumpy. It has made things more manageable [P13, Female, 35]
What do patients think of their medication?

• Theme: side effects
  – Some patients said that they experienced no side effects at all
    • “I have no bad reactions, no side effects” [P6, Male, 22]
    • “I haven’t experienced any side effects” [P16, Female, 27]
  – Sedation was the most frequently reported and most troubling side effect
    • “The first time after taking it I couldn’t get up for 12 hours. Now 2-4 hours after taking it I can ‘get up’, but I can’t get out of bed. It makes me dark under my eyes. It makes you feel weak for hours. I have somehow to get used to it” [Patient 1, Male, 23]
    • “If you move about a lot you don’t notice it. If you take down time the effects seem to snow ball and it gets on top of you. If you’re tired it makes you more tired. It’s like walking in water. You learn to fight the resistance” [Patient 2, Male, 30]
Exercise one

In small groups spend 10 minutes identifying the reasons why people may or may not take their medication.
## Factors affecting adherence

<table>
<thead>
<tr>
<th>Illness related factors</th>
<th>Treatment related factors</th>
<th>Prescriber related factors</th>
<th>Person related factors</th>
<th>Environmental factors</th>
<th>Cultural factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge about illness and treatment</td>
<td>Complex regimes</td>
<td>Non collaborative</td>
<td>Busy lifestyles</td>
<td>Family's view of treatment</td>
<td>Ethnic Background</td>
</tr>
<tr>
<td>Denial of illness</td>
<td>Unwanted side effects</td>
<td>Authoritative</td>
<td>Disorganised lifestyles</td>
<td>Religious beliefs</td>
<td></td>
</tr>
<tr>
<td>Severity of illness</td>
<td>Route of administration</td>
<td>Not explaining</td>
<td>Forgetting to take medication</td>
<td>Family influences</td>
<td></td>
</tr>
<tr>
<td>Level of disability</td>
<td>Lack of satisfaction</td>
<td>Not having faith/confidence in prescriber</td>
<td>Beliefs about illness</td>
<td>Peer pressure</td>
<td></td>
</tr>
<tr>
<td>Rate of disease progression</td>
<td>Fear of side effects</td>
<td>Lack of access to prescriber</td>
<td>Beliefs about treatment</td>
<td>Contact with other users</td>
<td></td>
</tr>
<tr>
<td>Impact of illness on lifestyle</td>
<td>Poor symptom control</td>
<td>Lack of follow up</td>
<td>Embarrassment</td>
<td>Media</td>
<td></td>
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<tr>
<td></td>
<td>Previous negative experiences</td>
<td>Prescriber overworked</td>
<td>Fear of being stigmatised</td>
<td>Access to alternative treatments</td>
<td></td>
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<tr>
<td></td>
<td>Not seeing immediate benefits</td>
<td>Service over burdened</td>
<td>Cognitive deficits</td>
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<tr>
<td></td>
<td>Misunderstanding treatment</td>
<td>Lack of training in appropriate interventions to improve adherence</td>
<td>Low self esteem</td>
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<tr>
<td></td>
<td>Frequent changes in treatment</td>
<td>Irregular medication review</td>
<td>Poor motivation</td>
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<td></td>
<td>Duration of treatment</td>
<td></td>
<td>Lack of perceived risk illness poses</td>
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</tbody>
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<td>Family's view of treatment</td>
<td>Ethnic Background</td>
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<td>Support from family</td>
<td>Religious beliefs</td>
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<td>Peer pressure</td>
<td>Family influences</td>
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<td>Contact with other users</td>
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<td>Media</td>
<td>Access to alternative treatments</td>
</tr>
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<td>The National Health Service</td>
</tr>
</tbody>
</table>
Why don’t people take their medication?

**TABLE 1: Results of the concept mapping study (adapted from Kikkert et al., 2006)**

<table>
<thead>
<tr>
<th>Adherence-modifying factors</th>
<th>Patient</th>
<th>Carers</th>
<th>Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Efficacy of medication</td>
<td>1†</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2. Side-effect self management</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3. Clinician characteristics</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>4. Medication side-effects</td>
<td>4</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>5. Subjective experiences of medication and illness</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>6. Beliefs and attitudes about medication</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

†1 = most important; 6 = least important.
Why don’t people take their medication?

- Cross sectional study
- 584 patients with SMI
- Measured
  - Adherence
  - Symptoms
  - Treatment attitudes
  - Insight
  - Side effects
  - Socio-demographic characteristics

Bressington D. Mui J. and Gray R. (in press)
Why don’t people take their medication?

• Adherent patients:
  – More positive attitudes towards treatment
  – Had greater awareness of the need for treatment
  – Were less symptomatic
  – Prescribed an atypical
  – Reported fewer side effects

Bressington D. Mui J. and Gray R. (in press)
Adherence is affected by the environment in which the patient is living
Why don’t people take their medication?

- Cross sectional study
- 44 prisoners prescribed antipsychotic medication
- Measured
  - Adherence
  - Symptoms
  - Satisfaction
  - Treatment attitudes
  - Insight
  - Side effects
  - Socio-demographic characteristics

Why don’t people take their medication?

• Three variable that explained 52% of the variance in adherence
    – I am motivated to take antipsychotic medication
        • I believe I’m going to need to take this medication for a lot of years because it suits me. It seems to be helping me and I’ve more self-esteem about myself when I take it (Y03)
    – My antipsychotic medication makes me feel better
        • The very first medicine I was on was [xx]… And it… Helped hold me back. It stopped me from kicking chairs, or throwing things out of the windows, or scream that “they’re out to get me” (X07)
    – Putting on weight (patients who put on weight were more likely to take medication)

Improving treatment adherence
What are the key elements of an adherence therapy intervention?
Candidate interventions

• Patient education
• Financial incentives
• Depot (long acting injections)
• Adherence therapy
  – Problem solving
  – Ambivalence
  – Beliefs
The knowledge fallacy…
Study protocol

Financial incentives to improve adherence to anti-psychotic maintenance medication in non-adherent patients - a cluster randomised controlled trial (FIAT)

Stefan Priebe*¹, Alexandra Burton¹, Deborah Ashby², Richard Ashcroft³, Tom Burns⁴, Anthony David⁵, Sandra Eldridge⁶, Mike Firn⁷, Martin Knapp⁸ and Rose McCabe¹

Address: ¹Unit for Social and Community Psychiatry, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, Newham Centre for Mental Health, London, E13 8SP, UK, ²Division of Epidemiology, Public Health and Primary Care, Department of Epidemiology and Public Health, Imperial College London, Norfolk Place, St Mary's Campus, London, W2 1PG, UK, ³School of Law, Queen Mary University of London, Mile End, London, E1 4NS, UK, ⁴Department of Psychiatry, University of Oxford, University Department of Psychiatry, Warneford Hospital, Headington, Oxford, OX3 7IX, UK, ⁵Section of Cognitive Neuropsychiatry, Institute of Psychiatry, King's College London, Denmark Hill, London, SE5 8AF, UK, ⁶Centre for Health Sciences, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, Abernethy Building, 2 Newark Street, London, E1 2AT, UK, ⁷South West London & St George's Mental Health NHS Trust, Springfield University Hospital, 61 Glenburnie Road London, SW17 7DJ, UK and ⁸Personal Social Services Research Unit, London School of Economics and Political Science, Houghton Street, London, WC2A 2AE, UK

Email: Stefan Priebe* - s.priebe@qmul.ac.uk; Alexandra Burton - a.burton@qmul.ac.uk; Deborah Ashby - deborah.ashby@imperial.ac.uk; Richard Ashcroft - r.ashcroft@qmul.ac.uk; Tom Burns - tom.burns@psych.ox.ac.uk; Anthony David - a.david@ioo.kcl.ac.uk; Sandra Eldridge - s.eldridge@qmul.ac.uk; Mike Firn - mike.firm@swlstg-tr.nhs.uk; Martin Knapp - m.knapp@lse.ac.uk; Rose McCabe - r.mccabe@qmul.ac.uk
* Corresponding author
Risk of re-hospitalization was lower for patients receiving depot medication compared with oral medication.

In a pairwise comparison between depot injections and their equivalent oral formulations, the risk of re-hospitalization for patients receiving depot medications was about one-third of that for patients receiving oral medications (adjusted hazard ratio = 0.36, 95% CI=0.17–0.75).

Calculated hazard ratios were adjusted for effects of sociodemographic and clinical variables, temporal sequence of antipsychotics used, and the choice of the initial antipsychotic for each patient.
Adherence therapy…
Adherence therapy: theory

Beliefs about illness and treatment → Adherence behaviour → Wellbeing
Foundation skills, key skills, assessment and intervention skills

Interpersonal skills:
- Exploring ambivalence
- Problem solving
- Talking about beliefs
- Looking forward
- Looking back

Assessment:
- Process

Keeping people engaged & resistance low
- Exchanging information & developing discrepancy

Evidence base
Assessment

• Template
• Should be conversational in style
  – Four areas
    • Practical considerations
      – What medicines, who supplies, other medicines, homeopathic remedies, alcohol and substance use
    • Side effects
    • Importance, confidence and satisfaction
    • Common beliefs about medication
Medication problem solving

• Following on from assessment
• Address practical issues
  – E.g. getting medication, affordability, dispensing, getting prescriptions etc
  – Side effects from medication
• The aim of the problem solving exercise is to build the service users own capacity to problem solve and enhance their self efficacy
John’s timeline*

1999

- Developed “stress problems” during gap year prior to starting university
- Saw GP who started sulpiride. No positive effects but took it because told to by parents
- Not keen but keeps taking haloperidol. Worried about long term effects

Stress slowly building up

- “Stress problems” got worse admitted to psychiatric hospital. Terrible experience. Dose of sulpiride increased still no effect.
- Had enough of haloperidol. Decide to stop. Don’t tell family who are angry
- Started on an atypical. “Like a lifeline”. Feels more alive

“Blow up”

- Leave hospital to live in hostel
- Second hospital admission. Given an injection. Resented staff. Very angry
- Things pretty good. “getting on with life”

Now

- Bit of a “hiccup”. Try to stop medication. Feel a bit stressed. See psychiatrist who starts medication. Feel much less stressed
- Stress OK. Stopped medication because it wasn’t working!
- Discharged from hospital. Stress OK.

*Based on a real case
Belief: “I can stop medication once I stop feeling so angry”
Belief: “I can stop medication when I don’t feel angry any more and smash things up”

• Step 1: Rate the conviction with which the belief is held

• T: “Out of 100 how sure are you that you can stop medication when you don’t feel angry any more”

• P: “Well I am pretty sure. I don’t know about 70%”
Belief: “I can stop medication when I don’t feel angry any more and smash things up”

• Step 2: Explore the evidence for and against the belief…

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<thead>
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<th>For (70%)</th>
<th>Against (30%)</th>
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<tbody>
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<td>• I am better</td>
<td>• Part of me knows that I need meds to protect me from getting angry</td>
</tr>
<tr>
<td>• I know my anger won’t come back this time</td>
<td>• My Mum tells me that I need it</td>
</tr>
<tr>
<td>• I have got a grip</td>
<td>• I know that when I have stopped before that’s when I have got into trouble</td>
</tr>
<tr>
<td>• I am in a better place, I have sorted out some of my problems</td>
<td></td>
</tr>
<tr>
<td>• I don’t like the idea of being on meds for life</td>
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Belief: “I can stop medication when I don’t feel angry any more and smash things up”

• Step 3: Adopt a Socratic style

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I am confused. Help me understand. On the one hand you say that you know that your anger won’t come back this time, but on the other your saying that when you’ve stopped before that’s when you have got into trouble… Can you explain?”
Belief: “I can stop medication when I don’t feel angry any more and smash things up”

• Step 3: Rate the conviction with which the belief is held

• T: “Out of 100 how sure are you that you can stop medication when you don’t feel angry any more”

• P: “Well I am not so sure. I don’t know about 60%”
Talking about beliefs

Video example
Foundation skills, key skills, assessment and intervention skills

Keeping people engaged & resistance low
Exchanging information & developing discrepancy

Interpersonal skills
- Exploring ambivalence
- Problem solving

Assessment
- Talking about beliefs
- Looking forward
- Looking back

Process

Evidence base
Looking Forward

• Service users with mental health problems have the same goals and aspirations as us all.
• The looking forward exercise helps people to identify their goals and what needs to happen to achieve them. It also explores how medication may fit in to their future plans to enable them to achieve their goals
From theory to therapy...

<table>
<thead>
<tr>
<th>Author</th>
<th>Population</th>
<th>n</th>
<th>Primary endpoint</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ford (2004)</td>
<td>Patients with schizophrenia attending a community health centre in Florida, USA</td>
<td>26</td>
<td>Change in PANSS total score compared to TAU</td>
<td>No effect on symptoms, a high degree of patient satisfaction</td>
</tr>
<tr>
<td>Gray et al. (2006)</td>
<td>Patients with schizophrenia in Italy, Germany, the Netherlands, and UK</td>
<td>409</td>
<td>Change in quality of life compared to a ‘health education’</td>
<td>No effect on quality of life, symptoms, or adherence</td>
</tr>
<tr>
<td>Maneesakorn et al. (2007)</td>
<td>Patients with schizophrenia following inpatient admission for acute exacerbation of symptoms in Thailand</td>
<td>32</td>
<td>Change in PANSS total score compared to TAU</td>
<td>Positive effect on symptoms, attitude towards, and satisfaction with medication treatment.</td>
</tr>
<tr>
<td>Maneesakorn (2008)</td>
<td>Patients with schizophrenia following inpatient admission for acute exacerbation of symptoms in Thailand</td>
<td>70</td>
<td>Change in PANSS total score compared to TAU</td>
<td>Positive effect on symptoms and satisfaction with treatment</td>
</tr>
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PANSS, Positive and Negative Syndrome Scale; TAU, treatment as usual.
From theory to evidence

Treatment adherence therapy in people with psychotic disorders: randomised controlled trial†


Background
Interventions to improve adherence to treatment in people with psychotic disorders have produced inconclusive results. We developed a new treatment, treatment adherence therapy (TAT), whose intervention modules are tailored to the reasons for an individual’s non-adherence.

Aims
To examine the effectiveness of TAT with regard to service engagement and medication adherence in out-patients with psychotic disorders who engage poorly.

Method
Randomised controlled study of TAT v. treatment as usual (TAU) in 109 out-patients. Most outcome measurements were performed by masked assessors. We used intention-to-treat multivariate analyses (Dutch Trial Registry: NTR1159).

Results
Treatment adherence therapy v. TAU significantly benefited service engagement (Cohen’s d = 0.48) and medication adherence (Cohen’s d = 0.43). Results remained significant at 6-month follow-up for medication adherence. Near-significant effects were also found regarding involuntary readmissions (1.9% v. 11.8%, P = 0.053). Symptoms and quality of life did not improve.

Conclusions
Treatment adherence therapy helps improve engagement and adherence, and may prevent involuntary admission.

Declaration of interest
None.
Design: Parallel group single blind randomised controlled trial (n=137)
Endpoint: Mean change in PANSS-total score 12 weeks post randomisation
From therapy to practice

• Mental health professionals don’t deliver “therapies”…

• Adherence therapy training (5-10 days)
  – Psychopharmacology
  – Assessment measures
  – AT interventions
From therapy to practice

<table>
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<tr>
<th>Author</th>
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<th>Results</th>
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<td>Gray et al. (2004)</td>
<td>Community dwelling patients with schizophrenia with suboptimal treatment adherence on the caseload of community mental health nurse participating in the trial</td>
<td>10 days’ medication management training</td>
<td>72</td>
<td>Significant change in PANSS total score compared to TAU</td>
<td>Significant effect on symptoms in the medication management training group compared to TAU</td>
</tr>
<tr>
<td>Harris et al. (2009)</td>
<td>Community dwelling patients with schizophrenia with suboptimal treatment adherence on the caseload of community mental health nurse participating in the trial</td>
<td>10 days’ medication management training</td>
<td>88</td>
<td>Change in KGV-M scores compared to TAU</td>
<td>Significant effect on symptoms in the medication management training group compared to TAU</td>
</tr>
<tr>
<td>Byrne (2008)</td>
<td>Community dwelling patients with psychosis with suboptimal treatment adherence on the caseload of community mental health nurse participating in the trial</td>
<td>4 days’ medication alliance training + monthly coaching (supervision) × 6 sessions</td>
<td>28</td>
<td>Change in BPRS scores compared to TAU</td>
<td>Significant effect on symptoms in the medication management training group compared to TAU</td>
</tr>
</tbody>
</table>

BPRS, Brief Psychiatric Rating Scale; KGV-M, Krawiecka Goldberg Vaughn (modified) Symptom Scale; PANSS, Positive and Negative Syndrome Scale; TAU, treatment as usual.
Effectiveness of adherence therapy in patients with early psychosis: A mirror image study

Ellie Brown,^1,2 Richard Gray,^1,2 Martin Jones^2 and Simon Whitfield^2

^1School of Nursing Sciences, University of East Anglia, Norwich, and ^2Surrey and Borders Partnership National Health Service Foundation Trust, Leatherhead, UK

**ABSTRACT:** In patients with early psychosis, medication non-adherence is associated with more frequent relapse. Observational studies have reported that up to 60% of patients fail to take medication as prescribed. This study aimed to establish the effectiveness of adherence therapy (AT) training for two multidisciplinary early intervention in psychosis (EIIP) teams in preventing relapse in their patients. This intervention involved six 1-day team AT training sessions delivered monthly over a 6-month period. Participants were patients with early psychosis who were on the caseload of the EIIP teams during the study period. A mirror-image design was used, comparing clinician ratings of relapse in the year preceding training (year 0) and the subsequent year (year 1). Results showed that in year 0, the mean number of relapses was 0.96 (standard deviation (SD) = 1.10). During year 1, relapses reduced significantly (P < 0.01) to 0.34 (SD = 0.64). No unexpected effects of training were reported. A thematic analysis of staff views of training, and service users’ views of their care received from EIIP teams, was also completed. Challenges in faithfully incorporating AT skills into practice were reported. In conclusion, AT training coincided with reductions in relapse rates in patients receiving services from an EIIP team, but no other changes in outcomes were detected.

**KEY WORDS:** adherence therapy, early intervention, psychosis, team training.
Adherence therapy training in early psychosis: effect on relapse rates

Design: Mirror image study (n=32)
Endpoint: Relapse in previous 12 months

Jones M. Brown E. Gray R. (in prep)
At the end of the workshop you will…

• Explored your beliefs about medication
• Be aware of how common non-adherence is
• Understand why people don’t take medication
• Be able to assess peoples beliefs about medication
• Be able to work with peoples beliefs about medication
Adherence Therapy
One day workshop

Richard Gray
E: richard.gray@uwe.ac.uk