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Collaboration, Shared Decision-Making, and Using Medication to Support Recovery

Medication is an important part of the treatment of people with serious mental illness. People with schizophrenia and bipolar disorder will have a more stable life, fewer relapses, and fewer hospitalizations if they consistently take appropriate medication (Gilmer et al. 2004; Lang et al. 2010). Despite its demonstrated effectiveness, many people with serious mental illness either refuse to take prescribed psychiatric medication or take it inconsistently (Fenton et al. 1997; Lacro et al. 2002; Velligan et al. 2010). Often, medication is considered not only important, but the critical element of treatment, especially for people with schizophrenia and bipolar disorder.

Inconsistent medication use is an issue not just with mental illness, but with all chronic illness. People with high blood pressure, diabetes, and other chronic illnesses also tend to be inconsistent with medication, despite clear benefit from following treatment recommendations (Yang et al. 2009; Mann et al. 2010). The issue is perceived as different for people with mental illness.

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Often there is an assumption that medication nonadherence is connected to impaired judgment that is part of the underlying illness (Cramer and Rosenheck 1998). Clinicians see their task as “convincing” a person to take prescribed medication, and attempting to use coercion when medication is refused. The common approach is to overcome the patient’s irrationality through exhortation about the benefit of medication, close supervision of medication use, or forcing the use of medication.

A person is labeled “treatment resistant,” even if they are willing to accept all other parts of a recommended treatment except for the medication. Unfortunately this attitude can lead to an adversarial relationship between clinician and consumer, focused more on medication compliance than on other important life issues. This chapter suggests an alternative view of medication that can serve to reframe the problem and potentially lead to different kinds of solutions. The issue is not “compliance” or “adherence,” but how medication can be used as effectively as possible in helping the person deal with some of the problems caused by the illness. The key strategy is to work with the consumer to develop areas of common understanding of a problem, and the potential role of medication in helping to decrease the distress caused by this problem. There is no need to agree about everything. Effective treatment only requires that there are some areas of agreement that can be addressed collaboratively by both consumer and clinician (Diamond and Scheifler 2007). The focus is not on “medication

compliance,” but rather on the person’s own goals, hopes, and beliefs about the problem and the solution. The most important clinical issue is not whether the person is taking medication as prescribed; it is whether the person’s life is getting better in ways that are important to him or her, and whether medication is being used as effectively as possible to support this improvement.

Medication Is More Likely to Be Used When Both Client and Clinician Can Agree on the Nature of the Problem, and Agree That This Problem Could Be Responsive to Medication

Medication is a tool. As with any tool, it can help with some problems and not with others. It is not “good” or “bad.” Rather it is either effective or ineffective. The goal of treatment is not to get a person to take prescribed medication; the goal of treatment is to help the person have a better life. Before we decide to use a tool, we have to understand what problem we want the tool to fix. An agreement on the problem is the first step to getting an agreement on the solution (Deegan 2005). This is more complicated than it might initially seem. The clinician may feel that frequent rehospitalizations or intrusive auditory hallucinations are the problem. The client may be more concerned about getting his own apartment or getting his driver’s license back, and less concerned about the voices or going back to the hospital.

What Is the Problem That the Medication Is Supposed to “Fix?” Or Help with?

A *clinician’s problem list* for a person with a psychotic disorder might include (1) hearing voices, (2) having a delusional belief that a large amount of money has been stolen, leading to frequent calls to police and complaints that frighten neighbors, and (3) having a delusional belief that people on the street are plotting about him, talking about him, following him, and making him too afraid to leave his apartment. Antipsychotic

medication would be seen as a reasonable tool to help with all three of these problems. It seems clear that these significant problems are all symptoms of an illness. Antipsychotic medication is useful in the treatment of this illness. Once one has this perspective in mind, the need for medication becomes obvious and a refusal to use medication is a sign of irrationality. Unfortunately, the patient’s problem list might look very different.

The client’s problem list might include (1) I want to get back to school, but I cannot concentrate enough to read my math books. I don’t really mind the voices all that much, but they are distracting and make it even more difficult to concentrate. (2) A large amount of money has been stolen from my apartment and no one believes me. When I call the police, they just laugh at me. The more I try to convince people, the more they just think I am crazy. (3) I am very afraid I am being set up to be murdered. I am not sure who or why, but always feeling afraid is terrible. (4) People talk outside of my window or seem to follow me when I go out. I realize that they are probably not always talking about me, but I am so scared that I cannot always figure out when they are talking about me and when it is just people talking.

The role of medication with this problem list is much less obvious. The voices themselves are not that big of a problem, medication is not going to help get his stolen money back or even get people to believe him, and he is not sure how medication will help him figure out when to be frightened and when not.

The clinician may feel that the medication has been very effective since the patient is less bothered by voices and is not going back to the hospital. The consumer may feel that the medication is useless, since even when taking the medication he still does not have enough concentration to do his school work, is still upset that no one believes him about the money being stolen, and is still concerned that he is being talked about and followed.

Medication is much more likely to be taken if it is helping in a way that the person taking it perceives is important, and will not be taken if it is not helping in ways that the patient feels is

important. If medication is a tool to help a problem, it will be used when both patient and clinician can agree on “target symptoms.” Target symptoms are most useful if they are observable behaviors that both client and clinician can track.

A Consumer Is More Likely to Listen to and Seriously Consider a Clinician’s Solution to a Problem, If the Clinician Is Willing to Listen and Seriously Consider the Consumer’s Understanding and Solution to the Problem

Clinicians are often so convinced of their view of the problem that they dismiss the client’s view as not worth serious consideration. Clinicians too often listen only enough to confirm a diagnosis. If I believe that something terrible has happened, I would be upset if no one believed me and still more upset if no one was willing to listen to me. If a friend told me about a catastrophe, I would be curious about the details, about when and what had occurred, who might have done what, or what else happened. I would not ask questions in an effort to disprove the event, but because I was interested in the details and in my friend’s experience. This interest must be real. A fake interest is shallow and has an altogether different tone. Too often, when a consumer talks about something bad happening, it is treated very differently.

A real interest is not the same as passively waiting until the client gets finished telling about his or her delusions. A real interest does not require that we agree with all parts of what the consumer is saying, and certainly does not mean that we should pretend to agree when we do not. It does require that we suspend disbelief enough to seriously consider what the consumer is saying, rather than automatically discounting the complaint as a fabrication caused by mental illness. If we consider the client’s account seriously, we develop a respectful curiosity about the details of the story that we may otherwise have dismissed.

This “serious curiosity” is the basis of cognitive behavioral therapy (Wright et al. 2009). The

goal is to understand the details of the story, not to collect evidence to prove that the client is wrong. Details allow for the experience to be looked at in new ways by both clinician and consumer.

Ambivalence About Taking Medication Is the Norm, Not the Exception

Few of us actually like the idea of taking medication. We may like feeling better, and we may feel that the medication is necessary. We may have learned to put our ambivalence away so that we do not continuously think about the risks and side effects and the dependency on our medication. Still, ambivalence is the norm, not the exception. A typical clinical response to client ambivalence is to try to overwhelm it with rationality, reason, and exhortation. Sometimes this works, but most often it does not. If we try to “push” on one side of the dilemma, we can inadvertently strengthen the person’s natural tendency to think about all of the arguments on the other side. Instead of convincing someone to do something we feel is important, we can incite the person to muster all of the arguments against this decision. Our push to get the client to make the “right decision” can sometimes strengthen the client’s inclination to make the opposite decision.

As discussed in detail in Chap. 17, Motivational interviewing is an approach to behavioral change based on the idea that people are more likely to follow through with a decision if it is their own rather than someone else’s (Miller and Rollnick 2002). Helping the client to develop his or her own argument about why something should be done will be a more powerful way to induce behavioral change than telling the client to make this same change. A client is likely to come up with a better decision if the clinician listens to him rather than argues with him. Once the client’s concern has been fully addressed, then attention can be gently directed to the potential benefit of the medication. There is a place for direct support that the medication is needed and is working, but this direct support will be much more effective after the client has had a chance

to express his own concerns. Our issue is to guide the client into making those decisions that support his or her own life goals. It is the client's goals, and it is the client's behavior that must change to support those goals. Our job is to help the client develop his or her own argument to support behavioral change.

Client: I am very worried about getting tardive dyskinesia. You told me about this risk, and now I look at myself in the mirror and think I see the beginning of it.

Prescriber: What do you see when you look in the mirror

Client: I am not sure, but I think I see my face twitch some time. I am not sure I have it, but the idea of it scares me.

Prescriber: So the idea that you might develop tardive dyskinesia is pretty scary, even if there is not much evidence that there are signs of it now. Do you think the medication is doing any good?

Client: Well I am back in school and able to concentrate better, and I guess that is from the medication. I am also spending more time with friends, and less worried about people talking about me, and that could be from the meds.

Prescriber: So on the one hand, taking the medication and the possible side effect of tardive dyskinesia are pretty scary, and on the other hand the medication seems to have helped you get back to school, and has made it easier to spend time with friends.

Client: I think that I need to keep taking it, but it still scares me....

A Person Is More Likely to Take a Medication from Someone He Likes and Trusts, and Less Likely to Take a Medication Prescribed by Someone Who Is More Focused on the Medication Than on Him

We are all more likely to follow through with a suggestion made by someone we like and trust,

and less likely if we distrust the motives of the person making the suggestion. Coming up with a diagnosis and writing a prescription is not enough. An effective physician must work to engender a trusting relationship. Many consumers have had the experience of feeling disrespected, not listened to, and not taken seriously. They bring this historical experience when they meet with new physicians. Many consumers are not at all clear if the physician is there "for them" or are there for some other more nebulous reason. Trust is something to be earned, and not assumed.

Medication Decisions Are Just That: Decisions. Dismissing a Consumer's Decision as "Just Part of the Illness" Interferes with the Development of a Dialogue and the Chance to Find Shared Understanding

Most of us would not take a medication just because we are told to do so by our physician. While we are influenced by our physician, we weigh the potential benefits of the medication and the potential risks and side effects and come up with our own decision. The same is true for people with mental illness. If the consumer agrees with the physician or is inherently compliant, then all goes well and the consumer takes the medication as prescribed, at least most of the time. At times, the consumer may weigh concerns differently than the prescriber, and decide to stop a medication or take it differently than prescribed. Most consumers have learned to avoid being too overt about their own views to avoid the inevitable pressure that would come if they openly disagreed.

It is important that the prescriber do everything possible to make the discussion about medication decisions overt rather than covert. The consumer must be encouraged to share his own views and decisions, and then not be punished for being honest. When I begin a dialogue with a patient, after asking about how his job is going or his painting or his goal of exercising, after I first focus on the person's own goals and hopes, I often ask how the medication is working and what he is taking. The answer is often a vague "it's going

OK.” and this begins the conversation rather than ends it. A response that “I am taking medication almost all of the time” leads to a query about what happens when he misses some doses of meds, how long has he gone without taking it, and what has persuaded him to restart it. The tone is not an inquisition, but rather an open conversation and respectful curiosity about what decisions the consumer is making and the thinking behind these decisions. The issue is not to just persuade the person to take the medication more consistently. The goal is to understand the consumer’s own ambivalence and thinking. If one assumes every refusal is just lack of insight connected to illness, then it becomes impossible to have a conversation that leads to the sharing of ideas, and that allows us to learn from each other.

Taking Medication Always Has Meaning, for the Patient, for the Family, and for the Clinician

One person experiences medication as something that controls his life. Another experiences taking medication as something he can do to take more control over his own illness and his own life. One person sees medication as one more proof that he is damaged and disabled and not able to work. Another person sees medication as a tool that can help him overcome his illness and get back to work. The meaning of medication can change over time.

The meaning that always accompanies medication is not unique to mental illness. Survivors of breast cancer are often required to take medication that decreases the risk of recurrence, but comes with significant side effects. One person is reminded with every pill that the cancer may come back, while the self-talk for another person reinforces the message that taking medication is something she can actively do to prevent it from coming back.

Medication can increase, or decrease, the sense of personal power and control the person has over his own life. If I “medicate you,” then I am doing something to you and your personal power will feel diminished. If medication is a

tool that you can use in your own recovery, the same medication can work to increase your sense of control over your own life. Many people with serious mental illness are struggling with issues of control. A patient trying to assert control may connect taking medication with ceding power to others. Taking medication too often feels like a further loss of control and a further loss of personal power.

The prescriber can work to reinforce the idea that the consumer can use medication to take more control over his illness. For this to be effective, the locus of control must be with the consumer. The consumer has no real control if he is only allowed to make decisions that agree with those of the psychiatrist. At times, this means the consumer may make decisions that disagree with what others think would be best. The disagreement between consumer and clinician can be minor, such as taking a slightly lower dose of medication or choosing a different but similar medication, or major, such as discontinuing all medications. The psychiatrist and support people do not need to be neutral about these decisions and in fact they should not be. They should be clear about what they think is best. There also needs to be acknowledgment of the consumer’s right to disagree with clinician decisions.

In the presence of mental health commitment and legal coercion, finding areas of collaboration becomes much more complicated. Even when there is a court order covering the use of medication, the goal is to support the consumer’s own decisions as much as possible. It may matter less if a person takes 4 or 5 mg of risperidone, or thiothixene instead of olanzapine, than the consumer feeling some legitimate say in his or her own treatment even in the face of court order (Diamond 2008).

Medication also has meaning for other people in the consumer’s life. Taking medication can be perceived as a sign of illness and damage, or a sign of the person becoming well. Family and even clinical staff often have unrealistic expectations of what medication could do if only the person would take it. Clinicians often feel the need to “do something” in the face of increasing distress. This translates into increasing the dose

of medication or adding a new one, even if this is more likely to increase side effects than increase efficacy.

Medication Decisions Are, in Part, Socially Mediated

Many of our decisions are strongly influenced by the views of our family and friends. What we choose to eat, what clothes we buy, and even whether we exercise or sit on a couch are all strongly influenced by those around us. It is not surprising that our decision to take or not take medication is similarly influenced. I am much less likely to take a medication if my friends feel this is a bad decision. There is often an assumption that only the direct consumer is involved in the decisions about what medications should be used. In reality there is a hoard of other people metaphorically in the room when the medication decision is being made and when the consumer decides whether or not to actually take the medication.

Even mass media play a part. If attractive, functional people are portrayed as using medication, we are more likely to be willing to take medication ourselves. If the only people taking psychiatric medication that we read about in magazines or see on TV are severely dysfunctional, then we get the message that we do not want to be doing what they are doing, we do not want our life to be like their life, and we certainly do not want to be taking psychiatric medication. We can get the message that medication is for “winners,” or only for “losers,” and this becomes part of our own conscious or unconscious decision-making process.

It can be useful, with the consumer’s permission, to invite support people into the medication appointment. This includes family and friends who are supportive of the use of medication, and also those most opposed. The close friend or brother who is opposed to the consumer’s use of medication will exert this influence whether or not they are included in the medication appointment. By including him, his concerns can be heard and perhaps addressed. Even if his views

do not change, the consumer may be in a better position to balance the contrasting views of the people who support the use of a particular medication and those who are concerned about such use. Speakerphones and Skype can be used to include support people.

Side Effects Are Real. Decreasing Side Effects Can Make It More Likely That a Person Will Continue Taking Medication

We ask consumers to take medication that causes side effects that we would have great trouble tolerating. A minor side effect to the clinician may be perceived as a major life obstacle by the consumer. We ask consumers to tolerate weight gain that we would find very upsetting, or drooling that would cause us to stop an offending medication. We may not hear the distress caused by “minor” askathisia. We need to think about how we would react if we were experiencing the side effect reported by our consumers. How upset would we be, and what would we want done? Sharing information and decision-making with the consumer can be an effective way of trying to address these problems.

Often the right course of action is not clear. Is weight gain more important than sexual side effects? Is maximum efficacy more important than some increase in long-term risk? Many of these are value decisions rather than medical decisions. Is it worth the risk of trying a new medication, or better to stay on a medication that is working but causing significant weight gain? We need to help decrease side effects as much as possible. Just as important, we need to involve the consumer in decisions so that together we come up with solutions that make sense for him. The decisions may not always work out, but that is true for many medication trials and many medical decisions. Some decisions are more risky than others, and some may have more chance of working than others. This does not mean that the prescriber must go along with every request made by the consumer. Some requests and some decisions lie outside of medical prudence. I may not agree to prescribe high-dose diazepam for someone

who I know abuses alcohol. The goal is to strive for a set of decisions that are acceptable to both prescriber and consumer, even if both may feel that it is not what they would ideally choose.

Organization and Structure Can Help. It Is Important to Simplify the Medication Regimen, Help Connect Medication Taking to Other Structured Activity, Build in Reminders to Take Medication, and Consider Using Pillboxes or Special Packaging

Make those changes that can help a person take medication more consistently. Be interested in the consumer's actual medication use, and ask about barriers that make taking medication more difficult. Most psychiatric medications can be taken once a day, even if the package insert suggests twice a day. Consumers may benefit from assistance that connects taking medication with some other consistent life activity. We do this so automatically in our own life that we may not realize that a consumer may need some concrete help to come up with these strategies. Does the person regularly brush their teeth, or eat breakfast, or have a morning cup of coffee, or have a nighttime pattern before going to bed. Some compromises on "ideal treatment" may improve actual outcome. I personally take medication that should ideally be taken in the morning, but my mornings are rushed and chaotic and I have found that I take my own medication more consistently if I take it before bed. Ideal management of diabetes often requires a complicated regimen of different medications at different times of day. Actual outcome is sometimes much better if the regimen is simplified to become practical rather than ideal. Some consumers are very sensitive to the "dose" of medication, and they prefer to take a medication with fewer milligrams even if this is explained as being an unimportant consideration. Other consumers are sensitive to the number of pills they are taking, and would prefer taking 100 mg tablet than three 25 mg tablets even though the dose is higher with the one pill.

Help the consumer use pillboxes and other packaging that assists in consistent medication use. At times, the pharmacy can set up assistive packaging, or perhaps a friend can help the consumer setup a pillbox system. Be aware of barriers to obtaining medication. Co-pays that seem small may still be enough to discourage medication use. Just getting to the pharmacy or the embarrassment of asking for a psychiatric medication at the pharmacy may all present barriers to obtaining medication. At times, clinicians may be only vaguely aware of insurance changes or prior authorization requirements that are overwhelming to a consumer. A pharmacy's decision to change from one brand of medication to another may make a consumer uncomfortable about taking the new pill and lead to a decision to just stop taking it.

Take a Long-Term Point of View. The Goal Is Not Just to Get the Person to Take Medication Today or Next Week. Consider the Impact of What You Are Doing Now on This Person's Willingness to Use Medication Next Year

Almost everyone who needs a psychiatric medication is likely to continue to need it for a considerable period of time. The issue is not just to "get the person on meds," but rather to work to help the person come to an understanding of his problems and of the role of medication as a potential solution to these problems. There is pressure to "medicate the person rapidly." It is desirable to keep periods of acute distress as brief as possible, to shorten periods of psychotic relapse, to decrease risk, and to shorten periods of hospitalization. On the other hand, the pressure to get someone "medicated" rapidly often requires pressuring the person to take a medication before he has had time to consider and absorb the various options. The pressure to "medicate" a person reinforces the locus of control of medication onto the clinicians and "other people," and decreases the opportunity for the consumer to consider whether and how medication might be useful. Taking a longer term point of view allows time

for the consumer to actively be involved in the decision of the goals and targets of the medication, what medication to take, how much, and for how long. This approach may require that it take a bit longer for the consumer to get onto an effective dose of medication. On the other hand, it may well make it more likely that the consumer will continue be on medication over time.

Not Everyone with Schizophrenia Benefits from Medication. This Means That When a Person with Schizophrenia Says That the Meds Do Not Help, At Least Some of the Time They Are Being Objectively Accurate

While it is clear that groups of people with schizophrenia will have fewer positive symptoms and fewer periods of relapse if they consistently take antipsychotic medication, this does not mean that every individual will benefit from these medications or benefit to the same extent. Some people with schizophrenia may get little or no benefit from antipsychotic medication. Others may find that the marginal benefit of medication is outweighed by the side effects. The idea that medication is not always required is heresy. There is a risk of even broaching this reality.

The belief in the efficacy of medication has become so imbedded in our treatment programs that we cannot even seriously discuss it. Many people who say that the medication does not help are probably misguided, and that for many of these people medication helps in very clear, objective ways based on their own history and changes in their own behavior. On the other hand, when someone says that the medication does not help, we should at least listen and think about what we know about this person's response to medication. If we were true empiricists, it should not be all that unusual to pick up the chart of a person with a note that indicates the person has schizophrenia with active psychotic symptoms, and has failed to have significant benefit from multiple trials of antipsychotic medication including clozapine; therefore all medication is being discontinued. The reason we do not ever see such

a note is because of the clinician's irrational belief in the power of medication, our unwillingness to admit impotency, and the pressure on the larger system to continue to prescribe medication whether it is effective for this person or not.

For the Vast Majority of People with Schizophrenia, Shared Decision-Making Is Not Only Possible but Leads to Better Outcomes

Shared decision-making refers to having the consumer and the prescriber come together to collaboratively make decisions that best fit the consumer goals, values, and preferences. There is an explosion of interest in shared decision-making (Deegan and Drake 2006). Unfortunately, actually implementing it is surprisingly difficult. Shared decision-making is much more than just sharing information

True participation in shared decision-making requires that all parties become educated about the range of treatment options. This means that the consumer needs way to become educated about the various treatment options, and that the prescriber becomes educated about the consumer's goals and values. Both sides of this education can be difficult. Historically, consumers have been provided with information about their medication. Such information is often overwhelming, always incomplete, and inevitably biased by the preferences of the person providing the information. Written information is often lists of indications and side effects. While such information is a start and helps to at least open the conversation, it usually does not give the consumer enough information to become a true part of a shared decision process. Too often, this written information provides information that is only vaguely useful to the consumer trying to absorb and comprehend it all (Shrank and Avorn 2007).

Web sites are another typical source of information for consumers, but again all such sites organize information based on their own biases. It is difficult to know which web sites provide reliable information and which do not. Even the idea of "reliable information" is problematic.

The authors of a web site or informational pamphlet will inevitably feel that medication is useful or that medication is dangerous. What one person sees as “reliable,” another person will see as a polemic. Some information is much more reliable and balanced than others, but it can be difficult for a consumer to sort this out.

These concerns have led to the development of “decisional aids,” structured ways of presenting information starting with the consumers own preferences, goals, and concerns. For example, is the consumer more interested in a medication that is most likely to help decrease voices, or more likely to avoid weight gain? Is the person more concerned with feeling “drugged out,” or more concerned about not sleeping? The information about options can then be filled in, within this structure. Education can be based on the persons’ own stated concerns. These decision aids are different than just an article or book about treatment options or medications, and tend to help consumers work through complicated information to arrive at a decision that works for them. Some of the decision aids are on paper, while others involve computer technology that allows for better customization of the information flow to fit each consumer’s needs. The better ones use concepts and language that are “consumer friendly.” Most importantly, they provide information based on the consumers own needs, so that it can be directly applicable to helping consumers to be true participants in the decision process. WRAP plans (wellness recovery action plans) are one form of a decisional aid (Copeland 1997).

Having information is necessary but not sufficient for having a true voice in decisions about one’s own life. It requires that the prescribers and other formal decision-makers become willing to share power with the consumer, not just when the consumer’s decision happens to agree with that of the prescriber. This in turn requires that the prescriber may need to support decisions that he or she would not necessarily choose. There is a range of such disagreement, from differences of opinion that can be easily tolerated and supported, to those that appear particularly self-defeating and dangerous. Part of the

process of shared decision-making requires developing a process to discuss and arbitrate these disagreements, when prescribers disagree with consumers and when consumers disagree with prescribers. This also requires that both consumers and prescribers receive training in the implementation of shared decision-making.

Shared decision-making is more than just another technique to convince a patient to do the right thing. Rather, it is a way for reestablishing a more collaborative, less hierarchical relationship. The relationship between physician and patient is equal but asymmetrical. Patient and physician have different sources of information, and different kinds of expertise. Shared decision-making requires that the physician relinquish certain kinds of control, even in the face of a variety of professional and societal pressure to maintain control. It requires that the consumer take on the burden of learning about his illness and treatment options in a serious way, and then taking on the responsibility for his own decisions. It requires time to enter into this collaboration, and it requires the development of decision aids that can assist the process. Shared decision-making is not equally applicable in every situation, nor will it resolve all conflicts about medication decisions. At the same time, Shared decision-making is an approach that is likely to allow more collaboration and less conflict, and as a result lead to better outcome.

There is no way to ensure that the consumers will always agree with our view of the problem, or our suggestions about treatment. Consumers may decide to stop taking medications that we feel are extremely helpful and even necessary. We will, at times, attempt to use various kinds of pressure or even legal sanctions to force the use of medications, at times over the strident objections of the consumer whose life it is. There will be some situations where it will be difficult to find areas of common ground for an understanding of the problem or the solution. At the same time, without being naive about the difficulties that can ensue, it is imperative to try to understand the world from the consumer’s point of view. It is important to look for areas where we can overlap with the consumer in a common view

of the problem. It is useful to think of medication as a tool that the consumer can use to facilitate his or her own recovery journey. It is hoped that this reframing of the role of medication will lead to better long-term outcomes than more traditional ways of thinking about compliance and adherence. Our goal is not to get consumers to take their medication but to help consumers get closer to their own recovery goals. Our job is to help consumers learn to use medication to facilitate this journey.

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