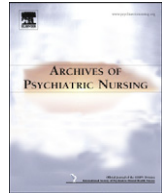




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## Improving Adherence in Hospitalized Patients Diagnosed With Schizophrenia: An Integrative One-on-One Intervention

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### ABSTRACT

**Objective:** This study examined an individualized integrative nursing intervention for improving attitude and adherence.

**Methods:** The sample included 60 patients, randomly assigned to an experimental or control group. Measures included The Visual Analog Scale for Assessing Treatment Compliance and the Drug Attitude Inventory (DAI-10).

**Results:** Significant differences were found in attitude and reported adherence for the experimental group, before and after. Significant differences were found between the experimental and control group in the degree of change in attitude and reported adherence.

**Conclusions:** This study indicates the benefit of integrative one-on-one tailor-made intervention versus routine care for improving attitude and adherence to drug therapy.

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The development of new generation anti-psychotic medications in the last two decades has revolutionized care by establishing drugs as an effective basis for the treatment and rehabilitation of schizophrenia. Evidence to date clearly points to anti-psychotic medication as the core treatment of schizophrenia (El-Mallakh & Findlay, 2015). Second generation drugs have been found especially affective in alleviating symptoms and preventing relapse of the disease (Sacchetti & Vita, 2014). Adherence to drug therapy plays an essential role in achieving best outcomes in the treatment of serious mental illnesses such as schizophrenia (Velligan et al., 2009). Non-adherence negatively affects the treatment outcome and has serious economic implications (Rittmannsberger, Pachinger, Keppelmüller, & Wancata, 2004). If a patient stops using antipsychotic medication, the risk of relapse increases (Novick et al., 2010; Weiden, Kozma, Grogg, & Locklear, 2004). Because of the high cost of hospitalization, relapse place a significant clinical and economic burden on the patient and health care providers (Barkhof, Meijer, de Sonnevile, Linszen, & de Haan, 2012). In addition, it raises the potential for violence, suicide, crime, and decreased quality of life (Czobor et al., 2015). Although varying according to the definition of the term, the method of assessment, and the patient population, the estimate is that approximately 50% of patients who have schizophrenia do not fully adhere to treatment (ibid). Despite these data, many clinicians do not periodically evaluate levels of adherence of their patients (Day et al., 2005).

There are various modifiable factors related to non-adherence: those related to the disease process itself (i.e., insight and health belief models), drugs (i.e., unpleasant side effects, such as extrapyramidal symptoms, sedation and elevated prolactin levels associated with typical drugs or weight gain associated with atypical drugs), the environment (interpersonal and physical), the therapeutic relationship (between the health care professional and the patient), and substance abuse. Thus, interventions should optimally integrate a variety of strategies: psychological, educational, and cognitive-behavioral (Bourgeois, 2005; El-Mallakh & Findlay, 2015; Lewis, Tarrier, & Drake, 2005).

Barkhof et al. (2012) reviewed the literature of the last decade with respect to interventions utilized in improving drug adherence among individuals diagnosed with schizophrenia. The following results emerged: interventions based solely upon psycho-educational strategies were generally not effective; those based upon cognitive-behavioral strategies fared better as did those tailor made for the patient. Long term programs with many sessions were more effective than short term ones with few sessions; those designed specifically to improve adherence were more effective than general interventions. Most of the studies in the review utilized tailored interventions and contained a cognitive-behavioral component. A minority included family-based, community based, and integrative interventions. Based on the accumulated research data, the reviewers concluded that individually tailored multi-component approaches to promoting adherence had the best chance to succeed (Barkhof et al., 2012). In addition, a positive relationship between attitude to treatment on the part of the patient and adherence emerged from the research (Baloush-Kleinman, 2007; Perkins, 2002; Vauth, Loschmann, Rusch, & Corrigan, 2004; Weiden et al., 2004).

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The aim of this study was to examine whether and to what extent a tailor made integrative intervention focusing on drug therapy and adherence will improve treatment adherence and positively change attitudes toward medications among inpatients diagnosed with schizophrenia.

## METHODS

The study sample consisted of sixty hospitalized patients diagnosed with schizophrenia (American Psychiatric Association (APA), 2000). Their ages ranged from 18–60; all were voluntary hospitalized. Due to the 6 months time frame available for this study, the researchers were limited to the subjects meeting the inclusion criteria that gave consent for this period. An observational power analysis yielded a power of .767 for attitude and .591 for adherence. These results point to fair power. They also indicate that although the results of the study were significant, had there been an option of a bigger sample, the results might have been stronger.

Two tools were utilized in this research:

- The Visual Analog Scale for Assessing Treatment Compliance which was developed for the purpose of assessing the degree of reported adherence of patients diagnosed with schizophrenia to drug therapy (Smith et al., 1999). Treatment compliance was measured using 0–100 point visual analog scales, with a score of 0 signifying no compliance and 100 reflecting perfect compliance. The tool was translated into Hebrew (via translation/back translation) and found sufficiently reliable in an Israeli population, with Alpha Cronbach scores ranging from 0.69 to 0.83 measured three times consecutively (Baloush-Kleinman, 2007). In this study the reliability reached 0.71.
- The Drug Attitude Inventory (DAI-10) which was developed for assessing a patient's attitude to psychotropic drug therapy (Hogan, Awad, & Eastwood, 1983). Scores range from –10 to 10 with higher scores indicating more positive attitude toward medication. It is a shortened version of the original Drug Attitude Inventory (Hogan et al., 1983). In this study, the tool was used to examine how the attitude of patients diagnosed with schizophrenia toward their medications affects adherence. The reliability of the short version reached a Cronbach's Alpha of 0.77 (Van Dongen, 1997); the translated Hebrew version also had solid scores of reliability ranging from 0.73–0.77 (Baloush-Kleinman, 2007). In this study the scores were somewhat lower, ranging from 0.59–0.62.

The research was conducted in an active, open unit within the Lev Hasharon Mental Health Center, after receiving approval from the institutional ethical review board. Data were collected between January 2009 and April 2010. Questionnaires were filled in twice, once at the onset of hospitalization and again after the intervention, or prior to discharge (average hospital stay was 52.8 days).

As opposed to routine care, the integrative intervention employed case sensitive evaluation with respect to each patient's challenges in achieving and maintaining drug adherence. In addition, the evaluations were conducted by psychiatric nurses trained specifically for this evaluation and the research process as a whole. Patients signed a consent form and were randomly assigned to either the experimental group (N = 31) or the control group (N = 32) via a lottery drawing. Sixty three lots were placed in a box, 31 were marked "experimental" and 32 "control".

The intervention combined a number of strategies: 1) Selection and titration of an effective antipsychotic, well tolerated by the specific patient. The research intervention specifically examined the complaints of the patient with respect to drug side effects as a barrier to adherence. These complaints were individually addressed by the patient's physician. In addition, work up for metabolic syndrome (e.g., blood pressure, blood levels for glucose and cholesterol and weight) were conducted periodically. 2) Psycho-educational strategies aimed to promote understanding of the disease process and improve attitude toward treatment (Xia, Merinder, & Belgamwar, 2001). This was essential with patients unfamiliar with their specific treatment and its purposes. 3) Motivational interviewing aimed at exploring the patient's perspective on the illness and placing it into a coherent life narrative. This latter technique crystallizes for the patient, discrepancies between current behavior and professed goals and behavior, while avoiding antagonism and focusing on the patient's freedom of choice and responsibility for actions (Miller, 1996). 4) Cognitive-Behavioral strategies aimed at diminishing chaotic thought and poor executive function and enhancing problem solving techniques for increasing attention and decreasing forgetfulness. These strategies were used to facilitate the incorporation of the drug regimen into the patients' daily schedule. The emphasis of each component differed according to each patient's specific needs. For example, for a patient that did not understand why he should take two medications that he considered to have the same effect, the nurse focused on psycho-educational strategies. For another patient who had trouble remembering the exact daily drug, the nurse used cognitive behavioral strategy (i.e., a personal drug case). For brief outline of the intervention see Table 1.

Each participant in the intervention attended an average of six sessions spread over once to twice a week and lasting approximately 20–40 minutes. The sessions were one on one with the same nurse always serving as a personal therapist for this purpose.

The control group continued to receive routine care which consisted of ad hoc sessions with a psychiatric nurse and/or a psychiatrist, varying in duration and frequency, but averaging one or two sessions per week. Routine care in Lev Hasharon Mental Health Center is based on the case management system. Each patient has a case manager that coordinates the patient's treatments and concerns. This routine care includes individual sessions designed in accordance with the patients' overall needs; there is, however, no specific focus on drug therapy and adherence.

**Table 1**  
Outline of the Integrative One-on-One Intervention.

Factors associated with medication non-adherence	Intervention
Patient forgets taking the medications	Cognitive behavioral strategies for the incorporation of the drug regimen into the daily schedule (fixed hours for medications, signs and reminders)
Patient has negative attitudes toward medications	Motivational interviewing designed to build awareness and recognition of the benefits of medications, Psycho-educational strategies aimed at promoting understanding of the disease process
Patient stops medications due to its financial cost	Involve family members in sharing the cost of medications and tap community sources of financial aid
Patient stops medications due to active psychosis	Report to the physician for acute treatment
Patient lacks insight for the need for medications	Psycho-educational strategies aimed to promote understanding of the disease process and improve attitude toward treatment
Patient is influenced by family's or friends' negative attitudes on medications	Reaching out to family and friends in order to promote their understanding of disease process and the medication regimen, as well as the impact they have on the patient
Patient suffers side effects	Report to the physician, Psycho-educational strategies concerning the positive effects of medications
Patient suffers from sexual dysfunctions	Report to the physician for modification of medication regimen as necessary
Patient lacks support concerning adherence	Recruit resources among family, friends, and various community organizations for appropriate support in time of need

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