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Meaning and Management of Multiple Medications Among Public Mental Health Service Users

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Abstract

Public mental health service users frequently manage multiple health conditions, and are often prescribed multiple medications. While medications are useful tools in treating diagnosed mental illnesses, they bring management challenges and also can carry complex meanings for the individuals taking them. This study utilized a qualitative methodological approach to examine the experience and meaning of polypharmacy among public mental health services users. This sample of service users (n=26) who were prescribed multiple medications described three distinct types of challenges they faced in managing medications: related to information, material tasks, and self-stigma. Nevertheless, respondents reported creative and resilient strategies to manage these challenges. Findings build on previous literature and reflect the increasing need to focus on challenges related to polypharmacy. Furthermore, findings indicate that low levels of literacy and high levels of material disadvantage, which are common among public mental health service users, complicate the management and meaning of multiple medications.

Keywords

medication; mental health; stigma; polypharmacy; public mental health services

Introduction

Medications are important tools in treating diagnosed illnesses. With complex mental illness diagnoses and symptom profiles, sometimes multiple medications are indicated to support an individual in their recovery. While the use of polypharmacy has become increasingly common, it has also been associated with problematic outcomes (Armstrong & Temmingh, 2017). Challenges often arise while managing multiple medications that extend beyond physical side-effects. Individuals may face challenges related to a lack of information or knowledge about the medications they are prescribed, difficulty performing medication-

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related tasks, and stigma associated with taking medication for a mental illness. This study draws on qualitative interviews with 26 public mental health service users to explore how they understood, interacted with, and made meaning of multiple medications and their anagement.

Polypharmacy

Definitions of polypharmacy vary extensively, with many scholars utilizing numerical definitions, such as taking 5 medications at a given time (Rambhade, Chakarborty, Shrivastava, Patil, & Rambhade, 2012; Turner et al., 2016)Rambhade; Turner). However, numerical definitions of polypharmacy fail to take into account comorbidities and assess appropriateness (Masnoon, Shakib, Kalisch-Ellett, & Caughey, 2017). Therefore, this study understands polypharmacy more broadly, as the use of multiple medicines, including potentially inappropriate medication use.

There are many reasons why multiple medications might be prescribed in mental health care. Some research suggests that polypharmacy occurs due to inappropriate prescribing, however, as a way to manage the harmful side effects of a high dose of one medication, an alternative may be prescribing two medications at lower doses, and this may be preferable to the person who is taking the medication (Rambhade et al., 2012). Additional medications may also be prescribed to treat side effects of other medications or in response to nonadherence by the person taking the medication (Rambhade et al., 2012; Takeuchi, Suzuki, Remington, & Uchida, 2015; Turner et al., 2016). While polypharmacy may be used to manage side effects, it can also increase the risk of side effects and of interactions between medications. Polypharmacy, although common practice in psychiatry, is not always effective and places a high medication burden on those living with mental illness who are taking these medications (Hjorth, Jørgensen, & Sørensen, 2013).

Informational Challenges of Medication Management

Mental health service users obtain information about the medication they are prescribed from multiple sources. Consumers of medication frequently obtain information from their doctor, from written information that comes with the prescription, or from the pharmacist, and feel that these sources are the most reliable ways to obtain information (Tio, LaCaze, & Cottrell, 2007). However, where individuals obtain medication information frequently differs from their preferred information source. For example, in a study of Latinx individuals living in the U.S. (Sleath et al., 2009), a majority of participants preferred to receive verbal information about their medications from their physicians, but in reality obtained most of their information from pharmacists.

In a study of 910 individuals taking multiple medications a significant number of individuals obtained information about their medication from television, magazines, websites, or friends and family members. Seeking information from these sources was associated with non-adherence to medication, perhaps because the information they obtained was less accurate than information from a health professional (Carter, Moles, White, & Chen, 2013). Accurate information about medications may be distorted by portrayals of mental illness and treatments in the media, in part because of a need to create newsworthy products (Nairn,

1999). In a study of the efficacy of a medication information program for mental healthcare users, Tran and Castle (2012) found that medication users had poor access to standardized information about their medications and that they preferred to receive both verbal and written information about the medications they were prescribed.

Task-Oriented Challenges of Medication Management

Managing medication is also accompanied by task-oriented challenges. Users of medication may have difficulty navigating the logistics involved in taking medication, especially multiple medications. For example, it may be physically difficult to get to the pharmacy to pick up a needed prescription. For those on multiple medications, organizing the pills and remembering how and when to take each requires coordination and planning which may be hampered by their illness, schedule, or side-effects they may be experiencing as a result of the medication. According to Vlasnik and colleagues (2005), task-oriented challenges to medication use that negatively impact adherence include: inability to afford medication; physical difficulties filling or picking up prescriptions; difficulties handling or swallowing tablets; difficulties opening containers; challenges related to distinguishing identifying markings on medications; and limited social support.

The experience of taking medication, especially for a chronic condition, often includes positive or negative bodily effects, and a need to exert control over one's condition (Shoemaker & Ramalho de Oliveira, 2008). Those prescribed medications often have concerns about the medications themselves (including side-effects) and this may affect how they take the medication (Pound et al., 2005). The side-effects of psychiatric medications have been well documented and can have serious impact on health and functioning, including weight gain and associated conditions (Schwartz, Nihalani, Jindal, Virk, & Jones, 2004), sexual dysfunction (Olfson, Uttaro, Carson, & Tafesse, 2005), gastrointestinal distress, and insomnia or sedation (DiBonaventura, Gabriel, Dupclay, Gupta, & Kim, 2012).

Stigma and Medication Management

For many, shame and stigma associated with mental illness serve as barriers to seeking care, including the use of psychiatric medication (P. Corrigan, 2004; P. W. Corrigan, Druss, & Perlick, 2014). According to Corrigan and colleagues (2014), the stigma construct includes three components: public, self and structural components. Efforts to counteract stigma, and therefore improve mental health service utilization, require separate strategies for each component (P. W. Corrigan et al., 2014). Both self-stigma and perceived public stigma negatively impact help-seeking behavior related to mental illness, where perceived public stigma refers to stereotypes and negative labels held by the general public and self-stigma refers to the application of those labels to oneself (Pattyn, Verhaeghe, Sercu, & Bracke, 2014). Sirey and colleagues (2001) argue that stigma is a barrier to recovery for many individuals with mental illness because higher perceived stigma is associated with medication nonadherence.

Those who try to conceal their use of medication to avoid stigmatization may be at higher risk of social isolation and may be less likely to seek help (Lincoln et al., 2017; Link & Phelan, 2006). In a latent profile analysis of 8,875 Swiss adults, a negative attitude towards

help-seeking (including medication use) was associated with higher levels of shame (Rüsch et al., 2014). In a qualitative study of adolescents (n=27), Kranke, Floersch, Kranke & Munson (2011) found that adolescents kept medication use a secret from others out of fear of being ostracized or humiliated. Kranke and colleagues (2011) also found that African American adolescents had greater negativity in their stereotypes of persons with mental illness, which may exacerbate self-stigma processes and increase the risk of non-adherence to medication prescriptions.

Identity and Meanings of Medications

Medications may also carry multiple meanings, often contextually influenced, for the individual who is prescribed them (Viswanathan & Lambert, 2005). A majority of research on medication, particularly in behavioral health, has focused on issues of medication compliance or adherence, which may fail to reflect the factors that drive patterns of medication use and the meaning-made from medication prescription (Conrad, 1985; Shoemaker & Ramalho de Oliveira, 2008). What appears to be noncompliance from a medical point of view may actually be a form of asserting control over one's disorder (Conrad, 1985). Medication can also become intertwined with identity. In a study by Adams, Pill and Jones (1997), accepting or rejecting the identity of an asthma sufferer was associated with different beliefs about the meaning of the prescribed medication and the nature of their medical problem. Psychiatric medication use can be particularly complex, with multiple physiological and psychological consequences.

Being prescribed and taking medication impacts the understanding of self and of disease in multiple ways. These meanings vary according to social contexts, including existing social supports, shame, and stigma (Cheraghi-Sohi et al., 2015; Hodgetts et al., 2011). While the experience of having a chronic illness impacts one's identity, the experience of medication prescription and use relates to the construction of sense of self in new and distinct ways. According to Bentley (2010), medication incites meaning, influences identity and impacts life. Themes emerged about medication as having multiple and complex meanings for those prescribed them. Some participants described medication as a positive force, a tolerated fact of life, a part of the story/evolution of one's mental illness, a basis of gratitude and source of victory over past struggles, necessary for prevention of relapse, or a symbol of differentness and dependency. These findings suggest that medication can be an avenue towards a more positive life experience but simultaneously can also be a source of felt otherness and resignation (Bentley, 2010). In another qualitative study with older Puerto Ricans, medication use reflected the dilemma of immigration and challenge of immigrant identity (W. E. Adams, Todorova, Guzzardo, & Falcón, 2015).

Recovery pioneer Pat Deegan described her experience with medication prescription (2007) as initially paired with a message of hopelessness related to her diagnosis. She suggests that had medication prescription instead been paired with a message about the goal of recovery she would have been able to view medication use as a means to a goal, rather than the goal itself. Adults with psychiatric illnesses are tasked with complex-decision making in an effort to weigh the costs and benefits of using prescribed medication in the context of their

recovery, and sometimes perspectives between the patient and prescriber are not aligned (Deegan, 2007).

The current study uses a qualitative methodological approach to examine service users' experiences with multiple medications including how they learned, thought and felt about their medication. The data about medication presented follows from initial presentation or prescription of the medication, to the users' integration and management of the medication in daily life. We drew upon data collected as part of a larger NIMH funded study (1R01MH096707-04) examining the meaning and impact of limited literacy among public mental health service users. As part of this work, data were collected on medication use and associated shame and stigma, as limited literacy has clear impacts on each of those domains.

Methods

The current study analyzed 26 qualitative interviews gathered as part of a larger mixed-methods study of public mental health service users. While the larger study aimed to understand the prevalence and impact of limited literacy among public mental health services users, this approach also allowed us to capture the experience and meaning of medication use. At the start of the research, the research team worked with study sites to organize a Consumer Consulting Group (CCG). This group, consisting of 5 users of public mental health services, assisted in research material development, offered guidance on how to improve recruitment strategies, and helped the broader research team understand preliminary results. Informed consent was obtained from all participants. The research was fully approved by five institutional review boards. The authors have no known conflicts of interest to disclose and certify responsibility for the manuscript.

The broader study included structured interviews, medical record review, and follow-up semi-structured interviews with service users at two research sites. For the current synthesis, we drew upon semi-structured interviews conducted at the second of the two study sites between March and April 2015. Interview data collected at site 1 led us to identify meaning and management of medication as an additional research question. The sequential mixed-methods design of the larger allowed interview questions about medication to be added to the interview guide at the second site. Thus, all participants who were included in this qualitative subsample constitute our sample of interest in this current study.

This site is an outpatient clinic that is part of a large, urban, safety-net hospital affiliated with an academic medical center. That hospital provides services regardless of an individual's resources and has no eligibility criteria for services; the clinic serves more than 4,000 people per year. According to clinic data, an estimated 5% of service users have a diagnosis of schizophrenia or schizoaffective disorder, 20% have a diagnosis of bipolar disorder, 45% have a depressive disorder, and 35% of service users have an anxiety spectrum disorder. Service users at the site are racially diverse, with 40% of service users identifying as Black or African American, 20% as Latinx, 30% as White, and 10% representing "more than one race." Our study sample reflects the diversity represented at these clinics. Service users who were English-speaking and aged 18 years or older were eligible for study participation. Multiple recruitment strategies were employed, including flier distribution,

clinician referral, and tabling on randomly selected days. This resulted in 199 participants completing structured interviews related to literacy and mental health service use at the second research site. Among these participants, 26 then completed follow-up in-depth qualitative interviews. This qualitative interview subsample was randomly selected but weighted for a higher proportion of participants with limited literacy, to further explore issues related to literacy. These interviews included qualitative queries about medication experiences. The demographics and mental health diagnoses of our sample are summarized in Table 1. The second author conducted all interviews in a private room on site, interviews lasted up to an hour. These interviews were audio recorded and later transcribed. Qualitative analysis was conducted using Hyper-Research software and an iterative coding processes by authors 1 and 3 was utilized.

Of the 26 participants who participated in qualitative interviews, 21 consented to a medical record review. In the medical record review, information about medication usage and type was recorded. Specifically, medication prescription for three categories of conditions were identified: psychiatric, physical and neurological conditions. Medication usage in each category meant that an individual was taking at least one medication in that category, and individuals might have been prescribed multiple medications within each of the 3 categories at the time of data collection.

Results

Our findings highlight the multiple challenges faced by public mental health service users as they use and manage their prescribed medication, including: the burden of polypharmacy; challenges related to the management of multiple medications – including information, task oriented challenges, and stigma; and how participants understood and made meaning of the medication use. Each theme is presented in greater detail below.

Medication Burden and Multiple Medications

The majority of interview respondents were taking multiple medications at the time of the study. Among the 21 individuals we interviewed who consented to a medical record review, 86% (n=18) were taking three or more different medications: one or more in each of the three categories (psychiatric, physical and neurological). 14% (n=3) were taking medication for one or two of the categories of conditions. This suggests a high degree of comorbidity in our sample. Our qualitative interview data showed how individuals experience and think about this heavy medication burden.

Managing multiple medications often proved difficult for participants. One man explained, “I have so many medicines that I take. Side effects are part of my everyday life actually. So when we’re trying to find something that’s supposed to work you’ve got to deal with the side effects and that bothers me more than anything because you know I’ve got to take at least eight medicines” (#227). Individuals expressed distress at the number of medications they were expected to take, not always understanding the rationale for all of them:

A lot of times I don’t take my pills because it gets overwhelming when you have so many. You have like a hand full of pills and then you get sick and they give you

another pill and then that's got to go in and then sometimes you gotta take this only in the morning this only in the night so it's not like I can just take them all at one time and get it over with. (#232)

As is frequently the case in polypharmacy, individuals must manage the burden of additional medications in order to correct adverse effects of other medications. One woman exclaimed, "who needs all this medication? I said to the doctor if I take all these meds that you people prescribe, I'd be dead" (#205).

With the use of multiple medications, some participants expressed confusion at frequent changes made in their medication regimen:

That's where the merry-go-round starts to be for me because I'm like I trust this doctor until I talk to this [other] doctor and then...medicine's changing all the time and then I take so many different medicines I can't tell you what's working and what's not. (#227)

Managing multiple medications, prescribed by multiple clinicians, increased the complexity and challenge for service users, particularly when changes were made to the medication regimens.

Management Challenges: Information about Medication

Individuals learned about medications and how to take them in multiple ways. Many people asked their identified doctor, psychiatrist or nurse about how to use the medication and what side effects might occur (n=18). Some participants did not feel comfortable asking their doctors about the medication or didn't believe their doctor could give them the information they sought in a way they could understand. These individuals instead identified persons they perceived as less threatening to tell them about their medication, such as the pharmacist mentioned in the previous quotation (n=7), or a family member or neighbor (n=5). One woman reported that when her doctor explained the medication to her, she did not feel like she understood enough to take it and so, "I wait for my daughter... she would explain to me" (#290). Others sought information about their medications through the internet (n=5), while still others gleaned information only from the prescription bottle label (n=6), despite varying levels of literacy in the sample. One woman explained her experience reading her prescription labels:

I can read those, but then I don't understand when it goes, um, caution: side effects. What do you mean, side effects? That's when I get aggravated about. I read my prescription it says, take one time, two times a day, drink with or without food, that confuses me, too. With or without food? ...Cause it really confuses me, I don't understand some of it, but the majority of my prescription bottles I can understand. (#157) In seeking to obtain information about their prescribed medication, literacy barriers were revealed. One man reported:

It has confused me because like my medication, they give me the paper what is, what explains the side effects and what it would do and there are a lot of words that I cannot understand on that. And I wait till the line clear up and I start reading it at the pharmacy. And if I don't understand it I just wait till the line clear down and ask

one of the pharmacists to explain it to me, you know read it to me... to you know, write it on the bottle for me in a way I can understand it. (#136)

Research suggests that many public service users have very low levels of literacy (Lincoln et al., 2017), and thus may be placed in the difficult position of being prescribed multiple pharmaceuticals without having the skill set to comprehend their written instructions.

It is also important to note that the majority of individuals interviewed had at least some trouble understanding how to use their medication and voiced concerns about side effects. Only two individuals reported having no trouble understanding how to use their medications. Public mental health service users who are prescribed medication obtained information about how to use it from a variety of sources, but they also faced challenges related to understanding and utilizing that information.

Management Challenges: Task-oriented Difficulties and Creative Resiliency

Individuals discussed the difficulties that they faced in keeping track of all their medications (n=5), confusion about how to take their medications correctly (n=7), forgetting to take their medications (n=6) or deciding not to because of past unpleasant side effects (n=10). One man told us about the difficulty he had remembering to take his medication:

I take them but sometimes I forget to, I forget them sometimes. You know what I mean? I might have to do something and rush out the house with it or when I come home I forget. I don't have difficulty taking the medication it's just that sometimes I forget. (#280)

For some, it was challenging to keep track of how and when to take their medication, particularly if they were using multiple medications. One man noted:

I can't really remember what the medicine is, but I know I'm taking it like they told me to take it and do what I'm supposed to. You know, they said try not to skip, cause it's not good for you to keep on skipping the medicine like that. (#129)

For some individuals, the instrumental challenges they faced keeping track of multiple medications was intertwined with the difficulty obtaining and retaining information about those different prescriptions.

Some individuals had trouble taking their medication as directed because of challenging life circumstances, such as housing instability, food scarcity, or other illness experiences. For example, one man mentioned, "I was in a shelter, and I couldn't take it in the morning time so I always had to take it at night instead" (#154) and another reported, "I forget stuff because I had gotten head traumas before so its most likely I'll forget stuff unless I write it down or have someone remind me" (#280). Instructions to take the medication at specific times or with other specifications were difficult for some to navigate:

Sometimes you gotta take this only in the morning, this only in the night so it's not like I can just take them all at one time and get it over with. I have to be careful about how I take it and when I take it and with food, without food. (#232)

Despite these reported challenges, many participants reported creative ways that they kept their medications organized and strategies for remembering to take them at the correct times.

For instance, one woman had “a pillbox that my friend just gave to me that I load, [it helps me] keep my life in order a little better” (#243). Even though not all individuals had pillboxes to help with medication organization, other individuals developed other strategies to keep track, including one woman who explained that she kept track of her medication schedule, “in my planner. It’s a seven-day planner. So I read the bottle, I have AM in a plastic bag, PM in a plastic bag...I try to be organized like that” (#288).

While the above respondent wrote things down to remember when and if they took their medications, others used creative visual techniques: “I put stickers on the wall. I have a sticker to remind me to take my medicine” (#136). Incorporating medication use into a daily routine seemed to help individuals to manage and navigate the use of multiple medications: “the night before I put everything on the counter the meds and when I get up, I take them. They’re right in front of me” (#205). The creative solutions for medication management that these respondents told us about reflect resiliency and dedication to their own recovery, despite the many challenges that individuals face when managing multiple medication. This is particularly notable given that study respondents reported few economic resources, and a majority of the sample had low levels of literacy.

Management Challenges: Shame and Stigma

Participants also described feelings of shame and self-stigma when discussing medication. This included shame around needing to take medication (n=8), fear about the possible harms of the medication (n=7) and discomfort with revealing or disclosing medication use to others (n=2). Participants implied that having to use medication meant that they were inferior, and that if they were stronger they would not “have” to use medications to manage their conditions and symptoms. For example, one man discussed discomfort around the necessity of medication use, “it’s always been something that I wished I could manage my depression without a pill. I wish I could do this, thought I could” (#227). For some, taking medication felt like a statement about their personal character. One woman said, “It made me feel a little bit sad that I have to take it because I felt like it was something wrong with me” (#157). Calling themselves by derogatory names was not uncommon in this sample; one woman called herself “a loser” for taking medication (#239), one man said he felt, “like I’m a knucklehead” for needing to take so many pills (#251), and another called herself a “bad girl” for having difficulty remembering to take her medication as prescribed (#232).

Some participants discussed concealment of their medication use, out of shame or perceived stigma that might come from sharing this information with others. One woman said that, “I normally don’t just throw it out there, because it’s a cruel world” (#227). Another said she didn’t usually share her medication use, “because people use it against you” (#299). Another woman discussed the impact on relationships with friends and family,

My family, my friends, they don’t even know, I don’t tell them that I take it cause it none of their business. But I notice they notice a change if I don’t take it. They say, wow [respondent’s name] was quiet yesterday, today, this morning she was loud. (#157)

Not only did respondents feel the necessity to conceal their medication use from their loved ones, this concealment had negative consequences on the relationships themselves.

Identity and Making Meaning of Multiple Medications

Finally, our participants shared compelling perspectives on the relationships among medication, identity, meaning-making and ambivalence. While many individuals spoke about how they felt their medication helped them (n=8), these same people also discussed a feeling that medication simultaneously “hurt” them and expressed a wish that they did not need the medication or dissatisfaction with taking it. For example, one woman discussed this paradox,

I think it’s helping me. But I hope this is you know I don’t know. I’m scared to ever stop to see what I might feel like without it. But then on the other hand this thing is killing me too. I don’t really want to take meds to the day I die. You know. That I have to take pills every day and night. I want to see one day to see what it feels like to not take a pill.” (#258)

Another woman expressed, “medication it calms me down, it works for me. But I just don’t like the feeling that I have to take it to calm me down, that’s what I hate. It makes me feel sad that I have to take it to, get help. But, I love it. Because it does help me out” (#157). Participants were endlessly grappling with this ambivalence, where medications were simultaneously improving and harming their selves and identities.

Some participants discussed accepting medication as a part of their life (n=4) and learning to deal with their symptoms differently as a result of medication (n=4). As one man put it, “things are still there, you know, but I just learned how to deal with things different now” (#180). It appears that for some, medication acted as a motivator in recovery from mental illness. As one woman explained:

Well, at first, I feeling sad I’m saying I had to take all this medicine, you know for my mind. I cried at first. Yeah, I broke down and cried at first, and then I said well then is going to help you, motivate you and help you to carry on with your life. (#136)

For this participant, the meaning of multiple medication use changed over time as she shed her feelings of grief and began to feel gratitude for the benefits that medication might bring to her life.

Discussion

Our findings suggest that individuals living with mental illness are taking multiple medications and experience several types of challenges related to managing those medications. High levels of limited literacy in this population, combined with material disadvantage, only further compound the stigma and practical difficulties experienced by these individuals. Furthermore, polypharmacy impacted individuals sense of identity in this sample. Despite these challenges, individuals reported creating and adopting innovative solutions for medication management in order to support their own recovery processes.

Many of the findings in this paper resonate with previous research. Our study confirms that many individuals with mental illness, specifically public mental health service users, are prescribed multiple medications, and that multiple providers amend those prescriptions.

Furthermore, participants reported multiple side-effects from their medications that negatively impacted their well-being. Individuals talked about feeling shame and self-stigma related to both mental illness and medication use, and some reported concealing their medication use, leading to social isolation (Corrigan et al 2014; Link and Phelan 2006; Lincoln et al. 2017). The prescription and consumption of medication impacted participants' sense of identity and the meaning they placed on understandings of disease and self, themes that have been well identified in past literature (Adams, Pill and Jones 1997; Viswanathan and Lambert 2005; Conrad 1985). However, we find that meaning of medication is particularly important for individuals who manage multiple medications. As polypharmacy is increasingly common, the importance of recognizing complicated psychosocial factors associated with medication prescription will also increase.

As in other samples, our participants reported receiving information about their medications from physicians and pharmacists (Tio, LaCase & Cotrell 2007) as well as from non-medical sources, including family members and the internet (Carter, Moles, White & Chen 2013). However, our findings also highlight the importance of literacy in medication management. Low literacy - including reading literacy, aural literacy, numeracy and health literacy – serves as a substantial barrier to the safe management and consumption of prescription medications. This is of particular concern among populations with high rates of low literacy combined with high rates of polypharmacy, as is the case for many public mental health services users. Furthermore, limited literacy is frequently a source of shame and self-stigma, leading to resistance to disclose challenges related to accessing or understanding medication information. Combined with the shame often related to having a psychiatric diagnosis and being prescribed multiple medications, this double stigma of limited literacy and public mental health service use (Lincoln et al 2017) serves as a substantial barrier to medication adherence.

An additional contribution that this research provides is a more in-depth exploration of the task-oriented challenges related to medication management. Vlasnik et al (2005) identified several task-oriented challenges to medication use, including: inability to afford medication, physical difficulties filling or picking up prescriptions, difficulties opening containers, challenges distinguishing medication markings, and limited social support. While respondents spoke of some of these challenges, they also reported challenges related to limited literacy (as discussed above) and remembering to take their medications. For many, the most challenging medication task was tracking how and when to use their medications. This is increasingly salient as individuals are prescribed higher numbers of medications. This reported difficulty understanding how to use prescribed medication, and confusion related to the rationale for the prescription, may be important barriers to effective use of medication. Furthermore, some of the instrumental challenges related to medication adherence were related to material disadvantage, which is particularly common among public mental health service users. For example, individuals in shelters or unstable housing have the additional burden of managing medications without a stable physical location, privacy and routine.

Limitations

This study is limited by its design. Our qualitative study used non-random sampling to identify participants and so our sample may not be representative of all public mental health service users. In addition, volunteer bias may be present if those who chose to participate are meaningfully different from those who declined participation. Despite these sampling limitations, our sample demonstrates considerable diversity in age and racial identity and participants reported a range of different mental health diagnoses. In addition, the qualitative design allows us to explore the nuanced perspectives of public mental health service users and their experiences with managing multiple medications.

Conclusion

These data highlight the importance of mixed-method, service user informed, approaches to research aimed at increasing our understanding of the use and experience of medication by people using mental health services. Our qualitative approach allowed us to explore the “hows” related to medication use: How do individuals take their medication? How do they learn about their medication? And how do individuals think, feel, and make meaning related to their medication use? Our service-user engaged strategy provided powerful tools for gathering data from an often difficult to engage population, on highly stigmatized and personal topics, in a respectful manner, and greatly increased our ability to understand and interpret our study findings.

While much attention has been paid to medication use among mental health service users, these efforts have often focused on understanding medication adherence without attention to these broader meanings and experiences of medication. This research begins to shed light on these topics, including honing in on specific challenges related to the management of multiple medications – information access, task oriented challenges, and stigma; the innovative strategies service users engage to support their medication management; and how participants understood and made meaning of the medication use. With the increased use of polypharmacy and the associated complexity of medication management, it is important to understand service users’ experiences of medication and medication management, particularly within the context of often limited resources and other structural disadvantage. Increasing understanding of these experiences of polypharmacy supports clinicians and programs in providing more effective care and promoting the health and well-being of mental health service users.

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Table 1

Summary of Demographic Characteristics (n=26)

Characteristic	<i>n</i>	%	<i>Valid%</i>
Gender			
Men	11	42.3	42.3
Women	15	57.7	57.7
Race			
White	5	19.2	19.2
Black	17	65.4	65.4
Two or more races	4	15.4	15.4
Highest Year of Education			
13 or Higher	6	23.1	23.1
12 th grade	6	23.1	23.1
11 th grade	5	19.2	19.2
10 th grade	4	15.4	15.4
9 th grade or below	4	15.4	15.4
Level of Literacy			
Not Low Literate	7	26.9	26.9
Low Literate	19	73.1	73.1
Mental Health Diagnosis			
Depression	8	30.8	38.1
Bipolar	2	7.7	9.5
Substance Dependence	3	11.5	14.3
PTSD	8	30.8	38.1
Anxiety	6	23.1	28.6
Schizophrenia	5	19.2	23.8
Medication Prescription Categories			
Psychiatric	17	65.4	81.0
Neurological	19	73.1	90.5
Physical	20	76.9	95.2
Age	Range		Mean
	25–77		49.6

Note: Diagnosis for each mental health disorder and medication prescription was not reported for all participants, data was missing for 5 participants, as such, valid percent is also reported for the 21 participants who consented to the medical record review.