

Review

Assessing and achieving readiness to initiate HIV medication

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Abstract

Objective: To summarise published HIV-specific research on readiness theories, factors influencing readiness, instruments to measure readiness and interventions to increase readiness for treatment.

Methods: Medline and PsychInfo were searched until August 2004.

Results: Two HIV-specific readiness theories were identified. Fear of side effects, emotions emerging from the diagnosis and lack of trust in the physician were some barriers to overcome in order to reach readiness. Of the three measurement instruments found, the index of readiness showed the most promise. Multi-step intervention programs to increase readiness for HIV treatment had been investigated.

Conclusion: Readiness instruments may be useful tools in clinical practice but the predictive validity of the instruments needs to be further established in the HIV-infected population.

Practice implications: Readiness instruments and practice placebo trials may serve as complements to routine care, since health care providers currently have no better than chance probability in identifying those patients who are ready to adhere.

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1. Introduction

Sub-optimal adherence to treatment is a health problem worldwide and results in reduced treatment outcome, decreased quality of life and increased costs of health care [1]. Adherence to treatment in chronic diseases in particular has been reported to be low and the number of doses taken as prescribed averages only 50% [1].

Highly active antiretroviral therapy (HAART) requires, in contrast to treatments for most other chronic diseases, adherence rates as high as 95% in order to obtain successful long-term effects on the HIV infection [2]. Sub-optimal adherence levels allows the virus to replicate, which will promote the selection of drug-resistant HIV variants, leading to treatment failure and limited options for future therapy [2]. As a result, the initial treatment is the one most likely to succeed [3].

Sub-optimal adherence to HAART is not only a problem for the non-adherent patient (as is the case in most other chronic diseases). The resistant virus can also be transmitted to others in the society. The proportion of treatment-naïve patients that are infected with resistant virus has been reported to be 8–17%, depending on the population [4–7].

A vast amount of research has been conducted on the topic of adherence to antiretroviral therapy [8,9] and numerous interventions to improve adherence in the HIV-infected population have been introduced [10,11]. Few interventions for chronic diseases, in general, however, have had any effect on the level of adherence and the effectiveness of these interventions has been limited [12]. As a result, low levels of adherence remains an extensive problem in the treatment of HIV-patients [13,14], making the issue one of the most crucial in modern antiretroviral treatment.

It is rarely an urgent matter to initiate HAART in asymptomatic patients [3]. Risks and benefits of early versus delayed therapy is continuously debated [15–18], but no clinical data has so far shown long-term advantages to initiating antiretroviral therapy at early disease stages, rather than later, in asymptomatic patients [3]. A return to the “hit hard, hit early” approach to HAART has, however, again become of current interest due to advances in therapy, which have provided new regimens that are less toxic, better tolerated and more effective [19].

Since treatment initiation can often be postponed (without any negative consequences) and the initial line of treatment is the one most likely to succeed in antiretroviral treatment, the patient’s readiness for treatment,

prior to treatment initiation, may be an important factor for a successful treatment outcome.

1.1. Definition of readiness

Although the term ‘readiness’ is frequently used, it is rarely defined by researchers using the term [20]. Fowler [20] performed a concept analysis of readiness, and for nurses in AIDS care, readiness was defined as “a conscious awareness on the part of the individuals that they, of their own will, have considered and determined that a particular change will be beneficial. In addition, the individual has identified barriers that may prevent this behaviour from occurring and has accepted responsibility for initiation of the behaviour. Finally, a sense of control and impending action on the part of the individual must be present”.

Readiness and motivation are sometimes considered to coincide, but are also regarded as different constructs, although related to each other. Motivation has been defined as “an individual’s desire and drive for change”, whereas, for readiness, it is emphasized that change occurs as a result of “an individual’s capability for change (i.e. the client has the skills to change) and faith that change both is possible and will produce a positive outcome” [21]. Motivation and readiness for treatment can be further differentiated by stating that “motivation includes the individual’s inner reasons for personal change, while readiness refers to the individual’s perceived need for treatment to assist personal change” [22]. To accentuate the relationship between readiness and motivation, there is an aspect of readiness, called “motivational readiness”, which is defined as “an individual’s readiness and willingness, or behavioural readiness, to engage in the behavioural practices required to produce a desired outcome” [23,24].

1.2. Theories of readiness

Readiness has been explained by general theories of motivation and change such as the wellness motivation theory (WMT [25]) and the transtheoretical model of change (TTM; for a review, see [26]). The former theory suggests that readiness is a separate step that precedes change, while the latter combines these two steps.

The WMT [25] suggests that the concept of “empowering potential” explains the individual’s motivation to initiate and sustain a health-related behaviour. “Empowering potential” is described as a continuous process of individual growth and development and consists of three stages. In the

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