The Need to Develop Innovative Interventions to Improve Treatment Adherence in Co-Occurring Severe Mental Illness and Substance Use Disorders

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Treatment nonadherence is a significant public health problem that spans medical and psychiatric populations, adding billions of dollars to healthcare costs [1]. Patients with chronic and severe mental illness (SMI), such as schizophrenia and bipolar disorder, as well as those with substance use disorders (SUDs) tend to exhibit high rates of nonadherence (e.g., 50% or greater) to their medication and psychosocial treatments [2-7]. Not surprisingly, then, nonadherence rates tend to be highest in SMI patients who also abuse drugs or alcohol compared with noncomorbid patients [8]. Nonadherence in co-occurring SMI and SUDs produces a host of negative consequences, including increased rates of relapse, hospitalization, suicide, and functional impairment [5,9-11]. Abrupt withdrawal from psychotropic medications for SMI can lead to a quick return of symptoms that is not just attributable to the original illness, but also due to potential rebound effects associated with withdrawal from medications [12,13]. Furthermore, premature treatment drop out averages 50% within the first few weeks of SUD treatment [4-6], which prevents early intervention that can alter illness trajectories and provide needed course corrections prior to the development of clinical crises. Nonadherence also contributes to the so-called “efficacy-effectiveness gap” [14]. We spend large amounts of money and resources developing efficacious mental health treatments, but these interventions will have little public health impact unless patients view them as acceptable and adhere to them.

A number of cognitive, behavioral, motivational, and psychoeducational adherence interventions have shown some promise in improving adherence [15-18]. Unfortunately, these interventions are suboptimal or not readily implementable [19], partly because many display an overly simplistic and sometimes paternalistic understanding of the problem and its resolution or are simply not practical to implement. For example, the recent Schizophrenia Patient Outcomes Research Team (PORT) [20] guidelines concluded that “there is insufficient evidence to recommend any specific intervention to promote adherence to antipsychotic medications among persons with schizophrenia.” Of course, the goal of finding a one-size-fits-all intervention that should be able to neatly address a complex behavior such as adherence may be the wrong approach to the problem. Thus, there exists a critical need to develop innovative new interventions that are designed specifically to address treatment nonadherence and ultimately improve the impact of treatments for patients with co-occurring SMI and SUDs.

Innovation in adherence interventions can be displayed in two primary ways: (1) in our understanding of the nature of adherence and how we address it and (2) in how we make use of novel treatment technologies and formats to target nonadherence. First, we must develop a more sophisticated understanding of adherence behaviors to identify more fruitful targets for intervention. Adherence is traditionally defined as: “The extent to which a person’s behavior—taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a healthcare provider” [1]. Unfortunately, many providers and researchers implicitly and explicitly regard treatment adherence (or more accurately perhaps, “compliance”) as simply an issue of the patient taking a medication as prescribed or automatically following treatment recommendations without prompting. A more comprehensive understanding of the construct acknowledges that adherence is a characteristic of patients who trust and have a strong working relationship with their treatment provider, accept and acknowledge their clinical problems, understand and appreciate the potential usefulness of the treatment being offered, possess the money and resources needed to follow treatment recommendations, and display a willingness to put in the time and effort to change their behavior in the hopes of not just addressing the problem, but also improving their quality of life [21]. When viewed from this standpoint, the challenges with addressing adherence problems become much more salient. This means that interventions will need to entail more than simply reminding patients to take their medications or educating them with facts and statistics about the consequences of being nonadherent. Instead, addressing adherence requires helping patients to address the myriad of cognitive, behavioral, and emotional barriers that inhibit any complex behavior change effort, whether the goal is abstaining from drugs and alcohol, maintaining a healthy weight and diet, learning new ways of coping with depression or psychosis, or adhering to treatments.

There also tends to be an over-focus in the literature on medication adherence and an under-appreciation of behavioral forms of nonadherence, such as dropping out of treatment prematurely, failing to attend scheduled treatment appointments, and not implementing recommended lifestyle changes or coping strategies [21,22]. Increased behavioral adherence is critical because it could lead to the reduced need for medications as patients implement lifestyle changes that have a greater long-term impact on their behavior. Interventions to improve medication adherence will not necessarily address the problems associated with behavioral adherence and vice versa. Specially designed interventions are needed to increase behavioral adherence related to engaging in treatment, staying in treatment, and implementing treatment strategies.

Second, adherence interventions will benefit from the use of innovative new strategies including the use of emerging technologies (e.g., computer-based interventions, smart phone monitoring) and nontraditional delivery formats (e.g., phone counseling, significant others). A more comprehensive understanding of the nature of adherence and an under-appreciation of behavioral forms of nonadherence is critical because it could lead to the reduced need for medications as patients implement lifestyle changes that have a greater long-term impact on their behavior. Interventions to improve medication adherence will not necessarily address the problems associated with behavioral adherence and vice versa. Specially designed interventions are needed to increase behavioral adherence related to engaging in treatment, staying in treatment, and implementing treatment strategies.

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Received June 07, 2012; Accepted June 08, 2012; Published June 11, 2012

Citation: Gaudiano BA (2012) The Need to Develop Innovative Interventions to Improve Treatment Adherence in Co-Occurring Severe Mental Illness and Substance Use Disorders. J Addict Res Ther S8:e001. doi:10.4172/2155-6105.S8-e001

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and providers [23]. Smart phones [24] and electronic pill bottles [25] will allow greater ease in tracking adherence behaviors between appointments and allow data to be communicated back to treatment providers faster, thus providing the opportunity for earlier intervention directly through the mobile device. Nontraditional delivery formats also should be explored. For example, phone counseling [26,27] can help to monitor patients between visits and may be less burdensome for those who would be willing to speak with a clinician over the phone when they are not willing or able to return to the clinic. Including family members and significant others in the patient's treatment can also produce opportunities to increase social support and to help identify problems earlier so that they can be addressed [27].

Or course, a major challenge is how to fund these programs and obtain adequate insurance reimbursement for adherence interventions [28]. For example, conducting phone sessions and working with family members is challenging to obtain reimbursement for in most healthcare plans [29]. Furthermore, new technologies, such as smart phones and computer access, will require additional costs in terms the devices themselves, as well as their management by technicians. However, the costs of nonadherence are so high and produce such a negative public health impact that the sensible use of evidence-based adherence interventions should prove cost-effective in the long-run [23].

Ultimately, we will need to change the healthcare environment to accommodate innovative new adherence interventions and devote the resources needed to seriously address this problem based on the future potential payoff. Adherence should not be treated as an afterthought during treatment and adherence intervention should receive the time and attention that it deserves as part of comprehensive healthcare. Addressing adherence during treatment could provide a valuable psychosocial intervention in its own right and lead to improvements in other related health behaviors (e.g., symptom management, healthy lifestyle changes), which can further help to improve quality of life and functioning for patients with co-occurring SMI and SUDs.

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