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# Effective Strategies for Nurses Empowering Clients With Schizophrenia: Medication Use as a Tool in Recovery

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**Clients with schizophrenia require maintenance treatment with antipsychotic medication and psychosocial therapy to maintain symptom control. Rates of medication adherence or follow-through are low in clients with schizophrenia. This increases the risk of relapse and contributes to poor quality of life. As educators and advisers, psychiatric nurses can collaborate with clients to improve adherence and other outcomes using shared decision-making techniques and tools that engage and empower clients to actively participate in decisions about their treatment. This article outlines effective strategies used by psychiatric nurses to improve outcomes in clients with schizophrenia and uses a case example for demonstrating this strategy in a client with schizophrenia.**

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## BACKGROUND

Schizophrenia is a chronic psychiatric disorder that affects approximately 1% of the U.S. population (National Institutes for Mental Health, 2014). It requires continuous treatment with antipsychotic medication in combination with psychosocial therapy to reduce the risk of relapse (Emsley, Chiliza, Asmal, & Harvey, 2013; Hasan et al., 2013; Kreyenbuhl, Buchanan, Dickerson, Dixon, & Schizophrenia Patient Outcomes Research Team, 2010). Although the exact pathogenesis remains unknown, research suggests that the etiology of schizophrenia is multifactorial and may include genetic, environmental, and neural components (Haller, Padmanabhan, Lizano, Torous, &

Keshavan, 2014; Modinos et al., 2013; Walder, Faraone, Glatt, Tsuang, & Seidman, 2014). Dysregulation of the neurotransmitters dopamine, glutamate, and/or GABA is implicated in the positive (e.g., delusions, hallucinations, disorganized thinking) and negative (e.g., blunted affect, emotional and social withdrawal) symptoms of schizophrenia (Emsley, Chiliza, & Asmal, 2013; Gaspar, Bustamante, Silva, & Aboitiz, 2009; Haller et al., 2014; Kim, Maneen, & Stahl, 2009). Antipsychotic medications have primary affinity for dopamine D<sub>2</sub> receptors and affect other neurotransmitter receptors (Correll, 2014). They are recommended in combination with psychosocial therapy as maintenance treatment to avoid relapses in clients with schizophrenia (Hasan et al., 2013).

Decisions about initiating, titrating, and switching medications involve ongoing discussions during clinical consultations and are part of learning to self-manage a mental disorder. Medication-related decisions are affected by factors such as lifestyle behaviors and the client's ability to engage in self-care. In the traditional medical model, clients played a limited role in treatment decisions and were expected to "comply" with provider recommendations. The President's New Freedom Commission on Mental Health titled "Achieving the Promise: Transforming Mental Health Care in America" (Freedom Commission, 2003) called for a paradigm shift from this model to the recovery model and the concept of shared decision-making gained momentum (Townsend & Glasser, 2003). In 2005, the American Psychiatric Association endorsed incorporation of the recovery model into psychiatric service provision (American Psychiatric Association, 2005). Between 2011 and 2014 the American Psychiatric Nurses Association and the Substance Abuse and Mental Health Services Administration collaborated on the initiative to transform and transition recovery concepts and beliefs to actionable recovery oriented practices as the

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standard of psychiatric nursing care delivery (American Psychiatric Nurses Association, 2011).

Recovery—a process of change through which clients improve their health and wellness, live a self-directed life, and strive to reach their full potential—is usually accomplished through a combination of personal empowerment, a sense of responsibility, choice, and active self-help (Substance Abuse and Mental Health Services Administration, 2012). In order to promote recovery, an integrated self-care strategy model based on a broader understanding of the meaning of “medicine” emphasizes the importance of using good communication tools and seeking to release the “powerful synergies” of pill medicine, personal medicine, and psychosocial treatment in order to manage illness (MacDonald-Wilson, Deegan, Hutchison, Parrotta, & Schuster, 2013). Personal medicine includes acts of client-initiated self-care, which may prevent relapses and improve client-reported outcomes (e.g., quality of life; MacDonald-Wilson et al., 2013).

The objective of this article is to outline effective strategies nurses employ as they collaborate with people with schizophrenia in their use of medication as a tool in recovery. We begin with an overview of shared decision making in psychiatric nursing and strategies to improve client follow-through with their antipsychotic medication regimen. This is followed by a case example that demonstrates these strategies in practice.

## SHARED DECISION-MAKING AND PSYCHIATRIC NURSING

Psychiatric nurses use a biopsychosocial model of holistic care, which involves client education and encourages self-management and spiritual support for clients with schizophrenia; in which the importance of the client’s perspective in treatment decisions is emphasized. Peplau’s (1952) “therapeutic use of self” has evolved in psychiatric nursing from simple client education, to discussing and confirming client preferences, acting as an advisor, and encouraging clients’ desired levels of independence (Adams & Drake, 2006; Olesen et al., 2012).

Selecting appropriate medication and behavioral therapies using shared decision-making is one strategy that may improve treatment follow-through (Haddad, Brain, & Scott, 2014). Shared decision-making pairs a collaborative style of communication with decision-making tools to introduce clinical information regarding health conditions and compare treatment options in the context of clients’ health experiences, cultural values, beliefs, and preferences (Schauer, Everett, del Vecchio, & Anderson, 2007). Shared decision-making is a “process of enabling clients to participate actively and meaningfully in their treatment by providing them with accessible information and choices” (Adams, Drake, & Wolford, 2007, p. 1219). It is a model that allows clients and providers to collaborate to assess treatment risks and benefits as part of a treatment plan (Deegan & Drake, 2006). Shared decision-making empowers clients with the knowledge needed to make informed decisions together with

their treatment team and to engage as active participants in their treatment plan (Mahone et al., 2011).

One study found that although 85% of clients preferred to be presented with treatment options and to be asked for their opinions on those treatment options, 64% of those clients wanted their healthcare provider to make the final treatment selection (Park et al., 2014). Hamann and colleagues found that overall, the Autonomy Preference Index scores (self-report instrument measuring the client’s general wish to participate) of inpatients with schizophrenia were higher than those reported for primary care patients (Hamann, Cohen, Leucht, Busch, & Kissling, 2005). Mahone (2008) found a similar number (82%) preferred a collaborative relationship, although only 70% had experienced collaboration in their most recent client-provider interaction. Another recent literature review concluded that most clients want greater involvement in mental health treatment decisions and that the desire to be included in treatment decisions is stronger in clients with schizophrenia than patients in primary care practices (Curtis et al., 2010). Gauging the client’s initial preference for and ability to engage in shared decision-making is helpful in beginning the provider-client communication about medication treatment options. Because preferences and ability to engage may change throughout the course of treatment, this preference and ability should be reassessed at follow-up appointments (Wills & Holmes-Rovner, 2006).

## FOLLOW-THROUGH AND RELATED OUTCOMES

When shared decision-making is practiced in determining the most appropriate treatment, medication adherence or compliance is more accurately called “follow-through” (Curtis et al., 2010). Whereas the terms “adherence” and “compliance” imply a rule or edict is being followed, taking one’s medication is an active choice made each day by the recovering client. It is a choice made in conjunction with the provider at first, but then autonomously.

Although psychiatric medicines and psychosocial treatments have clearly established efficacy, and guidelines have been created for their use, only 15% of people with serious mental illness in the United States receive minimally adequate antipsychotic medication (Wang, Demler, & Kessler, 2002).

Rates of medication follow-through in clients with schizophrenia remain as low as 40% during the first 3 months after treatment initiation (Offord, Lin, Mirski, & Wong, 2013). Physicians indicate that, on average, their clients with schizophrenia take only 51% to 70% of their prescribed medication (Velligan et al., 2009). A recent systematic review found that lack of medication follow-through increases the risk of relapse, hospitalization, suicide, and criminal arrest (Higashi et al., 2013). This frequently leads to disruptions in relationships and in housing and thus contributes to a poor quality of life (Haddad et al., 2014). A comprehensive literature review and expert consensus guidelines and recommendations were created to address how best to assess and manage nonadherence in clients with

serious and chronic mental illness (Velligan et al., 2009). It is notable that the expert panel in this study did not include a client, thereby overlooking a most important perspective—that based on lived experience, preferences, and values. Mulley, Trimble, and Elwyn (2002) speak of the failure to invite patients' voices to the table.

A systematic review of treatment team approaches to improving medication follow-through in clients with schizophrenia identified several client-specific factors that contribute to poor medication follow-through. These include cognitive deficits, anosognosia (i.e., lack of insight or awareness of illness), comorbid substance abuse, lack of access to healthcare services, financial constraints, and lack of social support (Shuler, 2014). Kikkert et al. (2006) identified four additional key factors: medication non-effectiveness, side effects, attitudes toward treatment, and a weak therapeutic alliance. Therapeutic alliance refers to the relationship between the medication provider (e.g., psychiatrist, psychiatric mental health nurse practitioner, or physician's assistant) and a client, whereby each hopes to engage with the other in order to effect beneficial change in the client. The therapeutic alliance takes on greater importance when addressing follow-through with clients with schizophrenia who experience anosognosia (Haddad et al., 2014; Shuler, 2014).

## STRATEGIES TO IMPROVE MEDICATION FOLLOW-THROUGH

### Psychosocial Interventions

Several psychosocial interventions with demonstrated efficacy are available for clients with schizophrenia (Fenton & Schooler, 2000). Examples of evidence-based psychosocial interventions include illness self-management, case management/assertive community treatment (ACT), social skills training (SST), family psychoeducation, and supported employment. Illness self-management programs aid clients in developing skills to manage the medical, social, and emotional aspects of a chronic illness. Self-management interventions improve clients' health behaviors and symptom severity and reduce long-term healthcare costs (Ahn et al., 2013). Case management/ACT is an intensive treatment team approach that is usually reserved for clients with the most severe symptoms and psychosocial needs, such as a history of homelessness or withdrawal from medical and psychosocial care. The case management/ACT requires a high frequency of contact (sometimes 24-hour coverage) and low staff-to-client ratios to provide intensive medical and psychosocial care and allows case managers to observe the client directly rather than relying on client or caregiver reports (Chien, Leung, Yeung, & Wong, 2013). Findings on the benefits of ACT are mixed, with some studies and reviews reporting reductions in hospitalizations and improved quality of life. Other reviews have noted no significant improvements in social or vocational functioning (Chien et al., 2013). The conflicting findings may be related to differences in ACT models (e.g., caseloads, multidisciplinary team members) or differences in assessments (e.g.,

improvements in vocational functioning may be minimal versus reductions in hospitalizations in a severe client population; Chien et al., 2013).

The Schizophrenia Patient Outcomes Research Team (PORT) came together in 1998 to identify and publish best practice guidelines for schizophrenia treatment (Lehman & Steinwachs, 1998). Their recommendations are based on empirical data and agreement between schizophrenia researchers, clinicians, and consumers. Revisions were accomplished in 2003 and then again in 2009 to incorporate evolution and best practices in psychopharmacology and psychosocial interventions in multiple treatment areas (Kreyenbuhl et al., 2010; Lehman et al., 2004). One of those areas is social skills training (SST). SST targets social-cognitive deficits and includes aspects such as facial affect recognition and understanding social cues (e.g., body language, voice tonality; Kurtz & Richardson, 2012). The impact of SST may extend beyond improvements in social skills. One meta-analysis found that SST improved functional outcomes in clients with schizophrenia (Kurtz & Richardson, 2012). Functional outcomes may also be improved through supported employment. The Schizophrenia PORT recommends supported employment for all clients with schizophrenia who would like to obtain work and remain employed. Supported employment includes aiding clients in searching for and obtaining a job. It provides ongoing support to maintain employment. Many clients in supported employment programs are, however, unable to remain employed for more than a few months; thus, additional psychosocial interventions that target social skills development (e.g., SST) should be offered in conjunction with supported employment (Lecomte, Corbiere, Simard, & Leclerc, 2014). The Schizophrenia PORT also recommends a family-based intervention for clients with regular family contact that continues for  $\geq 6$  to 9 months (Kreyenbuhl et al., 2010). Family psychoeducation provides disease state information, coping skills, and emotional support for family members of clients with schizophrenia (Lecomte et al., 2014). A literature review noted several studies of family psychoeducation interventions in schizophrenia that reported improvements in medication follow-through and reduced stress in clients and their family members (Lecomte et al., 2014).

### "Personal" Medicine

Deegan (2005) reports that psychiatric medication nonadherence occurs when pills interfere with personal medicine or with recovery goals. Personal medicine refers to the nonpharmaceutical activities that "gave life meaning and purpose, and that served to raise self-esteem, decrease symptoms, and avoid unwanted outcomes such as hospitalization" (Deegan, 2005, p. 29). This construct requires a shift in focus to the whole person and the factors that promote health and well-being (salutogenesis) and away from pathogenesis. Examples of personal medicine include participation in valued social roles (such as work), helping others, keeping busy, exercising, advocacy, time with loved

ones, sex, fishing, math, shopping, diet changes, a good cry, being with “normal” people, being alone, being in nature, talking on the phone, taking a car ride, a day off work, pushing to achieve, collecting dolls, or exposure to sunlight. Personal medicine has been reported to alleviate anxiety, confusion, and other distressing symptoms. Clients found the term validated their experience and acknowledged that recovery requires hope, fortitude, imagination, and resilience among other qualities and attitudes (Deegan, 2005). Personal medicine is not routinely reported to clinicians nor solicited by them.

### “Pill” Medicine

As educators and advisors, nurses have the opportunity to work with clients to make informed choices about antipsychotic medication. This may be accomplished by providing information on options for methods of administration (e.g., oral vs. long-acting injectable [LAI]), drug mechanism of action, and potential adverse events; by reviewing options for daily or monthly reminders to take medication or return for follow-up injections; and by discussing the negative effects of treatment nonadherence (Kirk Morton & Zubek, 2013).

To be successful, strategies for improving medication follow-through must target the underlying reasons for nonadherence (Haddad et al., 2014). For example, clients with schizophrenia who have cognitive deficits may find pill boxes with alarms or other reminders to be helpful aids for improving medication follow-through (Haddad et al., 2014; Velligan et al., 2010). Likewise, the use of an LAI antipsychotic may minimize reliance on reminders (Haddad et al., 2014; Hasan et al., 2013). Medication side effects and tolerability issues are another potential underlying reason for nonadherence (Haddad et al., 2014; Velligan et al., 2010). Switching to another antipsychotic may improve tolerability and thus medication follow-through. For clients with minimal social support, involving and providing education for family members, engaging clients in support groups, or switching to an LAI antipsychotic may be beneficial strategies (Velligan et al., 2009).

Nurses can play a vital role in improving medication follow-through by collaborating with clients to identify obstacles and working with clients, family members, and other healthcare providers to then identify effective strategies to enhance medication follow-through (Kirk Morton & Zubek, 2013; Shuler, 2014). Because nurses often have extensive and recurrent contact with clients, nurses can play a critical role in explaining to them the importance of medication follow-through and may be the first to detect clues to nonadherence, such as a missed follow-up appointment or missed appointment for administering an LAI (Kirk Morton & Zubek, 2013). When discussing treatment options, it is beneficial to understand clients’ treatment goals, to help them select a medication that meets their personal preferences, and to clearly explain potential treatment-related adverse events. The use of an electronic shared decision-making aid, such as the online decision-making aid developed by the Substance Abuse and Mental Health Services Admin-

istration (SAMHSA) may help guide this process (Substance Abuse and Mental Health Services Administration, 2012). For clients who would like to minimize pill burden or who have a history of poor medication follow-through, switching to an LAI is one solution (Hasan et al., 2013). Use of LAIs in real-world community settings has demonstrated superior efficacy over oral antipsychotics in preventing hospitalizations (risk ratio, 0.43; 95% confidence interval [CI], 0.35–0.53;  $P < 0.001$ ) and decreasing the number of hospitalizations (rate ratio, 0.38; 95% CI, 0.28–0.51;  $P < 0.001$ ) (Kishimoto, Nitta, Borenstein, Kane, & Correll, 2013).

The following case demonstrates how shared decision-making can be used to develop a treatment plan to increase client engagement and to improve medication follow-through in the hope of improving outcomes in a client with schizophrenia.

## CASE SUMMARY AND FINDINGS

### Initial Presentation

Sam is a 29-year-old white male who underwent an initial psychiatric evaluation because he was psychotic (hearing voices), delusional (believed he was psychic), paranoid (believed that there was a camera installed on his head), and was unable to focus. Sam started hearing voices >5 years ago, and he had his first psychotic episode shortly thereafter when he became paranoid and ripped a hole through the ceiling because he heard voices calling him through the walls. The voices belonged to three individuals, and there was a commentary going on among the voices. Sam noted that although the voices were sometimes helpful, they were generally troublesome. “They see things through my eyes” and “discuss everything I do.” One year ago, Sam’s apartment burned down because he was distracted by the voices while lighting candles.

He believes that he has psychic powers. Sam also notes that he sometimes smells a “burning smell” and sees “lights.” He hears words in the noise of fans. He admits to paranoia, indicating that people are spying on him and watching him, and he has no privacy. He also wondered if a needle was implanted in his brain for monitoring his thoughts, and he shaved his head last year in an attempt to look for needles and other devices. At one point, he drove to a hospital planning to request a computed tomography scan to find the needle.

For the last three months, Sam has been working full time at a medical coding company. He admits that the voices interfere with his performance at work, and he gets angry at them. His stress level at his job is high, and he has recently missed a few days of work because of the voices.

### Client History

Because Sam has no close family members or friends nearby to accompany him, client-reported history was relied upon.

### *Social history*

Sam graduated from a junior college with an associate's degree in information technology. He was married for four years and subsequently divorced. Sam has a son who is 6 years old but has no relationship with him. He is not currently in a romantic relationship, and he has few friends and no support system. He is able to support himself financially and has health insurance through his employer. He is renting a house, where he lives by himself and manages all activities of daily living, including occasional cooking and caring for his dog.

### *Family history*

Sam reported that there is no family history of schizophrenia. He stated that "everyone in my family has substance abuse issues," and that he had no siblings and did not have close relationships with other family members.

### *Sleep and appetite*

Sam sleeps 6 to 8 hours per night. He has nightmares 3 to 4 times weekly and wakes up feeling terrified. Occasionally the voices awaken him at night, but he is able to return to sleep. Sam reports a good appetite and notes that he cooks for himself.

### *Mood*

Sam described his current mood as happy but reports that when he is unable to cope with the voices, he misses work, stays in bed, experiences abdominal pain, and feels hopeless. He hears the voices reminding him of prior mistakes and prays that his symptoms will resolve.

### *Suicidal and homicidal ideation*

Sam denied suicide attempts and reported that the voices do not tell him to kill himself, but they do talk to each other about suicide. Sam does have suicidal ideations, thinking about "ending this torment," but thinking about a suicidal plan scares him, and although he would consider using a gun, he does not own one. He says having a dog helps keep him from committing suicide. Sam denies any desire or intent to hurt others.

### *Anxiety/Obsessive compulsiveness/Trauma*

Sam admitted that he is a worrier, has muscle tension, gets fidgety, and replays scenarios repeatedly in his head. He has social anxiety and a very small social network. He has had panic attacks in the past but not recently. Sam denies engaging in rituals. He admitted to being hypervigilant and believes that this is rooted in the physical abuse he experienced as a child.

### *Attention and focus*

Sam has struggled with focus and attention since childhood. He finds it difficult to both start and complete tasks. In school he had trouble following directions, organizing, and prioritizing his work. He did well on exams because he was intelligent, but he never completed his homework and therefore failed some classes.

### *Developmental history*

Sam recalled being abused as a child and has memories of his parents abusing cocaine together. His father left his mother, and she later remarried. Sam's stepfather physically abused him on multiple occasions, and he has ongoing nightmares about this abuse.

### *Alcohol and drug history*

Sam has a history of marijuana abuse predating the onset of delusions. He has attended Narcotics Anonymous meetings but does not currently participate. He stated that he continues to use marijuana to cope. He uses it more heavily when the voices are intense. He drinks 4–6 times monthly and may drink up to 5 drinks at one time.

### *Medical history*

Sam has no other chronic illnesses and no history of head injuries or seizures.

## **Clinical Assessment**

### *Physical exam and review of symptoms*

Sam's heart rate was 82 beats/minute; blood pressure, 120/72 mm Hg; and BMI, 30.0 mg/kg<sup>2</sup>. Sam reported stomach pains that worsen in the evening. He had not been to a primary care physician in the past 2 to 3 years.

### *Mental status assessment*

Sam was clean and neat in appearance, and was dressed appropriately for the weather. His affect was anxious. He had a cooperative attitude. His thought process was goal directed and logical. Sam had no unusual mannerisms or tics. He was able to understand similes and proverbs. However, his thought content was paranoid, and he struggled to avoid engaging with the voices. Sam demonstrated insight insofar as he was aware that he needed help and that the drug abuse had contributed to his symptoms. His memory was intact (Mini Mental State Exam score, 30).

## **Working Diagnosis and Initial Treatment Plan**

Sam met *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria for schizophrenia (American Psychiatric Association, 2013).

After discussing different features, particularly common side effects of antipsychotic medications, Sam and his provider together decided that olanzapine would be the best treatment choice for him based on his goals and stated preferences. He initiated oral olanzapine and was titrated up to 20 mg twice daily with oral haloperidol 0.5 mg at night.

In follow-up visits, he noted that he sometimes forgets to take his medications. He reported that his symptoms had improved since beginning the medication, but he still heard voices and found this distressing. He was also distressed by a weight gain of 15 kg since initiating the medication. He continued to

use marijuana approximately once per week. He was very socially isolated, but desired more social interaction. He was not currently participating in any psychosocial interventions.

### Treatment Decision and Follow-Up Care

Before discussing new treatment options and making a treatment decision, Sam was queried about the degree of involvement he would like in making decisions about treatment and services. Sam indicated that he would like to be involved in most decisions, but he also wants some assistance and reassurance as requested when making decisions.

Because Sam is socially isolated and does not have family or other social support to encourage him to maintain his oral antipsychotic treatment regimen, he and his care team discussed switching to an LAI antipsychotic. Sam was concerned that the injections would be painful, but he also welcomed the opportunity to be relieved of remembering to take multiple pills every day.

Various strategies exist for switching clients from oral to LAI antipsychotics. In general, gradual overlapping (e.g., initiating the new antipsychotic while slowly tapering off the old antipsychotic until therapeutic levels are achieved) is less likely to result in rebound and withdrawal effects compared with abrupt discontinuation of the old and initiation of the new antipsychotic (Correll, 2010). This strategy may be particularly relevant to maintain therapeutic levels during the initial weeks of LAI therapy (Correll, 2010).

Sam was concerned about antipsychotic-related weight gain. He had gained 15 kg since starting his current medication; therefore options for switching to and stabilizing him on an LAI antipsychotic with a more favorable metabolic profile were discussed. Other potential antipsychotic-related adverse effects, including somnolence and akathisia were also reviewed. Sam indicated that he wanted treatment with antipsychotic medication because he believed it would aid in his recovery and allow him to stop hearing voices and improve his work performance. He would like to keep track of how he feels and any potential treatment-emergent adverse events or tolerability issues in a daily diary. Some available smart phone apps that would allow him to conveniently record his daily experiences were reviewed.

Sam agreed to weekly phone calls from his nurse to monitor his well-being and to remind him to return in two weeks for his follow-up appointment. After he is stabilized on his new medication regimen, he would like to consider receiving fewer follow-up phone calls so that he can learn to manage his illness more independently.

Concomitant involvement in a psychosocial intervention is particularly important because Sam is socially isolated and would like to befriend people with similar struggles. After discussing different options for psychosocial interventions, Sam agreed to take a peer-to-peer course offered by the National Alliance for the Mentally Ill (NAMI). The course will allow him to meet other individuals in his area who struggle with similar is-

suues and will provide social skills training (e.g., how to interact with peers, co-workers, and healthcare providers).

Sam was aware that his marijuana use is not a healthy coping mechanism. To address this issue, Sam agreed to reinstate his attendance at Narcotics Anonymous meetings and to consider healthier alternatives such as exercising. Exercising would also help address his concern about being overweight. Although an excellent option, he is not comfortable joining a gym at this point. He decided to try walking his dog at a local running track. Sam has previously noted that he enjoys listening to music to “tune out the voices.” He will continue to listen to music as his personal medicine and is hopeful that listening to music while walking will also encourage him to walk more frequently. Sam is hopeful that the LAI will provide relief from daily use of oral medication, and he committed to using an electronic aid to track his mood and any potential treatment-emergent adverse effects.

### Measurable Treatment Goals

Looking forward to improvement, Sam and his provider identified how they will measure the effectiveness of his new treatment regimen. Sam’s personal goals were to improve attendance and receive a positive performance appraisal at work (functional improvement); attend Narcotics Anonymous meetings at least twice per month (reduce isolation); join a peer support group and make new friends (social support); reduce marijuana use (eliminate negative impact); and walk his dog daily (exercise). Sam agreed that beginning a daily exercise regimen would become a priority due to his weight gain with his prior antipsychotic.

### LIMITATIONS AND FUTURE DIRECTIONS

A single case study is described here; therefore, it limits the number of issues that can be examined, and thus the generalizability of the methods and strategies employed. The study is qualitative in nature; however, it is anchored in real-life situations and provides a complete clinical picture of shared decision-making. There exists a need for future clinical trials with shared decision-making tools. Attention should be focused on identifying barriers and facilitators to the implementation of shared decision-making. Studies assessing the impact of shared decision-making on medication adherence would be very informative. Efforts should be made to facilitate the shared decision-making process by providing educational intervention to patients as well as in-service training to staff at health care centers. Further research is warranted to delineate nurses’ engagement in implementation of shared decision-making in mental health care.

### CONCLUSIONS

The chronic nature of schizophrenia requires continuous engagement between clients and treatment team members. Transparent sharing of information and clear communication are essential to establish treatment decisions that support clients in

their personal goals. Psychiatric nurses play a vital role. Through knowledge and proficiency in the use of shared decision-making tools, they facilitate the incorporation of shared decision making into clinical practice to improve medication follow-through. As they engage with clients during assessments, medication administration, medication education groups, during one-on-one counseling, and coping skills education within the supportive structure of the milieu; nurses continuously assess treatment effectiveness and medication side effects. Because nurses are the most trusted health care professionals, skill and proficiency at soliciting patients' values and preferences for their plan of care is essential and psychiatric nurses are in a pivotal position to educate clients about the use of shared decision making tools for use in their partnership with their prescribing clinician. Helping a client identify their personal medicine, select targeted psychosocial interventions, and choose a medication that best fits their lifestyle and goals are all strategies that can improve medication follow-through. In the preceding case example, a client with schizophrenia was symptomatic, lacked social support, was not engaged in psychosocial interventions, and had experienced excessive weight gain. He admitted to inconsistently taking oral antipsychotic medication. In discussing potential treatment plans, he indicated that his goals were to alleviate his symptoms so that he could focus at work, become less sedentary, and form social connections. After trying an oral second-generation antipsychotic, he wanted to switch to a treatment regimen that would minimize his weight gain and alleviate the burden of daily medication. He chose to switch to an LAI antipsychotic with a more favorable metabolic profile. He selected psychosocial interventions that promote social engagement and that will aid him in forming healthy friendships and discontinuing marijuana use. Listening to music was identified as personal medicine, and he hoped to use this to promote engaging in physical activity.

Advance Practice RNs and other prescribers educate their clients about the purpose, anticipated benefits, risks, options, potential side effects, and client responsibility for symptom and side effect self-monitoring as standard practice. A team approach consisting of RN client assessment and education, and client/prescriber incorporation of shared decision-making tools into medication management visits and each health care encounter is essential. This method facilitates thoughtful, responsible, and collaborative partnerships that empower clients to follow through with medication and psychosocial interventions to achieve and sustain the best possible outcomes.

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