A Recovery oriented Approach to Psychiatric Medication: 
Guidelines for the Practitioner

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Abstract

Research has continuously shown that despite the well documented effectiveness of psychiatric medication, it is used only by approximately half of those for whom it is prescribed. While large scale studies have focused primarily on the correlates of not taking medication as prescribed, a number of recent qualitative studies have tried to understand the phenomenon from the perspective of the consumer, revealing that it may not always reflect “lack of insight” but rather a personal choice directed towards engaging in activities that provide meaning and purpose. In this paper we review literature on medication use, emphasizing the importance of the practitioner/consumer relationship. We go on to present a potentially useful recovery oriented perspective to understand medication use choices and discuss its consequential practical guidelines for the nurse practitioner.

Key Words: Psychiatric medication, Nurses, Severe mental illness, Recovery
One of the most puzzling, hard to explain, yet consistent findings in mental health research and practice is that despite strong evidence supporting the effectiveness of psychiatric medication (Thornley & Aams, 2000) only about half of the persons treated for a severe mental illness (SMI) choose to take their medication as prescribed (Zygmont, Olfson, Boyer & Mechanic, 2002). The high rate of choosing not to take medication as prescribed is viewed as a major clinical care concern, since as a result, many do not benefit from the potentially positive impact of medication. Instead they often experience more severe symptoms, frequent relapses and emotional suffering. Psychiatric nurses are well aware of the scope of choosing not to take medication as prescribed and its often negative impact on the person’s quality of life and efforts to pursue personal goals. The obvious question which emerges is: why is an intervention as effective as psychiatric medication taken advantage of by only approximately half of those who could potentially benefit from it? Furthermore, and from a more practical perspective, how might the front line practitioner better understand and deal with this issue?

The purpose of the present paper is to shed light on the complexity of consumers’ medication use choice. To do so we will begin with a brief review of the literature on medication use and interventions developed to facilitate effective use of medication. We will then move on to emphasize the importance of the practitioner/consumer relationship, and present a potentially useful recovery oriented perspective to understand medication use choices and discuss its consequential practical guidelines.

Medication use: its prevalence and correlates

Research has revealed negative correlates and consequences of choosing not to take medication as prescribed, including increased symptoms (Olfson, Marcus, Wilk, & West, 2006), and substance use and abuse (Coldham, Addington, & Addington, 2002), increased risk of relapse (Coldham et al., 2002; Fenton, Blyler, & Heinssen, 1997; Nose, Barbui, & Tansella,
increased potential for assault and dangerous behaviors (Fenton et al., 1997), and reduced insight and lower quality of life (Coldham et al., 2002; Nose et al., 2003). Despite these negative consequences, research has revealed consistently high rates of people choosing not to take medication as prescribed, which is estimated to be approximately 50% among people who have experienced a first psychiatric admission (Coldman et al., 2002; Verdoux et al., 2000), schizophrenia spectrum disorders (Day et al., 2005; Freudenreich, Cather, Evins, Henderson, & Goff, 2004; Rettenbacher et al., 2004) and affective disorders (Fleck, Keck, Corey, & Strakowski, 2005; Yen, 2005). Similar findings were reported in other literature reviews (Nose et al., 2003; Zygmunt et al., 2002).

Interventions to improve effective use of medication

In response to the severity, frequency and often negative impact of not using medication as prescribed, various approaches to improve adherence with psychiatric medication regimes have been developed. The nature of these interventions vary in terms of focus and emphasize different domains such as psychoeducation, peer support, family interventions, cognitive treatments, behavioral modification, behavioral tailoring techniques and community based programs involving supportive and rehabilitative services. Overall, the impact of these interventions to improve medication adherence has shown mixed results (Zygmunt et al., 2002).

Obviously, the nature of the intervention and its emphasis are influenced by the way the phenomenon is understood. Most studies on not taking medication as prescribed are correlational in nature and emphasize lack of insight (Bollini, Tibaldi, Testa, & Munizza, 2004; Fleck et al., 2005) and the experience of negative side effects (Fleck et al., 2005; Lambert, 2004) as causal factors. Thus, what these studies seem to suggest is that people stop taking their medication because they think they have no need for them (often because they do not believe they have an illness to begin with) or because of the aversive side effects they experience. It has been argued
(Zygmunt et al., 2002), that patient schemas, coping strategies and subjective experience might be important contextual factors that can improve the understanding of medication use.

Indeed, a number of recent studies provide preliminary evidence that beyond demographic and diagnostic features, choosing not to take psychiatric medication as prescribed may be influenced by one’s personal (Lingam & Scott, 2002; Perkins, 2002; Voils, Steffens, Flint & Bosworth, 2005) and cultural (Fleck, 2005) attitudes and explanatory models (Bollini et al., 2004). In addition, choosing not to take medication as prescribed may occur when it is perceived to interfere with the individual’s personal goals. For example, in one study (Freudenre, 2004), employment was found to be related to negative attitudes toward psychiatric medications. The findings suggest that individuals who work may view medications particularly negatively, because of their associated stigma which is a common barrier to continued employment.

These studies support the notion that a recovery oriented approach, focusing on personal attitudes, preferences, explanatory models and cultural context may help understand the complexity of choosing not to take medication as prescribed. Exploring these in a client centered manner requires an emphasis on the therapeutic alliance and practitioner-consumer relationship. The nature of this relationship, however, has gone through major developments in recent years. Following are some of the developments in the practitioner-consumer relationship and their contribution to a recovery oriented framework and practice to improve one’s choice in medication use.

**Understanding and responding to the choice not to take medication as prescribed from a client centered perspective**

The “doctor-patient” relationship has evolved over the last two decades and become less paternalistic (Charles, Gafni, & Whelan, 1997; Edwards & Elwyn, 2001). The traditional medical model, which held that the “doctor” (as the representative of authority) holds the
knowledge and wisdom and thus can selectively withhold and share treatment information, has been considerably weakened. There is a growing emphasis in general medical training on the importance of sharing information, inquiring about personal preferences, and considering cultural differences (O'Connor et al., 2001; Towle & Godolphin, 1999). Efforts to develop and integrate concepts such as “self determination,” “informed consent” and “shared decision making” into standard medical practice have had a great influence (President's Commission For The Study Of Ethical Problems In Medicine And Biomedical And Behavioral Research, 1982). This trend has recently become also prominent in the area of mental health. In the most recent (DHHS, 2005) policy in the Federal Action Agenda for implementing the New Freedom Commission recommendations directly address the issue of power and envisions:

“Transformation . . . is nothing short of revolutionary. . . It implies profound change—not at the margins of a system, but at its very core. In transformation, new sources of power emerge and new competencies develop” (DHHS, 2005).

This speaks to the need to work towards a redistribution of power in the mental health system in particular and society in general so that persons diagnosed with a mental illness will have a meaningful say in the way they are treated both within the mental health system and in society at large.

Shifting from a medical model to a recovery oriented model requires new ways to understand and approach the issue of medication choice. An example is a recent study where 29 people diagnosed with psychiatric disorders were interviewed (Deegan, 2005). The interview data findings revealed how not taking medication as prescribed was more likely to occur when psychiatric medication was perceived to interfere with “non-pharmaceutical personal medicine” which referred to activities participants identified as providing them with meaning, purpose and self-esteem (Deegan, 2005). From this perspective, what is commonly referred to as “nonadherence” may not simply be part of the illness (lack of insight or poor judgment) but
rather at times a personal choice directed towards engaging in activities that provide meaning and purpose. Indeed, many individuals diagnosed with mental illness develop and acquire skills and supports that help them successfully manage their symptoms and improve their quality of life (Copeland; 2002; Mueser et al., 2002). In some cases, these skills and supports may help bolster the positive effects of medications and perhaps even decrease the need for a higher dosage which often leads the individuals to not take the full dosage as prescribed. While such events would clearly meet the criteria typically used to assess “nonadherence”, its nature and process differ from the common phenomenon as characteristically portrayed in the literature. Thus, adopting a more holistic perspective and trying to understand medication choice within the personal life context of a person may result at times in reframing “non adherence” from a negative pathological event to a personally meaningful at times even goal directed effort. This perspective, which might be familiar to some consumers, require developing strategies to help the practitioner effectively and humanely deal with the range of such complex situations derived by medication choice.

**Practical implications for the psychiatric nurse**

As professionals, nurses face a prominent challenge when they observe a situation in which their impression is that a consumers’ choice not to take medication as prescribed is hindering their efforts to make progress towards their personal goals. There are no easy answers for addressing this issue. However, developing a trusting rapport with the consumer can be an important first step in engaging in a dialogue in order to better understand the his or her attitudes and preferences regarding medication and personal recovery goals. The interpersonal interactions between the consumer and nurse are a key starting point to promote personal choice directed towards engaging in activities that provide meaning and purpose.

Nursing personnel can play an important role in empowering mental health consumers to create and sustain recovery goals that may or may not include taking psychiatric medications.
Following are some strategies a psychiatric nurse may employ when working with consumers who are considering or already taking prescribed medications.

1) Empower consumers to prepare for their medication appointments which usually last approximately 15 minutes. Generally in these meetings there is a power imbalance in which the psychiatrist assumes a position of power. The consumer is often expected to assume the “patient role” of being quiet, unquestioning and passive. A nurse can help change the power imbalance during medication meetings with psychiatrist in a number of ways:

   a) Empower consumers to ask questions. Some common questions might include the following:

   - What am I really like when I am off these medications?
   - What is the "real me" like now?
   - Is it worth taking these medications?
   - Are there non-drug methods I can learn to reduce my symptoms instead of using medications?
   - Have my needs for medications changed over time?
   - What are the long-term studies on the medication and if there are no studies what are the risks of not knowing the long-term effects?
   - Will I become addicted to these medications?
   - Has long-term use of these medications resulted in memory loss or decreased my cognitive function?
   - Exactly how will I know if this medication is working for me?
   - How long before I should start to notice an effect from this medication?
   - What are the unwanted effects or side effects associated with this drug?
   - What should I do if I experience side effects?
- who can I contact if I have questions or concerns?

These types of questions should be expected and encouraged. Asking these questions might even be an indicator or important part of the person’s recovery. Helping a consumer to write questions and have the written list available at the meeting can help as some consumers experience meetings with their doctor as stressful and rushed.

b) A nurse can help a consumer prepare ahead of time for the meeting with a prescribing nurse or doctor and/or be present as an advocate. It is important to prepare for the meeting with an agenda by defining (and writing) immediate goals and questions. These might include issues such as discussing a medication change, planning for a medication reduction, planning for a medication withdrawal, checking for side effects and the impact of side effects or finding a solution for unwanted drug effects.

c) A nurse may role-play with the consumer to help prepare him or her for the meeting. Learning to talk to a psychiatrist from a position of personal power is a skill that can be acquired and practiced.

2) Practice of coping strategies. There are many non-drug coping strategies that can help alleviate symptoms and distress. Nurses can help consumers learn strategies for coping with voices, delusions, paranoia, depression, obsessive thinking, self injury, flashbacks, and so forth. Learning to use a variety of non-drug coping strategies can help to minimize the amount of medications an individual may need to take or, with practice; can actually eliminate the need for medications.

3) Teaching consumers about medications. It is easy to feel intimidated by all the big words and technical jargon that get used about psychiatric medications. However, there are a number of ways to access reliable and accessible information about the medications. It is
important to ask the psychiatrist about the prescribed medication and also learn from others how the medication has helped them (or how they have successfully coped with side effects). The pharmacist should provide a written fact sheet describing what the drug is supposed to do, what the unwanted effects are, and precautions including drug interaction information. These drug fact sheets are written in nontechnical jargon, though leave out a lot of detail that might be important. The nurse can encourage the consumer to ask for drug-insert information. The drug-insert information is essentially the same information that is contained in the Physicians Desk Reference (PDR). It is printed on a small roll of paper and inserted in the box of medications that the pharmacist receives. There is a lot of technical jargon in the insert but the information is more thorough than the fact sheet.

4) Supporting “Personal Medicine”. Recovery means taking an active stance towards the problems and challenges an individual may face. Psychiatric medications are one tool among many other tools that persons can use in their recovery. Wellness strategies such as physical exercise, eating well, avoiding alcohol and street drugs, love, solitude, art, nature, prayer, work, and a myriad of coping strategies may be equally important to one’s recovery. The nurse can explore with the consumer their “personal medicine” and how the prescribed medications relates to these and explore the pros, cons and possibilities to making the most of these different interacting helping mechanisms.

Conclusion

Research has consistently reported that nonadherence with prescribed psychiatric medication is common and associated with negative consequences. Strategies that have tried to address this issue have had limited success. Changes in the doctor-patient relationship have led to a more collaborative and less paternalistic alliance. Exploring the meaning and reasons for nonadherence within the context of a person’s life may facilitate its understanding. Practical ways
urses might use a recovery oriented client centered approach to deal with non adherence are discussed.
References


