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Article *in* Psychiatric services (Washington, D.C.) · June 2017
DOI: 10.1176/appi.ps.201600325

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First-Person Perspectives on Prescriber–Service User Relationships in Community Mental Health Centers

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Objective: Because of changes in health care, there is a greater focus on brief medication management visits as the primary method of providing psychiatric care in community mental health settings. Research on the first-person perspectives of service users and prescribers in these settings is limited. The objective of this study was to describe first-person perspectives on medication management visits and the service user–prescriber relationship.

Methods: Researchers conducted qualitative interviews as part of a larger comparative effectiveness trial at 15 community mental health centers, researchers interviewed service users (N=44) and prescribers (N=25) about their perspectives on the typical elements of a medication management visit and asked service users about their relationship with their prescriber.

Results: Both service users and prescribers described medication management visits as very brief encounters focused on medication and symptoms. Most service users reflected on the service user–prescriber relationship in positive or neutral terms; they did not describe the development of a strong therapeutic relationship or a meaningful clinical encounter with prescribing clinicians.

Conclusions: Service users described the service user–prescriber relationship and medication management visit as largely transactional. Despite the transactional nature of these encounters, most service users described relationships with prescribing clinicians in positive or neutral terms. Their satisfaction with the visit did not necessarily mean that they were receiving high-quality care. Satisfaction may instead suggest service users' disengagement from care. They may need more support to fully participate in their own care.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.201600325)

In 2014, more than four million people received care from community mental health centers in the United States (1). A variety of pressures affect services in community mental health centers. The shortage of psychiatrists (2) and the demand for services among people newly insured under the Affordable Care Act (3) place a disproportionate burden on community mental health centers to serve growing numbers of people. Health care policies, such as managed care (4), increased productivity demands on health care professionals (5), and the marketing success of pharmaceutical companies (6), all contribute to a greater focus on brief medication management visits as the primary way to provide psychiatric care to large numbers of patients within a short time.

To facilitate high-quality psychiatric care, we must understand the first-person perspectives of patients and prescribing clinicians. A patient's experience with psychiatric care can affect treatment adherence and ultimate recovery (7,8), and thus the perspectives of patients (or "service users") are of particular interest. Research has focused on service users' experience of medication and perspectives on medication adherence (9–13) as well as on service users' expectations of and satisfaction with community psychiatric care (14). In Sweden, service users in outpatient psychiatric settings described good care as the quality of the helping relationship (14). In the Netherlands, patients and physicians differed in their satisfaction with visits (15). Service users reported greater satisfaction than did physicians, suggesting that patients and physicians form opinions in different ways. Other work that explored the value of service users' satisfaction as an indicator of high-quality care found that patients may express satisfaction despite having had negative experiences (16).

This study drew on interviews with service users and psychiatric health care prescribers at community mental health clinics and provides initial insights on the nature of medication management visits. First, we examined service users' and prescribers' description of the typical elements of a medication management visit. We then examined prescribers' perspectives on the clinical goals of medication management visits and service users' descriptions of the service user–prescriber relationship. [Interview guides for the service user and prescriber interviews are available in an online supplement to this article.]

METHODS

We interviewed service users and prescribing clinicians during year 1 of a three-year comparative effectiveness trial at 15 community mental health clinics in a large state in the Northeast. The trial examined two technology-based approaches to psychiatric medication management. The first, measurement-based care, uses a Web portal to deliver assessments and track service users' symptoms. The second, person-centered care, implements CommonGround, a technology-based tool that provides psychoeducation resources and enables service users to orient prescribers to their personal goals for recovery. To participate in the study, service users had to receive Medicaid benefits and have a primary diagnosis of a mental illness.

We examined the experience of psychiatric care from the perspectives of service users (N=44) and clinicians (N=25). Data were collected between October 2014 and January 2015. The WIRB-Copernicus Group provided full review and approval of the study protocol to ensure human subject protection.

The project coordinator generated a list of study participants from each clinic, and a convenience sample of service users was solicited to participate in a telephone interview. Prescribing clinicians were a convenience sample from each of the sites. All participants gave informed consent prior to the interview.

A multidisciplinary team, including individuals with research, clinical, and lived-experience expertise, developed the interview guide. Service user interview domains included the typical medication management visit, medication decision making, relationship with the prescribing clinician, overall experience at the clinic, and impact of clinic psychiatric services on quality of life. Prescriber interview domains included typical medication management visit, clinical goals, experiences with patients, shared decision making, and clinic workflow. Interviews were audio recorded and averaged 20 minutes in length. Participants were encouraged to tell their own story, and the interviewer asked additional probing questions as necessary. Service users received a $20 gift card for completing the interview.

Transcripts were uploaded to ATLAS.ti, a qualitative analytic software program (17). Qualitative codes were developed by using researcher-driven categories based on the research questions, interview guides, and categories that emerged through inductive review of the transcripts. Transcripts were coded in a multistage process. Initial coding by the primary interviewer (IG) indexed transcripts according to the categories in the interview protocol. A researcher with lived experience aided in reviewing data for the development of codes and later interpretation. Examples of initial codes included elements of the medication management visit, service user–prescriber relationship, comparison with the previous prescriber, and typical visit (prescriber perspective). We then conducted focused coding (18,19) to examine service users' satisfaction with the medication management visit, qualities of the service user–prescriber relationship, and clinical goals. These fine-grained analyses are the basis for the findings reported here. The team met regularly to identify, discuss, and refine emerging themes.

In addition to qualitative data collection, as a further check on the credibility and trustworthiness (20) of the findings, two authors (ECS and IG) independently rated the valence of each service user's reflections on his or her relationship with the prescriber as positive (for example, "[the prescriber] is very nice and listens to everything I say"), neutral (for example, "[the prescriber] just refills the medicine"), or negative (for example, "[the prescriber] makes me feel belittled"). The goal of these ratings was to capture the service user's overall sentiment regarding his or her relationship with the prescribing clinician. The ratings were consistent in 34 of 44 (77%) interviews with service users. To resolve discrepancies, two additional raters (CN and NP) subsequently reviewed content for which there had been disagreement in the initial ratings. These ratings are presented in the results.

RESULTS

Research Setting

We conducted this research in rural and suburban areas of a large Northeastern state. The 15 clinics participating in the study provided outpatient behavioral health treatment to low-income service users.

Prescriber participants had worked at their respective clinics for an average of 6.00±4.84 years and had been practicing clinicians for an average of 21.00±11.18 years. Most reported that they usually worked from one to two days per week at these clinics.

Service user participants in this qualitative study were largely representative of overall study participants in age, race, and gender, as shown in Table 1. The proportion of participants with bipolar and schizophrenia spectrum disorders in the study reported here was lower than in the overall study. The frequency of service use among the participants in the qualitative study varied widely, and the number of medication management visits in one year ranged from one to 22 (mean±SD=5.56±3.89).

Medication and Symptom-Focused Services

We asked prescribers and service users to describe their typical medication management visits, including the sequence of events and common topics of discussion.

Service users' descriptions. Service users reported that their medication management visits were focused on medication. They reported discussing "how I've been feeling, especially side effects with the medicines." Many service users perceived that prescribers were primarily interested in minimizing symptoms and side effects, saying that prescribers asked "about if the medicine is working or if it's too strong," and "he sees if I need anything else, if I need a higher dose of

TABLE 1. Characteristics of service users in the overall and qualitative studies[a]

	Overall study (N=2,428)		Qualitative study (N=44)	
Variable	N	%	N	%
Age (M±SD)	42.80±11.32		42.10±12.41	
Gender				
Male	900	37	15	34
Female	1,528	63	29	66
Race				
White	2,090	86	34	77
Black	214	9	6	14
Other	124	5	4	9
Diagnosis[b]				
Major depressive disorder	847	35	26	59
Bipolar disorder	726	30	5	11
Schizoaffective disorder	308	13	3	7
Schizophrenia spectrum disorder	206	9	0	—
Other	601	25	10	23

[a] The qualitative study was part of the overall study, a three-year comparative effectiveness trial of two technology-based approaches to psychiatric medication management.

[b] For participants in the overall study, diagnostic categories were not mutually exclusive.

my medications or anything like that. Basically, that's all we talk about." One service user said that she and her prescriber "just discuss my case, and . . . [the prescriber] wants to know whether I'm running out of my medicine and how the medicine has been taking effect on my life . . . what can she do to prescribe more to help in the nearest future." Some also talked with their prescribers about "life," for example, trouble finding or keeping a job, family relationships, or changes in physical health. One service user referred to her prescriber as "a second therapist"; however, for most visits, discussions about life were secondary to medication decisions. Another service user reflected that her visits felt "very impersonal." Service users understood the primacy of medication decisions as a function of the brief visits; medication-management visits usually lasted between 15 and 20 minutes. As one service user said, "I sit down and talk with the therapist. The doctor just asks me a few questions about my medicine, how I'm doing, then he writes me a prescription and I'm out of there. I'm only in there for 13 minutes."

Prescribers' descriptions. Prescribers viewed the purpose of medication management as "symptom reduction" and "stability." Prescribers described their goals for clinical care from simply "symptom suppression and symptom control" to wanting service users to be "happy with their medication regimen and feel that they are able to function to the best of their ability." Prescribers reported that in typical appointments they would ask the patient "to review by name the medications that they've been taking"; use the clinic's "psychiatric review system" to determine how "[the patient] is doing with depression, anxiety"; ask the patient "about what are the issues, concerns for this visit"; or review "initially what medications the patient was prescribed and determine whether or not they're actually taking them. And then I ask them what impact the medication strategy has had on the symptoms." Although most prescribers focused on symptom suppression, many recognized that they were not often successful in helping service users achieve "total remission."

Prescribers described medication management visits that lasted about 15 minutes and that occurred every one to three months. Prescribers were stressed by the short visits, and some emphasized that they tried to give service users more than 15 minutes if necessary. One reported that he "frequently [runs] over with a patient that's having difficulties . . . if there's more problems to be dealt with, we'll go 25 minutes." However, another prescriber specified that the therapist at the clinic dealt with "bigger picture" pieces (that is, stresses and relationship issues), because he didn't have time for those questions.

Some prescribers also reported that they discussed service users' quality of life and "how [they're] doing," although this conversation was second to discussion about medication. Only two prescribers described conversations with service users about long-term goals for treatment.

Service User–Prescriber Relationship

Service user–prescriber relationship ratings. After a consensus process, the raters' classifications of how service users described the service user–prescriber relationship were as follows: positive, N=21 (48%), neutral, N=13 (30%), and negative, N=10 (23%).

Service users' perspectives on medication management. We asked service users questions that were designed to elicit a description of their relationship with their prescriber, including, "How would you describe your relationship with [your prescriber]?" and, "If you could change anything about the care you receive at [the clinic], what would you change?"

Many service users responded neutrally when asked to describe their relationship with their prescriber. Some had not previously thought about the relationship; one responded that he "didn't really know how to answer that question." Some mentioned that they had seen their current prescriber only once or twice. One said that she "never knew who [she was] going to see." More commonly, service users characterized their relationship with their prescriber in neutral terms, as a "patient-doctor relationship," or "just professional." One said that his prescriber "just refills the medicine." Another noted, "If I want to talk to him, I'll talk to him and he'll sit down and listen to me, but sometimes it's just in and out." Rather than describing positive interactions with prescribers, service users sometimes described a lack of negative interaction, saying, "I have no problems with [my prescriber]," or "[My prescriber] is not a bad guy." Many service users gave minimal responses and, despite multiple probing attempts, did not provide extensive descriptions of the relationship.

In reviews of care, service users often expressed gratitude for the support and treatment that clinics and prescribers had provided. When we asked service users about the impact of treatment at the clinic, some offered positive reviews of their therapists, such as, "My therapist has helped me a lot," and "Therapy is really good." Others simply said that treatment had been helpful and that they felt better. No service users gave extremely positive reviews of their prescribers or their medication.

When asked what they would change, most service users expressed their appreciation for the care they had received and could not think of anything that they would change. Others cited logistical aspects of their psychiatric care (that is, transportation issues and wait times at the clinic). A minority of service users expressed that they were frustrated by the short amount of time that they had for their medication management appointment and desired more time with their prescriber. One said, "I feel like it's almost a waste of my time . . . . I go up and [prescriber] says the same thing; what was the point?" Another noted, "I feel like [prescriber] is rushing."

A few service users expressed a desire for a different prescriber. These service users reported conflicts with their prescribers about medication decisions or felt that their prescribers did not listen to them during appointments. However, most of these service users were not hopeful about changing providers; the clinic was usually the only mental health care available to them.

DISCUSSION

Both service users and prescribers described the medication management visit as a brief, medication-focused encounter in which prescribers aimed to alleviate patients' symptoms and minimize the side effects of medications. Thirty percent of service users characterized their relationship with their prescriber in neutral terms. Most service users did not describe the development of a therapeutic alliance similar to those developed with therapists. Rather, service users viewed the service user–prescriber relationship as largely transactional. Service users spent time in the medication management visit in return for psychiatric medication and alleviation of symptoms.

Service users' self-described satisfaction with the medication management visit does not necessarily mean that they are receiving high-quality care (16). Certainly, some were likely satisfied; a minority of service users described interactions consistent with high-quality care. However, most participants in this study would not have the financial means to seek care in other settings, and their satisfaction may instead reflect acceptance of the status quo. Similarly, providers reported frustration with the structure of care at the clinics, and many did not work full-time at their respective clinics. Williams and colleagues (16) asserted that service users' evaluations of health care may depend more on their expectations than their experiences. High satisfaction ratings may reflect attitudes such as "they are doing the best they can" or "this is similar to care I've received before," rather than concrete positive experiences.

The service user–prescriber relationship may be affected by the service users' diagnosis and severity of illness. Although this study did not determine service users' respective levels of insight or medication adherence, service users who have less insight about their illness or who are less adherent to their prescribed treatment may describe service user–prescriber relationships differently, compared with those with more insight or adherence (9,11,12).

Patient activation, which emphasizes patients' willingness and ability to take independent actions to manage their health, has a role in forming service users' expectations about care (21). The transactional structure of current medication management visits may foster passivity among service users; a sense that one has no personal control over one's mental health care may discourage active strategies (13,22). Activated service users may be positioned to take a more critical view of the services they need and deserve. Highly activated patients are two or more times as likely as those with low activation levels to prepare questions for a medication management visit, to know about treatment guidelines for their condition, or to seek out health information (23,24). Although efforts to promote patient activation hold potential to contribute to more meaningful clinical interactions that support better health outcomes, this responsibility is shared by service users, health care providers, and health systems. Interventions such as CommonGround, a technology-based tool that provides psychoeducation resources and enables service users to orient prescribers to their personal goals for recovery, may prove useful in activating service users (25). CommonGround may also serve as a bridge between service users and prescribers, because it gives prescribers context about a service user's life and articulate goals for the visit, thus allowing both parties to engage in shared decisions regarding the course of treatment.

The transactional nature of service user–prescriber relationships in this study suggests another element of psychiatric care in community settings: compartmentalized care, in which service users' inner lives and goals for recovery are designated as the realm of the therapist and psychiatric medication as the concern of the prescriber. Partly because of time limits, lack of knowledge, and the culture of community behavioral health clinics (2–6), prescribers were often unable to integrate service users' personal goals into medication plans. Interventions such as CommonGround will need to facilitate easy communication between a service user's various providers, without adding extra time demands.

The study had some limitations. Results are based on retrospective recall of service users and prescribers. Although the narratives were consistent across participants, retrospective recall may not be the most reliable measure of human behavior. In the future, it will be necessary to have audio recordings of service user–provider interactions. We conducted research via telephone interview. Although this

method allowed access to participants from clinics statewide, telephone interviews may have limited our ability to elicit in-depth information about an intimate topic. As a result, interviews were brief and did not capture each service user's full illness experience. It would be ideal to conduct research in a setting that allows researchers to build rapport with service users and elicit a more complete narrative. Also, there may have been important heterogeneity in the service user–prescriber relationship on the basis of diagnosis and severity of illness. Qualitative interviews were conducted via telephone, and service users with more impairing psychiatric conditions or unreliable access to a telephone may not have been well represented in the sample. The proportion of service users with schizophrenia-spectrum disorders was lower than expected in a community mental health population.

CONCLUSIONS

Researchers, providers, and treatment centers must support service users in fully engaging in their own health care. Our findings suggest that service users in community mental health settings are not expressly dissatisfied with brief, medication-focused visits with their prescribing clinicians. However, service users did not report substantial therapeutic relationships with their prescribers, and they may have been disengaged from their own health care. Interventions such as CommonGround may help service users communicate their recovery goals and preferences to prescribers and may make the medication management visit more relevant to service users' lives.

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This work was supported through award CDR-1306-02474 from the Patient-Centered Outcomes Research Institute (PCORI). All statements in this report, including its findings and conclusions, are solely those of the authors and do not necessarily represent the views of PCORI or its Board of Governors or Methodology Committee.

The authors report no financial relationships with commercial interests.

Received July 13, 2016; revisions received December 5, 2016, and January 30, 2017; accepted March 2, 2017; published online June 1, 2017.

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