

A Case Study of Psychiatric Medication Noncompliance

Peggy Sotiropoulos
Katherine Poetter
Linda Napholz, RN, Ph.D
University of Wisconsin, Milwaukee

Abstract

This article highlights the issue of medication noncompliance as it relates to psychiatric re-hospitalization. The concept of medication noncompliance by psychiatric patients is examined, and interventions are described that are likely to promote compliance. The cycle of noncompliance and re-hospitalization is then described through a case study of an individual who is resistant to a medication treatment regime.

Introduction

Medication noncompliance is thought to be a major factor in psychiatric hospitalizations. Many individuals with psychiatric disorders are hospitalized for an exacerbation of their mental illness, stabilized with medications, and then discharged home. At home, a large number fail to take their medications properly, if at all. Relapse often occurs and re-hospitalization follows (Crane, Kirby, & Kooperman, 1996). Therefore, patient noncompliance is an important issue due to its consistent association with severe ratings of psychopathology (Fenton, Blyer, & Heinszen, 1997).

Medication noncompliance can be intentional or unintentional. Some underlying factors for unintentional noncompliance include complex medication regimes, an inability to pay for medications, forgetfulness, and/or failure to understand instructions due to auditory, visual, psychological, or intellectual impairments. According to Lehne, Moore, Crosby, and Hamilton (1994), 70% of noncompliance cases are intentional. In fact, it is the opinion of the authors that the patient's belief that the drug is not needed in the actual prescribed dosage is the primary reason for intentional noncompliance. In addition, unpleasant medication side effects, as well as the patient's denial of the severity or presence of the mental illness contribute to medication noncompliance (Crane et al, 1996).

Lehne et al (1994) and Napholz (personal communication, January 14, 1997) suggest a number of interventions that can promote compliance among patients with a psychiatric illness. These include:

1. Insuring that the medication is actually swallowed and not "cheeked" or vomited.
2. Encouraging family members to oversee medication administration.
3. Providing patients with written and verbal instructions on dosage and timing.
4. Informing patients and families that psychotropic medications need to be taken on a regular schedule to be effective.
5. Informing patients about side effects of treatment and teaching them how to minimize undesired responses.
6. Assuring patients that psychotropic medications, such as antidepressants, antipsychotics, and mood stabilizers do not cause addiction.

7. Establishing a therapeutic relationship with the patient and with family and/or significant others who are sources of support to the patient.
8. Using a depot preparation for long-term therapy or for patients that do not take their medication correctly or are forgetful.

Patient education is clearly the favored way to promote compliance among mentally ill individuals (Falvo, 1985). According to Falvo, patient education can be a key component in enabling patients to accurately follow the recommendations of the health professional. Patients cannot follow treatments and recommendations if they do not understand or accept them. Patient education also has been identified as an important preventive intervention to help break the cycle of multiple psychiatric re-hospitalizations (Haywood, Howard, Kravitz, Grossman, Cavanaugh, Davis, & Lewis, 1995).

The American Nurses' Association established the Standards of Psychiatric and Mental Health Nursing Practice in 1982, which states that psychiatric patients have the right to be informed about the specifics of psychotropic medications. These standards list patient teaching as a responsibility of psychiatric mental health nurses. Through education, the psychiatric mental health nurse can help empower patients by enabling them make informed decisions and take a more active role in their treatment. Effective communication creates an active partnership between the psychiatric mental health nurse and the patient that facilitates the education process. When the patient understands the symptoms and severity of the illness and the nurse provides timely feedback and clear, explicit instructions, the patient is more likely to assume increased responsibility for self-care, which can increase the likelihood of compliance with the medication regime (Crane et al, 1996). In the case of psychiatric patients, successful interventions aimed at medication compliance can result in "less time spent in hospitals, improved functioning in the community, greater family stability, and more satisfying and independent lives" (Crane et al, 1996, p. 8).

The Medication Noncompliance-Readmission Cycle

Medication noncompliance is a common factor leading to admission or readmission to mental hospitals. Often, medication noncompliance initiates a cycle that begins with an emergency detention. Law enforcement personnel bring a person to the Psychiatric Emergency Department. Often mechanical or chemical restraints are indicated to manage acting out behavior. From that point, the person may be admitted for inpatient treatment, outpatient treatment, or released. If a person is admitted, a court hearing follows within 72 hours. The person, now a patient, may remain medication non-compliant during his or her stay, or compliance may be achieved through nursing staff interventions. Discharge planning includes a plan of care developed by the treatment team that will follow the patient after discharge. Unfortunately, it is not uncommon for a patient to discontinue taking his or her medication post-discharge and to not follow the treatment plan, leading to readmission.

Nursing Responsibilities in Medication Noncompliance

The psychiatric mental health nurse has a responsibility to assess the patient for motivating factors as well as potential barriers to compliance. Motivation is associated with "beliefs and values held by the patient about the outcome to be achieved, the patient's intentions, and the patient's perceived ability to initiate and maintain behavioral change" (Lubkin, 1992, P. 223). Motivation-related aspects that need to be assessed and considered are: "What does the prescribed health behavior change mean to the patient? What environmental factors may interfere with the new behavior? What future events may challenge the patient's motivation? How will personal values affect the patient's ability to remain motivated?" (Carpenito, 1995 p. 604).

Assessing patients' knowledge of their illness and medication regimen includes: determining their understanding of their symptoms, evaluating their knowledge of the psychopharmacologic agents prescribed, assessing their motivation for obtaining symptom relief, and exploring their understanding of how the medication helps control their symptoms (Crane et al, 1996). Evaluating patients' beliefs, attitudes, strengths, and weaknesses can help the nurse identify other potential barriers to medication

compliance, as well as learning needs. Psychiatric mental health nurse also need to assess their own beliefs to make sure that their attitudes and beliefs are not negatively affecting the patient's medication compliance. For example, if the nurse enjoys the dependency of the patient and subconsciously does not want the patient to outgrow his or her need for the nurse, the relationship will not be therapeutic.

Compliance with a medication regimen involves a behavioral change on the part of the patient. Compliance and behavior change are positively influenced by the patients' usual patterns of compliance, family influence and stability, the patients' perceptions of their own susceptibility to the disease, their perceptions that the disease is serious, and the efficacy of treatment (Carpenito, 1995). Self-efficacy also affects motivation and behavior. Patients with a high degree of self-efficacy are more likely to be actively involved in developing and completing tasks related to a medical or treatment regimen (Habert, Leach, McMahon, Price-Hoskins, & Sideleau, 1992).

The psychiatric mental health nurse must always remember that the patient has the right to self-determination when all elements of informed consent are given. If the patient decides to initiate a behavior change, support still will be necessary from the nurse and other members of the health care team to help the patient incorporate the treatment into his or her everyday lifestyle.

Violence Related to Medication Noncompliance

Seriously mentally ill individuals who are treatment non-compliant are more likely to be violent than the general population. When a patient is brought into the psychiatric hospital, it is essential that an assessment be done promptly and expediently. A medical evaluation must also be performed, since conditions such as delirium or intoxication can contribute to violence (Hughes, 1994).

The first step in managing a potentially dangerous patient is to make the situation safe for the staff and the patient. According to Hughes (1994), there are six important steps to take if a patient is exhibiting increasing threatening behavior: (a) showing empathy, (b) setting verbal limits, (c) offering medication, (d) placing the patient in seclusion, (e) restraining the patient and, if all else fails, (f) involuntary medication. The ideal intervention is empathy. Saying things to the person such as: "I understand, your situation sounds awful" or "You are safe here; you don't need to be afraid" can help calm the patient. If this does not work, verbal limits can be set, such as "Please keep your voice down," or "You need to step away from the desk now." If restraints are necessary, at least five staff members should be available, and all should be trained in the proper restraining techniques. The clinical situation may require moving quickly through these steps or even choosing one of the more restrictive interventions first if violence is imminent.

In working with a potentially violent patient, it is important to try not to be alone with that patient, but rather, care for that patient in open areas such as the dining room or day room. If a situation arises in which you must be alone with a patient in his/her room, it is important to position yourself between the door and patient, to avoid being cornered. Last, when speaking with a potentially violent patient, stand far enough away so he/she cannot reach you quickly to attack, or stand very close so he/she cannot fully swing arms or legs in an attack.

Discharge Planning

Before a patient is discharged from a mental health facility a discharge note must be completed that provides information on the patient's behavioral status, physical condition, medications, follow-up treatment, and assessment of comprehension. A patient may have court ordered terms or a plan of care that must be followed upon discharge. For example, a person must be medication compliant for six months according to court ordered stipulations. If the patient does not take the medication as ordered, the court order is violated. Symptoms will eventually redevelop and the patient may then be readmitted to the mental health facility, and the cycle will again be initiated.



Case Study

Ms. Smith is a 72 year-old widowed white female with a diagnosis of paranoid schizophrenia. She has a history of medication noncompliance and has been an inpatient at a mental health facility three times during the past year. Each time Ms. Smith was hospitalized, she was brought in involuntarily by the police for displaying violent, psychotic behavior towards others. Ms. Smith is in denial about the severity of her illness and several times has decided not to follow her medical regimen. Each time this has resulted in an exacerbation of her psychiatric condition and readmission.

The Corbin and Strauss trajectory was utilized (Woog, 1992) to analyze the course of Ms. Smith's chronic mental health condition and how it has changed over time. Ms. Smith's trajectory reveals five hospitalizations within the past two years and a continuing downward trajectory. Several social factors were identified that influence her trajectory. Ms. Smith is widowed and lives alone in an apartment that is part of a group home facility. Her only family support is her daughter, with whom she speaks only occasionally by telephone. Financially, she has the resources to pay her bills and cover personal expenses.

Ms. Smith's current readmission occurred involuntarily through an emergency detention. Her psychotic and violent behavior was felt to be due to her failure to take her prescribed medications. Ms. Smith was admitted to a locked geropsychiatric unit. At a court hearing 48 hours following her admission, it was determined that Ms. Smith required inpatient care. Four days later, at a second court hearing, a 30-day mandatory stay was ordered. Ms. Smith was also ordered to continue outpatient treatment and comply with her medication regime following her discharge.

Denial of mental illness and paranoia were the key issues that contributed to Ms. Smith's noncompliance. Ms. Smith felt that the staff was involved in a conspiracy to retain her at the mental health facility. This paranoia further led to the belief that she was being over-medicated. There were also occasions when Ms. Smith did not understand why she was at the facility and denied that she had a mental illness.

The staff never fully gained Ms. Smith's trust. Even at the point of discharge, Ms. Smith believed that staff members were involved in a conspiracy against her. She was verbally aggressive, negative, and had a labile mood. Reliability and consistency were important behaviors that were maintained by the staff, yet Ms. Smith remained suspicious and mistrustful. Successful staff interventions included using positive reinforcement, such as spending additional one-to-one time with her.

Education about thought disorders and psychotropic medications was provided, although Ms. Smith's denial and paranoia interfered with her learning. Ms. Smith was motivated to learn about her prescribed medications and treatment regime only when they were congruent with her thinking, which they usually were not. Ms. Smith continually asserted her rights without truly comprehending the personal costs of refusing treatment and repeated her desire to live independently.

Motivating behaviors were difficult to assess due to Ms. Smith's paranoia and denial. Again, some of the education provided to Ms. Smith may not have increased her motivation due to her lack of belief that the information provided was true and her denial of being mentally ill. Staff personalized interventions to establish trust and provided consistent information about her illness to decrease her denial and paranoia.

When the police brought Ms. Smith into the psychiatric emergency room by, she was combative and paranoid and attempted to strike anyone near her so the staff decided to restrain her mechanically and chemically until her behavior was under control. However, while on the in-patient gero-psychiatric unit, Ms. Smith did not physically strike anyone, although on several occasions she was intimidating and physically invaded the personal space of many staff members. Ms. Smith often became frustrated and angry and would make verbal threats to staff members just inches from their faces, such as: "If you don't let me out of here, I'm going to jump out of the window," and "There's nothing wrong with me; you are all conspiring against me." Setting verbal limits with Ms. Smith proved to be an effective intervention.

Ms. Smith's discharge plan was typical. Clear, consistent information was provided to her regarding her illness. Her denial was confronted while maintaining respect for her personhood, and she was taught about her medications, including indications, side effects, dosage, and scheduling. As part of the discharge plan Ms. Smith began a staff-monitored, self-medication program two weeks prior to discharge that allowed her to become actively involved with her medication regime. Occasionally, Ms. Smith refused to take her medications at the prescribed times, but would take them when given additional one-to-one staff time. The schedule was altered once by the psychiatrist, allowing Ms. Smith to be involved in changing her medication schedule to times when Ms. Smith was more likely to take the drugs. Ms. Smith was ordered by the court to take the prescribed medications and attend an outpatient program upon discharge. If these stipulations were broken, Ms. Smith would be readmitted.

On discharge, Ms. Smith returned to the community-based residential facility where she had lived independently prior to admission. An initial home visit revealed continued signs of paranoia. For example, she remained convinced that the home visit was really a plan to re-hospitalize her. Final phone contacts with Ms. Smith and the residential facility director revealed that Ms. Smith had complied with outpatient treatment. The residential facility staff had continued to provide regular contact and support, as well as reinforcement for medication compliance. Socially, she resumed dance lessons that she had stopped when her husband died and again became actively involved in her church's social committee. Both activities have helped reduce her social isolation.

Ideally, Ms. Smith would develop a realistic insight into her mental illness and choose to take her medications regularly to enhance her quality of life. Unfortunately, court-ordered treatment has been the major influencing factor on her medication compliance.

Summary

Many psychotropic drugs take considerable time to stabilize psychiatric symptomatology. In the interim an individual may see no benefit to continue compliance and may abandon the medication regimen (Stuart & Laraia, 1998). Nurses are in a key position to reinforce the importance of staying on psychotropic medications by providing consistent education regarding the purpose, therapeutic value, and side effects of the medication. Through individualized educational interventions, medication compliance and awareness can be enhanced.

References

American Nurses' Association (1982). *Standards of Psychiatric and Mental Health Nursing Practice*. Missouri: American Nurses' Association.

Carpenito, L. (1995). *Nursing Diagnosis: Application to Clinical Practice (6th Ed.)*. Philadelphia: J.B. Lippincott.

Crane, K., Kirby, B., & Kooperman, D. (1996). Patient compliance for psychotropic medications: A group model for an expanding psychiatric inpatient unit. *Journal of Psychosocial Nursing* 34(1)8-15.

Falvo, D. (1985). *Effective Patient Education: A Guide to Increased Compliance*. Maryland: Aspen Systems Corporation.

Fenton, W., Blyer, C., & Heinssen, R. (1997). Determinants of medication compliance in schizophrenia: Empirical and clinical findings. *Schizophrenia Bulletin* 23(4)637-651.

Haber, J., Leach McMahon, A., Price-Hoskins, P., & Sideleau, B. (1992). *Comprehensive Psychiatric Nursing* (4th Ed.). St. Louis: Mosby.

Haywood, T., Kravitz, H., Grossman, L., Cavanaugh, J., Davis, J., & Lewis, D. (1995). Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. *American Journal of Psychiatry* 152(6)856-861.

Hughes, D. (1994). *Assessment of the potential for violence*. *Psychiatric Annals* 24(11)579-583.

Lehne, R., Moore, L., Crosby, L., & Hamilton, D. (1994). *Pharmacology for Nursing Care* (2nd Ed.). Philadelphia: W.B. Saunders.

Lubkin, I. (1994). *Chronic Illness: Impact and Interventions* (3rd Ed.). Boston: Jones & Bartlett.

Stuart, G.W. & Laraia, M.T. (1998). *Principles and Practice of Psychiatric Nursing* (6th Ed. St. Louis: Mosby.

Woog, P. (1992). *The Chronic Illness Trajectory Framework: The Corbin and Strauss Nursing Model*. New York: Springer Publishing Co.

Copyright© by The University of Arizona College of Nursing; All rights reserved.