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EXPERT PANEL SUPPLEMENT

STRATEGIES FOR IMPROVING ADHERENCE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER

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ABSTRACT

It is estimated that 15 million Americans have a depressive disorder, including major depressive disorder, and many of those afflicted do not receive recommended guideline levels of care. Of patients who are correctly diagnosed with depression, a majority of patients do not recover by 4–6 months, often due to discontinuing treatment prior to the initiation of therapeutic effect. It is important for clinicians to understand the factors involved in nonadherence to treatment for the depressive disorders, including presence of residual symptoms, younger age, and less educational attainment. Once clinicians believe a patient is at risk for nonadherence—which is the rule rather than the exception—health care professionals have various techniques available to increase treatment adherence, including communication techniques and other health care interventions.

In this Expert Panel Supplement, Richard C. Shelton, MD, reviews data from the Sequenced Treatment Alternatives to Relieve Depression study to determine the role residual depressive symptoms have in causing patients to become nonadherent to treatment as well as defines characteristics common to patients who discontinue their medications. Steven R. Hahn, MD, outlines several strategies for improving adherence among patients, including a four-step process to bolster patient comfort with treatment guidelines and "Ask-Tell-Ask," a communication technique aimed to provide clinicians additional understanding as to patient attitudes and beliefs. Finally, Wayne J. Katon, MD, describes how collaborative care—a health care model that involves not only primary care but also additional health care providers in patient treatment—can be beneficial in improving adherence by providing further patient education and additional screening to ensure that patients remain adherent to antidepressants.

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Accreditation Statement

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Statement of Need and Purpose

While physicians are routinely trained to recognize symptoms of depression and evaluate side effects of antidepressants, they receive almost no training on assessing nonadherence to antidepressant therapy or considering the facors (ie, nonresponse, adverse events, poor patient insight, etc.) that contribute to nonadherence. Nonadherence to antidepressant treatment in depression is very common and could be considered the single greatest impediment to successful antidepressant therapy. Patients often do not report nonadherence, not realizing that when a physician erroneously believes that a patient has taken the prescribed medications, the physician may make inappropriate medication changes or dosage adjustments which can lead to further complications and worse health outcomes. Unacceptable side effects are often the motivation for discontinuing antidepressant medication. Patient beliefs about the necessity of antidepressants, their understanding of and attitude toward depression as an illness, the frequency of dosing, and patient awareness of the length of treatment course also influence treatment adherence. Physicians would benefit from specific direction regarding fostering effective communication regarding adherence and depression therapy, including tools and techniques for assessing adherence throughout all stages of therapy and creating collaborative relationships with patients.

Learning Objectives

At the completion of this activity, participants should be better able to:

- Recognize the scope of patient nonadherence to antidepressant therapy and its effect on patient outcomes
- Identify clinically actionable barriers to adherence and formulate treatment plans that address these barriers
- Review the evidence regarding safety and tolerability of available and emerging agents, and their potential influence on patient adherence
- Implement communication strategies to assess and promote adherence to antidepressant treatment throughout the course of therapy

Target Audience

This activity is designed to meet the educational needs of psychiatrists.

Faculty Affiliations and Disclosures

Richard C. Shelton, MD, is James G. Blakemore Research Professor and Vice Chair for Clinical Research in the Department of Psychiatry at Vanderbilt University School of Medicine in Nashville. Dr. Shelton is a consultant to and serves on the advisory boards of Forest, Janssen, the National Institute of Mental Health, Novartis, Otsuka, Pamlab, and Repligen; and has received grant/research support from Bristol-Myers Squibb, Eli Lilly, Forest, Janssen, the National Institute of Mental Health, Novartis, Otsuka, Pamlab, Pfizer, and Repligen.

Steven R. Hahn, MD, is professor of clinical medicine and instructor in psychiatry at Albert Einstein College of Medicine of Yeshiva University in New York City. Dr. Hahn is a consultant to Astellas, AstraZeneca, Eli Lilly, GlaxoSmithKline, and Pfizer.

Wayne J. Katon, MD, is professor of psychiatry, director of the Division of Health Services and Epidemiology, and vice chair of the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine in Seattle. Dr. Katon serves on the advisory boards of Eli Lilly and Wyeth; and has received honoraria from Eli Lilly, Forest, Pfizer, and Wyeth.

CME Course Director **James C.-Y. Chou, MD**, is associate professor of psychiatry at Mount Sinai School of Medicine. Dr. Chou has received honoraria from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, GlaxoSmithKline, Janssen, and Pfizer.

Susan F. Abbott, MD, is assistant professor of psychiatry in the Division of Child and Adolescent Psychiatry at Mount Sinai School of Medicine, and Chief of Child and Adolescent Inpatient Psychiatry Units at Mount Sinai Medical Center in New York City. Dr. Abbott reports no affiliation with or financial interest in any organization that may pose a conflict of interest.

Activity Review Information

The activity content has been peer-reviewed and approved by Susan F. Abbott, MD.

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To Receive Credit for this Activity

Read this Expert Panel Supplement, reflect on the information presented, and complete the CME posttest and evaluation on pages 15 and 16. To obtain credit, you should score 70% or better. Early submission of this posttest is encouraged. Please submit this posttest by December 1, 2011 to be eligible for credit.

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CME Podcast Version

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