Promoting Concordance in Mental Health

Note

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The authors, editor and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

Promoting Concordance in Mental Health

edited by

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Foreword

Promoting Concordance in Mental Health is an invaluable reference point for mental health practitioners involved in the prescription, administration and/or monitoring of psychiatric medication. As the authors so rightly point out, the ascendancy of person-centred care, recovery-focused approaches and psychosocial interventions, alongside ever more convincing critiques of biological explanations and pharmacological treatments, has diminished attention to 'good practice' in relation to medication. Indeed, an anti-medication movement is developing on the back of compelling texts asserting the long-term harm perpetrated by medication. Whilst these should not be ignored, it remains the case that for many, if not most, people who experience disabling mental health conditions, medication is prescribed. It is also true that such prescriptions are rarely administered in concordance with the person who will be taking the drug.

This book draws on the broader literature relating to person-centred care, rights, recovery and shared decision making to develop a model of concordance for mental health practitioners and the people with whom they work. This details the opportunities and challenges to respectful, constructive and collaborative partnerships; both are located in the attitudes, knowledge, understanding and social situation of both parties involved.

Although the text focuses largely on concordance in relation to medication, this is discussed in the context of therapeutic relationships as a whole. The qualities of a relationship based on shared expertise and experience, and the many and varied skills, interventions and approaches that might be helpful are described in detail: active listening and Socratic questioning, CBT and psychosocial interventions, together with a range of assessment skills and tools, and a problem-solving framework – to name but a few. In addition, the people involved are seen in the context of their whole lives and attention is given to the role that friends, family and informal carers can play and ways in which they can be assisted in this.

The beauty of this book lies in the use of credible case studies of three people in different situations, experiencing a range of challenges and receiving various treatments. These develop through the book to illustrate the model – from initial assessment to treatment following the ongoing developments in their complaints

and the support provided. Thus, rather than providing an abstract set of prescribed techniques and interventions, the authors locate the developing model in day-to-day practice that all readers will recognise – demonstrating setbacks as well as successes and widening the focus of the practitioners beyond the questions that surround medication.

I whole heartedly recommend this text to mental health practitioners, whether in basic training or working in advanced specialists roles. It provides a well-referenced, balanced and useful account of their role in relation to medication in the context of a supportive and collaborative relationship.

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Preface

This book is inspired by the need to place concordance at the heart of mental health practice. It is important to revisit medicine-taking within the context of recovery-focused practice in mental health because practice based on compliance is unlikely to succeed and is not resonant with the principles of recovery. Concordance is a way of working together with people which extends beyond medicine-taking. Mental wellbeing associated with recovery is promoted, however, when service users and mental health workers collaborate in a therapeutic alliance to reach concordance in medicine-taking. This is because the collaborative processes involve choice, self-determination and empowerment, which are features of mental wellbeing. The aim of the therapeutic alliance is to maintain an optimal therapeutic effect from medicine-taking, not to inculcate compliance. This book purports that practitioners should not aim towards compliance or adherence, but that, in collaboration with service users, should steer towards a therapeutic interaction with medicines, and working in concordance is the best way to achieve this. Although of relevance to all mental health workers, the book rests heavily on the nursing literature and this also reflects the normal situation in multidisciplinary team working of the nurse being the person best placed to have ongoing contact and to build a relationship to facilitate concordance. The very significant importance of other multidisciplinary team members in the promotion of concordance is, however, consistently reflected and acknowledged.

This book is a practical illustration of concordance working, utilising three scenarios which unfold throughout based on the experiences of Dougie, Murdo and Susan. Although it is intended that the reader will pick up useful pointers for recovery-based practice, it is recommended to read the book through from start to finish and not just to dip in to each chapter. Practice without theory is blind, and because key concepts in concordance working have become clichéd it is essential to begin with the sound conceptual understanding conveyed by Chapter 1. The book starts by clarifying the terms *compliance*, *adherence* and *concordance*. In Chapter 2 the dynamic biological interaction between medicines and the person taking them is outlined. Chapter 3 explores the importance of the therapeutic alliance in concordance. Chapter 4 illustrates how assessment can be conducted

in a person-centred partnership and Chapter 5 gives some concordance-based interventions. Finally, Chapter 6 summarises all the key points made previously in ensuring that concordance is at the heart of mental health practice. Reflective exercises are included in each chapter and suggested responses are given at the end of the book.

The metaphor for concordance working shown on the book cover and referred to throughout is that of a dance. Concordance working is not simple, straightforward or continuously attainable. The mental health workers in the examples given sometimes find themselves out of step with the service users, but this is not fatal to the therapeutic alliance if it is recognised and worked through. It is important that, based on this awareness, attempts are made to get back in step using the premise of 'dancing not wrestling' (Miller and Rollnick, 2002).

The person being discussed is usually referred to as simply that: the 'person'. However, when it seemed clumsy or inelegant to use the term 'person', the alternative 'service user' has been adopted. Occasionally the term 'patient' is used for cogency and linguistic accuracy, because at these times the context is paternalistic and the person is cast in a passive role. No specific mental health service or legislative system is referred to or meant to be implied.

The benefits of written plans rather than just written notes are promoted throughout the book as a means of providing continuity and tangible links from one interaction to the next. These written plans evidence a scientific approach whereby learning and discovering is done together between service user and mental health worker.

Contributors

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Gary is a graduate of Heriot-Watt University and the University of Surrey. After completion of his PhD research he completed postdoctoral research at Purdue University (Indiana, USA), the Imperial Cancer Research Fund and at the University of Dundee. In 2003 he took up a lectureship in Pharmacology at the University of the West of Scotland (Paisley campus) and teaches in the undergraduate and postgraduate courses in Biomedical Science, Forensics and Nursing. His research interests include studies of the regulation of ion-channel receptors in the CNS and the efficacy of exercise interventions in the prevention and treatment of CVS conditions.

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CHAPTER 1

Working towards recovery in mental health practice

Abstract

The terms *concordance*, *compliance* and *adherence* are used interchangeably, appearing in the literature for example as *adherence/concordance*. This leads to confusion and misunderstanding and in many cases inappropriate interventions. This chapter makes the case that conceptual clarity is needed to drive recovery-focused practice in relation to medicine-taking. A substantial portion of this chapter therefore defines the scope and practical function of concordance in relation to person-centred care. It introduces significant factors impacting on the complex relationship between the health professional and the person seeking help. In order to operationalise these issues in practice the book uses scenarios throughout that develop according to the theme of each chapter. This chapter finishes by introducing the three main service user scenarios which unfold throughout the book.

Key points

- Concordance is not a synonym of compliance or adherence.
- Recovery-focused practice is congruent with the concept of concordance.
- Mental wellbeing is associated with concordance and recovery-focused practice rather than compliance and paternalistic practice.
- Mental health workers should facilitate a therapeutic interaction with medicines rather than uncritical compliance with a prescription.
- Conceptual clarity is needed to underpin recovery-focused practice which promotes mental well being.

Key words

adherence, compliance, concordance, medicine-taking, mental wellbeing, recovery

Objectives

- Outline current practices in working towards recovery in mental health even when capacity to make decisions is compromised.
- Discuss professional attitudes and perspectives on concordance.
- Summarise ethics and obligations regarding concordance.
- Outline potential challenges to concordance considered a function of complex mental health problems.
- Introduce case studies.

Reflective exercise
Reflect on what concordance means to you and in your own words define concordance.

Introduction

> Recovery is being able to live a meaningful and satisfying life as defined by each person in the presence or absence of symptoms it is about having control over and input into your own life (Scottish Recovery Network (SRN) 2006, p. 1).

Recovery is often depicted as a personally unique road or journey (Pelton, 2009; Raptopoulos, 2010), and it is more prevalent than some clinicians think. For example, longitudinal studies of people diagnosed with severe and enduring mental illness showed that half to two-thirds of the cohorts had positive outcomes exceeding the expectations of clinicians (Harding and Zahniser, 1994; Harrison *et al*., 2001). These older studies have recent anecdotal support from more current narratives grounded in modern notions of recovery (SRN, 2006). Recovery is not just possible: it is likely.

Entering into, and ultimately leading, a treatment decision is part of the recovery journey. This process of engagement (Tait *et al*., 2010) is characteristic of wellbeing. Traditionally, however, mental wellbeing and psychiatry have been uneasy bedfellows. Whilst mental wellbeing is associated with autonomy, self-determination, self-expression and self-responsibility (Evans, 1992; Clarke *et al*., 2009), psychiatry has historically involved paternalism, compulsory powers and compliance (Breggin, 1993).

It is not the goal of this book to blithely oppose psychiatry, and it is acknowledged that the claim above is a radical over-simplification of a constantly evolving process. However, the dichotomy it represents is a useful starting point to understand the main theme of this book. Much of what opposes recovery is erroneously classed as treatment. This is often a matter of semantics and is therefore sometimes easy to spot and other times not. A significant project of this book is therefore to bring these issues out into the open and examine their impact where possible.

For example, although mental disorder can compromise people's capacity to decide for themselves, this is usually not permanent or all-encompassing (Patrick, 2006), and therefore does not justify paternalism as a default approach. Compliance, which stems from paternalism, implies an authoritarian relationship; the health professional decides and the patient is expected to comply. This evokes an image of the health worker as expert and places the patient in a dependent role. It is quite straightforward to understand dependence and autonomy as occupying different ends of a recovery spectrum. Recognising this is the first step to addressing it.

The process of regaining mental wellbeing is the essence of recovery, the most commonly agreed components of recovery (Repper and Perkins, 2003) being:

- Hope
- Meaning and purpose
- Control and choice
- Self-management
- Risk-taking
- Relationships
- Inclusion

The Scottish Recovery Network undertook a narrative research project to establish a Scottish evidence base of factors helping or hindering an individual's recovery. Emerging from this was the clear wish for mental health workers to reframe their role and become facilitative rather than directive and to be in tune with the service user's aspirations. They regarded demonstrations of empathy, trust, collaboration, shared power, respect, personal investment and kind gestures as most helpful in their treatment relationship with mental health professionals (Brown and Kandirikirira, 2007). Narrators felt specifically that wherever possible they should have a prime role in the decision-making, management and evaluation of their own medicine regime, not only to allow them to better manage the side-effects and establish responsive regimes, but also to address the issues of power relations, rights, self-determination and self-esteem.

This sounds intuitively moral. It is clearly the right thing to do. There is also significant evidence that it is the best thing to do. The purpose of this book is to show how this can be facilitated. It does this by operationalising theoretical discussions within clinical settings in order to bring these abstract issues to life.

This chapter begins by defining the terms *compliance*, *adherence* and *concordance* in order to illustrate the conceptual differences. It introduces recovery-oriented practice as a function of concordance, and shows how difficult concordance can be given the enduring conflation between concordance, compliance and (most recently) adherence. It then clarifies that medicines are useful, but that their utility depends upon a risk–benefit analysis. It shows that this can best be achieved by keeping the principle of concordance in mind, and introduces many evidence-based techniques to this end. The complexity of person-centred care in general is then briefly grounded in the ethical framework underpinning the concept. This is to illustrate the factors that everyone needs to keep in mind when coming to decisions in mental health care. The chapter finishes by introducing the scenarios that weave throughout the book.

Reflective exercise
Think about what you value most in life. Would it be possible without the freedoms implied by Repper and Perkin's components of recovery?

Compliance/adherence/concordance?

Table 1.1 summarises the definitions of compliance, adherence and concordance.

Table 1.1 Definitions of key concepts in medicine management (adapted from Treharne *et al*. (2006)).

Concept	Summary definition
Compliance	The paternalistic view that the person is a passive party who has his or her prescribed treatment enforced.
Adherence	The (still paternalistic) view that the informed (but still passive) person will stick (adhere) to taking the recommended treatment.
Concordance	The process of enlightened communication between the person and the healthcare professional leading to an agreed treatment and ongoing assessment of this as the optimal course.