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The Importance of Medication in Consumer Definitions of Recovery from Serious Mental Illness: A Qualitative Study

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Abstract

The role of medication in the recovery of mental health consumers is important. In the context of a multi-site Canadian study on the meaning of recovery, five themes related to medication and recovery emerged from qualitative interviews with 60 consumers. For these consumers, recovery meant: finding a medication that works; taking medication in combination with services and supports; complying with medication; having a say about medication; and living without medication. Findings underlined consumers' need to communicate their concerns around medication and be supported in developing self-management strategies and more collaborative relationships with providers. The study suggests an expanded role for nursing practice in these areas.

Recovery from serious mental illness has emerged over the past two decades as a world-wide paradigm in mental health, challenging traditional biomedical models of care. Longitudinal studies have challenged century-long beliefs about mental illness as an inevitably deteriorative condition, establishing that the course of mental illness is heterogeneous and that recovery often occurs spontaneously (Ciompi, 1980; Fisher, 1999; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b; Harding & Zahniser, 1994; Harding, Zubin, & Strauss, 1992; Markowitz, 2001; McGlashan, 1988; Ogawa, Miya, & Watarai, 1987; Pevalin & Goldberg, 2003; Tsuang, Woolson, & Fleming, 1979). Advances in psychopharmacology have led to better outcomes for persons with psychiatric disabilities, and further opened the way for new recovery-based approaches in psychiatric rehabilitation (Anthony, 2004; Calabrese & Corrigan, 2005). In this context, treatment modalities in mental health have evolved from a traditional illness/stabilization model, to community/rehabilitation models, and most recently to a recovery model, in which mental health consumers play an important role in planning services and advocating for their own needs.

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While antipsychotic medication offers consumers new possibilities for stability and the self-management of symptoms (Noordsy et al., 2000), the decision to use, or not use, medication as prescribed is complex for consumers. It is important for mental health nurses to better understand the views of consumers around medication, particularly in relation to consumers' personal meanings of recovery. This article reports consumers' opinions on the role of medication drawn from a multi-site Canadian study on the meaning of recovery.

LITERATURE

Definitions of Recovery and the Recovery Process

Recovery from serious mental illness has been described largely by consumer-survivors, not as a "cure," but as a way of living a satisfying, hopeful, contributing life despite ongoing psychiatric disability or symptoms. For Patricia Deegan, one of the first consumer-survivors to write about her lived experience of recovery from schizophrenia, building personhood separate from mental illness, is crucial, because "once you and the illness become one, then there is no one left inside of you to take on the work of recovering" (P. Deegan, 1997). Mead and Copeland (2000) identified the key elements in recovery as hope, personal responsibility, self-advocacy, wellness, education, and peer support. Other aspects highlighted by consumer-survivors are acceptance (Spaniol, 1997), empowerment (Ahern & Fisher, 1999, 2001; Fisher, 1999); self-determination (Frese & Davis, 1997); symptom control (G. Deegan, 2003); a supportive psychiatric relationship (McGrath & Jarrett, 2004); the pursuit of happiness and peace (Schiff, 2004); and healing (Walsh, 1996).

One of the first studies to describe recovery as a process spoke of "moving forward," but also "regaining what was lost" (Young & Ensing, 1999). Among the myriad of studies on the recovery process that followed are Davidson and Strauss' (1992) seminal work on the reconstruction of self, as a key theoretical construct in recovery; research that identified internal and external recovery processes (Jacobson & Greenley, 2001; Ochocka, Nelson, & Janzen, 2005); and two large descriptive studies by Resnick et al. (2005; 2004), based on data from 825 recovering consumers, which developed an empirical model based on four recovery domains: empowerment, hope, knowledge, and life satisfaction. A theoretical model of the recovery process from a nursing perspective also has been proposed, based on the concept of human responses advanced by the American Nurses' Association (Noiseux & Ricard, 2008). As the recovery perspective extends to various professional fields, Silverstein and Bellack (2008) argue that the concept still lacks a strong scientific basis. They clarify this, as well as the meaning of recovery-oriented care, and present perhaps the most comprehensive research agenda to date for recovery.

Clinical Recovery and the Role of Medication

The notion of clinical recovery, as measured through outcomes and expressed as approximations to cure, remains a dominant perspective in mental health (Harding et al., 1987a, 1987b; 1992; Roberts & Wolfson, 2004). The use of psychotropic medications is central in the clinical perspective, since treatment has traditionally focused on symptom management and the reduction of side-effects (Drake, Green, Mueser, & Goldman, 2003; Noordsy et al., 2000; Roberts & Wolfson, 2004). Liberman and Kopelowicz (2005) argued

that subjective attributes of recovering are closely linked to symptomatic and functional improvement. As such, they propose that definitions of recovery need to include notions such as remission, relapse, and “entry and exit into the states of recovery.” Davidson et al. (2008) note that such terms are being promoted by persons with schizophrenia and their families, against the enduring tendency of clinicians to assume that patients remain seriously ill when outside of clinical care settings.

Consumer Views on Medication and Recovery

Studies suggest that medication figures into definitions of recovery in the minds of consumers. Smith (2000) identified “the right kind of medication” as a critical factor in recovery; whereas 72% of consumers in the Sullivan (1994) study considered medication important. (See also Paquette & Navarro, 2005; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Young & Ensing, 1999). Consumers in the Svedberg study (Svedberg et al., 2003) described medication as a safety net, protecting them from relapse and re-hospitalization. Yet, most would agree with Lunt (2002) that “the biochemical solution does not bring with it a dream, a goal, a journey, a direction, an inspiration, a faith, or a hope. These are what are sought in recovery.”

Consumers in other studies stated that their treatment was worse than the illness, and described how medication hindered their recovery (Andresen, Oades, & Caputi, 2003; Bassman, 2005; Frese III, Stanley, Kress, & Vogel-Scibilia, 2001; Lunt, 2002; Mead & Copeland, 2000). While 32% of respondents in the Tooth et al. (2003) study accepted the need to take medications as part of their recovery, over half considered the side effects of medication a hindrance.

All consumers in the Ng et al. (2008) study acknowledged taking medication, yet most did not consider themselves recovered precisely because of this fact. Others suggest that this perspective is typical of consumers with a biomedical view of mental illness (Davidson & Roe, 2007; Jacobson, 2001; Lynch, 2000; Tenney, 2000). Other findings from the study from which the present article derives are in line with this interpretation, as consumers spoke of what recovery meant for them in relation to illness, as well as in relation to wellness (Piat et al., in press).

Recovery and New Approaches to Medication

In recovery-oriented mental health perspectives, medication is viewed as only one of many elements for reducing psychiatric symptoms (Fisher, 2003; Jacobson, 2001; Mead & Copeland, 2000; Young & Ensing, 1999). Moreover, medication planning and management are key areas for consumer control and choice. For example, Svedberg et al. (2003) understood medication to be the basis on which patients could begin to recognize their strengths in other areas, thus introducing hope and empowerment into the issue of medication management. Happell (2008) found that having input into decision making also increased consumers' perceptions of the benefits that accrue from medication.

Rates of non-adherence or discontinuation of medication are generally high, as high as 74% in the major C.A.T.I.E. study (Lieberman & Hsiao, 2006), which met with calls for increased treatment options, and greater consumer participation in treatment (Clarke, 2008;

Salzer & Evans, 2006). Deegan and Drake (2006) have critiqued long-standing treatment models that focus on adherence to medication as prescribed, as these approaches undermine consumer choice, empowerment, and self-determination. Nor, they argue, do traditional models address the complex issues involved in using medication in the context of the individual's overall needs and aspirations. Other studies have suggested that non-adherence to medication as prescribed may reflect complex reasoning and a search for treatment alternatives (Roe & Swarbrick, 2007). Consumers are very aware of the trade offs that can be made in judging whether taking a particular medication is "worth it" (Carrick, Mitchell, Powell, & Lloyd, 2004; P. Deegan, 2005).

As Corin et al. (2007) reported, the therapeutic relationship provides the context in which consumers determine their personal meanings of medication, and negotiate medication use. Research has found that consumer relationships with providers have a bearing on medication adherence. Consumers want providers to listen to, and respect, their views around medication (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Day et al., 2005; Happell, Manias, & Roper, 2004; Malins, Oades, Viney, & Aspden, 2006). Other studies underline the need for collaboration between consumers and providers, and for consumer training, so that they will be able to participate more fully in treatment decisions (Deegan & Drake, 2006; Kopelowicz & Liberman, 2003; Mueser et al., 2002). Such partnerships would allow for a certain amount of risk taking, as consumers begin to participate in managing their medications within secure boundaries and learn to use medication as a tool in their recovery.

In sum, medication is as an important, but challenging issue for consumers as they reflect on what recovery means to them. However discussion on the role of medication in consumer definitions of recovery is lacking in the literature. This article presents one set of findings from a larger study which sought to better understand the meaning of recovery for mental health consumers, service providers and decision-makers.

METHODS

Setting and Sample

This study was conducted at three sites: (1) Montreal, Quebec, at the Douglas Mental Health University Institute, (2) Guelph/Waterloo, Ontario at the Canadian Mental Health Association and Self-Help; and (3) Quebec City, at Programme d'encadrement clinique en hébergement (PECH), a community organization providing housing and support services.

All three sites were attempting to integrate recovery into their organizations at the time of the study. The Douglas Mental Health University Institute had identified recovery as the focus of its strategic plan (Douglas Hospital, 2006), and created an official recovery program within its clinical services. In Quebec City, PECH described their services as strengths-based and recovery-oriented (Programme d'encadrement clinique et d'hébergement, 2007). In Ontario, the Canadian Mental Health Association (CMHA) had adopted a recovery "model" (Townsend, 2005), and recovery is the *raison d'être* of the consumer-run Self Help Alliance. The Ontario and Quebec City sites had also implemented staff training programs on recovery.

A national advisory committee oversaw the research. The Advisory Committee included three consumers, three service providers, two representatives from provincial psychosocial rehabilitation associations, two provincial Health Ministry representatives, and a researcher from the Yale University Program for Recovery and Community Health. The Committee met three times between September 2005 and June 2007 and validated the research process, interview guide, and emerging findings.

In order to be Included in this study, participants needed to: (1) be diagnosed with serious mental illness (bipolar disorder; schizophrenia; major depression); (2) be receiving mental health services for at least six months; (3) be between 18 and 64 years of age; and (4) not have a primary diagnosis of intellectual deficiency.

Procedure

Consumer recruitment was either by self-referral or through consumers' mental health providers. In Montreal, presentations on the research project were offered and written announcements were posted. Interested consumers were invited to telephone the investigators directly. A similar procedure was followed in Ontario. In Quebec City, staff distributed pamphlets describing the research to their clients. Individuals interested in participating were asked to return a self-addressed, stamped envelope to the Montreal research team. The project coordinator screened interested participants by telephone for eligibility and ability to undergo the interview. In all 113 consumers contacted the research team. Ten consumers did not meet the eligibility criteria, six could not be reached subsequently by telephone, and six others declined to participate for lack of interest. Another 29 consumers were not selected, as the interviewing phase had ended. In all, sixty-two participants were selected to participate in the study. Two persons missed their interviews.

The principal investigator and three research assistants conducted semi-structured interviews with the 60 participants. A second interview was conducted with six participants, whose original interviews provided insights that the team felt warranted further investigation; this provide the research team with a total of 66 interviews. Interviews were conducted between December 2005 and February 2007. They took place in offices at each site and lasted between 45 and 100 minutes. Standard probes were used, and questions were rephrased if not initially understood. Interviews were audio-taped and transcribed verbatim.

The interview guide was developed after consultations between the research team and Advisory Committee, and a literature review. Selected questions are presented in Table 1.

The interview guide was pre-tested with two respondents, and minor changes were made. A short socio-demographic questionnaire was administered following each interview. Participation in the study was voluntary and all participants signed a consent form. At each of the three sites ethics review boards approved the research. Participants received a copy of this article, and a small honorarium. In reporting the findings, no identifying information has been used.

Data Analysis

Data analysis was inductive and ongoing over a four month period (Erlandson, Harris, Skipper, & Allen, 1993), and involved three distinct stages. First, team members read each transcript several times, seeking to identify patterns or commonalities in the data (Morse & Field, 1995). In this stage, medication in relation to recovery emerged as an important topic for further analysis. Second, a search/find command for the word “medication” was performed on each transcript, revealing that 42 consumers spoke about medication in their interviews. The words that provided the context of the word “medication” were extracted from each transcript of the 42 participants, yielding segments that ranged from one-line phrases to as long as 22 lines. Third, two members of the research team coded each segment to the smallest unit of meaning, using substantive or open coding (Glaser & Strauss, 1967). Sixty-four initial codes were identified in this stage of data analysis. The codes were then regrouped into categories, and, through further data reduction, regrouped into five overall themes, which are presented as findings.

Specific efforts were taken to ensure the trustworthiness of the overall study: Data analysis was a shared process, involving constant feedback and discussion among members of the research team (principal investigator and two research assistants). The Advisory Committee reviewed the methodology and emergent findings at key stages. And a detailed audit trail was kept over the course of the study. This audit trail included: raw data (questionnaires/transcriptions); and data reduction and analysis materials (interview summaries, codebooks, and memos).

FINDINGS

Respondents included 60 persons, 52% female. Their mean age was 44 years ($SD = 9$). Fifty percent spoke English. Forty-eight percent had some high school education, and 45% had post-secondary education. Over half the participants reported their most recent diagnosis as bipolar disorder (30%), schizophrenia (28%), or major depression (15%). Social assistance was the principal source of income for 72%, although 45% were also involved in paid or unpaid work. The majority (93%) had been employed during their lifetime. Most (95%) were on psychiatric medications. Seventy-two percent had not been hospitalized in the previous year. The demographic characteristics of respondents are presented in Table 2.

Overall, 42 of the 60 respondents (70%) spoke about their expectations and concerns with regard to medication and recovery from serious mental illness. The following five themes emerged:

- Recovery means finding medication that works.
- Recovery means taking medication in combination with services and supports.
- Recovery means complying with medication.
- Recovery means having a say about medication.
- Recovery means living without medication.

Recovery Means Finding Medication That Works

Twenty-four consumers reported that medication was mainly responsible for their recovery. They needed medication to feel better. As Leo put it, medication works like a “volume pill,” keeping the noise down in his head and helping him sleep at night. Medications provide stability or equilibrium. George compared well-balanced medication to “driving a car and cruising.” Some consumers credited medication with changing their entire lives, as Harvey describes:

The biggest thing was the medication. The new medication brought back my initiative and my energy levels are higher. ... mostly feeling good about myself and moving beyond the illness all the time to wellness. Enjoying life, and moving on with things.

The path to recovery involved finding the “right” or “best” medication. Seven consumers were convinced that adjusting their medication, or changing one for another, had made the greatest difference in helping them return to their usual activities, and enjoying a better quality of life. Carol described different “levels” of recovery associated with different types of medication, whereas others, like David, understood recovery as directly linked to the effectiveness of their medication. He explained:

When my recovery progresses as it should, I see that my medications are effective, that they’re good, and things are going better ... you have highs and lows; the medication is not always 100% effective ... You have to deal with that, and understand that it isn’t 100% recovery.

Henri claimed that experimenting with different medications in the hospital was just as important to his recovery as his later struggle to reintegrate into society. He stated:

Before they let us out of hospital, they try new medications because some won’t be effective, etc. What I understand by the word “recovery” is the period when they inject us with different medications. That is also part of recovery because to recover is not simply to return to your personal routine and to be able to cook for yourself, and to find employment and function once again in society.

Some consumers placed their hope for recovery in finding a medication that would cure them from mental illness. William expressed this:

Ya know, because if your life really is hopeless, and there’s no cure for schizophrenia, and there’s no hope for you because you’ve been on every medication, I mean, what does it matter anymore without any hope? Ya know, but at least if the doctor says there is medication that’s coming to Canada. It’s in the States, but it’s not here yet. Then you can still have hope, even if none of them have worked for you yet. Or at least you hear, they’re working on new medications and new treatments all the time, you can at least feel, well, I’m struggling with this but maybe one day I won’t.

Even those, like Gina, who turned to medication as a last resort “when everything else didn’t work,” came to believe that medication would ultimately make the difference in their recovery.

Recovery Means Taking Medication in Combination with Services and Supports

Twenty-two consumers viewed their recovery as dependent on taking medication, but in combination with a variety of other factors. For example, Ophelia describes what helps her recover:

There is like a basket full of things. Good relationships. Trusting the doctor I deal with, having access to support staff that have enabled me to have accommodations, to get back into employment, or assistance from (service agency) in dealing with day-to-day items that come up in life. Medications play a part in it. There are so many variables.

Consumers identified several different factors that contributed to their recovery, in addition to medication, particularly professional services and supports. Seven consumers pointed out that taking their medication wasn't enough for recovery, but that they needed other sources of support including psychiatrists or family doctors, social workers, and caregivers, as well as rehabilitation programs and therapy. Geneviève spoke at length about the importance of a strong therapeutic relationship in her recovery, whereby "the professional has trust in you, and you trust his/her qualifications." Louis referred to his social worker as "my recovery."

Consumers described other factors on which they rely, as a complement to medication, in working toward recovery. These included enjoying life "at a good pace;" getting out and talking with people; decorating a new apartment; finding natural products that might replace medication; watching one's diet and controlling moods; and reading books on recovery. Four consumers spoke about the importance of having supportive people in their lives. For William, it was family that kept him going.

Consumers also emphasized the need to take personal responsibility for their recovery in addition to relying on medication. As Geneviève stated: "Recovery starts when people decide to go further than just taking medication." Simon spoke of "fighting" and "having a strong morale." Patricia described her recovery as emanating from a personal decision to use medication as a means, but also to change her living habits:

I never thought that medications would change me; I always thought that they could help me if I worked with other tools ... Because when you say, "Okay, I'm going to take my medication; I'm going to continue things more healthy, I'm going to eat properly ..." everything changes! ... It happens gradually, but it happens!

Recovery Means Complying with Medication

Fourteen consumers had decided that they would recover if they took their medication. Three stated that they were simply following orders in taking their medication on the promise that eventually their medications would work. David explains :

I have to respect everybody and I have to take my medication as prescribed, that's the first thing they said. They explained that, in order to have a good recovery, we had to respect their wishes, because we were ill and it took time to get back on our feet, with medication, and they explained to me that, as they saw it, it was important to take medication in order to be better later on.

Some consumers were warned by providers, while others had an innate fear that non-adherence with medication would lead to relapse. Three asserted that they would recover from mental illness, yet had resigned themselves to taking medication for the rest of their lives. Several consumers had resolved to accept medication, as a leap of faith, even though they were uncertain whether medication would bring recovery. Taking this decision was, in itself, an important step in accepting their illness and opening the door to recovery, as Patricia explains:

I am just as crazy as I was before. I laugh, I make stupid jokes, I still have my feelings as well. So, it is a big part of acceptance (taking medication). But there are plenty of people who don't get even that far, because they're all messed up in their heads. "Pills, medications, drugs, that doesn't work, that will never change me."

As Lucy asserts, after trying all kinds of cures and magic, adherence may pay off: "Let's say that Olanzapine transform[ed] me from a dark mood, low patience, crazy woman, into a very happy crazy woman."

Recovery Means Having a Say About Medication

Eleven consumers spoke about recovery in terms of having some control over their medication. Four recounted good experiences, where they had been able to communicate their concerns around medication with providers and felt that their views were taken into account. Harvey described the great boost to his self-esteem from negotiating a new medication with his doctor. This experience gave him confidence to make choices in other areas. By contrast, Cindy reported that her psychiatrist was not helpful: "It is in and out and it is like, 'Do you need a prescription today?'" Charlie had been unsuccessful in convincing his doctor to change a medication that was making Charlie feel "lousy" and, at times, "suicidal."

Other consumers spoke about the importance of experimenting with their medications, with or without the knowledge of their doctors. Benoit reported that he was very well served by his family doctor, who "respected his rights" to manage his own problems and decide for himself how much medication he should tolerate. Nancy, however, took risks on her own. She had experimented unsuccessfully with her medications, but remained frustrated over the need to take medication indefinitely:

I have stopped taking medication and I have ended up in the hospital but I always say to myself, I say I should stop taking [them] ... Sometimes I feel very annoyed and very mad about myself for taking medication for so long and then there is no way I can stop right away. I get very upset and mad about myself.

Recovery Means Living Without Medication

Twenty consumers insisted that they can not recover if they are taking medication. Barbara described her view of recovery: "for me, the ideal recovery would be without medication; and I hope that will maybe happen some day," while Pierre drew strength from the prognosis of his new doctor: "It isn't written in the sky that I will have to take medication for the rest of my life." Most consumers who rejected the idea of taking medication equated it with illness. According to Patricia, the first reaction to mental illness among newly diagnosed

people is: “Medication for life! I’m crazy!” However, other consumers were not, in principle, anti-medication, but were confused. Lyse, for example, recognized that her medication was helpful, but questioned how she could ever consider herself recovered from schizophrenia as long as she needed to take pills.

Consumers articulated that recovery was incompatible with medication because their medications gave them serious side effects, including fatigue, sleepiness, or lethargy, weakness, shaking, and feeling “drugged up.” These symptoms prevented consumers from working, having a family, or otherwise enjoying a normal life. Denise described her recovery as elimination of the side effects from medication that had compromised her social relationships:

So when I say I’m recovering, [I] do not have all the symptoms that I once had, it makes me feel a little bit free and relieved from being so drugged up ... this is not funny when you’re facing someone and you’re twitching and you’re shaking and you’re drooling, so ... that right now I can talk to you and just be pretty much like a normal person ... it’s, it’s good.

Benôit, whose term for medication is “chemical constraint” described the trade-off between gaining some relief from the “heaviness of life,” when he opted for a high dose of medication, but at the expense of losing his “intellectual mechanisms.” Lowering the dose forced him to deal more with reality, but was his preferred course of action whenever possible.

Recovery also had little to do with taking medication for consumers who had experienced coercion. Mark commented that he had “never wanted anything to do with medication,” yet had it imposed on him. At the time of his interview, Al dreaded going back to his doctor, stating:

I am hoping this Friday when I go and see him that he doesn’t say, “Listen, you have got to take that drug Zyprexa.” I hope he doesn’t say that to me because if I say I am not taking it, he is liable to give me a needle.

Angela, who described being given medications in hospital, without explanation, added:

I feel that giving medication to a person if they don’t want to take them is coercive. I don’t care what they say and I don’t think the family should be responsible because chances are the family is the reason the person is in there in the first place. That has been my experience in talking to people around [my network].

Cheryl recalled her experiences with the mental health system in the eighties. She marvelled that consumers were supposed to feel “lucky to be on medication,” even though it was “for the rest of your life,” making her feel “different” and “labelled.” She described treatment as:

very clinical. And nothing to do with recovery. It was maintenance, it was “On your medication. You have to stay on your medication or you won’t remain well. ... if you go off your medication, you will be back here.”

William suggested that approaches to mental illness have not changed very much:

A lot of what I see in the psychiatrist's ... in the community is about medication. And talking about symptoms and whether symptom are well controlled.

DISCUSSION AND CONCLUSIONS

Findings from this study reveal that, when mental health consumers were asked about what recovery means for them, the majority linked their recovery to medication. This finding was unexpected, as we didn't ask any specific questions about medication in relation to recovery. Overall, consumers felt that their medication was important in their recovery, either alone or in combination with other factors. A number had decided to adhere to their prescriptions, either relying on the advice of providers or complying from fear of relapse. It is important to note that, in addition to taking medication, consumers placed considerable value on the support they received from professionals and mental health services in order to recover. Even consumers who linked recovery to the possibility of having some control over their medication expressed satisfaction at being able to communicate their concerns about medication to providers, and from having their views taken into account. They underlined the importance of a strong therapeutic relationship.

Similar to previous literature, consumers in this study expressed mixed views about whether taking medication helps, or hinders, their recovery. Findings in this study also revealed that taking medication created the same kind of dilemma regarding self-attributions of recovery as in findings reported by Ng et al. (2008). Where consumer perspectives in the present research differed from the literature on the meaning of recovery, was in consumers' lack of understanding that recovery from mental illness implies much more than finding "the best" medication and achieving symptom control. Recovery from mental illness is much more than a medication effect when thought of in terms of hopes and dreams, and the transition to a new self that can thrive despite the presence of disability. Medication needs to serve people's larger life ambitions and goals; it is not, as many of our findings suggest, that life should center on medication regimens. Perhaps participants in the present research still tended to think of recovery as a "cure," and mental health providers were still insisting on unconditional adherence to medication as the most important aspect of treatment. Thus it is not surprising that consumers tended to become "trapped" in viewing medication as their sole or primary support to recovery.

Overall three new insights can be taken from this research: (1) that differences between mental health consumers and their providers around their values or levels of confidence in medication are a potential source of misunderstanding. Such differences must be explored and addressed, as was done in a recent comparison of consumers and providers on their conceptualizations of recovery (Brown, Rempfer, & Hamera, 2008); (2) that mental health consumers need training to look beyond medication, and to develop a larger repertoire of strategies for taking control of illness, of their lives, and for returning to their communities; and (3) that the most important adjunct to medication is communication and a strong therapeutic relationship between mental health consumers and providers.

This study has important implications for mental health nursing practice. Nurses are often the consumers' primary contact within the mental health system, and are best positioned to

explore the role of medication in the recovery journey of individuals with serious mental illness. The concerns of consumers around medication and recovery speak to the importance of furthering the shift to a recovery orientation in mental health services where consumers and providers work in partnership. Mental health nurses can make a major contribution to implementing recovery-oriented services. The recovery approach requires a different relationship between nurses and consumers, particularly on the subject of medication. Findings from this study point to the need for nurses to open a dialogue with consumers around their needs and preferences in relation to medication, and to explore other avenues toward wellness. Nurses can help educate consumers toward greater responsibility for self management of their medications, and can facilitate more collaborative relationships between consumers and their doctors. Nurses, so highly regarded for humanizing service delivery, can also provide ways for consumers tell their stories.

These findings share the limitations inherent in qualitative studies, as they do not represent a generalized portrait of consumer views on medication and recovery in Canada. Possible biases of social desirability also must be acknowledged. Further research is needed in order to better understand the treatment climate in which consumers experience recovery, as well as the views of other stakeholder groups on the role of medication in recovery. Specifically, consumer preferences around the management of medications and shared decision-making between consumers and mental health practitioners should be explored.

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TABLE 1

Selected Interview Guide Questions that Elicited Responses Related to Medication and Recovery

•	What are some of the things that you've heard about recovery?
•	When you think of recovery what comes to mind? What does it mean for you?
•	What do you need to recover? What are some of the things in your life that have helped you to recover?
•	What choices have you made that helped you in your recovery?

TABLE 2Demographic Characteristics of Respondents ($N = 60$)

	<i>N</i>	%
Gender		
Male	29	(48.3)
Female	31	(51.7)
Mean age	43.6 ($SD = 8.96$)	
Language spoken		
English	30	(50.0)
French	29	(48.0)
NA	1	(2.0)
Education completed		
Less than high school	2	(3.3)
High school	29	(48.3)
More than high school	27	(45.1)
NA	2	(3.3)
Most recent diagnosis		
Bipolar disorder	18	(30.0)
Schizophrenia	17	(28.3)
Dual/multiple diagnoses	8	(13.3)
Major depression	8	(13.3)
Personality disorder	3	(5.0)
Psychosis	2	(3.3)
No more diagnosis	1	(1.8)
NA	3	(5.0)
Sources of income		
Employment income	7	(11.7)
Social assistance	43	(71.7)
Other	8	(13.3)
NA	2	(3.3)