Strategies Can Improve Treatment Adherence

If alcohol abusers don't improve, they may need to be reeducated about their medications.

BY TIMOTHY F. KIRN
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SCOTTSDALE, ARIZ. — Sometimes an alcohol abuser prescribed a medication such as disulfiram, acamprosate, or naltrexone has no improvement in their drinking behavior. Sometimes the reason is that the patient has not been adherent to the medication, but not willfully so. In those cases, there are strategies a physician can use to help, Dr. Roger D. Weiss said at the annual meeting of the American Academy of Addiction Psychiatry.

No one knows for sure what level of adherence is necessary for the drugs used to treat alcohol dependence, and it is probably different for each drug, but it is clear that adherence does dictate efficacy, said Dr. Weiss, clinical director of the alcohol and drug abuse treatment program at McLean Hospital in Belmont, Mass.

In a classic study of disulfiram, patients who were largely adherent to their medication had an 80% likelihood of becoming abstinent during the study, whereas those who were nonadherent had only a 20% chance. Most patients were nonadherent, Dr. Weiss said.

In a study of naltrexone treatment, the relapse rates were 10% for those adherent to naltrexone and 34% for those adherent to placebo. But in nonadherent patients, the relapse rates were roughly the same: 42% and 40%.

When a patient's treatment is not working, the treating physician needs to ask about adherence, Dr. Weiss said. He said he does not ask the patient if he or she is taking their medication. Instead, he asks, "How much are you taking your medication?" The more specific question invites discussion that can be enlightening.

"By doing that, I found a lot of people who are taking more than prescribed, less than prescribed, and all kinds of odd dosing patterns," he said.

Nonadherence can involve patients who, often because they are impatient, take too much of a medication, and this can be as big a problem as omission because they run out or develop side effects that discourage them from continuing the regimen.

Dr. Weiss said he also keeps in mind that patients tend to exaggerate their adherence, for a variety of reasons apart from conscious deception, and that the most common reason patients miss a dose of medication is that they forget—and then they forget that they forgot.

When the patient is nonadherent, possible strategies include:

▶ **Reeducation.** Be certain the patient understands his or her condition, the need for the medication, and the importance of following the drug regimen, Dr. Weiss recommended. If the physician has doubts or uncertainty about a medication, that can be communicated to the patient and needs to be dealt with. As with all medications, the placebo effect and the commitment the patient makes to their treatment can be the most important components of the treatment's success.

▶ **More appointments.** Patients tend to be most adherent during the 5 days preceding and the 5 days after a doctor visit, a well-known phenomenon waggishly known as "white-coat adherence."

▶ **Reminders.** Notes on the bathroom mirror, pillboxes with individual wells for each day of the week or month, and alarm watches help forgetful patients remember.

▶ **Education of the family.** Family members who are aware of the condition and need for medication can be strong allies.

▶ **Mutual thanking.** One research study of alcohol-dependent patients and their significant others developed a script for reminding patients to take their medication, which was disulfiram. This strategy has since come to be known as the "Antabuse contract."

According to the study's script, the significant other first gently reminded the patient when it was time to take the medication. When the patient took the medication, he or she thanked the other for the reminder. The significant other then thanked the patient for taking the medication.

One crucial part of this contract was that the couple was not allowed to discuss any past drinking or future drinking events. Although the participants found the interaction uncomfortable initially, the researchers showed that it improved not only outcomes, but relationship satisfaction as well.

▶ **Simple regimens.** Even patients with diabetes or asthma are adherent to their medications only an average of 40%-60% of the time. And full adherence to a regimen drops dramatically when once-daily dosing is changed to twice-daily dosing. That means long-acting medications are more forgiving than short-acting ones. A depot formulation of naltrexone has recently been developed, and when it becomes available, it could be extremely useful for nonadherent patients, Dr. Weiss said. In a recent 6-month trial of once-monthly injections, 74% of patients came in and received between four and six of their injections, and 64% received all six (100% adherence). Overall, the median number of heavy drinking days declined 48%.

▶ **Blood levels.** Measuring blood levels, even when possible, is expensive but not practical or entirely foolproof, because patients may be more adherent than usual before an appointment. Still, it is an option, Dr. Weiss said. ■

Treating Depression Can Curb Drinking in Alcoholic Patients

BY TIMOTHY F. KIRN
Sacramento Bureau

SCOTTSDALE, ARIZ. — Most physicians who treat alcohol-dependent patients know that studies have shown that depressed patients are much less likely to quit, or reduce, their drinking.

It is less well known that treating depression in these patients can improve alcohol treatment results, Dr. Edward V. Nunes said at the annual meeting of the American Academy of Addiction Psychiatry. "The evidence shows if you do careful diagnosis—preferably in the setting of abstinence, but not absolutely so—treatment works," said Dr. Nunes, research director at the Substance Treatment and Research Service, New York.

Until fairly recently, treating depression in alcoholic patients has not been a standard practice, because researchers have had difficulty proving that it had any benefit, said Dr. Nunes, who reviewed the history of the research. Studies conducted before the 1980s were mostly inconsistent, largely because of the absence of a standardized diagnosis for depression that differentiated the depressive effects of heavy alcohol use from primary depression in a person abusing alcohol, said Dr. Nunes, who also is a psychiatrist at the New York State Psychiatric Institute.

Then the use of selective serotonin reuptake inhibitors (SSRIs) came into practice. But studies with SSRIs were generally seen as disappointing. Researchers interpreted study results to mean that the drugs appeared to reduce drinking behavior but had little impact on mood.

One study even suggested that SSRI treatment might increase drinking behavior in individuals with early onset alcoholism. So, for a while it was thought that depression treatment was irrelevant to people seeking help with an alcohol problem.

A study conducted by Dr. Nunes helped rekindle the idea of addressing depression in alcohol abusers. He gave imipramine to a group of alcoholic patients who appeared to have depression. He then continued the study with the patients who responded to the treatment to potentially identify only those who had a true primary depression. These patients were randomized to continued treatment or to placebo. Patients who were switched to placebo tended to get worse and relapse, whereas, those who remained on imipramine continued to respond (Am. J. Psychiatry 1993;150:963-5).

The study has since been replicated, without the first phase, using instead a newly available diagnostic tool that helps identify primary depression from alcohol-induced depression, he said (Arch. Gen. Psychiatry 1996;53:232-40).

The more recent study suggested a response rate of 50% with imipramine treatment, compared with 25% for patients on placebo. Though the number of patients who achieved complete abstinence from alcohol was low, the study was able to show that drinking decreased and that mood was correlated with drinking behavior.

Recently, Dr. Nunes conducted a literature review and an analysis of 14 of the most rigorously conducted trials of depression treatment in substance abusers (mostly alcoholics), out of the 44 placebo-controlled trials identified in the review (JAMA 2004;291:1887-96).

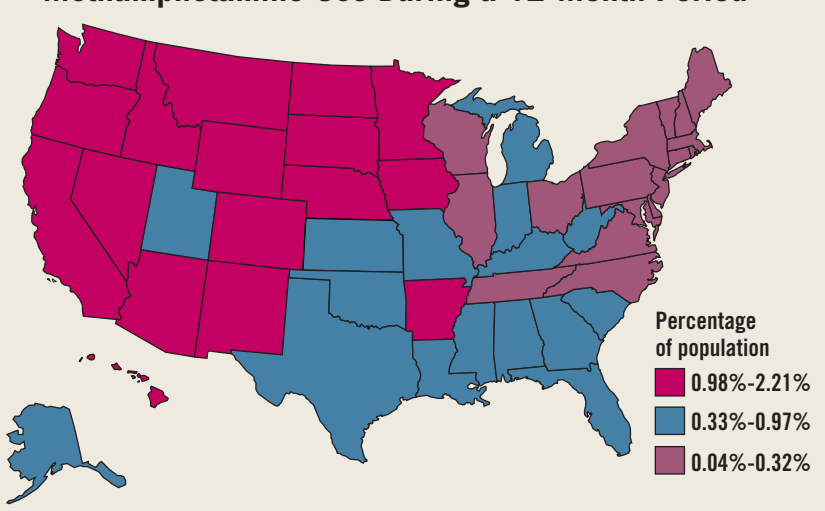
Overall, the data from those studies suggest that drug treatment for depression has a significant benefit, as measured by Hamilton Depression Scale scores. Not surprisingly, the benefit is similar in degree to that seen in drug studies for general depression: Fifty percent of treated patients showed improvement, compared with 30% of placebo controls.

Deeper analysis showed that the six studies that failed to show a benefit from treatment tended to have high placebo response rates, in the range of 40%-60%. This suggests that perhaps the placebo response masked the true response.

These six studies also tended to have patients receive structured alcohol treatment psychotherapy, which probably alleviated some depression and increased the placebo-response rate, Dr. Nunes said. ■

DATA WATCH

Methamphetamine Use During a 12-Month Period



Note: Based on a study of 203,670 persons aged 12 years or older during 2002-2004.
Source: U.S. Substance Abuse and Mental Health Services Administration

Julie Keller/Elsevier Global Medical News