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Communicating with elderly mental health clients about medication concordance

Eva Mary Miller

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COMMUNICATING WITH ELDERLY MENTAL HEALTH CLIENTS

ABOUT MEDICATION CONCORDANCE

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Eva Mary Miller

June 2007
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ABSTRACT

The purpose of this qualitative study was to assess the effectiveness of communication with elderly mental health clients regarding medication concordance. It identified when, whether, and with whom elderly mental health clients discuss medication issues. The study evaluated the client's perception of the effectiveness of that communication in reaching concordance on their medication regimen.

Clients were at least fifty-five years old and receiving mental health services within San Bernardino County. The study gathered information directly from eleven clients through the use of one-on-one interviews. The interviews were conducted by this researcher. This method allowed for an in-depth face-to-face analysis. The interviews were held during the winter quarter of 2007.

This study found that elderly mental health clients actively seek healthcare providers with whom they feel comfortable and confident. They also feel a sense of responsibility for getting the information they need and understanding adequately the medications they are taking.
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Thank you to Dr. Thomas Davis who is an inspirational teacher and saw me through the early stages of developing this research.

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DEDICATION

With deepest thanks to my family for their loving support: Rex, Jeanine, Michelle, and Jessica.

Also thanks to the many friends who encouraged and supported me. Special thanks to the Quaker Center staff and the Labyrinth retreat who helped me to find my path to this program and a new career.

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CHAPTER ONE

INTRODUCTION

This chapter will examine the growth of the elderly population, the prevalence of mental health issues and challenges with medication regimes among the elderly.

Problem Statement

Advances in the medical field have lengthened the human lifespan and allow many more people to live into old age. “About four out of five individuals can now expect to reach age 65, at which point there is a better than 50 percent chance of living past age 80” (Hooyman & Kiyak, 2005, p. 13).

The elderly are greatly over represented in the proportion of the population that is on medication and requires multiple medications. Eighty percent of Medicare beneficiaries routinely use prescription medications (Klein, Turvey, & Wallace, 2004, p. 779), and costs of prescriptions make up a third of out-of-pocket healthcare costs for the elderly (Klein et al., 2004, p. 780). “Although those aged 65 years and older make up 12% of the population, they consume over 30% of all prescriptions medications” (Mitchell, Mathews, Hunt,
Hayes, & Watson, 2001, p. 348). A recent study of elderly patients on medication for depression found that 83.5% were also taking medications for other conditions (Baca et al., 2006 p. 339).

Elderly persons often experience problems with self care and the process of managing medications. As many as 59% of elderly clients are non-compliant with medication regimens (Banning, 2004, p. 14) and 10 - 25% are not taking any of their prescribed medications (Howes, 2005, p. 1). "Taking medication is a complex process that places both cognitive and physical demands on elderly people" (Beckman, Parker, & Thorslund, 2005, p. 186). Medication non-compliance causes unnecessary and avoidable problems and expense for clients, the healthcare system, and caregivers.

Social workers involved with the elderly find that changes to medication regimens are often made by clients without professional consultation. The reduction or elimination of a medicine can have adverse consequences because chronic illness that is not managed causes patients to be twice as likely as others to end up in a nursing home (Mitchell et al., p. 349). It has also been shown that missing medication can contribute to
"emergency room visits, inpatient admissions, and overall health costs" (Klein et al., 2004, p. 780).

Non-compliance with medication regimens causes unnecessary and avoidable negative consequences such as a decline in the physical and mental well-being of the patient, a drain on the healthcare system, and increased stress to the client’s family and caregivers. Poorer health has been shown to be consistent with reports of poor medication compliance (Caskie & Willis, 2004, p. 176).

In examining policies which effect medication compliance, one of the most important areas is Medicare and insurance rules which impact the elderly client’s access to prescription medications. “Research examining medication adherence and the elderly population has reported the cost of medications as one factor that may affect adherence” (Brand, Smith, & Brand, 1997, p. 74).

Current best practice in treatment of consumers with mental health issues frequently combines counseling and psychotropic medications. The current clinical focus on a strengths based perspective leads micro practitioners to seek ways to empower their clients. Previously, therapists have perceived medication non-compliance as a
form of resistance. The current recommended approach is to gain concordance with the client about medication taking.

Concordance is defined as “the aim to involve and assist patients in making informed choices about their treatment and its associated risks and benefits” (Howes, 2005, p. 2).

For community dwelling individuals age 65 years or older, rates of depression are between 14 and 30% (Baca, Roca, Garcia-Calvo, & Prieto, 2006, p. 337), anxiety symptoms are seen with up to 65% of clients with depression (Lenze, Mulsant, Shear, Houck, & Reynolds, 2002, p. 754), and bipolar disorder has been found in up to 0.4% of this population (Schaffer et al., 2006, p. 275). “Twenty percent of all first admissions to psychiatric hospitals are persons over age 65” (Hooyman & Kiyak, 2002, p. 193).

Use of antipsychotic medications is widespread among the elderly (Baca et al., 2006, p. 341). A study found that 50% of residents in assisted living facilities take psychotropic medications (Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004, p. 1775). Clinical guidelines for treatment of depression and anxiety, the most
frequent mental health diagnosis among the elderly, specify pharmacotherapy (Sewitch, Blais, Rahme, Galarneau, & Bexton, 2006, p. 364).

An examination of elderly mental health clients' communication on the issue of medication concordance will provide information to guide effective interventions with that population.

Purpose of the Study

The purpose of this study was to assess the effectiveness of communication with elderly mental health clients regarding medication concordance. Clients were at least fifty-five years old and receiving mental health services within San Bernardino County. The study gathered information directly from clients through the use of one-on-one interviews. This study identified when, whether, and with whom elderly mental health clients discuss medication issues. The study evaluated the client's perception of the effectiveness of that communication in reaching concordance on their medication regimen.

An elderly mental health client who is not taking prescribed medications, or is not taking them correctly,
is at risk for unnecessary physical and mental health problems. Addressing the problem of non-compliance requires recognition of the problem, assessing the reason for non-compliance, and resolving the non-compliance issue to the client’s satisfaction. This study sought to understand when and why clients engage in a medication discussion, with whom, and their level of satisfaction after the discussion. Understanding client communication goals and barriers will help social workers gain medication concordance.

There has been considerable study of non-compliance. Most studies hypothesize a cause for non-compliance, make changes to eliminate that cause, then measure whether compliance improves.

Factors that have been identified for non-compliance include: where mediation costs were a problem compliance was often poor (Klein et al., 2004, p. 780); complexity of the regimen leads to non-compliance (Sclar, 1991, p. 437); and non-compliance is most frequent for medications prescribed for less serious conditions and healthier individuals. (Caskie & Willis, 2004, p. 183)
Though it is acknowledged that patients often make changes to a medication regimen without consultation with a healthcare provider, understanding of when and with whom compliance discussions take place and perceived client satisfaction with that discussion seems lacking in the literature.

It is important to view elderly mental health clients as a distinct population because there are important differences between the elderly mental health client population and the general mental health client population. “In comparison with younger subjects, the elderly population reports a higher rate of depressive symptoms but a lower rate of more severe depressive symptoms” (Baca et al., 2006, p. 337). Comorbid anxiety disorders are associated with more severe depression symptoms and a higher incidence of suicidal ideation in elderly clients (Lenze et al., 2002, p. 754). One study found that 90.7% of elderly mental health clients had other medical conditions and 83.5% were taking other medications (Baca et al., 2006, p. 338).

Using a qualitative approach, this study examined older adults currently being treated for a mental health issue with medication, counseling, or both at West End
Family Counseling Center in Ontario, California. Clients come from a variety of ethnicities and social classes. The study excluded elderly who are currently institutionalized or hospitalized. Clients were at least fifty-five years of age and living in their own home, with a family member, or in an independent living facility.

The study was conducted face-to-face interviews. Eleven elderly mental health clients participated. Interviews were be guided by a Rapid Assessment Instrument. The instrument contained about twelve open-ended questions. A small amount of demographic information was also gathered. Studies have found that respondents are most willing to answer sensitive questions face-to-face (Grinnell, 2001, p. 304).

Significance of the Project for Social Work

There are four primary reasons why examining the reasons for non-compliance among elderly persons is important for social work practice:

1. This is a growing problem as the aging of the baby-boom generation means that by 2011 there will be forty million people sixty-five years
or older and by 2040 seventy-seven million.
People aged eighty-five and older are the fastest growing population segment and today make up 12% of the population (Schwab, Leung, Gelb, Meng, & Cohn, 2003, p. 353).

2. Non-compliance creates other social problems such as workload and stress to caregivers, additional burdens on the health care system due to hospitalizations and emergency room visits, and decline in quality of life for the patient.

3. Treatment plans for elderly clients with mental health problems can be seriously compromised by a lack of medication compliance which can cause health problems related to both mental and physical illness. Development of a medication concordance with a patient can improve the therapeutic alliance and give the patient an opportunity to discuss concerns (Banning, 2004, p. 15).

4. Lessons learned about communication barriers to developing medication concordance may be generalizable to other populations.
The study focused primarily on examining steps within the Assessment phase of the Generalist Model. It is critical that the social worker identify medications which have been prescribed to an elderly mental health client and determine whether they are being taken as prescribed, and whether there are any issues with the medications. Findings from the study will inform the Planning and Implementation stages of the Generalist Model. The planning stage should create a strategy to make compliance possible and implementation of the strategy is designed to reach concordance with a client on a medication regime, recognizing the associated risks and benefits. As with most uses of the Generalist Model, the process is circular and steps may need to be revisited over time.

The question which this study addressed is: What are the obstacles to effective communication with elderly mental health clients about medication concordance? It was this researcher’s hope that the study’s outcome would provide insight into the most effective process for identifying and resolving medication issues in this population. Armed with that information social workers
will be able to more effectively develop medication concordance with clients.
CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will review literature on communication with elderly mental health clients regarding medication concordance. This literature review will cover five distinct domains. The domains are: a) studies of elderly persons with mental health issues, b) medication compliance among the elderly, c) mental health counselors who work with the elderly, d) psychotropic medications and the elderly, and e) communication with elderly clients. It also will discuss theories which will guide the conceptualization of the study.

Studies of Elderly Persons with Mental Health Issues

Studies by Kawamoto et al. (2003) and Toseland et al. (1999) both examined community dwelling elderly and the impact of their illnesses. Both studies found that lack of treatment and care options caused further withdrawal from the community. Kawamoto et al. (2003) identified that depression caused a decline in clients' physical functioning which resulted in withdrawal from
work and other activities while Toseland et al. (1999) determined that service availability to caregivers strongly influenced whether a dementia patient stayed in the community. Kuruvilla et al. (2006) and Lenze et al. (2003) both examined treatment options for depression. Kuruvilla et al. (2006) obtained the views of depressed clients on treatment options finding that antidepressants and psychotherapy are well accepted and ECT is not. Lenze et al. (2003) studied depressed elderly persons with concurrent symptoms of anxiety and found the quality of clinical management had more influence on treatment outcome than the medication chosen. Gruber-Baldini et al. (2004) linked mental health issues and undesirable behavioral symptoms and found that mental illness is prevalent in residential care and assisted living facilities.

Medication Compliance among the Elderly

Klein et al. (2004) and the Mitchell et al. (2001) both found that where medication cost was a problem, compliance was often poor. Klein et al. (2004) identified elders with low income, high out of pocket prescription costs, and poor health as most vulnerable to medication
delays and Mitchell et al. (2001) predicted non-compliance among African Americans, those in poor mental health, and those who find payment difficult. However, Caskie and Willis (2004) found non-compliance was most frequent for medications prescribed for less serious conditions and healthier individuals. Kihlstrom (1998) found that while managed care provides new systems and methods for tracking adherence, communication with patients and interventions need improvement. Sclar’s literature review (1991) found that complexity of the regimen is a leading factor in non-compliance and recommends the intervention of a medication review to simplify regimens.

Mental Health Counselors Working with the Elderly

Both Schwiebert et al. (2000) and Langer (2004) proposed methods for counseling older adults. Schwiebert et al. (2000) recommends a decision-making model using the principles of fidelity, autonomy, and beneficence to assess the counseling relationship with the elderly and to ensure that the best interests of the client are maintained. Langer (2004) found that in counseling older adults the primary focus should be on strengths and
problem solving rather than diagnosis and assessment. Myers and Shelton (1987) recommend increasing knowledge of elders and their families about the aging process and care giving to reduce the likelihood of elder abuse.

Psychotropic Medications and the Elderly

The findings by Schaffer et al. (2006) and Baca et al. (2006) validate the efficacy of the use of psychotropic drugs with the elderly. Schaffer et al. (2006) found that clinicians should be aware of the value of antidepressants to prevent unnecessary hospitalization for mania for this population, and Baca et al. (2006) documented a decrease in depressive symptoms using Venlafaxine. Sewitch et al. (2006) determined that female elderly patients were less frequently prescribed first line pharmacotherapy for depression and that sustaining an ongoing relationship with the doctor prescribing the medication was a strong indicator for compliance. Givens et al. (2005) and Estes and Binney (1989) provide a cautionary note about psychoactive medications for the elderly. Givens et al. (2005) found evidence that clients "view medications with caution and resist taking them" (p. 150), and Estes and Binney (1989) determined that
geriatric specialists propensity to view aging as a medical problem reduces the recognition of the importance of social and behavioral factors in health and aging.

Communication with Elderly Clients
Smith (1998) and Smith et al. (1994) found that patients value thorough information on medications but that doctors do not raise the topic of adherence frequently. Charles et al. (1996) found a lack of information provided on drug side effects was a key area of patient dissatisfaction in hospital care. Niven (2006) identified that older patients are more adherent but non-adherence is less easily detected.

Theories Guiding Conceptualization
There are several theories which guide the conceptualization of this study.

Saleebey challenges Strengths Based practitioners, "People are always working on their situations, even if just deciding to be resigned to them; as helpers we must tap into that work, elucidate it, find and build on its possibilities" (Saleebey, 1992). His research looks to the client's singular knowledge of medications' effect on their physical and emotional health as an asset to the
healing process and asks whether healthcare providers empower them to share that knowledge. In defining Empowerment Based Practice, Torre says it is, “a process through which people become strong enough to participate within, share the control of, and influence events and institutions affecting their lives” (Torre 1985).

The principal of Strategic Solution Focused Therapy has been described as, “‘If it works do more of it.’ ‘If it doesn’t work, don’t do it any more. Do something different’” (Quick, 1996). This approach is reflected in the behavior of many elders in their process of changing or discontinuing the use of medications.

Summary

This chapter reviews literature on communication with elderly mental health clients regarding medication concordance. It covers five distinct domains. The domains are: a) studies of elderly persons with mental health issues, b) medication compliance among the elderly, c) mental health counselors who work with the elderly, d) psychotropic medications and the elderly, and e) communication with elderly clients. The chapter also
discusses theories which guided the conceptualization of the study.
CHAPTER THREE

METHODS

Introduction

This chapter will review the methods used to obtain and analyze data for this study. It will specifically describe a) study design, b) sampling, c) data collection and instrument, d) procedures, e) protection of human subjects, and f) data analysis.

Study Design

The purpose of this study was to examine communication between elderly mental health clients and professionals on the topic of medication concordance. The research question was: What are the obstacles to effective communication with elderly mental health clients about medication concordance?

The study used a qualitative method to solicit information on when, whether, and with whom elderly mental health clients discuss medication issues and their satisfaction with the outcome of those conversations.

The interviews were conducted by this researcher; the sample was 11 participants. This method allowed for
an in-depth face-to-face analysis. This researcher expected to find that older adults are infrequently asked about medication concordance and that the client rather than the professional most often raises the topic. It was also expected that client satisfaction ratings on results of the conversations would not be high.

The limitations of the study were a small sample size and while the study focused on the elderly, the oldest old were not represented.

Sampling

Participants for the study were drawn from clients of the West End Family Counseling Services agency in Ontario, CA. Participants were at least 55 years old and being treated for a mental health issue with medication, counseling, or both.

The process of screening participants was as follows. The researcher was given a list of the West End Family Counseling Services clients aged 55 years or older. The list identified the therapist for each client. There were a total of nine therapists. A form was sent to each therapist. The form explained the study, identified the therapist’s clients who were potential participants,
and requested the therapist's evaluation of whether the client had the mental acuity to safely participate. See Appendix A for a sample of this form. All nine therapists returned the completed forms.

The method chosen, to recruit only participants from an agency treating elderly mental health clients, was in order to provide the safeguard of the therapist evaluation of suitability for inclusion. If instead, volunteers had been solicited from the general elderly population, participants without the mental acuity to understand the decision to participate might have been unwittingly included.

From the total client base of West End Family Services, forty-one potential participants were identified. Thirteen clients were deemed unsuitable for the study by their therapist. Four clients spoke Spanish only and were excluded because this researcher could not interview them in that language. The twenty-four remaining potential participants were asked to participate. Eleven clients did not respond. Thirteen clients agreed to participate but two later withdrew. Eleven clients completed the interview process. The
clients interviewed were made up of nine women and two men. The clients’ ages were between fifty-six and eighty.

Data Collection and Instrument

Because there is no standardized instrument on this topic, the questions are based on key themes in the literature.

This study asked the following questions: How many medications are you currently taking each day?, In the past two years have you not taken a prescription medication or taken less than the dosage prescribed? If yes, what was the medication?, Did you discuss the change in medication with someone? If yes, with whom?, Did that person raise the topic of medication or did you?, When and where was this discussion held?, What was your goal in discussing the medication?, How helpful was the conversation in resolving your questions or concerns?, What would have made the conversation more helpful?, Did you feel you had sufficient input in decision making about the medication? Did you discuss the problem again with this person or someone else?

If the participant responded No to the question of: In the past two years have you not taken a prescription
medication or taken less than the dosage prescribed?, the following question was inserted. In the past two years have you had any concerns about a medication or its side effects? If yes, did you discuss the medication with someone? The remaining questions were the same. If the participant answered no to both of the compliance questions, indicating full compliance, the interview was complete.

Demographic data collected included the nominal variables of sex, mental health diagnosis, and living situation, the interval variables of age and how long in counseling, and the ordinal variable of level of education completed.

The weakness of the instrument was the potential propensity to give a socially desirable response. The study asked elderly mental health clients in this agency to admit that they are not taking their medications as prescribed and to think critically about who helps them with medications issues. It required a willingness of participants to be open and honest about an important health topic.
The instrument was pre-tested by conducting an interview with a mental health client in the community. See Appendix B for instrument.

Procedures

The screening process produced a list of twenty-five potential participants who passed the therapists' review. A flier was then sent to the potential participants telling them about the study and asking them to volunteer to participate. If the client wished to participate they signed the form and provided a phone number to be contacted. Fliers could be mailed back in a preaddressed stamped envelope to the agency or hand delivered at the client's next appointment. See Appendix C for flier.

Once the client returned the form agreeing to participate, this researcher phoned to set a time for the interview. The potential participant was told that the interview would take fifteen to twenty minutes, that participation was totally voluntary and had nothing to do with continuing to receive services at West End Family Counseling, that their answers would be entirely confidential, and that they would receive a $5 gift card for their assistance. If the participant confirmed their
willingness to become part of the study, this researcher and the participant set a date and time for the interview. Interviews were held at the West End Family Counseling Services agency in Ontario, CA. Three participants were interviewed over the telephone because mobility, health, or transportation made coming to the West End office overly difficult.

Interviews were held during the winter quarter of 2007. They took place during the day and early evening, over the course of 5 weeks. Eight interviews were held in a conference room at the agency, two were held by telephone, and one was held at the Ontario Senior Center.

The participants interviewed in person were seated in a conference room with this researcher, the study was described, the informed consent reviewed, and the interview conducted. Then the participant was thanked and presented with the gift card and a copy of the debriefing statement. Participants interviewed by telephone were mailed the gift card and debriefing statement. A copy of the informed consent information is included in Appendix D. The Debriefing Statement is included in Appendix E.
Protection of Human Subjects

This researcher conducted all interviews. The data gathered in the interview was taken to the home of this researcher at the end of each day. No data was left at West End Family Counseling Services. The data was kept in the researcher’s home in a box with a lock.

Confidentiality was insured by identifying participants with a number and not associating that number with a name. Informed consent, debriefing, and privacy during the interview are discussed in the preceding section.

Data Analysis

This study used qualitative cross-tables and categories that were extracted and recorded by hand. Such tables are common among qualitative researchers.

The study sought to determine whether there was a correlation between the professional that the elderly mental health client chose to discuss their medication issue and their level of satisfaction with the outcome.

Summary

This chapter provided information on the study of elderly mental health clients at West End Family
Counseling Services agency about communication on medication issues, including a) description of the design of the study, b) the sample, c) data collection and instrument, d) procedures followed, e) how the human subjects were protected, and f) how the data was analyzed.
CHAPTER FOUR

RESULTS

Introduction

This chapter provides a summary of the study results. Eleven mental health clients aged fifty-five and older were interviewed to examine and understand their communication about medication concordance with healthcare providers. A single round of interviews was conducted.

Presentation of the Findings

This sample was composed of older adults who are mental health clients. Participants were drawn from West End Family Counseling Services (WEFCS) clients aged 55 years and older. There were a total of forty-one clients who made up the pool of eligible participants. Thirteen clients (32%) were withdrawn from the pool by their therapist. Four clients (10%) were not included because they were Spanish speaking only. The remaining twenty-four clients (58%) were solicited to participate. Thirteen (32%) clients did not respond to the solicitation to participate. Two clients (5%) agreed to
participate but later withdrew. Eleven clients (27%) completed the interview process.

Interviews were scheduled at the participants’ convenience. Eight interviews were held in a conference room at West End, two were conducted by telephone, and one was held at the Ontario Senior Center. Each participant was given as much time as needed to answer the questions.

Participants ranged in age from 57 to 80. The average age of participants was 64.5 years (S.D. = 8.3 years). Participants’ average age was 2.3 years older than the average age of the WEFCS clients eligible to participate, 62.2 years. The average age of clients eligible to participate that did not respond to the request for participation was 58 years (S.D. = 2.7 years). A T-test comparing the mean ages of participants (64.55) with that of non-respondents (58.36) was significant (t = 2.350) (df = 12.146). The oldest persons in the pool of eligible participants were two people aged eighty years old. One of those persons participated in the study and one did not. The youngest potential participants from the pool of eligible participants were two clients 55
years old. Both of these clients were withdrawn by their therapists. 

There were two male and nine female participants. Male participants made up 22% of the study population. The percentage of men in the pool of eligible participants was 12%. Both of the males in the study lived with another person and all of the females lived alone.

Length of time in counseling ranged from two months to five years with three participants not currently receiving counseling and an average duration in counseling of 16.75 months (S.D. = 17.2 months).

For a summary of demographic data refer to Table 1 (Appendix F).

The questions in the taped interview were designed to gather information on the topic of communication about medication and achieving medication concordance. Two main themes were recognized which related to participants' commitment and motivation to establish and maintain relationships with healthcare providers who they experience as willing and able listen to and respond to their needs. A secondary theme about the need to
strategize with healthcare providers to resolve insurance
prescription coverage issues was also identified.

The following is a list of the questions in the
questionnaire. A summary of the purpose, results, and
integration of themes is provided for each question.

1. How many medications are you currently taking each
day?

The purpose of this question was to determine the
extent of use of prescription drugs by participants.

The participants took between five and sixteen
medications per day with the average number of
medications taken being 7.8 (S.D. = 3.8 medications).
This researcher did not attempt to capture the names of
all of the medications taken. Some participants mentioned
vitamins, eye-drops, and oxygen in the medications
reported but those items were not included in the count.

2. In the past two years have you not taken a
prescription medication or taken less than the dosage
prescribed?

This question was used to establish whether the
participant had been non-compliant. The timeframe of the
previous two years was to focus on recent events. If more
than one event was identified during that timeframe the
most recent situation was discussed. If there was no non-compliance in the previous two years the participant was asked about any non-compliance regardless of timeframe.

Ten out of eleven participants identified a time when they had not taken a prescription medication as prescribed. Eight respondents (73%) identified non-compliance in the past two-year period and two respondents (18%) indicated that the event was more than two years previously. One participant stated that he had never had any problem with medication or side effects and had never taken less than the dosage prescribed.

3. If yes, what was the medication?

The reason for asking this question was to attempt to determine whether non-compliance was more frequent with specific drugs or types of drugs.

Four participants (36%) identified a specific prescription drug:Prevacid, Effexor, Prozac, and Norvasc. Three participants (27%) identified a medication by type/purpose: water pill, depression medication, and sleep medication. Two respondents (18%) stated that their non-compliance event involved ceasing all medication. One respondent did not state the type of medication involved.
The final participant had never taken less than the dosage prescribed on any medications.

4. Did you discuss the change in medication with someone?
   If yes, with whom?

   The purpose of this question was, in part one, to identify whether the participant had made a medication change without consultation with a healthcare provider. If the answer to the first part of the question was positive the second part was intended to ascertain whether the client discussed this change with a healthcare provider and if so, which kind of provider.

Nine out of eleven participants (82%) discussed the medication change with someone. Participants most frequently discussed the medication change with the prescribing physician. The prescribing physician was in four cases (36%) the primary care physician and in the four other cases (36%) the psychiatrist. One participant had a discussion with her son, who she described as a hospital worker. One participant made changes without discussing the change with anyone and one participant made no changes.

This question began to reveal the theme of clients' motivation to find healthcare providers with whom they
feel comfortable and feel they can communicate. "You see my doctor is a diabetic too...I've got a nice doctor." "I don't want to change doctors because I like the doctor." "She's a good doctor, you know."

5. Did that person raise the topic of medication or did you?

The intent of this question was to determine whether those conversations were initiated by the healthcare providers or by the client in order to analyze communication patterns about medication concordance.

Four clients (36%) reported that they raised the topic of medication compliance with their primary care physician or psychiatrist. "Always when the doctor gives me a prescription I always be concerned about it. After I find out what it's all about then I'm Okay about it." "I always discuss it with my doctor, she knows what I'm doing." "I told him sometimes I don't take it when I go out." These three responses reinforce the theme of clients' taking responsibility for sharing information and communicating with the healthcare provider. In three cases (27%) the doctor raised the topic of medication changes. "They always ask, every month." One participant (9%) got a letter from her insurance company which caused
her to raise the problem with her primary care physician. "They (the prescription insurance provider) gave two options of things we could use...But he (the doctor) maintained that neither one of those were anything he would have prescribed." The participant (9%) who spoke with a family member raised the question herself. The participant who had no history of non-compliance mentioned that his psychiatrist asks him about medications at each office visit.

6. When and where was this discussion held?

This question was aimed at getting information in situations when clients were the instigator of the communication. It seeks to determine whether the client made a special effort to contact someone at the time the medication change was made. If the communication on compliance took place during a regular office visit, this might indicate perceived lower urgency than a phone call to a healthcare provider.

Of the eight participants who had a discussion with a healthcare provider, seven of the discussions (88%) were held at a regular office visit. One participant (12%) telephoned her doctor between office visits to have
the discussion. The participant who discussed her concern with a family member did so by telephone.

7. What was your goal in discussing the medication?

This question was used to establish the motivation of the participants in the discussion. Anticipated possible responses were: change of medication, mitigation of side effects, and seeking information.

Of the eight participants who had a discussion with a healthcare provider four (50%) had concerns about side effects and were seeking information or medication changes to resolve those problems. Two clients (25%) indicated their motivation was to resolve a problem with the medication or dosage, "It wasn't working anymore."

One participant’s (12.5%) goal was to discontinue a medication; "Ideally I didn’t want to need the medicine when I could do it naturally with changing my diet." One client’s (12.5%) problem was related to insurance coverage of a medication. The goal of the client who had a conversation with a family member was to identify a way to organize medications to make compliance easier.
8. How helpful was the conversation in resolving your questions or concerns?

The purpose of the question was to evaluate the participants' level of satisfaction in getting their needs met and achieving the outcome which they were seeking.

Two participants (22%) felt that the conversation resolved the medication problems and felt positively about the outcome achieved. Three more participants (33%) felt positively about the outcome of the conversation but were unsure of the resolution because of insurance coverage issues for the medication. Four participants (44%) did not feel that the conversation resolved the issue to their satisfaction.

This question probed a key area in the theme of responsibility for quality communication between the client and the healthcare provider. Responses to this question were illuminating about the client's views on the client/provider relationship. "I just told him, I'm not going to take it." "I think he understands the problem I was having." "I always said, well, he saved my life so I appreciate him for that."
9. What would have made the conversation more helpful?

This question sought to identify weaknesses in the communication process about medication concordance and whether clients have suggestions for improvement.

Four participants (44%) stated there was nothing that would have made the conversation more helpful. One of them gave a very strong endorsement of her healthcare provider's communication, "Dr. ___ understands me and she writes everything down where a four year old can understand it and she'll even call me sometimes, you know, just to check on me and I appreciate that. She don't have to do that." Three other participants' (33%) responses were tied into the theme of the need to strategize about prescription coverage. They felt that knowing if insurance would cover the medication would have been helpful in resolving the issue. One participant felt that she needed a thorough physical exam for further diagnosis of her problem. "My main problem is I need a thorough, thorough physical." One participant wanted the doctor to further diagnose a side effect. "I guess I thought he could run some kind of test and find out."
10. Did you feel you had sufficient input in decision making about the medication?

This question also asked clients to evaluate the medication discussion in order to determine whether the interaction with the healthcare provider was part of a unilateral decision making process or participatory and empowering.

Six out of nine participants (66%) who had a conversation about medication compliance felt that they had sufficient input in the decision making process. However, three clients reported that they felt the choices for resolution were limited not by the doctor but by insurance coverage for medications. In all three cases, insurance did eventually cover the medication prescribed. There were three participants (33%) who felt that they did not have sufficient input.

This question dealt with the theme of responsibility and partnership between the client and the healthcare provider. Responses indicate whether the client felt empowered as part of the decision making process. Three responses illustrate client/healthcare provider relationships which demonstrate the theme of shared responsibility: “I’m very fortunate that I’ve finally got
a physician that I felt he listens, he actually hears me." "He told me to see how that worked and if it didn’t work, call him back."

One response from a client who had experienced significant problems with side effects indicated adversarial feelings about her physician. "I don’t believe in these doctors anymore. These doctors are in cahoots with the pharmaceutical companies. They get a kickback on everything that they push . . . I think they make us guinea pigs.

11. Did you discuss the problem again with this person or someone else?

The intent of this question was to determine whether the participant considered the problem resolved or if additional information or other solutions were sought.

Seven of the nine clients (72%) who had a discussion did not seek a second conversation about the problem. One participant was unable to make the medication change recommended and planned to discuss it again at his next visit. One participant found that the medication change agreed on in the discussion with her psychiatrist did not resolve the problem and had a second conversation and a second medication change at a later date.
The theme of shared responsibility and partnership between the client and the healthcare provider surfaced again in these responses. The clients' answers demonstrate that partnership. "She wants me to come in often like I'm supposed to and I have to take my book with me so she can see how my sugar is running and everything." "He didn't think the insurance company would pay for it, but we tried it anyway and they did."

Summary

This chapter reported the study results. Responses were analyzed from eleven interviews of elderly mental health clients. Demographic information was provided. Details of the demographic information can be found in Appendix F. The purpose of each question and the information sought was identified and the results for each question were presented. The responses of the participants in this study showed some common themes about their communication with healthcare providers related to their feelings of responsibility for communication with healthcare providers and motivation to find healthcare providers who suit their needs. An additional theme of the need to strategize with
healthcare providers to resolve insurance prescription coverage issues was identified.
CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the narrative data collected from elderly mental health clients receiving care in San Bernardino County. The findings are presented in relation to three major themes which were found in interviews about perceptions of communication with healthcare providers.

Discussion

This research expected to find low satisfaction of older adults with healthcare providers, that they were infrequently asked about medication concordance and that the client rather than the professional most often raised the topic. Although the data did not confirm the expected finding of low client satisfaction ratings, it was found that the client rather than the professional most often raised the topic of medications and side effects. The study provided useful information about elderly mental health clients' attitudes about healthcare providers and their relationships and communication with them.
It is worth examining two areas of the demographic data which stand out as meaningful age of participants versus non-participants and rate of participation.

There was a significant difference between the average age of those eligible to participate that did not respond and the participants. The average age of participants’ was 2.3 years younger than the average age of clients eligible to participate and the standard deviation between the ages of non-participants was much smaller than that of participants. The T-test comparing the mean ages of participants with that of non-respondents was significant. Non-participants were all between the ages of 56 and 63. People between those ages are more likely to be working and have less free time and this may have prevented their participation. Older adults who are still working would be likely to have more disposable income which would have made the incentive of the gift card less valuable. Finally, the younger, older adults may be more mobile and have more social interactions and so might not have been as motivated to seek out the personal contact provided by participation.
The participation rate was high, 27% of clients eligible to participate completed the study. In evaluating this high participation rate it is worth noting that, in order not to pressure clients to participate, the recruitment process was fairly cumbersome. Clients were solicited by mail and to be part of the study they either mailed or brought back a form to the agency. Once the older adult agreed to participate, an interview was scheduled and 72% of those interviewed traveled to the interview location. This expenditure of time and effort to accept, schedule and arrange transportation to the interview shows considerable commitment.

There are several factors which could help to explain the high participation rate. It is likely that the topic of medications and healthcare providers is one of interest to many older adults. The request to participate may have been particularly inviting. Several participants mentioned their eagerness for the gift card. One went so far as to mention to her therapist how much she had enjoyed going to Denny’s with her gift card. While the value of the card was kept at a small amount to avoid financial pressure to participate, for people with
a limited income it may have been just enough to enable them to justify having a meal out.

It seems likely that the most important factor leading to a high participation rate was institutional transference. West End Family Counseling Services provides critical services to this population and a request to help with a study at that agency was clearly well received by the clients.

The narrative data collected from the interviews were analyzed to determine relevant factors that contributed to the participant’s perceptions about communication with healthcare providers about medications. Responses were then analyzed for significant themes that describe the beliefs of the elderly mental health clients.

The two main themes involved participants’ commitment and motivation to establish and maintain relationships with healthcare providers who they experience as willing and able listen to and respond to their needs. A secondary theme identified was the need to strategize with healthcare providers to resolve insurance prescription coverage issues.
The following is a discussion of the questions and participants' responses which illuminated the three themes.

1. How many medications are you currently taking each day?

The findings from this research differed from other studies in the literature, as in this study all participants took medications and were taking an average of 7.8 medications per day. Smith's study of older adults and side effects (Smith, 1994, p. 202) found that 90% took medications averaging 3.8 medications per day and another study found 93.7% taking medication with an average of 4.0 per day (Smith, et al, 1987, p. 282). Mitchell's study of rural elders medication management only included participants taking medication and found an average of 3.8 medications taken per day (Mitchell et al., p. 349).

The fact that 100% of the participants in this study were taking medications can be explained by the recruitment process. As the flier inviting clients to participate indicated that the study was of older adults and medication; people who were not taking medication may have felt they were not the target of the study.
The second notable difference in the findings between this study and others is the higher average number of drugs being taken by participants. Two probable explanations for this are the study population and the study timing. First, this study specifically targeted elderly mental health clients. This population would be likely to be prescribed psychotropic medications as well as medications for physical ailments. Second, the three studies used for comparison were conducted between 1987 and 1997. Prescription drug use has been growing a double-digit rate annually since 1980 (Mitchell, 2001, p. 348). This trend means that the number of drugs taken by study participants would have been likely to rise. Additionally, the other studies predated the prescription drug coverage plans provided by Medicare. All participants in this study had Medicare coverage. The addition of the coverage may have allowed older adults to afford to take more prescriptions by relieving them of some of the financial burden.
2. In the past two years have you not taken a prescription medication or taken less than the dosage prescribed?

All but one of the participants reported a non-compliance event. Reasons for the non-compliance were not specifically asked but were often revealed in subsequent discussion. The primary reasons were drug effectiveness, side effects, and insurance coverage. Almost all participants had clear reasons for the non-compliance. They reported that they stopped taking the medication because of a problem and once the problem was resolved resumed adhering to their medication regimen.

3. If yes, what was the medication?

The medications mentioned in the non-compliance events were widely varied. The commonality was that there was a problem with the medication not the medication type.

4. Did you discuss the change in medication with someone?

If yes, with whom?

There were eight participants who discussed the medication change with a healthcare provider, in all cases the prescribing physician. This finding is in
agreement with the study which found that older adults “look to their physicians for information about medicines” (Smith, 1994, p. 200).

Participants made a change to their medication before discussing it with their physician but afterward wanted to make the doctor aware of the situation and consulted about the change. The commonality of experience was that client felt empowered to make a decision about whether to take a medication when they had a problem but sought a physician’s advice about how to resolve the problem.

The theme of finding a healthcare provider able to listen and respond to their needs emerge in the responses to this question. The theme was evidenced in statements such as “She’s interested in me.” “He understands when there is something really important that happens to me.”

5. Did that person raise the topic of medication or did you?

Five of the discussions about medications were initiated by the client. In one case this was instigated by a letter from an insurance company. The clients’ initiative to seek information from their doctor continued to develop the theme of their desire to have
healthcare providers with whom they could communicate effectively. Clients showed a desire to discuss problems with their physician and a willingness to abide by the doctor’s decisions once they had the discussion. “He did say take it and I did start it again.” “When I told her I stopped the Paxil she said that’s why you’re so depressed and I started right back on it.” “He took me off Effexor because it just stopped working.”

In the three cases where the doctor raised the topic of medications the participants indicated that it was routine for the topic to be discussed at each office visit. “He always asks, every month.” This is an indicator that many doctors have a practice to check on medication compliance.

There was one participant who chose to consult a family member instead of a physician about her medication issue. The advice sought was not about a medication, but about a method for organizing her medications to ensure that she took them correctly.

The one participant who did not discuss the medication compliance issue with anyone reduced medication dosages to delay refilling prescriptions. She said that “Once or twice last year I did it because of
problems with money sometimes." She was confident she knew which medications were most important and which could be delayed or reduced. She was making the decision to be non-compliant based on financial necessity and did not see a reason to discuss this temporary change with her doctor. The literature shows that five percent of older adults delay medications because of cost (Klien, 2004, p. 783).

6. When and where was this discussion held?

Seven out of eight of the participants waited for a regular office visit to discuss the medication change. Participants felt that they had enough information to make a determination to stop or reduce the medication until they could speak to their doctor about the issue. The one participant who needed an immediate answer about dosage phoned her doctor between visits.

7. What was your goal in discussing the medication?

In all cases the clients' goal was to resolve a question or problem about a medication. "I'm very much one for being educated on what I'm taking and being forthright with my physician. Very important."

The findings in this study that half of the participants' conversations were instigated by a concern
about side effects are consistent with the literature. A study on communication with the elderly about medications found that clients want to hear about all side effects "even those with a small possibility" and that "adverse drug reactions increase with increasing age" (Smith, 1998, p. 204).

8. How helpful was the conversation in resolving your questions or concerns?

The responses to this question dealt with the major theme of client commitment and motivation to get what they need from healthcare providers. "You have to be prepared with questions and be assertive to get answers. Also you need to get there on time."

Five of the eight participants reported feeling positive about the communication and that it was helpful in resolving the compliance issue. This is in agreement with studies that suggest, "patient satisfaction is positively related to compliance with clinical advice" (Kihlstrom, 1998, p. 373).

Several clients described strong long-term relationships with healthcare providers and feelings of confidence and partnership. "He’s known me for twenty years so he, pretty much, you know, knows what’s going
on. I feel confident with him. ” “She gave me some pamphlets to read and to think about it and let her know. ”

Two of the four participants who did not feel the conversation resolved their issue had problems which they attributed to side effects that the doctor was unable to resolve. It is possible that the doctor believed the somatic symptoms were not side effects of the medication mentioned by the patient. Research has shown that “depressed patients anticipate adverse drug effects and that “people with anxiety tend to be fearful of medications and have increased somatic symptoms that they misinterpret as adverse effects” (Lenze, 2002, p. 756).

The two clients indicated that they experienced lots of side effects. “I usually have some of the side effects that come from the medicine.” “Some of it has a tremendous amount of side effects and they have to realize that everything affects people differently.”

9. What would have made the conversation more helpful?

It is significant that four of the participants felt that they got all that they needed from the healthcare provider and that nothing would have made the conversation more helpful. The theme of clients feeling
responsible for communication and motivated to change healthcare providers when the communication is inadequate, were central to this question. “I always see a doctor I can communicate with. If I cannot communicate with a doctor then I know it’s not a good match.” “I told him it wasn’t working for me so he gave me a new prescription.”

The other theme that was prominent in this question was the need for partnership between clients and healthcare providers to resolve issues with prescription medication insurance coverage. Three clients whose problem was resolved by a medication change were satisfied with the doctors’ response but were uncertain whether insurance would cover the new medication. “We were worried whether or not it would be covered by my insurance. I could not afford it otherwise.” “It did pay for it, that’s why I’m on it now.” “He didn’t think my insurance company would go for it but they did.”

10. Did you feel you had sufficient input in decision making about the medication?

This question reinforced the themes of responsibility and satisfaction with communication. The majority of participants felt they had sufficient input
in decision making stating, "he knows me", "my doctor understands me", "it was helpful".

These high levels of satisfaction may indication alignment with research which found that "older patients appear to be more reliant on their physician and less desirous of sharing in medical decisions" (Smith et al., 1994, p. 283). This study found that most participants valued consultation and information sharing with a healthcare providers. They sought out physicians who they felt listened to them, answered their questions, and cared about them. When this kind of rapport was in place they felt confident in following the doctors guidance. "I always discuss it with my doctor, what I'm going to do.”

"So, he told me what to do and I done it."

11. Did you discuss the problem again with this person or someone else?

Only two participants raised the medication question again a second time and in both cases it was with the same healthcare provider. Both problems involved change of dosage and the second conversation involved making additional adjustments.

The very high resolution rate found among the remaining participants reinforces the theme that
successful patient/healthcare provider relationships are marked by effective communication. Some participant remarks which characterize that relationship are: “when things are important he takes care of it right away, when it’s not he doesn’t harp on it”, “I like to have a woman doctor, it’s better for me”, “I used to be shy about asking questions but now I need to get my answers”.

Limitations

There were several limitations of this study. First, the small sample size of eleven participants prohibits generalization to a wider population. The fact that only two men participated and one of the two had no experience with non-compliance makes the generalizability of the results to men in the cohort questionable.

Second, only clients seeking services at one mental health agency in the county were studied and only those clients deemed by their therapist competent to safely participate were solicited. In addition, of those eligible to participate, clients self selected as to whether to volunteer. This may have skewed those studied toward those with an unknown factor that led them to respond.
Two qualities are obvious in the participants who volunteered. The average age of participants was 64.5 years which is 2.3 years older than the average age of the WEFCS clients eligible to participate, 62.2 years. That might suggest that clients on the younger end of the cohort had less time available and so did not volunteer. The second factor which may have influenced participation was that clients with more positive feelings about the agency and care received there would be more likely to volunteer to participate. This process of institutional transference was reflected in comments by two participants when they agreed to be part of the study. Each stated that they would like to “give back” to West End because they were grateful for the assistance they had received there.

A final limitation noted was that the participants did not include the oldest-old. The oldest-old is defined as adults aged eighty-five and older (Hooyman & Kiyak, 2005, p. 15). The oldest participant in the study was aged 80 and the oldest persons being served by the agency were both aged eighty.
Recommendations for Social Work Practice, Policy and Research

The study provided narrative data from the participants on healthcare they are receiving and the professionals providing that care. This study provides social workers with a view of factors which influence communication about medication concordance and its effectiveness. Further research to identify factors which establish, sustain, or damage client/provider communication could be useful in propagating productive communication.

Social work practice could be informed by this study to provide additional services needed by this cohort. Two clients mentioned that they would like to be part of a seniors' support group but had been unable to find one in their area.

The findings also indicate that elderly mental health clients do not often raise medication questions with social workers. Therefore, if social workers are to be part of the medication concordance process, the impetus is on social workers to raise the topic with clients. The study indicates that the best role for social workers may be to encourage clients to advocate
for themselves, to find the best healthcare providers available and those they can communicate with effectively.

Conclusions

This study found that elderly mental health clients actively seek healthcare providers with whom they feel comfortable and confident. They also feel a sense of responsibility for getting the information they need and understanding adequately the medications they are taking. The study results point to a need for study of factors which promote, sustain, or damage elderly mental health clients’ communication with healthcare providers.
APPENDIX A

CLINICAL STAFF REVIEW FORM
CLINICAL STAFF REVIEW FORM

To: (Clinical Staff Member's Name)
From: Eva Miller – MSW Intern
Date: December 1, 2007
Subject: Research study on medication compliance with elderly mental health clients

I am conducting a research study about communicating with older adult mental health clients on medication issues. Study participants are being recruited from West End clients. I am looking for your help to assess whether client's of yours who meet the age criteria are appropriate for inclusion.

The study will examine when elderly mental health clients discuss medication issues, with whom, who raises the topic, and the client’s level of satisfaction with the outcome of the communication. A complete list of the interview questions can be provided to you, on request.

Participants will be asked a series of ten questions and some demographic data will be collected. The interview will take about 20 minutes and each participant will receive a $5 gift card in appreciation. All responses will be completely confidential. Those clients identified as appropriate for the study will be telephoned to request their participation and an interview scheduled.

The clients listed below are potential participants in the study. Will you please fill in Yes or No as to whether these clients are capable and appropriate participants?

You can put a copy of this completed form in my mail slot. I would greatly appreciate receiving your response by (date). Thank you for your assistance.

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<td>Mary Kincannon</td>
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<td>John McFadden</td>
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Signature

Date
APPENDIX B

QUESTIONNAIRE
MEDICATION CONCORDANCE RESEARCH QUESTIONS

1. How many medications are you currently taking each day?

2. In the past two years have you not taken a prescription medication or taken less than the dosage prescribed?*

3. If yes, what was the medication?

4. Did you discuss the change in medication with someone? If yes, with whom?

5. Did that person raise the topic of medication or did you?

6. When and where was this discussion held?

7. What was your goal in discussing the medication?

8. How helpful was the conversation in resolving your questions or concerns?

9. What would have made the conversation more helpful?

10. Did you feel you had sufficient input in decision making about the medication?

11. Did you discuss the problem again with this person or someone else?

*If the researcher gets a response of No to the question of: In the past two years have you not taken a prescription medication or taken less than the dosage prescribed?, this question will be inserted,

In the past two years have you had any concerns about a medication or its side effects? If yes, did you discuss the medication with someone?

The remaining questions would be the same. If the participant answers no to both of the compliance questions, indicating full compliance, the interview would be complete.

Demographics collected: Sex, age, mental health diagnosis, living situation, how long in counseling, level of education completed.
APPENDIX C

RECRUITMENT FLYER
SINCE YOU ARE 55 YEARS OLD OR OLDER AND GETTING SERVICES AT WEST END FAMILY COUNSELING YOU ARE ELIGIBLE TO PARTICIPATE IN A CONFIDENTIAL SURVEY

Would you be willing to complete a 20-minute survey?
- You will receive a $5 gift card to Denny's
- You will be helping with important research

The survey is looking at communication about medications. The survey will be completed at the West End offices and will take about 20-minutes. All responses will be strictly confidential and participation has no effect on receiving services at West End Family Counseling Services.

If you are willing to be contacted by phone to schedule a convenient time to complete the survey, please put your name and phone number on the form below. Return the form in the stamped envelope provided, no later than February 28, 2007. You will be contacted within a week to schedule a convenient time to complete the survey.

If you have questions about participating in the survey, please call Eva Miller at 909/983-2020 x323

THANK YOU!!
APPENDIX D

INFORMED CONSENT
INFORMED CONSENT

The study in which you are being asked to participate is designed to examine communication between elderly mental health clients and professionals on the topic of medication concordance. This study is being conducted by Eva Miller under the supervision of Professor Rosemary McCaslin, Professor of Social Work. This study has been approved by the Department of Social Work Institutional Review Board Subcommittee, California State University, San Bernardino.

In this study you will be asked to respond to a series of questions about medications and your communication with healthcare providers about medications. The survey should take about 15 to 20 minutes to complete. All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion at June 2007 at the following location Pfau Library, California State University, San Bernardino.

Your participation in this study is totally voluntary. Services are not affected by a decision not to participate in the study. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the survey you will receive a debriefing statement describing the study in more detail. In order to ensure to validity of the study, we ask that you not discuss this study with other participants. There is a small risk that the interview will create mild psychological discomfort about your medication regime or your compliance with that regime.

The study’s outcome will provide insight into the most effective process for identifying and resolving medication issues with older adults and armed with that information social workers and others will be able to more effectively develop medication concordance with clients. Clients will obtain an increased awareness of their medication compliance issues and a $5 gift card for their participation.

If you have any questions or concerns about this study, please fell free to contact me Rosemary McCaslin at 909/537-5507.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here □       Today’s date: ______________________

I agree to have the interview audio taped □
Study of Communicating with Elderly Mental Health Clients about Medication Concordance

The purpose of this study is to examine communication between elderly mental health clients and professionals on the topic of medication concordance. The research question is: What are the obstacles to effective communication with elderly mental health clients about medication concordance? The study is seeking information on when, whether, and with whom elderly mental health clients discuss medication issues and their satisfaction with the outcome of those conversations.

Thank you for your participation. If you have concerns as a result of participating in the study please contact West End Family Counseling Services at 909/983-2020. If you have any questions about the study, please contact Eva Miller or Professor Rosemary McCaslin at 909/537-5507. If you would like to obtain a copy of the group results of this study, please contact the Pfau Library at California State University, San Bernardino at the end of Spring Quarter of 2007.
APPENDIX F

DEMOGRAPHIC DATA
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REFERENCES


