Alliances With Patients Help Foster Adherence

BY ALICIA AULT
Associate Editor, Practice Trends

NEW ORLEANS — Adherence with medication regimens is poor among the mentally ill and tends to worsen as those patients age, but there are ways to help patients stick to their regimens, several speakers said at the annual meeting of the American Association for Geriatric Psychiatry.

There are not a lot of data on the elderly mentally ill and drug adherence, but a review of 39 studies published since 1980 that included patients of all ages estimated that the mean rate of nonadherence with antipsychotics was about 50% (J. Clin. Psychiatry 2002;63:892), said Dr. Dilip V. Jeste, distinguished professor of psychiatry and neurosciences at the University of California, San Diego.

While age was not a consistent risk factor for nonadherence, age might still contribute, he said.

Another study looked at adherence to antipsychotics and to medications for hypertension and hyperlipidemia in middle-aged elderly patients with schizophrenia. The authors found that the patients were as nonadherent with antipsychotics as with the medications for medical conditions, with fill rates ranging from 52% to 64% (Psychosom. Med. 2003;65:156). Nonadherence takes many different forms, Dr. Jeste said. A study of Medicaid beneficiaries with schizophrenia found that 41% were fully adherent, 16% were partially adherent, 24% were nonadherent, and 19% were excess fillers (Am. J. Psychiatry 2004;161:692), he said.

Adherence is affected by many factors, including side effects and the cost and complexity of the regimen, said Lawrence D. Cohen, Pharm.D., professor of pharmacotherapy at Washington State University, Spokane.

To get at the root of adherence issues among the elderly mentally ill, try assessing mood, cognition, vision, mobility, and ability to pay for the prescription.

To get at the root of adherence issues, psychiatrists should assess mood, cognition, vision, mobility, and ability to pay for the prescription, said Dr. George T. Grossberg, director of the division of geriatric psychiatry at St. Louis University.

Adherence can be assessed through patient self-reports, but most overestimate their adherence, Dr. Jeste said. Caregivers may also be a source of information, but most don't observe the patient on a day-to-day basis, he said. Pill counts are not very accurate, because patients can throw the medication away.

He often uses the Brief Evaluation of Medication Influences and Beliefs, which was developed by a colleague (J. Clin. Psychopharmacol. 2004;24:404). The patient self-administers the eight-item test, which can be done in the waiting room in less than 5 minutes. The scores can be correlated with pharmacy refill records and Drug Attitude Inventory Scores, Dr. Jeste said.

To improve adherence, strike an alliance with your patients, Dr. Cohen said. That includes educating patients and families about the medications and emphasizing their value. "Patients have to believe that the medications or treatments we're suggesting are valuable, are worth their costs, even if they have adverse events," he said.

Dr. Grossberg agreed that collaboration is important. He advocates what he calls "AIDES"—assessment, individualizing the regimen, choosing appropriate documentation, providing ongoing education tailored to the individual's age and needs, and continuing supervision after initiation.

Electronic caps, unit dosing, blister packs, and pillboxes with timers or calendars can also help, Dr. Grossberg said. He also encourages patients to keep a medication list in their purse or wallet. Telephone follow-up reminders from the physician office are very effective, he said.

Dr. Grossberg is a consultant for Bristol-Myers Squibb, Forest Pharmaceuticals, Janssen, Novartis, Organon, Sanofi-Aventis, Sepracor Inc., and Takeda Pharmaceuticals North America Inc. In addition, he receives grants or support from Abbott Laboratories, AstraZeneca, Eunoe Inc., Forest, GlaxoSmithKline, Myriad, Novartis, Ono Pharmaceutical Co., Pfizer Inc., and Wyeth.

Dr. Jeste is a consultant for Bristol-Myers, Janssen, Otsuka America Pharmaceutical, Solvay Pharmaceuticals, and Wyeth, and he receives other financial support from AstraZeneca, Bristol-Myers, Eli Lilly & Co., and Janssen.

Dr. Cohen is a consultant with Eli Lilly, Solvay, and Wyeth and is on the speakers' bureau for AstraZeneca, Eli Lilly, Forest, GlaxoSmithKline, Janssen, and Sepracor. ■

Collaborative, Evidence-Based Approach Encouraged for Depression

BY SARAH PRESSMAN LOVINGER
Contributing Writer

CHICAGO — The development of guidelines to treat depression in the elderly using evidence-based research is important, said a panel of experts at a joint conference of the American Society on Aging and the National Council on Aging. However, inadequate research and an unwillingness among providers to rely on evidence-based research make the process challenging.

"The mental health community needs to do a better job of getting on the evidence-based bandwagon," said Sharon Dumberg-Lee, a licensed certified social worker at the Council for Jewish Elderly in Chicago.

Depression Is Undertreated

Despite the lack of evidence-based treatment, mental health practitioners seem to agree that undertreated depression is a serious problem. "We care about depression because it's a fairly common psychiatric disorder, and because it causes a fair amount of morbidity," said Dr. John Frederick, a psychiatrist at the University of Washington, Seattle. He noted that depression in older adults complicates chronic medical conditions and, if it is not properly treated, can lead to self-neglect, premature death, and suicide. But the importance of treating depression does not necessarily translate into adequate treatment. "Older adults are often suboptimally treated," Dr. Frederick said.

Dr. Frederick worked with his colleague, Dr. Mark Snowden, on the Depression Special Interest Project, sponsored by the Centers for Disease Control and Prevention.

Working with other experts, they performed a literature review of research on the treatment of depression in community settings. The investigators looked at 174 studies, each with 25 or more participants, that evaluated community-dwelling adults who were at least 60 years old and in treatment for a wide range of depressive disorders. They determined that the research indicates that two types of treatment improve outcomes in this population: cognitive-behavioral therapy, and depression care management both in the home and in the primary care clinic.

Mixed Report on Interventions

The project also revealed certain interventions that the researchers said do not seem to benefit older adults who seek treatment for depression. These treatment modes included individual psychotherapy, education skills training, and exercise.

The project results not only indicated which treatments of depression in older adults are effective and which are not, but also helped the researchers to understand which areas need improvement. They specifically said that research on the prevention of depression and suicide is lacking. "Suicide is a very tough area to study," he said.

Dr. Snowden pointed out the large gap between efficacy research and real-world practice. Many practitioners "treat patients all the time, and they get better," he explained, even though the treatment plans and outcomes may not fit neatly into a publishable research study.

He urged psychiatrists and other community mental health providers to contribute to the knowledge base by participating in research projects.

Lynda A. Anderson, Ph.D., director of Health Aging Program at the CDC, shared her thoughts: "We already know there's a gap between evidence-based research and use in community settings," she said. She stated that reaching out to social service agencies to promote evidence-based research is important. ■

Genes May Explain Some Depression After Fracture

NEW ORLEANS — New-onset depression after hip fracture is fairly common and may be explained in part by certain polymorphisms of the serotonin 1A and 2A receptors, Dr. Eric J. Lenze said in a poster presented at the annual meeting of the American Association for Geriatric Psychiatry.

He and his associates undertook the study to determine whether people with a given vulnerability gene might be more susceptible to late-life depression onset, and hip fracture was considered a good laboratory, Dr. Lenze, of the psychiatry department at the University of Pittsburgh, said in an interview.

Since serotonin is part of the stress response system, the investigators posited that a variation in those receptors might predict a depression response, he added.

They examined 145 older women (median age 81 years) hospitalized after a hip fracture and followed them for a year. Depression and functional status were measured by the Geriatric Depression Scale, the Physical Activities of Daily Living scale, and the Instrumental Activities of Daily Living (IADL) scale. Serum samples also were obtained. The women were genotyped for the risk allele for the two serotonin receptors: 5HTR1A and 5HTR2A.

Women with one to two copies of the risk allele for 5HTR1A had more depression and poorer IADL scores than women without the allele. Dr. Lenze noted the link between depression and bad outcomes.

Interestingly, women with one to two copies of the risk allele for the 2A receptor did not have a higher risk of depression, and they had higher IADL scores after hip fracture, he said.

Dr. Lenze said that the 2A finding might indicate some adaptability afforded by this allele in the 2A receptor, which might help explain why some elderly people are more resistant to the impact of injuries or disease.

The researchers aim to replicate the findings in a larger study and also use them as a springboard to possibly develop a model to help clinicians determine who is at risk for new-onset depression after hip fracture, said Dr. Lenze.

—Alicia Ault