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# Medication management in mental health: nurses' perceptions of their work with service users and carers

Steve Hemingway presents findings of a study exploring how mental health nurses implement medicines management

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## **Abstract**

**Aim:** This study aimed to ascertain registered mental health nurses' perceptions of their role involving medication management interventions with clients and their carers. **Medicine-related interventions** include administration, assessment of therapeutic effect potential side-effects, education, liaison with service users and influence in prescribing decisions. **Design and methods:** The study used a qualitative design. Ten registered nurses were interviewed. **Findings:** Three themes were identified all related to the nurse context of work, role and client and carer need: improved dialogue, information and education, and adherence issues. **Practice implications:** Nurses use their clinical expertise in medication management to help achieve optimum therapeutic outcomes.

## **Key words**

Medication management, role, mental health nursing, carers, service users

## **Reference**

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## **Introduction**

Mental health nurses' medicine management interventions have the objective of addressing the needs of the person who is prescribed medication, including effect and side-effect assessment, management and information exchange (White, 2004).

Whether the mental health nurse prescribes or includes medicine management in their role, the aim is ensure the service user (and carer) receives the optimal therapeutic effect of the medication while minimising any potential adverse reactions (Snowden, 2010).

Psychotropic medication remains a leading intervention despite opposition to it claiming its use is for the social control of people with symptoms of mental distress (Cutcliffe and Happell, 2009; Gray et al, 2009).

There are questions about the long-term efficacy of psychotropic medication, for example antidepressants (Moncrieff, 2007) and antipsychotics (Leiberman et al, 2006, National Institute of Health and Care Excellence, 2008).

Indeed, rather than increasing wellbeing and life expectancy, antipsychotics (DeHert et al, 2010), some mood stabilisers and antidepressants can increase morbidity and subsequent mortality (McCloughen and Foster, 2011; Hemingway et al, 2014). This also applies to younger (McCloughen et al, 2012) and older people (Baker et al, 2008) diagnosed with a mental illness.

There have been calls to minimise the use of psychotropic medication as their supposed benefits in treating mental health conditions have been described as mythical

(Barker and Buchanan-Barker, 2012). Other commentators have suggested mental health nurses need to be at least more critical of psychotropic medication they might administer and prescribe (Harris and Shatnell 2012).

More than 90% of people in the UK diagnosed with a mental illness are prescribed some form of psychotropic medication – with the figure being over 90% in an inpatient (Care Quality Commission 2009) and 80% in the community context (Care Quality Commission, 2013).

Psychotropic medications, either used alone or alongside psychological therapies, remain the mainstay for the 'treatment' of mental health problems (Wand, 2013).

Medicines management is also established as a major part of the mental health nursing role, including prescribing, and mental health nurses are the largest group of registered practitioners involved in the care of mental health service users (Snowden, 2010; Hemingway et al, 2011b; Mutstata 2011).

Mental health nurses are at the centre of medicines management interventions (Gray et al, 2005; Hemingway and Ely, 2009), as they administer oral medicines or intramuscular injections, prescribe medications, advise clients and carers, liaise with other healthcare practitioners on prescribing decisions and assess the outcomes of medicines taken.

## **Aim and objectives**

This study focused on exploring the medicines management interventions that mental health nurses undertake and their

subsequent interactions with service users and carers.

It was part of a wider study exploring the impact of training on clinical competence for mental health nurses in medicine management interventions.

### Methods

A qualitative design was used with in-depth semi-structured interviews for mental health nurse participants to reconstruct their perceptions of medicine management education they had experienced and how these transferred to clinical practice.

Registered mental health nurses were sought who were graduates from the University of Huddersfield and who worked for South West Yorkshire Foundation NHS Trust.

Recruitment was done by a trust wide-email inviting interested nurses to take part, and ten participants were recruited to the study.

Written informed consent was obtained before interviews. Participants were informed they could withdraw from the study at any time without giving a reason.

In the interview the aim was to explore the social aspect of the participants' medicines management role in the clinical setting. Therefore the researcher is positioned within the research process, not as an objective observer outside of it (Hoare et al, 2012).

The semi-structured interview data was subject to qualitative content analysis outlined by Newell and Burnard (2006) by the researcher. Qualitative content analysis is a research method that involves making replicable and valid inferences from data, with the purpose of providing new knowledge, insights and representation of real life, and a guide to future action (Elo and Kyngas, 2008).

For this study the intention was to investigate mental health nurse participant experiences of medicine management interventions.

Six steps were involved in the analysis process. Stage one involved taking notes and memos of ideas and impressions during the interview. Stage two involved the researcher forming general ideas about emerging categories. Stage three involved the start of categorisation and some text reduction. Stage four involved finding overlapping data, and collapsing and refining categories. Stage five involved putting categories in place and

linking them ready for reporting. The final stage is this reporting of the findings.

The length of graduate experience ranged from one to four years. The roles of the sample were broad ranging, involving working with people from 14 years to old age. The clinical contexts included inpatient, clinic and community settings, typical of where mental health nurses in the UK work.

### Findings

The participants' responses identified three key themes: dialogue, education and information, and adherence issues.

#### Dialogue

Communication is central to the client and carer being at the centre of decisions about the medication they are prescribed. Narrative accounts from the mental health nurses in the sample provided evidence that dialogue is enacted in different ways.

The content and the timing of the conversations depend on the mental status of the client. One participant illustrated this: 'We've got people who are so acutely unwell, and they're so disturbed that they can't even have a conversation about what they want to drink or eat.'

In more open acute wards interactions with service users increase as their mental state improves: 'We do have those discussions with service users, but it tends to be as the admission progress rather than from the very beginning really. The dialogue just starts a little bit later in the care pathway.'

Medicine administration was described as an opportunity to talk to clients about medication and other issues. For example, one participant said of being on a busy older people's inpatient environment: 'You don't always get chance to talk to people. It's a couple of minutes where you can have a chat.'

A participant who worked in a low secure rehabilitation setting said the medication round is an important opportunity for different reason: 'Medication time is an opportunity when I might ask them if they feel it's working or if they're experiencing side-effects. Because unless I ask clients do not generally talk about them.'

For a participant working in acute adult inpatient care, discussion of client experiences' of medication is a major focus: 'I always ask how they find it, if it works, if

**“ We're big on giving leaflets and advising on any medication that is prescribed ”**

it helps, if they've experienced anything that they could report, just to make sure that they really get to grips with what we're giving – not just giving things to people who don't understand about how medication works.'

For an admiral nurse participant whose main focus is to support the carer of someone diagnosed with dementia, interactions often involve discussing the risks and benefits of medication for carers, and sometimes there is resistance: 'Because they've not been in mental health services at any point in their life, they find it quite difficult sometimes to accept taking medications. So we discuss the risks and benefits of antidepressant medication.'

#### Education and information

Educating the client and carer increases their understanding of medication, and their involvement in decision-making can be more informed.

Education interventions are employed in different ways according to capacity of the client, context and motivation. In the acute adult inpatient setting one participant discussed the use of information to facilitate understanding: 'We're big on giving patients leaflets and advising them about any medication they are prescribed. We educate them on their medication so they know what to expect and the potential side-effects.'

Information is also used in the community setting for service users under the care of the early intervention service (EIS): 'We use a lot of the trust information on the website for managing medications, such as information sheets. These have up-to-date information that increases understanding of what they are facing.'

The need to provide dedicated time to discuss medication-related issues was illustrated by one participant: 'We've found from getting feedback from people that ward

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round isn't long enough for people to ask questions about side-effects, why they're taking a medication, what are the expected outcomes. So it's giving people that bit of follow up to then feel that they've got an arena to ask any questions that they might not have had time to do in ward round.'

The approach taken is determined by the specific situation. On the inpatient acute ward this appears relatively straightforward for one participant: 'It's all about knowing what side-effects are there and educating patients. We also need to know more about potential side-effects of medication and so do patients as well.'

Another participant, from a psychiatric intensive care unit (PICU), explained how it differed from the open acute ward: 'You can't have that extended and kind of in-depth information exchange with people because they can't take it in often. I suppose it's about adapting the way you deliver medication, you know, deliver that knowledge to people.'

In the PICU setting education for the carer or family member can take place when service user involvement is restricted: 'We spend a lot of time with carers, explaining treatment plans, change of medications, what we intend to happen when we change someone's medication.'

The participant from the low secure inpatient unit also said they make sure the client has some knowledge of the medication they are taking: 'Because sometimes they don't even know what it is, especially when they first come here, some of them didn't even know what they were taking, I'm sure it has been explained to them in the past, but if they've been quite psychotic, the information's probably not sunk in properly.'

Information on medication as a therapeutic option is also used for carers where appropriate:

'This is for the carers, because they're often quite reluctant, so we'll discuss the benefits, we'll discuss what side-effects they should be looking for, we'll discuss how long they should expect to stay on their medication, that's really more to kind of bridge that gap for them because quite often the talk in therapies can only go so far. If somebody's really at the bottom, they need some medication to try and pick them up, so that's what we'll do to try and move that on before we start doing some counselling.'

A participant working with adults in

the community identified the importance of medication discussions in outpatient appointments: 'I think the ones that stand out are outpatient appointments. We discussed how the medication should be given, both on the ward, whilst under the care of the crisis team and now coming to an outpatient appointment. We've reduced some of the medication so then I can go every week to make sure that her mental health is ok and that the medication is still doing its job, but not too sedating. So hopefully that means that her quality of life's going to pick up.'

### Adherence

Medication adherence has been highlighted as a major cause of poor therapeutic outcomes or relapse. However, this is a very normal occurrence as people may not take medication because they are reluctant, see it as an inconvenience or may forget.

The participant working on the inpatient ward for older people had experienced such situations: 'We do have some people who, because of mobility issues or whatever or they're just flat out refusing to come round, then we do have to go to them and maybe don't have the opportunity to spend as much time with them.'

The participant employed in an EIS involves young people with are self-conscious about their appearance, so finding out about potential side-effects can be frightening and this may affect adherence: 'They're on the internet, having a look, thinking oh my god, I can't take that because I'm going to be impotent and I'm going to have boobs when I'm a man and Olanzapine has weight gain. Because of our client group being so young, they're bothered, they want to know, and they want to be slim and fit.'

Discussing issues important to the service user and carer helps adherence: 'The medication that they receive will go alongside our one-to-one sessions that we have. We unpick things so that clients are able to understand it easier, like the thinking, the perception, the behaviours, everything that happens, in their thought process. We try and help them to understand this by having these discussions at their homes where they're comfortable, and then obviously with parents as well.'

For the memory service adherence issues are related to the capacity of service users, and reluctance to report side-effects can

present a challenge: 'When you ring people directly, we've been told that everything's fine in the past and then, we'll find out that they haven't been taking them or they've not been able to get off the toilet or then sometimes we find that the spouse have noticed side-effects, but they're that keen at keeping people on the memory medication that they don't tell us. So but we've got to say something, it's about quality of life.'

Establishing successful collaboration with carers of people diagnosed with dementia is of crucial importance: 'I've just had a couple come back to me that they weren't taking it, they were taking it haphazardly, they'd deteriorated and we've got them back on the higher dose and they're doing really well because the family are involved now and they're making sure that they're taking it and it's about knowing what to put in place for that person.'

The memory nurse highlighted individualising interventions: 'If someone's always had a role in doing their own medication, the old-fashioned way, by laying out stuff, we usually leave them to that because they're usually alright with that. Pill dispensers, they're brilliant, but they're not good for everyone that can't do with technology.'

Attitudes toward medication was identified as a reason for non-adherence. The admiral nurse participant said: 'We also talk to carers who are feeling very low and because they've not been in mental health services at any point in their life, they find it quite difficult sometimes to, accept taking medications.'

Self-administration of psychotropic medication was also discussed. A participant in low secure services uses an approach that takes into account client independence but still needs to monitor the adherence to good practice and safety protocols: 'You're being vigilant, you're making sure you're not interfering with them doing their thing, but

“**They are on the internet thinking ‘oh my god I can’t take that because I’m going to be impotent’**”

you're making sure they're dispensing the correct medication as well and you do have to remind them to look at their card, they know what medication they're on and they just dispense it. It's getting them to pick up the good habits of looking at the meds card, looking at the back of the blister strip and making sure that the dosage is right.'

### Discussion

This paper evidences the perceptions of mental health nurse interventions and subsequent interactions they have with mental health service users and carers.

What emerged in the findings is that participants reported they actively tried to involve the service user in the management of their medication.

Comments on the themes of dialogue, information and education, and adherence show how in their daily interventions mental health nurses sought to make medication appropriate and in keeping with service users' and carers' wishes and needs, their capacity to understand, and the context of their care.

Studies involving mental health service users show that medication is recognised as the primary therapy in inpatient settings that contributes toward their recovery (Bowers, 2005; Gray et al, 2005; Piat et al, 2009).

However, the relationship service users have with mental health nurses can determine if they are adherent to what is prescribed, and if they feel they are part of the decisions about the management of their medication (Day et al, 2005; Gilburt et al, 2008; Piat et al, 2009).

If the service user is not included and feels that care is coercive and not inclusive, this can negate the chances of a therapeutic engagement (Happell, 2004; Cutcliffe and Happell, 2009). It also goes against mental health nursing training, ethics and the code of practice.

Hemingway and Snowden (2012) and Wakefield (2013) discuss how approaches to medicines management interventions are determined by best interest and the law. In circumstances where the service user lacks capacity this may mean dialogue is kept to a minimum.

In other circumstances, as emerged in this study, it is the nurse who is the instigator of conversations regarding the outcomes of medication. In these cases the mental health nurse is acting in the service user's best

interest and thus using an informed approach (Haglund et al, 2004)

Nurses have been criticised for communicating while administering medicines, yet where quality time is not available it may be the one time the nurse can talk to the carer during a busy shift.

In contrast the participant who worked in an EIS talked about a purposeful approach to allow the service user to reflect on their understanding and perception of medicines.

Another participant from an inpatient unit included discussions about medicines so the service user understands about the medicines they are taking.

Such dialogue is recognised as central to successful outcomes (Day et al, 2005; Piat et al, 2009) and something service users see as central to establishing a therapeutic relationship (Duxbury et al, 2010).

Information sharing is seen as pivotal in engaging service users (Duxbury et al, 2010). The information and education category included aspects of how the mental health nurses use such interventions in their day-to-day work.

Leaflets about prescribed medication were used that are obtained from the trust website. The trust uses information from the choice and medication website originally developed by Professor Stephen Bazire and colleagues in East Anglia, which has information about 150 medicines used in mental health care (South West Yorkshire Partnership Foundation Trust 2014).

Process consent for service users taking psychotropic medication is highlighted as an essential medicines management intervention (Harris, 2009). This intervention seeks to empower the service user to be informed about the medicines they are prescribed. Thus the mental health nurse participants appear to be utilising such an approach. Educating carers also emerged in this category. Carers are recognised as being key to optimum treatment outcomes and their engagement is crucial (Mutstata, 2011).

Adherence to medications is an important issue in the service user-mental health nurse interaction. Adherence, in terms of taking the dose of medication as prescribed, is the one main factor in the prevention of relapse for the client certainly for people diagnosed with a severe mental illness (Gray et al, 2009; Hemingway et al, 2013).

However, episodic or total non-adherence

with taking neuroleptic medication has led to increases in relapse rates, hospital admissions and higher rates of suicide (Valenstein et al, 2006; Norvick et al, 2010).

Non-adherence is a very normal fact when compared to people taking any form of prescribed medication. There is no one intervention or factor for any health condition or context that increases the likelihood of service users taking medication that is prescribed for them (National Institute of Health and Care Excellence, 2009).

NICE (2009) also concluded that the best approach is to engage the client with a person-centred approach that involves them to be informed and involved in decision-making about medicines.

There are significant factors that mental health nurses encounter that lead to non-adherence. One participant working in an inpatient older people's environment pointed to problems with physical mobility as well as people avoiding being administered medicines.

Such difficulties are recognised in the research literature for the inpatient environment with an understanding problem-solving approach suggested (Happell, 2004; Duxbury et al, 2010).

A mental health nurse who worked with younger people with a mental illness related to the stark reality that antipsychotic medication side-effect profile is significant, for example weight gain is negative issue when personal image is so important to them.

Addressing non-adherence to treatment in early intervention services for psychosis is one intervention noted as a key factor in positive outcomes for clients. For the memory nurse memory problems or side-effects from taking cholinesterase medication may lead to non-adherence. The importance of educating service users and carers toward their condition and monitoring and managing

“ **Adherence to medications is an important issue in service user-mental health nurse interaction** ”

side-effects is a key intervention to promote adherence (Ownby et al, 2006; Wattis and Curran, 2013).

Mental health nurses in this study used various adherence interventions. For the memory nurse the key to adherence is to collaborate with the carer when memory problems may lead to non-adherence (Smith and Hemingway, 2005; Stapleton, 2010).

Using a person-centred approach to tailor interventions to the service user's particular outlook and abilities also increases the chances of successful treatment (Stapleton, 2010; Snowdyn, 2010).

For the mental health nurse seeking to support the service user's recovery in the early phases of psychosis, engaging them in medication decisions as one aspect of their treatment increases their feeling of control of their life (Roberts, 2007).

Establishing a therapeutic relationship allows for meaningful conversations to take place and a focus on adherence to medication can decrease relapse rates for people under the care of the EIS (Brown et al, 2013).

Ambivalence or an attitude against taking medication are identified as risk factors to taking medication (Harris 2009; McCann et al, 2008). Such attitudes are normal, and are issues to address in adherence interventions by the mental health nurses (Harris, 2009; Piat et al, 2009).

In the case of the admiral nurse the time spent on discussing the risks and benefits of medication for the family member is the key link in the care of the service user that could enhance the chances of a an optimal outcome of antidepressant therapy (Chong et al, 2011; Scrandis and Watt, 2013).

Self-administration of medicines by service users can involved challenging the traditional medical model of nurses administering medications (Murray, 2011).

One participant described how they took

“**Education can lead to improvements in satisfaction, knowledge and independence**”

a balanced approach that ensured safety but ensured the service user is in control of dispensing the medication. Mental health nurses' assessment of the service user's skill and capacity in self-administration is an important determinant in assessing future adherence to prescribed medication (Manias, 2004).

Although ultimately it is the service user's choice if they take medication when they go home, education about what is prescribed and its risks and benefits can lead to improvements in satisfaction, knowledge and independence (Anderson et al, 2014).

## Conclusion

This study sought the perspective of mental health nurses' work with service users and carers involving psychotropic medication. Mental health nurses felt they implemented important activities that enable service users to get the optimum treatment outcome.

In a world where nurses are under increasing pressure to prove the value of their interventions, more emphasis is needed on how to implement evidence-based knowledge and skills in relation to medicines, which engage and involve the service user.

Medication can contribute toward a meaningful recovery. Medicines management very much remains an activity the mental health nurse undertakes and the growing case against the long-term use of psychotropic medication should not obscure the very real need for mental health nurses to have medicines knowledge and skill so that inherent issues can be discussed with the service user and carer so that choices can be made in an informed manner.

This study involved a small sample and claims of transferability need to be treated with caution. The participants were not asked to critique their own practice, so the findings may have been more positive about the mental health nurse role than might otherwise have been.

Participants in the study also volunteered with an apparent recognition that they saw medication as a major part of their role. Other mental health nurses may not have identified with it as comfortably.

Further research is needed to determine what skills and knowledge mental health nurses need to impact on health outcomes in terms of service context and service user need in relation to medication. **MHN**

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