

in August 1995 a change in medication as a result of retinal deterioration drastically altered his behavior, leading to a shooting spree in August 1996. For the past nine months he has been homeless and has started drinking. However, he is still keeping his clinic appointments and taking his new medication.

Even though I am a registered psychiatric nurse employed in a psychiatric hospital, my constant reports about the changes in my son's behavior after he was taken off his old medication were ignored under the guise of confidentiality. The professionals who treated him—who saw him for ten minutes a month—told me they couldn't talk to me and never brought up the issue with him. Improper use of the confidentiality rule ruined my son's life.

We often do not realize how our behaviors affect others. Incorrect antipsychotic medications or dosages do produce adverse behavior, just as proper medications and dosages correct adverse behavior. Professionals must adjust doses and change medications for those who want to be treated.

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Improving Patients' Drug Compliance

Our psychiatric hospital, like many others (1,2), has a substantial number of patients whose noncompliance with prescribed medications is a factor in readmission. We have developed a program for inpatients that addresses noncompliance. It is based on the assumption that many patients are dissatisfied with the overall effects of their medications, and that no one discipline is in a position to deal with noncompliance in its entirety. Thus it relies on the cooperation of staff in medicine, psychology, and nursing.

Patients can be referred to the program by any member of the treatment

team. Participation is voluntary; no patient is denied privileges for choosing not to participate.

The program consists of three parts. First, the psychologist consults with nursing staff to determine the patient's medication regimen. He then talks with the patient to find out if he or she remembers what drugs have been prescribed and on what schedule. The psychologist provides such information if the patient cannot recall.

When the patient can successfully recall the drug regimen, the psychologist proceeds to the second part, in which he consults with the psychiatrist to determine the symptoms treated by the medication, the length of time the patient is expected to remain on the medication, anticipated dosage changes, and so forth. The psychologist discusses these issues with the patient and inquires about the patient's overall satisfaction with the medication, covering such areas as desirable and undesirable effects and the patient's willingness to take the drug after discharge.

The psychologist encourages the patient to discuss any problems with the doctor. However, doing so is problematic for many patients for several reasons, including the fear that the doctor will keep them in the hospital longer. Role playing is often used to help patients focus on medication issues, and assertiveness skills are also taught. Ultimately, however, it is the patient's responsibility to resolve the issues with the physician; the psychologist does not intervene further.

When the patient indicates complete satisfaction with the prescriptions, the last part of the program is initiated. The nursing staff instructs and monitors the patient in the mechanics of self-administration.

The program was implemented in 1984. By 1988 a total of 138 patients had participated, of whom 29 were successful in administering their own medication before discharge. To examine the impact of the program on further hospitalization, these 29 patients were compared with 29 randomly selected participants who were not successful in self-administration of their medication. T tests revealed no statistically significant differences between

the groups in age, years of education, number of psychiatric hospitalizations before participation in the program, or the number of prescribed medicines or dosage levels, calculated using the method described by Clary and associates (3). Qualitatively, there were very few differences between the groups in diagnostic and medication categories.

However, substantial and statistically significant differences in hospital recidivism were found between the groups during the year following each patient's entry into the program. The successful group was hospitalized an average of 48.6 days compared with 85 days for the unsuccessful group ($t=3.44$, $df=56$, $p<.01$). Similarly, during the same period the successful group had a mean of three readmissions compared with eight for the unsuccessful group, ($t=2.19$, $df=56$, $p<.05$).

These results have several possible explanations. The capacity to work toward self-administration may simply be a marker of a less disturbed or more intelligent patient, qualities not reflected in other clinical measures. Learning the mechanics of self-administration of medication may be all that is necessary for continuing compliance. However, it is also possible that resolving often-unspoken dissatisfaction with one's prescription and understanding its relationship to mental illness is critical. Clearly, further research in this area is warranted.

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