Patients’ views about taking medication for depression

People with depression said that their attitudes to taking medication varied according to how they felt at different stages. There were numerous concerns about unwanted effects, and about the quality of information about the risks and benefits of medication. Sometimes people varied how they took their medications with or without professional advice. There was some concern from the national voluntary organisation, Rethink, that the cost of medication undermined compliance for some people.

“...At first I just wanted something. I needed something as I was in such a state and I needed to try something. I was aware I needed help... When I first started feeling better I heard birds sing and that lifted my spirits and I knew something was better. But as I felt better I have sometimes tried to stop [medication] as I feel so good now...I felt so well I thought I could cope without medication. It led me into a false sense of security.” (Man, 38, with depression and schizophrenia)

“...At that time [when the depression started] I was quite happy to take medication... In my third spell, following a suicide attempt, they gave me lithium and I read up about it. I came off it because of what I read about the effect on the liver and kidneys... At one stage I was referred to a reflexologist, she was someone to talk to and was influential at that stage. She believed medication was a poison to the system so I came off the medication.” (Man, 61)

“If people are given more information they’d be more likely to take the medication, if there is a positive approach e.g. “these are the things to look out for, and if you have a problem, come back to me”... The doctor and nurse did not tell me about side effects, but when I went back and said that I have problems like I need to scratch myself all over, then they told me.” (Man, 38, with depression and schizophrenia)

“I don’t bother reading the leaflets — well I do now. But at first the leaflets are not simple. They are too much as you are depressed and not feeling on top of the world. It would be better if there was just a card with the most vital bits of information. When I was depressed I just did not want to read... It would be good if the person who prescribes the medicines could talk more about them. It wouldn’t have stopped me taking the pills as I needed to get well in the head. But I would have liked to have an honest explanation of possible side effects, such as weight gain.” (Man, 38, with depression and schizophrenia)

“I got to the point of thinking: what is me and what is the medication? So I took myself off the medication. I told my psychiatrist and he said if I had problems to let him know. When I went back, he said “You’re doing OK. We could probably have taken you off the medication years ago”.” (Man, 61)

“I have sometimes started on a high dose and when I steadied I felt I could do with less, so I reduced the dose. When I am under stress I take a half or quarter tablet more. I don’t make an appointment with the psychiatrist first. I wait for my appointment to come round then I tell him. That approach works. In fact, he compliments me on it.” (Woman, 54, with depression)

“I get a season ticket and that is equivalent to a week’s incapacity benefit.” (Woman, reported by Rethink)
Research evidence

The World Health Organisation has estimated that, by the year 2020, unipolar depressive illness will rank second (after ischaemic heart disease) among the causes of disability worldwide. Yet despite the scale of this problem and the importance of controlling it effectively, information on compliance in depression therapy is relatively limited (Pampallona et al 2002). (The treatment of manic/bipolar depression and other depressive psychoses are not discussed in this report.

Depression is often a chronic condition. At least half the people who are diagnosed as depressed will experience a recurrence. Many clinicians argue that patients should take medication for long periods of time, perhaps for life, to protect against relapses. But others point out that the evidence available on the effectiveness of drug treatments (compared with placebo medicines) is — particularly for mild to moderate depression — relatively weak.

Medication compliance is a well established issue in the care of depression. There is evidence that more than 50% of depressed patients discontinue treatment prematurely (Katon et al 1996). The reasons for poor compliance include unpleasant side effects and not feeling better. In addition, beliefs and attitudes to treatment can be a major influence (Demyttenaere 2001). Despite the fact that severe depression may be disabling enough to demand hospital admission and is potentially life threatening, the nature of the illness means that sufferers may underestimate their capacity to respond to treatment.

Non-compliance rates

Reported rates of non-compliance with medical treatments prescribed for unipolar depression vary considerably. A recent review examined 32 relevant studies (Pampallona et al 2002). Most used direct measures of compliance, such as pill counts; some used the number of therapeutic appointments kept. Only four studies used composite measures of medication intake. The review cited medication compliance rates from 14 epidemiological studies, varying from 30% to (a questionable) 97% (Figure 8). Some other non-randomised clinical trials have reported compliance rates below 10% in groups that received no intervention beyond their drug treatment.

A review of studies conducted between 1975 and 1996 in the US showed that patients on antidepressants took an average of 65% of the prescribed amount. These rates contrasted with an observed 76% compliance in physical disorders (Cramer and Rosenheck 1998). Other research has claimed that depressed patients are three times more likely to be non-compliant with medical treatment recommendations in general, as compared to non-depressed patients (DiMatteo et al 2000).

Differences between antidepressants

Compliance rates may also vary between classes of drug and dosing regimens. For example, in the US Claxton et al (2000) found that compliance with a once-weekly dose of fluoxetine was higher (86%) than with a once-daily dose (79%). Similarly in the Netherlands, when patients changed from a once-daily dose of fluoxetine to a once-weekly dose, compliance did not decrease, while those who remained on the daily dosage became less compliant over time (de Klerk 2001).
Many studies have compared compliance in relation to the newer selective serotonin re-uptake inhibitors (SSRIs) with the older tricyclic antidepressants (TCAs). SSRIs tend to have fewer, and more tolerable, side effects than TCAs. Unsurprisingly, this appears to have an effect on compliance.

Thompson et al (2000) assessed compliance using pill counts, patient questionnaires and a device called the Medication Event Monitoring System (MEMS), a medication dispenser containing a microchip that records when the container is opened. The MEMS provides a useful indicator of compliance, although the medication is not necessarily consumed each time the container is opened. They found that the level of compliance with fluoxetine was higher than with the TCA dothiepin on all outcome measures, although the differences were not statistically significant. An increased level of compliance seemed to translate into improved health outcomes — patients taking fluoxetine scored better on the health transition scale of 36-item Short-Form Health Survey Questionnaire and showed an improvement on the Hamilton Depression Rating Scale, although there may not be a direct causal relationship with compliance.

Better tolerance of SSRIs has been generally reflected in lower dropout rates from clinical trials, compared with those of TCAs (Barbui et al 2000).

**Adverse health outcomes**

Depending in part on how bad the depression is, symptoms can recur if medication is stopped before the patient has made a full recovery (Melfi et al 1998; Sood et al 2000). But taking antidepressants as prescribed can be difficult for patients, especially when side effects appear before symptoms are relieved. There is strong evidence that even with drugs like dothiepin, which many prescribers have believed to be the safest of the TCAs, there are significant associations with conditions like ischaemic heart disease (Hippisley-Cox et al 2001). But the literature on adverse health outcomes from non-compliance with antidepressant medication is limited.
Factors affecting compliance

Several variables have been found to influence whether people take antidepressants as prescribed. The recent review by Pampallona et al (2002) found the following factors correlated with better compliance:

- **Demographic factors**
  - female
  - married
  - relatively high educational status
  - high IQ

- **Medication-related factors**
  - lack of severe side effects
  - lack of relapse
  - previous use of antidepressants or psychiatric treatment

- **Provider-related factors**
  - prescription by psychiatrist
  - referral to private psychiatrist
  - non-emergency referral

- **Social factors**
  - good social adjustment
  - diagnosis other than personality disorder and substance abuse

A review by Delgado (2000) emphasised the importance of a patient’s ‘personal model of illness’ in relation to compliance. This model encompasses their attitudes, beliefs and expectations about their illness and treatment. Kadam et al (2001) found that many depressed patients do not perceive medication to be an effective response to their needs.

Interventions to improve compliance

In their review of the literature, Pampallona et al (2002) found few quantitative studies on interventions to increase compliance in depressed patients. Most studies investigated a variety of interventions, and it was not possible to determine which components of the intervention (or combinations of components) had been effective. Studies also tended to present aggregated data relating to both major and minor depressive episodes and mixed diagnoses, so the authors could not assess whether an intervention worked better for some diagnostic sub-groups than others. There was a tendency, however, for interventions with more components (for example, patient education plus management changes plus a medication clinic) to produce better results. This is consistent with findings in a variety of other conditions.

One UK randomised controlled trial compared the effects of antidepressant drug counselling and providing information leaflets, on compliance with prescribed medication programmes for depression (Peveler et al 1999). The drug counselling consisted of:

- assessments of daily routine and lifestyle, and attitudes to treatment
- education about depression
The leaflet contained information about the medicine prescribed, its side effects and what to do if a dose was missed. As shown in Figure 9, significantly higher percentage of patients (65%) who received drug counselling at the beginning of their treatment continued medication to 12 weeks, compared with those who received no intervention (36%), or just the leaflet (42%). But this did not affect their depressive symptoms.

An ‘attention control’ group confirmed that these results were not simply due to the extra attention given to patients. The investigators concluded that the information leaflet had no significant effect on compliance with antidepressant medication regimens.

Specific patient groups

Few studies have focused exclusively on treatment compliance in depressed elderly, adolescent, or ethnic minority populations. These patient sub-groups are likely to have specific issues related to compliance.

Carers of elderly depressed people took part in focus groups for a UK study conducted by Boyle and Chambers (2000). They were found to have little knowledge of depression, or its medication. They nevertheless took an active role in trying to ensure compliance. Such observations highlight the need for health care professionals to support the carers of older people with depression in their efforts to help deliver effective treatment programmes, and to provide them with relevant information.
Summary

Non-compliance with drug treatments for depression is high. Factors that may affect it include side effects, lack of efficacy, relatively complicated dosing patterns and lack of belief in the appropriateness of drug treatment for this form of mental distress.

Depressed patients appear less likely than others to be compliant with any form of medication. This has important implications in other fields, such as the prevention and treatment of CHD. Information leaflets appear to have little or no impact on compliance rates. However, therapeutic counselling has been shown to help people with depression to take antidepressant medicines for extended periods. There is evidence that patients who are given relevant support continue with their treatment for longer than non-supported patients. The extent to which increased compliance is likely to lead to improved long term health outcomes amongst patients with mild to moderate depression is debatable. But for people with severe depression, the benefits of increased compliance may be much more significant.

References


