

Assessing Medication Adherence Among Adult Psychiatric Patients In An Outpatient Setting

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Introduction

According to the World Healthcare Organization, the term medical adherence can be defined as the extent of the coherence between a person's behaviour and the professional's proposed medicine recommendation (WHO, 2003). Failure to medical adherence is referred to as medical nonadherence, and it can be fatal for the psychiatric patient and the overall healthcare system. The failure of medical adherence is significantly high in outpatient settings owing to the lack of surveillance. Also, medical nonadherence is remarkably high in old-age psychiatric patients due to various baseline reasons; the literature shows that failure of medication adherence in psychiatric patients can lead to the severity of the condition and also lead to an increased hospitalization cost (Semahegn, A., 2020). This essay focuses on analyzing medication adherence among adult psychiatric patients in an outpatient setting from the viewpoint of various nursing paradigms and theories.

Patient adherence to the medication is one of the critical factors in determining the progress of the medication. The more the patient adheres to the medicine, the swifter will be the remission of the illness. Medication adherence has been raised as a serious concern for all psychiatrists, as nonadherence to the psychiatric patient's medication can have chronic outcomes. The extent of the medication adherence to the patients affects the whole targeted population, affecting all age groups, from children to elderly patients. The problem also has an association with the outpatient setting.

Metaparadigm:

The concept of the Meta paradigm implies the set of globally acknowledged concepts about a particular field. The metaparadigm concept is also concerned with establishing the relationship between these concepts (Chaffee & McNeil, 2007). Like any other field, the concept of the metaparadigm also implies the nursing profession, which helps in determining nursing as a standalone profession. In this regard, in 1978, Fawcett presented a four-paradigm nursing concept; the paradigms were

- Human Beings
- The Environment
- The Nursing staff and

- The Health (Lee & Fawcett, 2013).

Briefly stating Fawcett's concept: the first paradigm, namely the humans, are the individuals who are receiving medical treatment. The human concept is broad in that any patient is under the surveillance of either hospital, nurses, or family. The environment can be taken from narrower and broader perspectives: the overall society or the immediate surroundings. While health is one of the natural processes of dying and living, in the end, the nursing profession encompasses taking care of all health processes in the monitored environment (Chaffee & McNeil, 2007). The idea of the imposition of medical practices relies on all four factors. Additionally, the success of the treatment or the elevation of the disease's remission is also dependent on all the Meta paradigms of nursing. There is a need to inculcate all these paradigms in all the nursing theories, and explicitly explaining the four paradigms' inculcation while describing or devising these nursing theories can make their application easier.

All these four units can be regarded as the key stakeholders, and the theory's imposition is upon all. So, if any new theory encompasses all the paradigms' roles and responsibilities, it can help in the easy application as everyone knows their expected responsibilities. The nursing paradigm concept is broad enough to include any of the nursing theories. Moreover, all the concepts are relevant enough, and the central focus always remains on the client/person who is obtaining the treatment. So, the nursing paradigm structure emphasizes that the client or the patient should be the central focus when devising any nursing theory.

Although it may look like a trivial task, the nonadherence of medicine globally causes a great strain on the overall healthcare budget. Recently, in England, a nonprofit organization discovered that nonadherence to the medication caused an expenditure of 290 billion dollars annually (wood, D.).

One of the main paradigms of nursing is the Fawcett theory. Nursing has the highest impact on the general quality of the healthcare setup. Adherence to medication has been a challenging problem since the last century, as medication adherence determines healthcare procedures. The need for the topic has urged researchers to have thorough research on the topic. Recent research in the Journal of Medicine in England has evaluated that almost half of the patients don't take their medication as per the prescriptions. However, the reasons may vary widely (Brown, M. T., 2011). Nurses, being the frontline dealers, can train the patient to understand the medication very well.

An interactive session with the patients can also do wonders in convincing the patients to follow the plan vigilantly. A team of researchers at Harvard University recently took a survey at the Birmingham Women's Hospital and a Caremark pharmacy; the research showed the influential link between the nursing paradigm and drug adherence efficacy. The researchers concluded that the nurses who used to instruct their patients about the medication before leaving the hospital setup had a higher proportion of drug adherence than the others. Likewise, the patients with whom the pharmacists interacted and talked during the medicine selection procedure had a better impact on the patient's adherence to the medication (Lauffenburger, J. C., 2018). Thus, the nursing paradigm has a more significant and direct influence on medication adherence than print media and emails.

The second paradigm, the people paradigm, also has a significant impact on medication adherence efficacy. Elderly patients' nonadherence to medication is a common scenario; the nonadherence among elderly patients is most exaggerated in psychiatric patients. In psychiatric patients, the behaviour of nonadherence to the medication not only varies between the individuals but also among the same individual at different times. The pattern of the behaviour depends on the condition and severity of the illness. Patients' compliance rate with medicine adherence varies from 38 to 57 per cent in elderly psychiatric patients (Jimmy & Jose, 2011).

Inadequate knowledge about health and medical procedures is also one of the significant lackings of the people paradigm. According to estimation, the failure of medication adherence in elderly psychiatric patients often arises due to inadequate knowledge (Jimmy, B., 2011). Hence, they are reluctant to make medical decisions on their own. Moreover, the interventions' success also heavily relies on the social and economic condition of the patient. Also, in the outpatient setting, the family's involvement poses a greater risk in some cases. Sometimes, the family cannot spare much time to be physically and emotionally present with the patient throughout treatment.

The environment is one of the significant contributors to the attainment of the human experience. Thus, the environment is undeniably a significant paradigm that affects human behaviours. Considering our POI, medicine adherence in the outpatient setting, the environment plays a more crucial part. In Fawcett's paradigm model, the term environment encompasses the physical and geographical surroundings and includes all the social norms, rituals, and beliefs (Lam & Fresco, 2015). Thus, if the environment is not made feasible for psychiatric patients, then medication adherence will significantly burgeon.

Health can be considered the interaction between the environment and the patient's struggles to cope with a psychiatric disorder. According to the chosen POI, this paradigm will result in better medical compliance among psychiatric patients. If all the other paradigms perform their associated responsibilities in the outpatient settings, then the health paradigm will emerge as a promising result/outcome. However, the overall concept of health can be rational. Still, compromised health can be improved by caring nursing interventions, thus regulating medical adherence (Bahramnezhad, Asgari, & Afshar, 2015).

Grand Nursing Theory:

Generally, Grand Nursing theory refers to the set of ideas and concepts that help decide the actions' core. In nursing, many theories have been proposed over time. The central theme behind these theories was establishing better work practices. In conclusion, the nursing theory can be referred to as a set of concepts driven by nursing models and other interrelated disciplines. The nursing theories have a higher circle of application. These theories can help explain the patients' behaviours, predict the intervention's outcome, and guide further prescriptions. Nursing theories have been of two natures: inductive and deductive.

Many theorists like Myra Levine, Virginia Henderson, and Jean Watson have presented many grand theories on how to improve nursing practices. All the theorists mentioned above have presented grand theories that are patient-centric. In some way, all these theories emphasize designing and practising the nursing course of action according to their requirements. The grand theory that was selected was that of Jean Watson.

Jean Watson's Grand Nursing Theory

Jean Watson's grand nursing theory focused on the principle of caretaking. He defined care from a broader perspective in the medical environment as unconditionally supporting, respectful, and non-judgmental while treating the patients. He also identified care as one of the significant contributors to psychological, emotional, and physical healing. Jean Watson's theory defines care beyond the physical realms and insists on establishing the spiritual relationship between the medical healthcare professional and patients. Thus, it can be concluded that Jean's theory also targeted the nursing metaparadigm (Revels, Goldberg & Watson, 2016, p.234). Jean also targeted the environment paradigm. If a conducive and professional environment is provided to the nursing staff and the patients, it eases the nurses' and the patients' spiritual connection.

Medication Adherence in Psychiatric patients is very crucial, as stated earlier. Nonadherence to medication is very common; the literature also shows that outpatients with major psychiatric disorders are generally not medicine adherent on account of baseless reasoning, ignorance of the severity of illness, and the lack of surveillance (Colom F, 2002). The reasons mentioned above for the medicine's nonadherence can easily be understood by applying Jean Watson's grand nursing theory. Moreover, as per the suggestion of Jean Watson, the transpersonal caring relationship can further help in devising actions for coping with the issues. As previously mentioned, Jean's theory is patient-centric and emphasizes considering the individuals via a holistic approach. Thus, the adaption of the theory will help healthcare professionals to let individuals adapt to their illness and treatment procedures so that they have better chances of recovery (YANGÖZ, Şefika & ÖZER, Zeynep, 2020).

Middle Range Theory:

Middle-range theories are operational in nature, especially when it comes to addressing problems in nursing practice, mainly the problems affecting vulnerable populations. These theories have a wide range of applications in nursing practice settings despite addressing definite phenomena in nursing practice. In this section, Bandura's social cognitive theory will be explored for [patients with mental disorders](#), precisely its relation to poor medication compliance in such patients. This theory states that a person's cognitive processing is a form of reflective thinking that helps him set a behaviour standard and then acquire a specific set of skills to meet that behavioural goal (Bandura, A., 1977). Bandura also asserts that self-efficacy is a crucial facilitator of cognition, behaviour, and other environmental and personal influences. (Stacey et al. 2015) the elements of self-efficacy suggested

by Bandura are the outcome expectations and self-efficacy expectations. He further explained in his theory that outcome expectation as a person thinking that his particular behaviour will result in an individual income could be explained as believing that he can carry out a specific behaviour to develop the desired outcome. In this case, a person may believe that his particular behaviour can produce the desired outcome but may not necessarily believe that he can successfully continue that behaviour in the long run.

Bandura's approach proposed interrelated self-effective sources. From the broader perspective, compared to Fawcett's paradigms, this approach encompassed the human paradigm specifically. In the first step, Bandura proposed that human behaviour in response to various treatments has a particular relation to the individual's physiological state. Relating to our discussion, the physiological indicators of anxiety can have conformable influences on the psychiatric patient's medication adherence. If the physiological indicator, i.e., anxiety, is left untreated, the patient can undergo severe behavioural changes affecting the medication procedure's overall progress. The other area targeted by Bandura was the significance of verbal assertion. Verbal communication and verbal suggestions can have a long-term impact on the behavioural changes of psychiatric patients. If the patient is undergoing medical nonadherence, then verbal persuasion can cast an impact.

Complexity Theory:

Upon discussing the complexity theory, it must be kept in mind that it does not refer to a single theory; however, it results from interdisciplinary theories. These theories are used to test and validate the systems that originate from interdisciplinary actions. These complex theories show the mechanics of these systems, but they also suggest how order can be kept in the system. The healthcare sector's contemporary concerns can quickly be addressed by applying these complex theories (Braithwaite et al. 2017). The contemporary healthcare paradigm encompasses the staff's professional development, research, development, clinical practice, etc.

Medical adherence can be increased in psychiatric patients by analyzing the healthcare setup's organizational structure using complexity theory, as modern-day healthcare issues need an intuitive approach and dynamic view (Anthony & Vidal, 2018). In our POI case, the healthcare professional can adapt varied communication techniques to alter the behavioural changes that hamper medical adherence.

Ethical Framework And Principle:

Ethical frameworks can be implemented to keep the medical adherence ratio higher. As many of the grand nursing theories suggest, keeping the patient-centric system and devising medication plans after analyzing the behaviour and response of the patient can increase medication adherence. As digital records have replaced paper-based records, if hospital setups make sure that they introduce a

centralized patient record database for out-patients, it can bring magnificent changes. As the in-house admitted patients have routine procedures, and the nursing staff is quite well familiar with each patient's psychiatric behaviour, it's easy for them to develop medication adherence. However, for the outpatient setting, this is not feasible. Also, there is a fair chance that the patient loses track of the medication between the visits. In these scenarios, the centralized server's use can keep the patient's medical history, prescribed medicine, and dosage. Suppose the hospital shares the server access with the rest of the paradigms, like the physician, psychiatrist, and pharmacist. In that case, each one can perform its job by better understanding the process specificity (O'Connor A, 2007). For out-setting patients, the education of the family members is essential. Raising concern, knowledge, and awareness regarding psychiatric disorders can make the family members more considerate and responsible, and thus, they can create a feasible environment for developing medical adherence (Kamran, A., 2014).

The promotion of one-to-one sessions and the introduction of the shared decision-making strategy can increase psychiatric patients' involvement in making the medication plan (Ramli, A., 2012). The greater the patients' involvement will signify mutual agreement, the greater the chances of developing medical adherence. Also, sets of standardized questionnaires are present to evaluate adherence rates, such as the Morisky adherence scale and BMQ (brief medication questionnaire) (Elwyn, G., 2012). These questionnaires greatly help identify the root cause and minimize the incidence of noncompliance with the medication.

Conclusion

The adherence to medicine in elderly patients can be significantly improved by understanding the actual cause of noncompliance. Once the actual cause of the nonadherence to the medication plan is understood, the outpatient setting nonadherence incidences can be reduced significantly (Hugtenburg, J. G., 2013). As in the wake of Jean's theory, if the treatment plan is devised according to the patient's concerns, significant gaps in the psychiatric patients' handling will be bridged. Increasing the patient's awareness and literacy about the actual illness and its severity level can positively reform medication adherence. Moreover, effective patient monitoring plans have proven to be of higher accuracy than conventional self-reporting. Thus, the inclusion of technology, such as digital devices for keeping track of medication adherence in outpatient settings, can work correctly, as the conventional practice of self-reporting is often objected to with low sensitivity.

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