A Systematic Approach to the Management of Patients Who Refuse Medications in an Assertive Community Treatment Team Setting

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A significant proportion of patients of assertive community treatment (ACT) teams will adamantly refuse medication. Whether the team should continue to encourage medication or put a hold on advocating for medication is a clinical and ethical dilemma. On the basis of their clinical experiences, the authors propose best-practices criteria that ACT teams can consider in deciding whether medications may be temporarily discontinued when a patient refuses them. The authors suggest that in some circumstances stopping medications in such a case may help in the development or repair of a therapeutic alliance over the long term. (*Psychiatric Services* 58:457–459, 2007)

Assertive community treatment (ACT) is a comprehensive, evidence-based model for delivering treatment, support, and rehabilitation services to individuals with severe mental illness (1). Research has shown that ACT is efficacious in reducing psychiatric hospitalization and improving patient functioning in many countries worldwide (2).

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One of the many services that an ACT team provides is monitoring medication compliance. It is well known that rates of medication noncompliance in schizophrenia can be as high as 40% to 50% (3). Risk factors that strongly predict medication noncompliance include poor insight, a negative attitude toward medication, previous noncompliance, current or past substance use, shorter duration of illness, inadequate discharge planning, and poor therapeutic alliance (3). The consequences of poor compliance with treatment include increased risk of illness relapse, greater likelihood of hospital admission, and longer hospitalizations (4).

Despite an ACT team's efforts to engage with patients and promote treatment compliance, a significant proportion of patients will adamantly refuse medication, either during the treatment process or even before treatment is initiated (5). What often follows is a clinical and ethical dilemma. One option is to continue to assertively encourage medication at the risk of weakening the therapeutic alliance. Another option is to put a hold on assertively advocating for medication to preserve alliance, at the risk of illness relapse, and to work with patients on their own terms. Given that each choice poses its own risks and benefits, clinicians may be tempted to put off deciding on an immediate course of action, opting instead to "wait and see." But in the face of persistent medication refusal, clinicians ought to be more active and decisive in the approach that they are going to take. How, then, does an ACT team decide what is the best action to take?

We conducted a review of the literature to see how this particular dilemma has been addressed. Our search indicated that there is a large knowledge gap in regard to this common medical dilemma. On the basis of our own clinical experiences with ACT patients who refused treatment, we propose best-practices criteria that ACT teams can consider in deciding whether temporary medication discontinuation is a viable option among patients who refuse medication. We believe that this approach can help ACT teams to achieve improved teamwide understanding of the clinical situation, improved documentation, and enhanced quality of care.

Medication discontinuation: a systematic approach

Capacity to consent to treatment

Severe mental illnesses often interfere with a patient's capacity to make treatment decisions (6). Patients may be too disorganized to attend to the information given to them or so delusional that they have a grossly distorted interpretation of what is being offered to them. Nevertheless, having a diagnosis of major mental illness does not necessarily mean incapacity. A patient is deemed capable of making decisions regarding treatment if the patient appreciates that he or she has an illness and if he or she understands the nature of the proposed treatment, the risks and benefits of the treatment, and the prognosis with and without treatment (7). The patient who is refusing medication should be assessed for capacity to make decisions as frequently as possible, and the results should be documented.

The team will need to respect the capable patient's decision, albeit with due considerations of the following.

Safety

As in any psychiatric assessment, ensuring safety of the patient and others is of utmost importance. Is the risk for harm to self or others higher or unlikely to change when the patient goes off medication? This determination is best derived from the individual's current presentation and past history. Any evidence that a patient's level of risk is acutely elevated may propel the ACT team to advocate assertively for medication adherence or to consider involuntary certification and hospitalization. Moreover, a history of relapse with dangerousness to self or others or requiring hospitalization after medication withdrawal is a relative contraindication to attempting a trial off medications (8).

Insight

Given the high prevalence of poor insight among patients with schizophrenia (9) and the overall goal of respectful, dignified rehabilitation in the community, nuanced consideration is warranted when these patients choose not to adhere to the prescribed treatment plan. There are some circumstances in which the patient's understanding of his or her illness and treatment in general justify refusal of treatment (for example, if the patient believes that taking medication will interfere with his or her special powers). ACT teams may need to take time and focus first on building trust and addressing other psychosocial concerns that are affecting a patient's overall functioning (10). Over time patients may change their minds about not taking medications after a rapport has been established with the team and a medication-free period has been attempted (11).

Symptoms

Consideration should also be given to the particular symptoms being targeted for treatment. Schizophrenia symptoms are often classified into positive ones (for example, delusions or hallucinations) and negative ones (for example, alogia or avolition). Even with the advent of second-generation antipsychotics, it is well known that positive symptoms respond better to antipsychotics than do negative symptoms (12). In a similar vein, symptoms that do not initially respond to antipsychotic treatment are less likely to have a good outcome with continued treatment (13). Taken together, about 20% to 30% of patients with schizophrenia do not benefit from antipsychotic treatment (14). Thus it is important to be cognizant of the limits of psychotropic medications. When side effects of treatment, including serious complications, are factored in with a patient who has a known history of being treatment resistant, there may be limited benefit to insisting on treatment for a patient who does not want it.

This situation constitutes a special dilemma as clinicians in general are reluctant to acknowledge the limits of medical treatment and have an understandable need to remain positive about and faithful to the efficacy of treatment. The special population served by ACT teams will have patients who will not respond to medication, and it may be particularly worthwhile to acknowledge and validate the patient's views and grounds for refusal. In doing so, the patient is viewed as collaborative rather than as oppositional, and this may help in improving the therapeutic alliance.

History

ACT teams typically have the advantage of possessing comprehensive knowledge of their patients. No other service would know as intimately how well a patient functions on a day-to-day basis in his or her own milieu. Patients with previous periods of noncompliance, but who were able to sustain themselves in the community for long periods of time without safety concerns, hospitalization, legal difficulties, or other significant compromises, are patients who can likely withstand temporary discontinuation of medication (15).

Current functioning

Some patients, despite being floridly psychotic, may not find the illness too distressing subjectively. Patients who become grandiose when they decompensate may, ironically, prefer to remain grandiose rather than to have an awareness of reality that comes with treatment (16). Additionally, patients may possess resilience and the coping strategies to weather any stress that they may encounter. They know how to go about obtaining shelter, how to earn some extra money on the streets, and where to go for help. Taken together, there is a subgroup of chronically ill patients who may achieve fairly good levels of functioning in the long run, despite being unresponsive to antipsychotic treatment (17). For these stable patients, then, it may be reasonable to temporarily withdraw medications should they insist (18). However, for patients whose symptoms create dysphoria and who decompensate more readily in the face of stress, ACT teams may decide to advocate more for treatment compliance.

Living environment

Many ACT patients live in supported housing. Regular liaising with housing workers can be helpful in the management of medication refusal. When patients are in stable housing and when housing workers have a certain level of expertise and tolerance with lower-functioning individuals, ACT teams may feel that it is less risky to stop medications. On the other hand, patients whose disruptive behavior is putting their housing in jeopardy will require

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more urgent intervention to treat symptoms in order to prevent further deterioration and loss of housing (19).

Family and social supports

ACT teams should also determine the impact of a patient's illness on family members and other current social supports. Patients whose untreated illness begins to interfere with the wellness of the family or with other significant relationships would increase the urgency for advocating medication in order to preserve the precious and available support network. In addition to looking at the stability of relationships, clinicians should involve a patient's social supports in their decision (19). What are the opinions of the family caregivers or of the substitute decision maker, if one is involved, regarding the benefits reaped from medications? How experienced and tolerant are the family members toward the patient who refuses medication? Soliciting the viewpoints of a patient's social supports will assist an ACT team in deciding how to manage a patient who does not want to be medicated.

Monitoring capabilities

An ACT team should assess what resources it has available to monitor a patient should the decision be that medication be temporarily discontinued. For patients who live at a fixed address and who live in close proximity to the team's office, the team can provide more frequent home visits or clinic appointments. A good attendance record at visits or appointments will also bear out well for close follow-up. The ability of other individuals (for example, family members or housing workers) to check the patient and communicate their observations to the team also helps ensure that the patient will be looked after in the community. Close monitoring will ensure that if an untreated patient starts to decompensate, the ACT team will be able to easily intervene.

Team expertise and goals

A final consultation should be conducted with the entire ACT team, all of whom should have had some degree of involvement in a patient's care. The team should assess what the goal is of discontinuing medications. Would the therapeutic alliance improve if the team was not to press the patient to take his or her medications? Would the patient allow contact or increased frequency of contact with the team if medication was not a subject of contention? Different team members will likely have different opinions. It is important to process the reactions and struggles that may develop between individual members in order that the team can be effective as a whole in implementing its decision (20). Having a team consensus will ultimately lend support to a psychiatrist's decision to assertively encourage medication or to discontinue treatment.

Conclusions

We have outlined various factors that ACT teams may consider in deciding whether medications may be temporarily discontinued among patients who refuse them. Our view is that all patients with chronic psychotic illness should remain on long-term pharmacological treatment. ACT teams should therefore consider when they should broach the topic about restarting medications with their patients. In the interim, though, we suggest that stopping medications in the short term may help in the development or repair of a therapeutic alliance, a key element for patients in long-term care. Although outcomes of this approach have not been formally studied, it is our hope that these best-practices guidelines will serve as a useful decision-making tool for ACT teams.

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