Types of non-adherence and reasons why patients do not adhere

Lesson 5.2.1 | Health psychology

Core ideas

Adherence means following agreed medical advice, such as taking medication correctly, changing behaviour or attending follow-up appointments.

Non-adherence can be intentional, when a patient chooses not to follow advice, or unintentional, when barriers such as forgetting or confusion interfere.

Primary non-adherence happens when treatment is never started, such as not collecting a prescription.

Secondary non-adherence happens after treatment has started, such as stopping tablets early or taking the wrong dose.

Reasons for non-adherence include side effects, cost, complex routines, low perceived risk, poor understanding, lack of trust and social pressure.

Non-adherence matters because it can reduce treatment effectiveness, increase complications and make it harder to judge whether a treatment works.

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Key terms

Adherence: Following agreed medical advice or treatment as intended.

Non-adherence: Not following medical advice or treatment as intended.

Intentional non-adherence: Choosing not to follow advice because of beliefs, preferences or concerns.

Unintentional non-adherence: Failing to follow advice because of practical barriers such as forgetting or confusion.

Primary non-adherence: Not starting treatment, such as not collecting or filling a prescription.

Secondary non-adherence: Starting treatment but not continuing it correctly.

Side effect: An unwanted effect of a treatment that may reduce willingness to continue.

Treatment regimen: The plan for how and when a treatment should be followed.

Further detail and evidence

Non-adherence can involve not starting, missing doses, changing timing/amount, stopping early, or missing appointments. Intentional non-adherence is a considered choice; unintentional non-adherence includes forgetting, misunderstanding and practical difficulty. Both can occur in the same person.

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Continued

Consequences include reduced treatment benefit, complications, unnecessary changes to prescriptions and wasted appointments/resources. A clinician can mistake non-adherence for an ineffective medicine if the pattern is not explored.

Rational non-adherence considers a person's trade-offs between expected benefits, adverse effects, cost and demands. Laba et al. (2012) used a discrete-choice experiment in an Australian community sample to investigate such medication choices. Hypothetical choices reveal preferences rather than directly observing a prescription being followed.

Use the HBM explicitly: a person may see little susceptibility or benefit, perceive severe barriers, lack confidence or receive no cue to act. A treatment plan viewed as sensible by a clinician may be judged differently by the patient.

Applying the ideas

A person can forget a dose (unintentional), deliberately skip it because of an expected side effect (intentional), or be unable to afford a refill (practical barrier). A reminder addresses memory but not all concerns about benefits and costs. Identify the barrier before choosing an intervention.

Evaluation and connections

Calling a decision rational describes the patient's reasoning, not proof that the medical outcome is optimal. Self-report may hide missed doses. Belief models organise factors but can understate poverty, access and habitual behaviour. Cultural and individual differences limit one universal explanation.