



## Reasons for poor asthma control

### 3: Patients' beliefs and adherence

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**Nonadherence to asthma therapy, particularly to inhaled steroids, is a common problem contributing to poor asthma control. It is recommended that adherence be assessed at each consultation; however, both patients and doctors may prefer to avoid the subject. Appreciating the factors involved is the first step toward improving adherence.**

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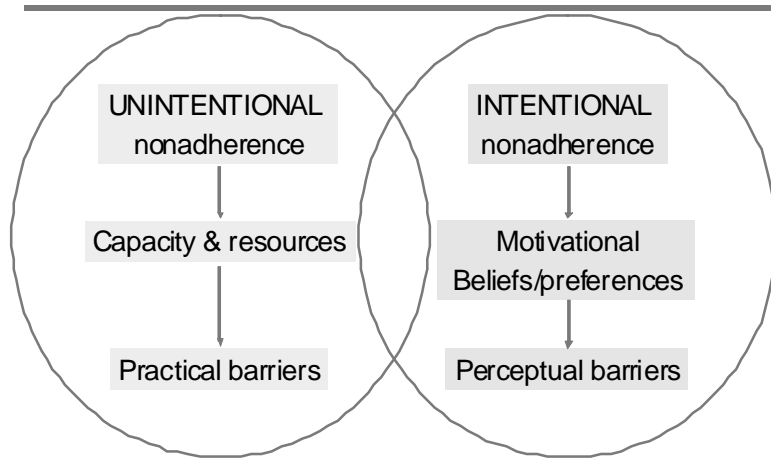
#### Understanding nonadherence: Perceptions and Practicalities Model<sup>1</sup>

There are two types of nonadherence (Figure overleaf):

1. **Unintentional nonadherence** results from practical barriers to adherence, such as:
  - misunderstanding the prescribing instructions;
  - language barriers; and,
  - frequently and understandably, forgetfulness.
2. **Intentional nonadherence** results from the patient's decision not to take the medication as prescribed, i.e., to take less or none or to take it differently than prescribed. Intentional nonadherence is related to a patient's beliefs about treatment (which may differ from the clinician's) and derives from the balance between the individual's beliefs about his or her personal *necessity* of taking a given medication relative to any *concerns* about taking it. Thus, in the case of asthma, for example:
  - patients may doubt the *necessity* of taking a daily medication for a condition that they experience episodically, while
  - they may have *concerns* about potential adverse effects of inhaled steroids.

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## Perceptual–Practical Model of Adherence (can't take, won't take)



### Tools to identify and understand nonadherence

First we must identify the extent and type of nonadherence. The first challenge is to take a 'no-blame' approach to identifying nonadherence. This can be achieved with the Medication Adherence Report Scale (MARS©).<sup>2</sup> Identifying common perceptual barriers to adherence, including doubts about the necessity of regular treatment and concerns about potential adverse effects can be achieved with the Beliefs about Medicines Questionnaire (BMQ©)<sup>3</sup> which can also be adapted to include practical barriers (e.g., regimen complexity, forgetting etc). The BMQ and MARS can be combined with other scales to evaluate asthma control, patient adherence to medication, and comorbidities such as allergic rhinitis and smoking.<sup>4</sup> Research is now justified to examine whether these questionnaires can assist asthma review in primary care by identifying poor control and potentially modifiable causes of poor control such as rhinitis, smoking, and nonadherence to controller therapy.

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