



Adherence of mental therapy for mental disorder patients to drug health treatment*

Adesão do portador de transtorno mental à terapêutica medicamentosa no tratamento em saúde mental

Adhesión del portador de trastorno mental a la terapéutica farmacológica en el tratamiento en salud mental

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How to cite this article:

Borba LO, Maftum MA, Vayego SA, Mantovani MF, Felix JVC, Kalinke LP. Adherence of mental therapy for mental disorder patients to drug health treatment. Rev Esc Enferm USP. 2018;52:e03341. DOI: <http://dx.doi.org/10.1590/S1980-220X2017006603341>

* Extracted from the thesis: “Adesão do portador de transtorno mental ao uso de medicamentos no tratamento em saúde mental”, Universidade Federal do Paraná, 2016.

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ABSTRACT

Objective: To assess the adherence of mental disorder patients to drug therapy for mental health treatment and the association between demographic, socioeconomic, clinical and pharmacotherapeutic variables to treatment adherence. **Method:** A cross-sectional study conducted with mental disorder patients in two Psychosocial Care Centers in Curitiba/Paraná in 2014. Data from structured interviews and medical records were submitted to descriptive and bivariate analysis. **Results:** 300 patients with mental disorders participated in the study. 51% of participants adhered to the drug therapy, the highest adherence was among males with no family history of mental disorder, diagnosed with schizophrenia, with disease duration of less than 1 year, who did not forget to take the medicine not even once in the previous month and who relied on family participation. Adherence was lower among the interviewees with individual income lower than one minimum wage, perception of regular and poor health, diagnosis of depression associated with another disorder, treatment time in the service over 2 years and with a history of attempted suicide. **Conclusion:** Low adherence to the drug therapy was observed. The variables associated with adherence were gender, individual income, family history of mental disorder, perception about their health, diagnosis of mental disorder, duration of illness and treatment, suicide attempt, failing to take the medication at least once in the previous month and family participation.

DESCRIPTORS

Mental Disorders; Medication Adherence; Psychiatric Nursing; Mental Health.

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Received: 02/27/2017
Approved: 01/31/2018

INTRODUCTION

Mental disorders are characterized by specific signs and symptoms such as changes in consciousness, emotion, behavior, thought, perception and memory, which can lead to significant functional impairments, difficulties in self-care and interpersonal relationships, low quality of life and social and occupational impairment of the people affected by them⁽¹⁻²⁾. In this sense, treatment for the mentally ill requires multiple interventions, including drug therapy.

The rational use of medication associated with other therapeutic modalities seeks recovery of the best health state, relief of the symptoms and a reduction of incapacities and relapses^(1,3). However, one of the problems found in clinical practice is the irregular use or the abandonment of drug therapy by people with mental disorders⁽⁴⁻⁵⁾.

The difficulty of medication access, the complexity of the therapeutic regimen, a lack of family support, side effects, the belief that the medication is ineffective, the lack of insight about the disorder, the perception of being cured due to symptomatology remission and difficulty in remembering to take the medicine are predictors of poor adherence^(2-3,6-7).

The phenomenon of adherence constitutes an important challenge for mental health professionals, since non-adherence to treatment can result in an increase in the frequency and intensity of the crises, in the number of hospitalizations/readmissions and thereby burden to the health system. Moreover, non-adherence is related to an increase in care demands in emergency services, an increase in suicide rates, worsening of the prognosis and impairment in the quality of life of patients with mental disorders^(1,4).

Thus, considering that a better understanding of the adherence phenomenon may enable changes in the practice of health professionals in order to plan care actions and implement strategies to promote adherence, the objective of this study was to verify the adherence of mental disorder patients to drug therapy for mental health treatment, and the associations between demographic, socioeconomic, clinical and pharmacotherapeutic variables to treatment adherence.

METHOD

This was a cross-sectional study⁽⁸⁾ carried out in two Psychosocial Care Centers (*Centros de Atenção Psicossocial – CAPS*) in Curitiba/Paraná from April to June 2014 with 300 patients with mental disorders. Individuals over 18 years of age who attended the CAPS to carry out their activities during the data collection period and who were prescribed medication for mental health treatment were included in the study. Those who were in a situation of crisis, occasional care or who were not able to answer the questions according to the evaluation of the service's health team were excluded.

Patients with mental disorders were invited to participate in the study through verbal invitation. Three-hundred and seventy (370) of the 510 registered in the two CAPS were approached, of which 300 accepted to participate, 14 refused and 56 did not meet the inclusion criteria. The 140 individuals who were not approached did not attend CAPS during the data collection period.

Data were collected by structured interview and by consulting the medical records. Collection took place simultaneously in both services and was performed by 10 trained interviewers. The interviewers remained at the CAPS during the service hours of operation, which allowed all subjects who met the inclusion criteria to be approached.

Two instruments were used; one with 65 questions related to the demographic, socioeconomic, clinical and pharmacotherapeutic characteristics of patients with mental disorders developed for this study, and the Measurement of Adherence to Treatment (MAT)⁽⁹⁾ composed of seven items that evaluate individual behavior in relation to adherence to drug treatment, which has an internal consistency of 0.74, specificity of 0.73 and sensitivity of 0.77.

The dependent variable was adherence to medication use for mental health treatment. Adherence can be understood as the degree to which the person follows the recommendations of the health professional, returns to the service and maintains the prescribed treatment, whether it is a behavioral or drug treatment. It is a multidimensional phenomenon which does not solely depend on the patient, as it is a product of the interaction between the dimensions related to the patient, the health service, the socioeconomic factors and the proposed therapeutics⁽¹⁰⁾.

The independent variables were: gender, age, marital status, religion, education level, work status, individual income in the previous month, use of alcohol or of other drugs, family history of mental disorders, perception of their health, clinical comorbidity, use of clinical medication, diagnosis of mental disorder, disease duration and treatment time at the service, information provided by health professionals about the mental disorder and medications, attempted suicide, prescribed drugs, questions regarding the medication, acquisition of medication, motivation to use medication, feeling pleasant or unpleasant changes, failing to take the medication at least once in the last month, family participation and participation in other activities.

Regarding the family participation variable, any activity developed by the family with the person with mental disorder was considered as participation, such as participating in health service activities, providing comprehensive care for the mentally ill, administering or supervising the use of prescribed medications.

Double checking of the tabulation and coding of the questions were performed for statistical analysis. The data were entered into an Excel[®] database, and after verification and correction of typing errors were then transported to the BioEstat[®] Program. The independent variables were compared to the outcome based on contingency tables using the Chi-square test and Williams G-test at a significance level of 5%. The prevalence ratio calculation was applied when p-value was ≤ 0.05 .

The study was approved by the Research Ethics Committee of the Universidade Federal do Paraná under the number 406.158/2013, and conducted in accordance with Resolution 466/2012. In order to safeguard the rights of the subjects with mental disorders, all participants were clarified about the objectives of the study, and secrecy, anonymity and the possibility of declining participation at any time of the study were assured.

RESULTS

Of the 300 interviewed individuals, 63% were female, 34.7% were in the 40–49 age group, 44.7% were single, 42% were Catholics, 59.4% had an education level of more than 8 years, 38.4% were unemployed, 45% indicated family income as the main source of income (financially dependent on the

family), 85.3% lived with relatives and 51% adhered to the drug therapy.

Male participants adhered 1.47 times more to drug use for the mental health treatment compared to female participants, and those with individual income lower than a minimum wage adhered 0.51 times less than those who received more than 2.5 minimum wages, according to Table 1.

Table 1 – Distribution of demographic and socioeconomic variables of patients with mental disorders associated with treatment adherence – Curitiba, PR, Brazil, 2014.

Variables	Adherence		p-value	PR [§]	CI [95%] [¶]
	Yes n (%)	No n (%)			
Gender			0.0006 [*]		
Male	71 (64)	40 (36)		1.47	[1.19;1.83]
Female [†]	82 (43.4)	107 (56.6)		[1]	
Age group			0.2671 [*]		
18 to 29 years	26 (57.8)	19 (42.2)			
30 to 39 years	31 (45)	38 (55)			
40 to 49 years	49 (47)	55 (53)			
≥ 50 years	47 (57.3)	35 (42.7)			
Marital status			0.5153 [*]		
Single	71 (53)	63 (47)			
Married	51 (52.6)	46 (47.4)			
Other	31 (45)	38 (55)			
Religion			0.7687 [*]		
Catholic	62 (49.2)	64 (50.8)			
Evangelican	59 (53.2)	52 (46.8)			
No religion	21 (55.3)	17 (44.7)			
Other	11 (44)	14 (56)			
Education level			0.5592 [†]		
No education level	3 (75)	1 (25)			
Up to 8 years	58 (49.2)	60 (50.8)			
> 8 years	92 (51.7)	86 (48.3)			
Work status			0.1607 [*]		
Unemployed	66 (57.4)	49 (42.6)			
On leave	36 (41.4)	51 (58.6)			
Retired	32 (52.5)	29 (47.5)			
Working	19 (51.4)	18 (48.6)			
Individual income in the previous month			0.0227 [†]		
No income	62 (59.6)	42 (40.4)		0.89	[0.60; 1.32]
< 1 minimum wage [‡]	12 (34.3)	23 (65.7)		0.51	[0.29; 0.92]
1 to 2.5 minimum wages	62 (45.6)	74 (54.4)		0.68	[0.46; 1.02]
> 2.5 minimum wages [‡]	10 (66.7)	5 (33.3)		[1]	
Not reported	7 (70)	3 (30)			

Notes: ^{*}Chi-Square Test; [†]Williams G-Test; [‡]Minimum wage at the time: R\$724.00; [§]Prevalence Ratio; [¶]95% Confidence Interval; ^{††}Reference category. Note: (N=300).

Table 2 shows that participants with no family history of mental disorder adhered 1.34 times more to drug therapy than those with a family history. Individuals with regular and poor health perception respectively adhered 0.67 and 0.69 times less than those who considered their

health as very good. Participants with depression associated with another mental disorder adhered 0.42 times less than those who had another diagnosis, while individuals with schizophrenia adhered 1.52 times more than those who had another disorder.

Table 2 – Distribution of clinical variables of patients with mental disorders associated with adherence – Curitiba, PR, Brazil, 2014.

Variables	Adherence		p-value	PR ^{**}	CI [95%] ^{††}
	Yes n (%)	No n (%)			
Tobacco use			0.7177*		
Yes	47 (49)	49 (51)			
No	106 (52)	98 (48)			
Alcohol use			0.9500*		
Yes	17 (51.5)	16 (48.5)			
No	136 (51)	131 (49)			
Use of illicit drugs in the previous year			0.6167 [†]		
Yes	14 (46.6)	16 (53.4)			
No	139 (51.5)	131 (48.5)			
Family History of MD[‡]			0.0100 [†]		
Yes ^{##}	84 (45)	103 (55)		[1]	
No	67 (60.4)	44 (39.6)		1.34	[1.08; 1.67]
Not reported	2 (100)	-			
Perception about their health			0.0143 [†]		
Very good ^{##}	22 (64.7)	12 (35.3)		[1]	
Good	46 (63)	27 (37)		0.97	[0.48; 0.93]
Regular	45 (43.3)	59 (56.7)		0.67	[0.48; 0.93]
Poor	40 (45)	49 (55)		0.69	[0.50; 0.97]
Clinical Comorbidity			0.7529 [†]		
Yes	92 (50.3)	91 (49.7)			
No	61 (52.1)	56 (47.9)			
Use of clinical medication			0.7183 [†]		
Yes	75 (49.3)	77 (50.7)			
No	17 (54.8)	14 (45.2)			
Can report the MD diagnosis			0.2957 [†]		
Yes	114 (49.4)	117 (50.6)			
No	39 (56.5)	30 (43.5)			
Diagnosis of depression			0.0415 [†]		
Depression	26 (52)	24 (48)		0.98	[0.73; 1.31]
Depression + another MD	4 (22.2)	14 (77.8)		0.42	[0.18; 1.00]
Another MD ^{##}	123 (53)	109 (47)		[1]	
Diagnosis of schizophrenia			0.0049 [†]		
Schizophrenia	40 (70.2)	17 (29.8)		1.52	[1.22; 1.90]
Schizophrenia + another MD	7 (53.8)	6 (46.2)		1.17	[0.69; 1.97]
Another MD ^{##}	106 (46)	124 (54)		[1]	
Diagnosis of BD[§]			0.2497 [†]		
BD	45 (47.9)	49 (52.1)			
BD + another MD	11 (39.3)	17 (60.7)			
Another MD	97 (54.5)	81 (45.5)			
Disease duration			0.0292 [†]		
< 1 year	12 (80)	3 (20)		1.74	[1.27; 2.38]
1 – 10 years	78 (53)	69 (47)		1.16	[0.91; 1.47]
> 10 years ^{##}	62 (46)	73 (54)		[1]	
Not reported	1 (33.3)	2 (66.7)			
Treatment time at the CAPS[¶]			0.0103 [†]		
< 1 year ^{##}	110 (55)	90 (45)		[1]	
1 to 2 years	38 (50.7)	37 (49.3)		0.92	[0.71; 1.19]
> 2 years	5 (21.7)	18 (78.3)		0.40	[0.18; 0.87]
Not reported	-	2 (100)			
Information about the MD			0.4870 [†]		
Yes	94 (49.5)	96 (50.5)			
No	59 (53.6)	51 (46.4)			
Attempted suicide			0.0008 [†]		
Yes	90 (44.3)	113 (55.7)		0.68	[0.55; 0.84]
No ^{##}	63 (65)	34 (35)		[1]	

Notes: *Chi-Square Test; [†]Williams G-Test; [‡]Mental Disorder; [§]Bipolar Disorder; [¶]Centro de Atenção Psicossocial; *N=183; ^{††}Prevalence Ratio; ^{##}95% Confidence Interval; ^{##}Reference category. Note: (N=300)

Participants with disease duration of less than 1 year adhered 1.74 times more compared to those who had more than 10 years of the disorder, and those with treatment time at the CAPS greater than 2 years adhered 0.40 times less than those who had been on treatment for less than 1 year. Also, individuals who attempted suicide adhered 0.68 times less to drug therapy than those who did not.

Participants who did not fail to take the medication even once in the previous month adhered 1.74 times more to the drug therapy than those who had failed to take it, since failure to take the medicine, even if sporadically, compromises adherence. Finally, those who had the participation of the family adhered 1.54 times more to the use of medication than those who did not, according to Table 3.

Table 3 – Distribution of pharmacotherapeutic variables of patients with mental disorders associated with adherence – Curitiba, PR, Brazil, 2014.

Variables	Adherence		p-value	PR [‡]	CI [95%] [§]
	Yes n (%)	No n (%)			
Can inform medication for their MD[‡]			0.0655*		
Yes	121 (48.6)	128 (51.4)			
No	32 (62.7)	19 (37.3)			
Pills taken/day[†]			0.8950*		
1 pill	9 (56.3)	7 (43.7)			
2 to 5 pills	63 (50)	63 (50)			
> 5 pills	78 (50.6)	76 (49.4)			
Has information about the medication			0.0659*		
Yes	84 (46.6)	96 (53.4)			
No	69 (57.5)	51 (42.5)			
Questions regarding the medication			0.7388*		
Yes	37 (49.3)	38 (50.7)			
No	116 (51.6)	109 (48.4)			
Acquisition of medication			0.1885*		
Own resource	22 (61.2)	14 (38.8)			
Public health	58 (45.3)	70 (54.7)			
Public health + own resource	67 (55.4)	54 (44.6)			
Another	6 (40)	9 (60)			
Difficulty in acquiring the medication			0.3133*		
Yes	64 (47.8)	70 (52.2)			
No	89 (53.6)	77 (46.4)			
Motivation to use the medication			0.1358*		
Yes	114 (53.8)	98 (46.2)			
No	39 (44.3)	49 (55.7)			
Feeling pleasant changes			0.4970*		
Yes	107 (49.8)	108 (50.2)			
No	46 (54.1)	39 (45.9)			
Feeling unpleasant changes			0.0672*		
Yes	94 (47.2)	105 (52.8)			
No	59 (58.4)	42 (41.6)			
Participation in other activities			0.0710*		
Yes	122 (54)	104 (46)			
No	31 (41.9)	43 (58.1)			
Failure to take the medication			<0.0001*		
Yes [¶]	23 (27.4)	61 (72.6)		[1]	
No	130 (60.2)	86 (39.8)		1.74	[1.20;2.53]
Family participation			0.0029*		
Yes	125 (56)	98 (44)		1.54	[1.12;2.12]
No [¶]	28 (36.4)	49 (63.6)		[1]	

Notes: *Chi-Square Test; [†]N=296, four interviewees only used injectable medication; [‡]Prevalence Ratio; [§]95% Confidence Interval; [¶]Mental Disorder; [¶]Reference category. Note: (N=300).

DISCUSSION

It is worrying to conclude that 49% of the interviewees did not adhere to taking their medication considering all the implications of non-adherence to the mentally ill person, such as worsening of the prognosis, more frequent

and intense seizures, increased risk of attempted suicide and impairment of quality of life^(1,3-4).

Other studies⁽¹¹⁻¹⁶⁾ corroborate our findings; however, the literature does not present consensus regarding this as there are reports of adherence prevalence higher than 71%^(6,17-18). The

method used to verify adherence, the study design, the type of medication used and the location where the study was carried out should be considered in analyzing the results, since these variables may interfere in the prevalence of adherence found⁽⁴⁾.

When not adequately identified by health professionals, a lack of adherence to drug therapy has repercussions on unnecessary adjustments such as inclusion or replacement of medications and dose escalation in face of the possible non-effectiveness of the previously prescribed medication^(4,7).

Adherence at any given moment does not guarantee subsequent adherence, since the meaning attributed by the individual to the use of the medication and the motivation to do so are not permanent, they are influenced by their perception and past experiences. Thus, even adherent patients need attention and monitoring regarding the use of medication^(3,7,15).

It was observed that the male participants adhered more to the drug therapy than the female gender. Studies have shown that men have a lower risk of discontinuing drug use and that the female gender is more associated with non-adherence^(5,19).

Regarding this finding, weight gain and consequent alterations in body image have been reported by women as a negative factor experienced during drug therapy. Such a factor may cause dissatisfaction with physical appearance and imply in interruption or irregular use of the prescribed medication⁽²⁰⁻²¹⁾.

The lower adherence among those who received less than one minimum wage is justified, since before deciding whether or not to follow the recommendations of health professionals about drug therapy, the individual must first have access to medication, and a lack of financial resources to purchase them restricts or precludes such access and greatly jeopardizes the continued use of prescribed drugs.

Although there are free drug distribution programs for the treatment of chronic diseases in Brazil, individuals with mental disorders experience failures in the delivery of medication by the public health services^(6,22). Medications that are not provided free of charge and that present interruptions or failures in distribution may lead to users not adhering to drug therapy due to their inability to afford purchasing the medicines, since with an income below one minimum wage a person often cannot even afford their basic necessities such as food, clothing and housing⁽²³⁾.

As for the family history, a study⁽²⁴⁾ developed in the Czech Republic mentioned that adherence did not differ between participants with or without a family history of mental disorders. Given the scarcity of studies that have investigated this variable, we suggest that further studies are carried out to verify whether this pattern of association is repeated and to allow a more consistent discussion about the finding.

In relation to those who considered their health poor or regular adhering less in comparison to those who considered it very good, a study of 11,842 patients with chronic diseases found that self-perception of health was strongly associated with non-adherence, in which the probability of non-adherence was three times higher among individuals who had a poor or very poor self-perception of health⁽²³⁾.

The desire to quit using the medication seems to be more intense when the person does not notice an improvement in

their health state; a fact that leads them to believe that the medication is ineffective. On the other hand, a perception of improvement in the quality of life, subjective well-being, diminished symptoms and, consequently, of limitations and suffering are benefits attributed by people with mental disorders to the use of medication^(2,7). This perception may reinforce adherence to drug therapy, since the person wishes to remain well, which corroborates the result found.

However, the literature also describes the correlation between feeling good and discontinuing medication, since the individual does not perceive the need to continue the therapy due to the absence of symptoms of the disorder, since they believe they are recovered and prioritize how they feel in their daily lives, and therefore do not base their decision to continue the drug therapy on the possible complications that can occur due to abandoning or irregular use of the medication^(6,14).

Participants diagnosed with depression associated with another mental disorder adhered less to drug therapy. The presence of psychiatric comorbidity requires the use of more than one medication, and complex treatment regimens tend to be associated with low adherence^(6,12). In addition, depression symptoms such as a lack of energy and initiative, difficulties in making decisions, hopelessness and feelings of worthlessness, may alone compromise adherence to drug therapy, since patients with mental disorders who feel unmotivated to live will be more prone to non-adherence⁽²⁵⁾.

Individuals diagnosed with schizophrenia adhered more when compared to individuals with other mental disorders. People with mental disorders, for the most part, consider schizophrenia as a serious disorder that imposes serious limitations on their lives; they also express fear of experiencing new crises. In this context, they understand drug therapy as a resource that is capable of attenuating the susceptibility and severity of the disorder, which favors correct use of the prescribed drugs⁽⁶⁾.

However, a cohort study with 11,797 patients with schizophrenia, bipolar affective disorder and depression did not show differences in adherence, considering that the percentage of discontinued medication use was similar among all three disorders⁽⁵⁾. As they have a chronic course, mental disorders can present permanent limitations according to the disease duration, thus contributing to the person's lack of motivation for continuous and regular use of medication.

In this sense, the long period of treatment and the continuous use of medications are identified as factors that hinder adherence to medication use⁽²⁵⁻²⁶⁾. However, there are reports of an inverse association to this, since patients with a mental disorder with a longer treatment time adhered more to the medication because they had become aware of the medication benefit only after periods of constant non-adherence, in which they coexist with the burden imposed by worsening of the signs and symptoms of the disorder^(12,19).

Regarding the association between attempted suicide and adherence, it has been observed that non-adherence favors worsening of the disorder's signs and symptoms, and a person with a mental disorder in this condition is more exposed to suicide ideation⁽²⁰⁾. In addition, a systematic review on adherence to drug treatment has shown that among the consequences of non-adherence are greater risk of relapse,

hospitalization and suicide. The risk of suicide was estimated five to seven times higher among non-adherents⁽²⁷⁾.

Those who failed to take the medication at least once in the previous month and those who had no family involvement in drug therapy adhered less. Eventually forgetting to take medication is a predictor of poor adherence^(3,6-7). Not counting on aid for the supervision and administration of prescription drugs are factors that make adherence difficult, mainly in situations of complex drug regimens or in the presence of expressive functional difficulties⁽⁶⁾.

Family members play a significant and decisive role in the adherence process, as they assist and supervise self-administration of medicines, accompany the patients in consultations, acquire medicine, reinforce the motivation for their use, as well as constantly assess the skills and limitations of the mental disorder patients to perform medication administration alone^(3,7).

In a recent publication, family support manifested by encouragement or direct participation of family members in both the comprehensive care of patients with mental disorders and in purchasing the medication was a facilitator in the complex dynamics of using the drugs prescribed for treatment of mental disorders⁽²⁰⁾.

In the same sense, a study developed in the United States with 761 people diagnosed with depression found that participants who reported greater satisfaction with family involvement in their treatment had lower odds, over time, of failing to take their medicine due to not having the

medication or of taking the medication differently from the medical prescription⁽²⁸⁾.

CONCLUSION

The present study showed 51% adherence by patients with mental disorders to their medication therapy for mental health. The adherence factor was associated with the variables gender, individual income, family history of mental disorders, perception about their health, diagnosis of mental disorder, disease duration and treatment time at the CAPS, attempted suicide, failure to take their medication at least once in the previous month and family participation.

Faced with the complexity and dynamicity of the adherence phenomenon to the use of medication by patients with mental disorders, the present study may contribute to the interdisciplinary practice of health professionals working in mental health by highlighting that they should remain alert to factors that predispose patients to poor adherence. Furthermore, they should implement strategic actions such as medication groups, guidance/information and inclusion of the family in the treatment in order to minimize the difficulties presented and to promote adherence and patient safety to drug therapy. We also emphasize the need for policies that guarantee access to medication.

As limitations of this study we can point out the cross-sectional design and the verification of adherence through self-reporting by the participants.

RESUMO

Objetivo: Verificar a adesão do portador de transtorno mental à terapêutica medicamentosa no tratamento em saúde mental e a associação entre as variáveis demográficas, socioeconômicas, clínicas e farmacoterapêuticas à adesão. **Método:** Estudo transversal, realizado em dois Centros de Atenção Psicossocial em Curitiba/Paraná, em 2014, com portadores de transtorno mental. Os dados oriundos de entrevista estruturada e de consulta a prontuários foram submetidos à análise descritiva e bivariada. **Resultados:** Participaram do estudo 300 portadores de transtorno mental. 51% dos participantes aderiram à terapêutica medicamentosa, sendo a adesão maior nos indivíduos do sexo masculino, sem histórico familiar de transtorno mental, com diagnóstico de esquizofrenia, com tempo de doença inferior a 1 ano, que não deixaram de tomar o medicamento nenhuma vez no último mês e que contaram com a participação da família. A adesão foi menor entre os entrevistados com renda individual inferior a um salário mínimo, percepção de saúde regular e ruim, diagnóstico de depressão associado a outro transtorno, tempo de tratamento no serviço superior a 2 anos e com histórico de tentativa de suicídio. **Conclusão:** Houve baixa adesão à terapêutica medicamentosa. As variáveis associadas à adesão foram sexo, renda individual, histórico familiar de transtorno mental, percepção sobre sua saúde, diagnóstico de transtorno mental, tempo de doença e de tratamento, tentativa de suicídio, deixar de tomar o medicamento alguma vez no último mês e participação da família.

DESCRIPTORIOS

Transtornos Mentais; Adesão à Medicação; Enfermagem Psiquiátrica; Saúde Mental.

RESUMEN

Objetivo: Verificar la adhesión del portador de trastorno mental a la terapéutica farmacológica en el tratamiento en salud mental y la asociación entre las variables demográficas, socioeconómicas, clínicas y farmacoterapéuticas a la adhesión. **Método:** Estudio transversal, realizado en dos Centros de Atención Psicossocial en Curitiba/Paraná, en 2014, con portadores de trastorno mental. Los datos provenientes de entrevista estructurada y de consulta a fichas médicas fueron sometidos al análisis descriptivo y bivariado. **Resultados:** Participaron en el estudio 300 portadores de trastorno mental. El 51% de los participantes adherieron a la terapéutica farmacológica, siendo la adhesión mayor en los individuos del sexo masculino, sin antecedentes familiares de trastorno mental, con diagnóstico de esquizofrenia, con tiempo de enfermedad inferior a un año, que no dejaron de tomar el fármaco ninguna vez el último mes y que contaron con la participación de la familia. La adhesión fue menor entre los entrevistados con ingresos individuales inferiores a un sueldo mínimo, percepción sanitaria regular y mala, diagnóstico de depresión asociado con otro trastorno, tiempo de tratamiento en el servicio superior a dos años y con antecedentes de intento de suicidio. **Conclusión:** Hubo baja adhesión a la terapéutica farmacológica. Las variables asociadas con la adhesión fueron sexo, ingresos individuales, antecedentes familiares de trastorno mental, percepción sobre su salud, diagnóstico de trastorno mental, tiempo de enfermedad y de tratamiento, intento de suicidio, dejar de tomar el medicamento alguna vez el último mes y participación de la familia.

DESCRIPTORIOS

Transtornos Mentales; Cumplimiento de la Medición; Enfermería Psiquiátrica; Salud Mental.

REFERENCES

1. Miaso AI, Cassiani SHB, Pedrão LJ. Affective bipolar disorder and ambivalence in relation to the drug treatment: analyzing the causal conditions. *Rev Esc Enferm USP* [Internet]. 2011 [cited 2014 Aug 10];45(2):425-32. Available from: http://www.scielo.br/pdf/reeusp/v45n2/en_v45n2a18.pdf
2. Nicolino OS, Vedana KGG, Miaso AI, Cardoso L, Galera SAF. Schizophrenia: adherence to treatment and beliefs about the disorder and the drug treatment. *Rev Esc Enferm USP* [Internet]. 2011 [cited 2014 July 15];45(3):703-13. Available from: http://www.scielo.br/pdf/reeusp/v45n3/en_v45n3a23.pdf
3. Vedana KGG, Miaso AI. The meaning of pharmacological treatment for schizophrenic patients. *Rev Latino Am Enfermagem* [Internet]. 2014 [cited 2015 Sep 05];22(4):670-8. Available from: <http://www.scielo.br/pdf/rlae/v22n4/0104-1169-rlae-22-04-00670.pdf>
4. Silva TFC, Lovisi GM, Verdolin LD, Cavalcanti MT. Adesão ao tratamento medicamentoso em pacientes do espectro esquizofrênico: uma revisão sistemática da literatura. *J Bras Psiquiatr*. 2012;61(4):242-51. DOI: 10.1590/S0047-20852012000400008
5. Conti V, Lora A, Cipriani A, Fortino I, Merlino L, Barbui C. Persistence with pharmacological treatment in the specialist mental healthcare of patients with severe mental disorders. *Eur J Clin Pharmacol*. 2012;68(12):1647-55. DOI:10.1007/s00228-012-1298-2
6. Miaso AI, Miamoto CS, Mercedes BPC, Vedana KGG. Adherence, knowledge, and difficulties related to pharmacological treatment for people with schizophrenia. *Rev Eletr Enf* [Internet]. 2015 [cited 2016 Dec 10];17(2):186-95. Available from: <https://www.fen.ufg.br/revista/v17/n2/pdf/v17n2a03-en.pdf>
7. Vedana KGG, Cirineu CT, Zanetti ACG, Miaso AI. Acting for relief: coping with schizophrenia and nuisances caused by drug treatment. *Cienc Cuid Saúde*. 2013;12(2):365-74. DOI: 10.4025/ciencuicsaude.v12i2.20342
8. Medronho RA, Bloch KV, Luiz RR, Werneck GL. *Epidemiologia*. São Paulo: Atheneu; 2009.
9. Delgado AB, Lima ML. Contributo para a validação concorrente de uma medida de adesão aos tratamentos. *Psicol Saúde Doenças* [Internet]. 2001 [citado 2014 fev. 06];2(2):81-100. Disponível em: <http://www.scielo.mec.pt/pdf/psd/v2n2/v2n2a06.pdf>
10. World Health Organization. Adherence to long-term therapies: evidence for action [Internet]. Geneva: WHO; 2003 [cited 2017 Aug 27]. Available from: <http://apps.who.int/iris/bitstream/10665/42682/1/9241545992.pdf>
11. Lucca JM, Ramesh M, Parthasarathi G, Ram D. Incidence and factors associated with medication nonadherence in patients with mental illness: a cross-sectional study. *J Postgrad Med*. 2015;61(4):251-6. DOI: 10.4103/0022-3859.166514
12. Alene M, Wiese MD, Angamo MT, Bajorek BV, Yesuf EA, Wabe NT. Adherence to medication for the treatment of psychosis: rates and risk factors in an Ethiopian population. *BMC Clin Pharmacol* [Internet]. 2012 [cited 2014 Jan 15];12:10. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3416691/>
13. Montes JM, Maurino J, Dios C, Medina E. Suboptimal treatment adherence in bipolar disorder: impact on clinical outcomes and functioning. *Patient Prefer Adherence* [Internet]. 2013 [cited 2014 Mar 22];7:89-94. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3553333/>
14. Tesfay K, Girma E, Negash A, Tesfaye M, Dehning S. Medication non-adherence among adult psychiatric out patients in Jimma University specialized hospital, southwest Ethiopia. *Ethiop J Health Sci* [Internet]. 2013 [cited 2016 Apr 20];23(3):227-36. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3847532/>
15. Arvilommi P, Suominen K, Mantere O, Leppämäki S, Valtonen H, Isometsä E. Predictors of adherence to psychopharmacological and psychosocial treatment in bipolar I or II disorders-an 18-month prospective study. *J Affective Disord*. 2014;155:110-7. DOI: 10.1016/j.jad.2013.10.032
16. Remondi FA, Cabrera MAS, Souza RKT. Não adesão ao tratamento medicamentoso contínuo: prevalência e determinante em adultos de 40 anos e mais. *Cad Saúde Pública* [Internet]. 2014 [citado 2016 out. 20];30(1):126-36. Disponível em: <http://www.scielo.br/pdf/csp/v30n1/0102-311X-csp-30-01-00126.pdf>
17. Sylvia LG, Hay A, Ostacher MJ, Miklowitz DJ, Nierenberg AA, Thase ME, et al. Association between therapeutic alliance, care satisfaction, and pharmacological adherence in bipolar disorder. *J Clin Psychopharmacol* [Internet]. 2013 [cited 2016 Apr 23];33(3):343-50. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3873324/>
18. Fornaro M, De Berardis D, Iasevoli F, Pistorio ML, D'Angelo E, Mungo S, et al. Treatment adherence towards prescribed medications in bipolar-II acute depressed patients: relationship with cyclothymic temperament and "therapeutic sensation seeking" in response towards subjective intolerance to pain. *J Affect Disord*. 2013;151(2):596-604. DOI: 10.1016/j.jad.2013.07.004
19. Kooij JJS, Rösler M, Philippen A, Wächter S, Dejonckheere J, Van der Kolk V, et al. Predictors and impact of non-adherence in adults with attention-deficit/hyperactivity disorder receiving OROS methylphenidate: results from a randomized, placebo-controlled trial. *BMC Psychiatry*. 2013;13:36. DOI: 10.1186/1471-244X-13-36
20. Ferreira ACZ, Brusamarello T, Capistrano FC, Marin MJS, Maftum MA. The experience of mental disorder patients using psychotropic medication under the perspective of complex thinking. *Texto Contexto Enferm*. 2017;26(3):e1000016. DOI: 10.1590/0104-0707017001000016
21. Kamei K, Terao T, Katayama Y, Hoaki N. Affective temperaments and psychotropic adherence. *J Affective Disord*. 2013;150(3):1142-7. DOI: 10.1016/j.jad.2013.05.064
22. Borba LO, Maftum MA, Vayego SA, Kalinke PL, Ferreira ACZ, Capistrano FC. Perfil do portador de transtorno mental em tratamento no centro de atenção psicossocial (CAPS). *REME Rev Min Enferm*. 2017;e-1010. DOI: 10.5935/1415-2762.20170020
23. Tavares NUL, Bertoldi AD, Mengue SS, Arrais PSD, Luiza VL, Oliveira MA, et al. Factors associated with low adherence to medicine treatment for chronic diseases in Brazil. *Rev Saúde Pública* [Internet]. 2016 [cited 2017 Aug 31];50 Suppl 2. Available from: <http://www.scielo.br/pdf/rsp/v50s2/0034-8910-rsp-s2-S01518-87872016050006150.pdf>
24. Hajda M, Kamaradova D, Prasko J. Self-stigma, treatment adherence, and medication discontinuation in patients with bipolar disorders in remission: a cross sectional study. *Eur Psychiatry*. 2016;57(1-2):6-11. DOI: <http://dx.doi.org/10.1016/j.eurpsy.2016.01.1160>

25. Ibanez G, Mercedes BPC, Vedana KGG, Miasso AI. Adesão e dificuldades relacionadas ao tratamento medicamentoso em pacientes com depressão. *Rev Bras Enferm* [Internet]. 2014 [citado 2016 nov. 15];67(4):556-62. Disponível em: <http://www.scielo.br/pdf/reben/v67n4/0034-7167-reben-67-04-0556.pdf>
26. Teferra S, Hanlon C, Beyero T, Jacobsson L, Shibre T. Perspectives on reasons for non-adherence to medication in persons with schizophrenia in Ethiopia: a qualitative study of patients, caregivers and health workers. *BMC Psychiatry* [Internet]. 2013 [cited 2016 Nov 15];13:168. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3686587/>
27. Higashi K, Medic G, Littlewood KJ, Diez T, Granström O, Hert M. Medication adherence in schizophrenia: factors influencing adherence and consequences of nonadherence, a systematic literature review. *Ther Adv Psychopharmacol*. 2013;3(4):200-18. DOI:10.1177/2045125312474019
28. Bolkan CR, Bonner LM, Campbell DG, Lanto A, Zivin K, Chaney E, et al. Family involvement, medication adherence, and depression outcomes among patients in veterans affairs primary care. *Psychiatr Serv*. 2013;64(5):472-8. DOI: 10.1176/appi.ps.201200160



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ERRATUM

DOI: <http://dx.doi.org/10.1590/S1980-220X2018errata00303365>

Erratum – Adherence of mental therapy for mental disorder patients to drug health treatment

In the article “Adherence of mental therapy for mental disorder patients to drug health treatment”, DOI: <http://dx.doi.org/10.1590/s1980-220x2017006603341>, published by the journal “Revista da Escola de Enfermagem da USP”, Volume 52 de 2018, elocation e03341, on page 1:

Where was written:

Adherence of mental therapy for mental disorder patients to drug health treatment

Now read:

Adherence of mental therapy for mental disorder patients to drug health treatment



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