EFFECTIVENESS OF MULTIMEDIA PSYCHOEDUCATION PACKAGE ON KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS AT SELECTED SETTING TRICHY, 2015

DISSERTATION SUBMITTED TO

THE TAMIL NADU DR.M.G.R.MEDICAL UNIVERSITY

CHENNAI

IN PARTIAL FULFILMENT OF REQUIREMENT FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

APRIL 2016

Internal Examiner:

External Examiner:

EFFECTIVENESS OF MULTIMEDIA PSYCHOEDUCATION PACKAGE ON KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS AT SELECTED SETTING TRICHY, 2015

Certified that this is the bonafide work of

Mrs. SASIKALA. A
Omayal Achi College of Nursing
No. 45, Ambattur Road
Puzhal, Chennai – 600 066

COLLEGE SEAL:

SIGNATURE :

Dr. (Mrs.) S.KANCHANA
R.N., R.M., M.Sc.(N)., Ph.D., Post. Doc(Res).,
Principal & Research Director, ICCR,
Omayal Achi College of Nursing,
Puzhal, Chennai – 600 066,
Tamil Nadu.

DISSERTATION SUBMITTED TO

THE TAMIL NADU DR.M.G.R.MEDICAL UNIVERSITY

CHENNAI

IN PARTIAL FULFILMENT OF REQUIREMENT FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

APRIL 2016

EFFECTIVENESS OF MULTIMEDIA PSYCHOEDUCATION PACKAGE ON KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS AT SELECTED SETTING

TRICHY, 2015

Approved by the Research Committee in December 2014.

PROFESSOR IN NURSING RESEARCH
Dr. (Mrs.) S. KANCHANA ____________________
R.N., R.M., M.Sc.(N)., Ph.D., Post. Doc (Res).,
Principal & Research Director, ICCR,
Omayal Achi College of Nursing,
Puzhal, Chennai – 600 066, Tamil Nadu.

MEDICAL EXPERT
Dr. M. PETER FERNANDEZ _____________________
M.D., D.P.M., T. D. D. F. I. P. S
Professor Emeritus (Psychiatry),
Director, Dr. Fernandez Home for Schizophrenia,
Mugalivakkam, Chennai – 600 125, Tamil Nadu.

CLINICAL SPECIALITY – HOD
Mrs. HEMAVATHY _____________________
R.N., R.M., M.Sc.(N)., [Ph.D(N)]., Head of the Department,
Mental Health Nursing,
Omayal Achi College of Nursing,
Puzhal, Chennai – 600 066, Tamil Nadu.

CLINICAL SPECIALITY – RESEARCH GUIDE ____________________
Dr.Mrs.P.JAYANTHI
R.N., R.M., M.Sc.(N)., Ph.D(N).,
Asst. Professor, Mental Health Nursing,
Omayal Achi College of Nursing,
Puzhal, Chennai – 600 066, Tamil Nadu.

DISSERTATION SUBMITTED TO

THE TAMIL NADU DR.M.G.R.MEDICAL UNIVERSITY

CHENNAI

IN PARTIAL FULFILMENT OF REQUIREMENT FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

APRIL 2016

ACKNOWLEDGEMENT

I owe my gratitude to all those who have supported and guided me in the completion of the project.

I extend my immense thanks and gratitude to the **Managing Trustee**, Omayal Achi College of Nursing, for having given me an opportunity to uplift my professional life.

I am indebted to the **Vice Chancellor and Research Department** of **The Tamil Nadu Dr.M.G.R.Medical University**, Guindy for giving me an opportunity to undertake my postgraduate degree in nursing at this esteemed university.

I consider myself extremely fortunate to express gratitude and sincerely thank **Dr.K.Rajanarayanan**, **M.B.B.S., FRSH** (London), Research co-ordinator, ICCR and Honorary Professor in Community Medicine for his commendable encouragement, support and guidance in completing this study.

My genuine gratitude to **Dr.(Mrs).S.Kanchana**, Principal, Omayal Achi College of Nursing for sharing her expertise, sincere and valuable guidance and encouragement extended in completing the study.

I acknowledge my genuine gratitude to **Dr.(Mrs).D.Celina**, Vice Principal, Omayal Achi College of Nursing for sharing her pearls of wisdom and timely motivation in proceeding with the study.

I express my sincere thanks to the **Executive committee members** of International Centre for Collaborative Research (ICCR) for their insightful comments and encouragement which incented me to widen my research knowledge from various perspectives during research proposal, pilot study and mock viva presentation.

I extend my deepest gratitude and immense thanks to my research guide **Dr.(Mrs).P.Jayanthi**, Assistant Professor, Mental Health Nursing, for her constant motivation, guidance, patience and valuable suggestions in all the time of research and writing of this dissertation.

My immense and deep gratitude to **Mrs.Hemavathy**, Head of Department, Mental Health Nursing and **Mrs.S.Kalaiyarasi,** Assistant Professor, Mental Health Nursing for their direction, valuable guidance, suggestions and constructive criticism in completing this study successfully.

My heartfelt thanks to **Prof.(Mrs). Sumathy**, Class Co-ordinator for her timely help, patient endurance, and valuable guidance which helped me in completion of the study.

I sincerely thank my Medical Expert, **Dr.M.Peter Fernandez**, MD., D.P.M., T.D.D., FIPS Professor Emeritus (psychiatry) Director, Dr.Fernandez Home for schizophrenia for his valuable suggestions rendered throughout the study.

A special note of gratitude to all the **Head of the Departments** and **Faculty** for their constructive ideas and moral support given towards the progress of the study.

My sincere thanks to all the **Nursing** and **Medical experts** who gave their valuable suggestions in validating the tool for the study.

A memorable note of gratitude to the **Medical Directors of Mercy Hospital and Athma Hospital**, **Trichy** for granting permission and support rendered throughout the study.

My sincere gratitude to **The Principal**, **Jennys College of Nursing**, **Trichy** for permitting their students to perform psychodrama in my study and I extend my thanks to the students who actively enacted the psychodrama.

I extend my deepest gratitude and immense thanks to each and every study participant, who gladly involved themselves in the study and extended their immense co-operation.

My sincere thanks to **Dr.Sakthivel,** statistician and **Mr.Yayathee Subbarayulu**, ICMR - Senior Research Fellow for their effective assistance in statistical analysis.

A special note of gratitude to **Mr.G.K.Venkataraman**, of Elite computers, for his effort and co-operation in completing the manuscript.

My immense thanks to the **Librarians** of Omayal Achi College of Nursing, The Tamilnadu Dr.M.G.R Medical University, Chennai for their help extended in locating appropriate search materials.

I am grateful to my friend **Mrs.S.Kavitha** in **Department of Mental Health Nursing**, for her constructive ideas and comments that greatly improved the manuscripts of the study. I extend my thanks to all my classmates, **SSPCKTRRMB GALSS** (M.Sc Nursing II year 2014 – 2016 batch) for their encouragement and support throughout to mould my study in a better way.

Words are beyond my expression of thanks to my beloved father **Mr.M.Arumugam**, my mother **Mrs.A.Kamatchi**, my sister **Mrs.A.Krishnapriya**, my brothers **Mr.A.Pradeep Raju**, **Mr.V.Senthil Kumar**, **Mr.S.Praveen** and my in laws **Mr.V.Periasamy** and **Mrs.P.Tamilselvi** for their unconditional love, constant encouragement, and moral support rendered for the entire study.

I owe my eternal gratitude to my dearest husband **Mr.P.PremKumar**, and my son **Master.P.S.Krithikshan** for their sacrificies, support, love and encouragement to complete the dissertation.

Above all, I thank **God Almighty** for being with me, guiding me and sustaining me in all endeavours to complete the dissertation to my optimal satisfaction.

LIST OF ABBREVIATIONS

ANOVA	-	Analysis of Variance
BPAD	-	Bipolar Affective Disorder
CINAHL	-	Cumulative Index to Nursing and Allied Health
CNE	-	Continuing Nursing Education
DVD	-	Digital Video Disc
GAD	-	Generalized Anxiety Disorder
ICCR	-	International Centre for Collaborative Research
ICT	-	Information Communication Technology
IERB	-	Institutional Ethical Review Board
MDD	-	Major Depressive Disorder
N	-	Number of sample
NCMH	-	National Commission on Macroeconomics and Health
OCD	-	Obsessive Compulsive Disorder
QOL	-	Quality Of Life
SD	-	Standard Deviation
WHO	-	World Health Organization

LIST OF SYMBOLS

Symbol		Meaning
=	-	Equals To
<	-	Less than
>	-	More than
%	-	Percentage
+/-	-	Plus or minus
F	-	ANOVA
p	-	Significance

TABLE OF CONTENTS

CHAPTER NO.	CONTENT	PAGE NO.
	ABSTRACT	
1	**INTRODUCTION**	1
1.1	Background of the study	2
1.2	Significance and Need for the study	4
1.3	Statement of the problem	7
1.4	Objectives of the problem	7
1.5	Operational definition	7
1.6	Assumptions	9
1.7	Null hypotheses	9
1.8	Delimitations	9
1.9	Conceptual framework	9
1.10	Outline of the report	13
2	**REVIEW OF LITERATURE**	
	Scientific reviews of related literature	14
3	**RESEARCH METHODOLOGY**	
3.1	Research Approach	21
3.2	Research Design	21
3.3	Variables	22
3.4	Setting of the study	22
3.5	Population	22
3.6	Sample	22
3.7	Sample size	23
3.8	Sampling technique	23
3.9	Criteria for sample selection	23
3.10	Development and description of the tool	23
3.11	Content validity	26
3.12	Ethical considerations	27
3.13	Reliability of the tool	28
3.14	Pilot study	28

CHAPTER NO.	CONTENT	PAGE NO.
3.15	Data collection procedure	29
3.16	Plan for data analysis	30
4	**DATA ANALYSIS AND INTERPRETATION**	32
5	**DISCUSSION**	47
6	**SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS**	52
	REFERENCES	59
	APPENDICES	i – lxxv

LIST OF TABLES

TABLE NO.	TITLE	PAGE NO.
1.1.1	Non-adherence rate	3
3.2.1	Schematic representation of a Pre experimental design	31
4.1.1	Frequency and percentage distribution of demographic variables of caregivers of clients with chronic psychiatric illness with respect to age in years, gender, duration of care (years), duration of stay with the client and education.	33
4.1.2	Frequency and percentage distribution of demographic variables of caregivers of clients with chronic psychiatric illness with respect to occupation, family monthly income, type of family and number of family members.	34
4.1.3	Frequency and percentage distribution of demographic variables of caregivers of clients with chronic psychiatric illness with respect to residence, type of chronic physical illness, marital history and relationship with the client.	35
4.2.1	Frequency and percentage distribution of demographic variables of clients with chronic psychiatric illness.	36
4.4.1	Comparison of pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.	39
4.5.1	Correlation between post test knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness.	40
4.6.1	Association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.	41

TABLE NO.	TITLE	PAGE NO.
4.6.2	Association of selected demographic variables with their pre test mean score of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness.	42
4.6.3	Association of selected demographic variables with their post test mean score of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness.	43
4.6.4	Association of selected demographic variables with their pre test mean score of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.	45
4.6.5	Association of selected demographic variables with their post test mean score of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.	46

LIST OF FIGURES

FIGURE NO.	TITLE	PAGE NO.
1.9.1	Conceptual framework based on J.W.Kenny’s open system model.	12
3.1	Schematic representation of Research methodology.	31
4.3.1	Frequency and Percentage distribution of pre and post test level of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness.	37
4.3.2	Frequency and percentage distribution of pre and post test level of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.	38

LIST OF APPENDICES

APPENDIX	TITLE	PAGE NO.
A	Ethical clearance certificate	i
B	Letter seeking and granting permission for conducting the main study	ii
C	Content validity	
	1. Letter seeking expert's opinion for content	iii
	validity	iv
	2. List of experts for content validity	vi
	3. Certificate for content validity	
D	Certificate for English and Tamil editing	xiii
E	IEC certificate	xv
F	Informed consent	
	1. Informed consent request form	xvi
	2. Informed written consent form	xviii
G	Copy of the tool for data collection with scoring key	xx
H	Coding for the demographic variables	xxxvii
I	Blue print of the data collection tool	xli
J	Intervention tool	xlii
K	Plagiarism report	lxxiii
L	Dissertation Execution Plan-Gantt chart	lxxiv
M	Photographs	lxxv

Effectiveness of Multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

ABSTRACT:

Aims & objectives: To assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness. **Methodology:** A pre experimental study was conducted at a selected setting, Trichy. 60 caregivers were selected by non-probability purposive sampling technique. Researcher used structured knowledge questionnaire and attitude scale for collecting the data and administered multimedia psychoeducation package (lecture cum discussion, video show, psychodrama and DVD). **Results:** The findings of the study revealed that the pre test mean knowledge score was 6.96 with SD of 2.38 and the post test mean knowledge score was 11.98 with SD of 1.65, the calculated paired 't' value was t = 17.438. The pre test mean attitude score was 17.30 with SD of 4.21 and the post test mean attitude score was 27.0 with SD of 3.26, the calculated paired 't' value was t = 27.877. The results also revealed that there was a high positive correlation between the knowledge and attitude among the caregivers of clients with chronic psychiatric illness. **Conclusion:** The study findings of the study revealed that multimedia psychoeducation was effective in improving the knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness which clearly depicted that the caregivers understood the importance of drug compliance which prevents relapse, re-hospitalization and improves quality of life of both clients as well as caregivers.

Key words: *Multimedia psychoeducation package, knowledge, attitude, drug compliance, caregivers of clients with chronic psychiatric illness.*

INTRODUCTION

Caregivers are the primary resource for persons with chronic psychiatric illness as they spend time with them and they are directly and actively involved in patient care. They play a crucial role in the optimal care of patients with mental illness. In order to support caregivers and improve patient condition it is necessary to educate them regarding drug adherence.

Poor medication compliance is found to be almost certainly the single most important factor in poor treatment response. It worsens the course of the illness and leads to impaired functioning. The consequences of drug non-compliance are clinically equivalent to those of untreated or inadequately treated psychotic illness.

Drug compliance is vital in preventing, managing and curing psychiatric illness and has a positive health outcome which upgrade healthy family functioning and reduces the caregivers burden.

Objective

To assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy.

Null Hypothesis

NH_1: There is no significant difference between the pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

Methodology

Pre experimental one group pre test and post test design was adopted for this study. The independent variable was multimedia psychoeducation package regarding drug compliance and dependent variable was knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness. The study was conducted in ATHMA hospital, Trichy. Caregivers of clients with chronic psychiatric illness who fulfilled the inclusion criteria were samples of the study. Non-probability purposive sampling technique was adopted. Structured knowledge questionnaire and attitude scale was used to assess the pre test and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness. The caregivers were seated comfortably in a well ventilated room as a group consisting of 10 members in each session. Multimedia psychoeducation package in this study focuses mainly on creating awareness and develop a positive attitude among caregivers about the importance of drug compliance and their roles through lecture cum discussion,

video show, psychodrama and Digital Video Disc (DVD) distribution for reinforcement for about 1hour. Both descriptive and inferential statistics were used for data analysis.

Result

The findings revealed that the pre test mean score of knowledge was 6.96 with SD of 2.38 and the post test mean score of knowledge was 11.98 with SD of 1.65. The calculated paired 't' value was t = 17.438 was found to be statistically significant at $p<0.001$ level. The pre test mean score of attitude was 17.30 with SD of 4.21 and the post test mean score of attitude was 27.0 with SD of 3.26. The calculated paired 't' value was t = 27.877 found to be statistically significant at $p<0.001$ level. Hence the study concluded that multimedia psychoeducation package had high statistical significance in imparting adequate knowledge and developing favourable attitude towards drug compliance among caregivers of clients with chronic psychiatric illness.

Discussion

The interpretation of the present study showed that there was a high statistical significance in caregivers knowledge and attitude towards drug compliance and had a positive influence in preventing relapse and re-hospitalization. Thus multimedia psychoeducation package is an effective intervention for the improvement of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Conclusion

Caregivers are the primary authoritative individuals who are obliged to provide compassionate care to the clients with chronic psychiatric illness. They lack awareness regarding drug compliance. The education to the caregivers led to decrease in relapse and re-hospitalization and improved the quality of life of both the clients and caregivers. The findings indicated that the multimedia psychoeducation package is an effective intervention to improve the level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Implications

The mental health nurse can use multimedia psychoeducation to caregivers of clients with chronic psychiatric illness for imparting knowledge and developing favourable attitude towards drug compliance. The nurse educator can plan for conferences, workshops, seminars regarding drug compliance to the nursing personnel. The nurse educator can arrange for mass awareness campaign regarding drug compliance in the community area. Nurse researcher communicates these findings to the public sector to enhance health care programs and extensive researches can be done in various settings regarding drug compliance to improve the knowledge and attitude of the caregivers of clients with chronic psychiatric illness.

CHAPTER – 1

INTRODUCTION

INTRODUCTION

Caregivers are the primary authoritative individuals who are obliged to provide compassionate care to the clients with chronic psychiatric illness. In order to support caregivers and improve clients condition it is necessary to educate them regarding drug compliance.

Non-compliance or non-adherence to treatment is the degree to which a patient does not carry out the clinical recommendation of a treating physician or in other words it is failure of the patient to follow the prescribed treatment regimen. **(World Health Organization, 2005)**

The prognosis in psychotic patient is not very good always and recurrence is very common due to non-compliance to medication. Psychotropic drugs are the first line treatment for almost every psychiatric illness with growing availability of wide range of drugs to treat mental illness. The patient on psychotropic drugs needs to take drug as prescribed and regular follow up is necessary to regulate long term therapy. Some patients do not follow the prescribed treatment because of various reasons. One of the major factors for re-hospitalization is found to be non-compliance in taking drugs. Noncompliance is a personal behaviour that deviates from health related advice given by health care professionals. **(Ambreen Jawed Tharani, 2013)**

Relapse is common in chronic psychiatric illness and seriously impacts patients quality of life and social functioning. The consequences of non-compliance can be devastating for patients and their family members in terms of personal suffering, hospitalization, reduced quality of life as well as society in general.

The risk of non-compliance goes three times in clients who are not supported by their family for treatment adherence. Literatures state that assistance and supervision provided by family can enhance medication compliance which can improve clinical outcomes and decreases the rate of relapse.

Relapses, deterioration of cognitive functioning, negative symptoms, neuroleptic resistance are the consequences of drug non-compliance in psychiatric illness. Supportive family environment has been reported to have a positive effect on compliance. The family members awareness of the patients illness is also connected to a better compliance. (**Drug and Therapy Perspectives, 2013)**

1.1 BACKGROUND OF THE STUDY

Chronic psychiatric illness is a condition that persists for more than 6 months and requires a long term treatment. Chronic psychiatric illness interferes with the way a person behaves, interacts with others and functions in daily life. 1 in 20 lives with a chronic psychiatric illness such as schizophrenia, bipolar disorder, major depressive disorder and anxiety disorder. In addition to the person directly experiencing psychiatric illness, family, friends and communities are also affected.

Caregivers are the primary resource for a person with chronic psychiatric illness, the effect of being a family caregiver though sometimes positive, are generally negative with high rates of burden. Caregivers face the problems of coping with social withdrawal, poor interpersonal behaviours and disruptive attitude of clients with chronic psychiatric illness. Numerous studies report that caring a psychiatric illness client is more stressful than caring for clients with a physical disability.

Drug compliance is vital in preventing, managing and curing psychiatric illness and has a positive health outcome which upgrades healthy family functioning and reduces the caregivers burden.

Poor medication compliance is found to be almost certainly the single most important factor in poor treatment response. It worsens the course of the illness and leads to impaired functioning. The consequences of drug non-compliance are clinically equivalent to those of untreated or inadequately treated psychotic illness.

Global Scenario

Nearly 450 million people suffer from a mental or behavioural disorder. Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder). One in four

families has at least one member with a mental disorder. Currently mental and behavioural disorders account for about 12 percent of the global burden of diseases. This is likely to increase to 15 percent by 2020. Family members are often the primary caregivers of people with mental disorders. The extent of the burden of mental disorders on family members is difficult to assess and quantify, and is consequently often ignored. However, it does have a significant impact on the family's quality of life. (**WHO, 2013)**

Non-adherence among patients with severe mental illness has been estimated to be between 30% - 65% .The following non-adherence rates have been reported:

Table 1.1.1 Non-adherence rate

Non-adherence rate	**Disease conditions**
30% - 66%	Major Depressive Disorder
30% - 65%	Bipolar Disorder
40% - 50%	Schizophrenia

(Source : American Pharmacists Association, 2013)

Medication management related training for the mental health workers have demonstrated that improvement in knowledge, attitude and skill of staff help to address non-compliance. **(Pharmacy today, 2013)**

Untreated mental disorders exact a high toll, accounting for 13% of the total global burden of disease. Unipolar depressive disorder is the third leading cause of disease burden, accounting for 4.3% of the global burden of disease. The estimates for low- and middle-income countries are 3.2% and 5.1%, respectively. When only the disability component is taken into consideration in the calculation of the burden of disease, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively.(**Global Burden of Disease, 2011)**

Indian Scenario

Mental illness is a global public health problem. One out of 4 (25%) persons are affected with some kind of mental illness. The higher in developed countries, but the global burden of untreated mental disease is higher in developing countries. Most of the

population suffering with mental illness lives in low and middle income countries. **(National Sample Survey Organization Report, 2015)**

Mental health was a much neglected field until recently. There is, however, increasing realization that conditions such as schizophrenia, mood disorders (bipolar, manic, depressive and persistent mood disorders) and mental retardation can impose a marked disease burden on Indians. This was confirmed by a study conducted for the National Commission on Macroeconomics and Health (NCMH) which stated that at least 6.5% of the Indian population had some form of serious mental disorder, with no discernible rural–urban differences; women had slightly higher rates of mental disorder than men. If one were to include some other 'common' mental disorders and alcohol and drug dependency, the estimates would be substantially higher. With the increasing size of the population, these numbers are expected to grow substantially by 2015; the population with serious disorders is expected to grow to more than 8crore in that year, and even higher if the category of 'common mental disorders' in the population was included in the projections. (**Burden of Diseases in India, 2011)**

1.2 NEED AND SIGNIFICANCE OF THE STUDY

Compliance with psychiatric drugs play a significant role in managing clients with psychiatric illness. It not only helps in controlling the symptoms, but also decreases the risk of relapse and ultimately improves quality of life for the clients. However it remains a challenge for the client, family and health care providers.

Contribution of family, friends and community play a major role in overcoming the obstacle of drug non-compliance. The caregivers lack awareness regarding the importance of drug compliance, if they are informed they may have positive influence and help in promoting long-term drug compliance, be the first line of assessment for side effects and supervise administration of drug and refill prescriptions. It has been reported that 7 out of 10 people with chronic psychiatric illness had family members as their caregiver.

Rath (2014) conducted a descriptive, co-relational study to identify the factors affecting non-compliance to psychotropic drugs as perceived by patient's relatives

visiting outpatient department of Father Mullar Mental Hospital Mangalore using a structured interview schedule to 100 subjects by using purposive sampling method. Findings revealed that various factors perceived as contributing to non-compliance were disease characteristics related (62%), transportation problems (56%), poor community mental health services (55%), drug side effects (52%), cultural myths (49%), social factors (48%), psychological and motivational factors (47%), economic factors (43%), knowledge and insight (31%), illiteracy (36%), and other factors such as misconception about treatment and difficulty in swallowing the tablets contribute to non-compliance (17%).The study recommended that more emphasis must be given on patient's family education to overcome the above attributes and reduce relapse.

Jerone L.Benedicta (2011) conducted a descriptive study on assessment of attitude on risk factors associated with compliance and non-compliance of neuroleptic treatment among patients with schizophrenia. The study samples were recruited from the outpatient and inpatient units in Raju Hospital, Chennai. The researcher used modified Reasons of Medication Influences scale (ROMI) and Drug Attitude Inventory scale. Results revealed that 94% of client had mild medication influence, 6% had moderate medication influence and 18% of clients had unfavourable attitude and 82% had moderately favourable attitude.

Nora.M (2014) conducted an exploratory study using quasi experimental design to assess the effects of psychoeducation intervention in improving insight and medication compliance of schizophrenic clients, Saudi Arabia. The study was carried out at inpatient unit of Al Amal mental hospital with 20 participants 10 in study group and 10 in control group. The tools used were insight observation and assessment sheet, medication observation checklist and psychoeducation intervention guidelines developed by the researcher. The results revealed that psychoeducational intervention had improvement in insight that led to improved medication compliance and it also showed correlation of these three variables knowledge, insight and drug compliance.

Usha.VK, Lini and Vivin (2012) conducted a non-experimental descriptive study to understand the compliance to treatment and relapse of patients with mental illness who attended district mental health programme clinic in Idduki district. 90 patients selected by non probability sampling technique were assessed for compliance by using rating

scale and the relapse using structured interview schedule. The findings revealed that 83.3% were having poor compliance and 58.9% patients had one exacerbation of symptoms and 75.6% had two times hospitalization before attending district mental health programme services whereas 83.1% had no exacerbation and 70% had no hospitalization after attending district mental health programme services.

Maqura (2011) conducted a study on factors associated with medication adherence among psychiatric outpatient at substance abuse risk. The study participants were patients newly admitted to a psychiatric outpatient department who took psychiatric medications from different providers and also has the substance abuse histories. The sample size was 131. Medication adherence rating scale and drug toxicologies were used for assessment. The study revealed that non-adherence ranges between 28% - 52% in major depressive disorder, 20% - 50% in bipolar disorder, 20% - 72% in schizophrenia and 57% in anxiety disorder.

Banerjee and Ravi (2013) conducted a cross sectional study on factors affecting non-adherence among patients diagnosed with unipolar depression in a psychiatric department of a Tertiary hospital in Kolkata, among adult patients both men and women diagnosed with unipolar depression (N=305) were administered with morisky medication adherence scale. The results revealed that 66.9% were non-adherent and 33.1% were adherent and suggested for suitable interventions to overcome drug non-compliance.

Jennings, Harris, Gregoire et al., (2011) conducted a quasi experimental study on effect of a psychoeducation programme on knowledge of illness insight and attitude towards medications among caregivers of schizophrenic clients, Qatar. Tool consisting of 25 items regarding drug compliance was administered to 73 schizophrenic clients and their caregivers (36 in study group and 37 in control group). The results revealed that the patients and caregivers acquired knowledge about the illness and its treatment and also psychoeducation had a positive impact on the attitude towards medications.

During the training period in various settings the researcher witnessed that most of the mentally ill clients had relapse and were re-hospitalised. The common reason behind this re-hospitalisation was drug non-compliance and poor attitude of caregivers towards

drug therapy. The caregivers response to poor drug non-compliance were discomfort resulting from treatment, cultural beliefs, forgetfulness, presence of other priorities, lack of information, self decision to omit / stop medications.

Hence the investigator wanted to create awareness regarding the importance of drug compliance among caregivers and undertook the study.

1.3 STATEMENT OF THE PROBLEM

A Pre experimental study to assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy.

1.4 OBJECTIVES

1. To assess the pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.
2. To assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.
3. To correlate the post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness.
4. To associate the selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

1.5 OPERATIONAL DEFINITIONS

1.5.1 Effectiveness:

Refers to the outcome of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness which was assessed by using structured knowledge questionnaire and attitude scale with 7 days of time interval.

1.5.2 Multimedia psychoeducation package

Refers to the information provided by the investigator regarding drug compliance through lecture cum discussion, video show, psychodrama and reinforcement through digital video disc to a group of 10 members.

- **Lecture cum discussion:**

Includes meaning of drug compliance, factors affecting drug adherence, its importance, strategies to overcome non-compliance and counselling for adherence for about 30 minutes.

- **Video Show:**

On effects of drug adherence and drug non-compliance for 20 minutes.

- **Psychodrama:**

On role of caregivers in drug adherence for 15 minutes. The researcher trained the nursing students to enact psychodrama.

- **Digital Video Disc:**

Contains information regarding meaning, factors affecting adherence, reasons for non adherence, its importance and strategies to overcome non-compliance.

1.5.3 Knowledge:

Refers to the awareness and ability of the caregivers to respond to the questions regarding drug compliance which was assessed by using structured knowledge questionnaire developed by the researcher.

1.5.4 Attitude:

Refers to the perception of the caregivers of clients with chronic psychiatric illness regarding drug compliance which was assessed by using attitude scale devised by the researcher based on Drug attitude inventory 30.

1.5.5 Drug compliance:

Refers to clients those who take the prescribed medications during the course of treatment.

1.5.6 Caregivers of clients with chronic psychiatric illness:

Refers to the individuals those who provide care to the clients regularly during the course of treatment.

1.6 ASSUMPTIONS

1. Caregivers may have some knowledge and attitude regarding drug compliance.
2. Multimedia psychoeducation package may improve the caregivers knowledge and develop favourable attitude regarding drug compliance of clients with chronic psychiatric illness.

1.7 NULL HYPOTHESES

NH_1: There is no significant difference between the pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

NH_2: There is no significant correlation between the post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

NH_3: There is no significant association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

1.8 DELIMITATION

The study was delimited to a period of four weeks.

1.9 CONCEPTUAL FRAME WORK

A conceptual framework is comprised of interrelated concepts that explain natural phenomena. The concepts are linked together to express the relationship between them. It is the schematic representation of the steps, activities and outcome of the study.

The conceptual model used for this study is based on J.W.Kenny's Open System Model. The system consists of a set of interacting components, with a boundary that filters both the kind and rate of exchange with the environment. The system has been defined as "set of components or units interacting with each other within a boundary that filters both the kind and rate of flow of inputs and outputs from the system". The open system theory concerned with changes due to interaction between the various factors in a situation. The general system theory provides a way to understand many influences on the whole person and the possible input of change of any part of the whole.

This model explains the breaking of whole thing into parts and gaining knowledge about how the parts works together in a system and decision pertinent concept about them as well as making predictions about how these parts of whole will function, behave and react.

INPUT:

Input is defined as any information, energy or material that enters into system through its boundary. In this study, the input is the material and information regarding drug compliance. The multimedia psychoeducation package comprises of lecture cum discussion, videoshow, psychodrama and DVD for reinforcement. The investigator assessed the pre test level of knowledge and attitude through structured knowledge questionnaire and attitude scale regarding drug compliance among caregivers of clients with chronic psychiatric illness.

THROUGHPUT:

It is the common process by which a system transforms, creates and organizes input, resulting in a reorganization of input. In this study, the investigator administered multimedia psychoeducation package regarding drug compliance among caregivers of clients with chronic psychiatric illness.

OUTPUT:

It is energy, matter or information given out by the system as a result of its process. In this study it refers to the attainment of adequate level of knowledge and attitude regarding drug compliance. The investigator assessed the post test level of knowledge and attitude regarding drug compliance using the same tool.

FEEDBACK:

It is the evaluation or response of the system. Feedback may be positive or negative. Positive feedback indicated the attainment of adequate level of knowledge and favorable attitude, negative outcome indicated inadequate level of knowledge and unfavorable attitude, which motivated the investigator for further reinforcement of multimedia psychoeducation package.

The conceptual framework adopted for this study helped the investigator to accomplish the research in an organized manner. In the input process, the researcher collected the information on the demographic variables of the caregivers and clients and the need for administering the multimedia psychoeducation package. In the throughput process, the nurse investigator taught the multimedia psychoeducation package to the caregivers and in the output process, the nurse investigator reassessed the level of knowledge and attitude regarding drug compliance. The adequate level of knowledge and favorable attitude showed the positive feedback. The moderately adequate knowledge and inadequate knowledge, moderately favourable attitude and unfavourable attitude showed the negative feedback.

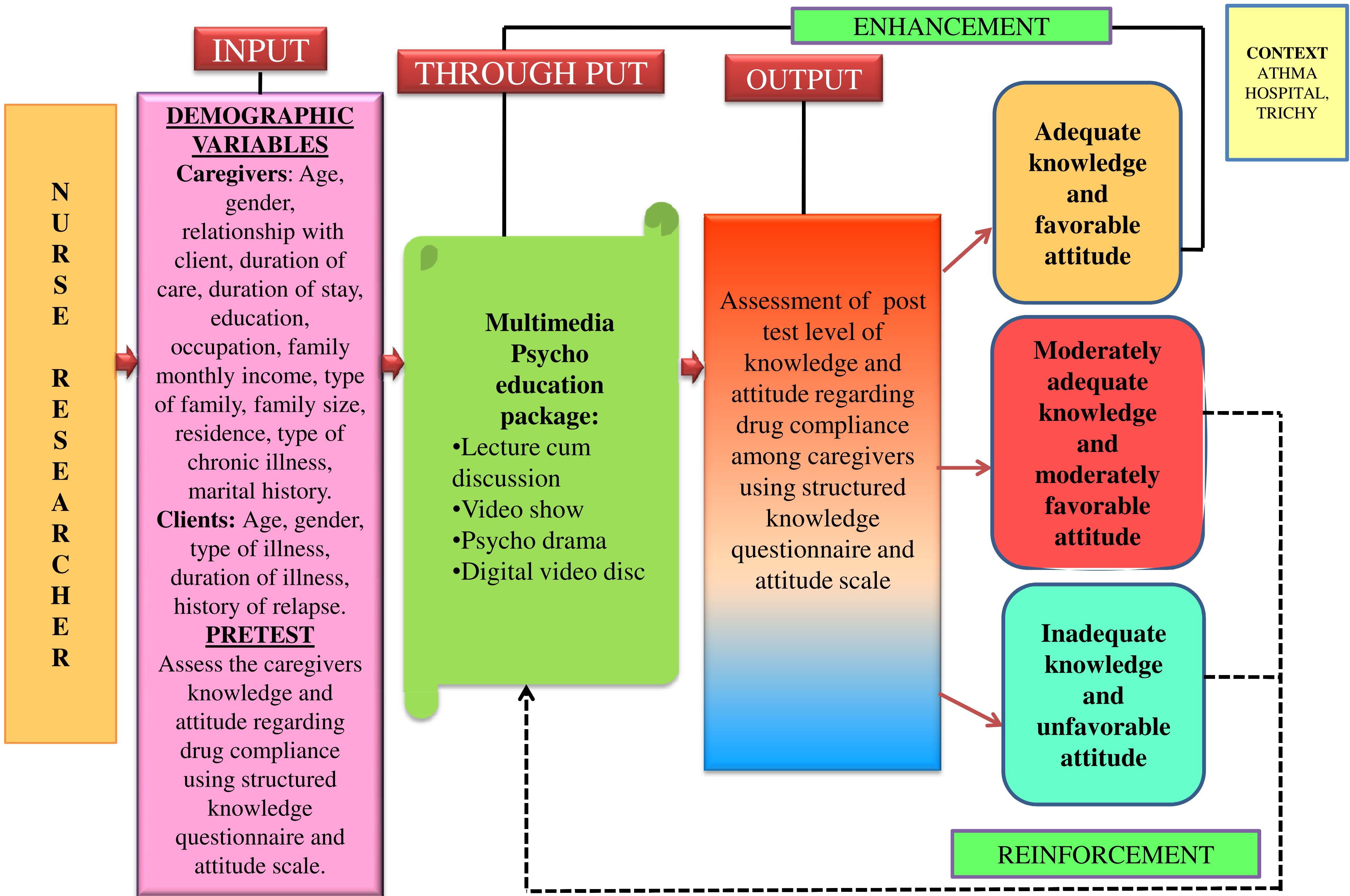


FIG.1.9.1: CONCEPTUAL FRAMEWORK BASED ON J.W. KENNY'S OPEN SYSTEM MODEL

1.10 OUTLINE OF THE REPORT

Chapter 1: Deals with introduction, background of the study, significance and need for the study, statement of the problem, objectives, operational definitions, assumptions, null hypotheses, delimitation and conceptual framework.

Chapter 2: Contains the scientific review of literature related to the present study.

Chapter 3: Presents the methodology of the study and plan for data analysis.

Chapter 4: Focuses on data analysis and interpretation.

Chapter 5: Enumerates the discussion and findings of the study.

Chapter 6: Consists of summary, conclusion, implications, recommendations and limitations of the study.

The study report ends with selected References and Appendices.

CHAPTER – 2
REVIEW OF LITERATURE

REVIEW OF LITERATURE

Literature review is defined as a summary of research on a topic of interest often prepared to put a research problem in context (Polit & Beck, 2008).

Literature review is a review of the evidence on a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant primary research, and to extract and analyze data from the studies that are included (Gerrish & Lacey, 2007).

The researcher entailed systematically searching the literature, selecting relevant studies, assessing the quality of the literature, extracting key information from the selected studies, summarizing, interpreting and presenting the findings, and writing up the research in a structured manner.

The researcher utilized electronic database to gather relevant articles. The databases include CINAHL, Pub MED, PMC National library of medicine and National institutes of health. The search terms used were drug non-compliance, knowledge and attitude, caregivers of psychiatric clients, prevalence of mental illness and multimedia psychoeducation package. The researcher collectively reviewed 110 studies. Out of which 54 relevant and updated studies within the duration of 2010 – 2015 were utilized to support the current research topic.

2.1 ORGANISATION OF REVIEW OF LITERATURE

The scientific reviews were placed under various sections

SECTION 2.1.1: Knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

- Prevalence of drug non-compliance
- Knowledge and attitude of caregivers regarding drug compliance
- Factors affecting drug compliance

SECTION 2.1.2: Psychoeducation regarding drug compliance.

- Multimedia psychoeducation
- Other psychoeducation methods

SECTION 2.1.1: KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE

Prevalence

Multiple studies (Aldona, Gomex, Moreno, 2010; Hardeman & Narasimhan, 2010; Maan, 2013; Kassis, 2014) reported that most common chronic psychiatric illness leading to drug non-compliance were bipolar affective disorder (BPAD), schizophrenia, obsessive and compulsive disorder (OCD) and major depressive disorder (MDD). Maan (2013) stated that the clients diagnosed with psychosis, epilepsy, generalised anxiety disorder (GAD), somatization disorder, substance induced psychosis, panic attack with agoraphobia also reported with drug non-compliance.

Hardeman & Narasimhan, (2010) reported that on an average patients prescribed with antipsychotics the adherence rate was 59% and for antidepressants the adherence rate was 65%. The adherence rate for MDD in acute treatment phase was 65% and 44% in maintenance phase. The adherence rate in BPAD was 32% were partially adherent and 50% reported adherence within past 2 years. The researcher recommended for further studies in various context.

Maan (2013) reported that there was a significant association between age, income and psychiatric illness with causes of drug non-compliance. Several studies (Kassis T, Ghuloun, Mousa and Bener, 2014; Aldona et al., 2010) revealed that high drug compliance was more among young adults and Aldona et al., (2010) also reported that non-compliance was seen in men and unmarried psychiatric clients.

Knowledge and attitude of caregivers

Multiple studies (Corrigan, 2010; Magaru, 2012; Shine, Desai & Pawar, 2012) reported that majority of the caregivers were family members and they lack knowledge about psychiatric illness and the efficacy of drug treatment.

Sullivan, Wells & Leake, (2010) reported that lack of support by the caregivers associated with re-hospitalisation and non-compliance has also been associated with re-hospitalization and it is also said to be the major cause of relapse in chronic psychiatric illness.

Shine et al., (2012) stated that caregivers considered medical intervention to be the factor that impacted negatively on follow up of clients. Hence the researcher suggested for educational programmes for the caregivers by developing psychoeducational intervention and sensitization campaign.

Mei, Jen & Chaun, (2014) reported that drug non-compliance was positively associated with the patients attitude because patients believed that an environment shift was effective in treating their psychiatric illness. Knowledge of drug side effects had a negative influence on drug compliance. The researcher suggested all patients and their caregivers should receive psychoeducation and plan for higher level of care like implementing pill organizers, involving families in drug supervision.

Rizwan, Saleem K, Heramani N, Lenin & Hussain, (2013) stated that caregivers social stigma, objection by a particular religious group to treatment and concellation of disability grants were also factors that linked non-compliance to treatment. Sharif (2014) reported that stigma and caregivers attitude towards mental illness and treatment affect drug compliance strongly and secondly relapse rate and self harm. Similarly Peter M Haddad, Cecilia Brain and Jan Scott, (2014) reported non-compliance with drugs occurs in all chronic psychiatric illness. It increases the risk of relapse, re-hospitalisation and self harm.

Factors affecting drug adherence

Multiple studies (Roy, Masroor & Sushma, 2010; Mibei, 2013; Nkangala, 2011; Kenfe Tesfay, Eshetu Girma & Alemayehu, 2013; Kyoko, Tansella & Barbuic 2013; Nirojini, Mounica & Rao 2014) revealed that more than one factor is responsible for poor or better compliance of therapeutic regimen. Main reasons of drug non-compliance identified were financial difficulty, distance from the hospital, improvement or no improvement in symptoms, side effects, lack of insight into the mental illness, old age of caregivers / lack of caregivers and lack of awareness about need of long-term

medication. Roy R et al., (2010) recommended plan for proper management of these factors. There is a need to provide community level mental health care and proper counselling to patients and their caregivers. Studies on socio-demographic and clinical correlates of drug non-compliance will add more information into our understanding of non-compliance by psychiatric patients.

Nkangala (2011) reported some of these factors can be modified like practical support by the caregivers and creating awareness on need of long-term medications. This would lead to a reduction in the rate of re-hospitalisation and costs.

Mibei (2013) reported fear of addiction to medication as a contributing factor for drug non-compliance. Kenfe et al., (2013) also reported afraid to get dependant on drugs as a factor hindering for drug adherence and various other factors responsible for drug non-compliance were forgetting, to get better without more medicine, shift to religious or traditional medicine, to try without drug, too embarrassed to take the drug, absence of drug supply. Nirojini et al., (2014) reported in addition to the above factors inability of the physicians to explain basic information on the medications and patients lack of knowledge on the benefits of medications are also factors associated with poor drug compliance.

Kyoko et al., (2013) revealed key drivers of non adherence as lack of insight, medication beliefs and substance abuse. Key consequences of non adherence included greater risk of relapse, re-hospitalisation and suicide. Factors positively related to adherence were a good therapeutic relationship with physician and perception of benefits of medication. Improving adherence can be achieved by focusing on the identified factors driving non adherence.

2.1.2 PSYCHOEDUCATION REGARDING DRUG COMPLIANCE

Dipanjan, Altul, Narendra, Pradeep, Sanjay & Basudeb, (2011) reported that several different models of psychoeducation were developed in accordance with the needs of mentally ill clients and their caregivers. The researchers suggested that psychoeducation can be initiated to draw the attention of caregivers of mentally ill clients to remain cooperative and complaint to treatment team.

Multimedia psychoeducation

Jeste, Craig, Theresa, Gannon, Louise & Dixon, (2010) compared the effects of multimedia (video or computer based) educational aids with those of routine procedures to inform health care consumers about medical evaluations or management of mental illness. The authors concluded that multimedia educational aids hold promise for improving the provision of complex medical information to patients and caregivers.

Iram TK, (2014) conducted a similar study to examine the effect of an interactive computerized psychoeducational system Vs traditional pamphlet educational approach for patients suffering from depression. Results reported that participants who underwent the interactive computerized educational system had considerably decreased incidence of medication non-compliance compared with traditional approach. The researcher recommended that multimedia learning concepts have been applied in the area of education and not been widely used in psychiatric outpatient departments. A combination of both may help patients and caregivers maintain better drug compliance in addition to improving their knowledge of depression.

Pei (2014) intended to review and analyse multimedia as the educational medium for patients or their caregivers. The author stated that the evolution of multimedia as an educational medium is growing and its incorporation has benefited health education management especially in improving patients and their family's psychosocial outcomes. However, due to still limited scientific evidence to support its value, further multimedia based interventions should be developed.

Other psychoeducation methods

Bergen, Glenntt, Armitage & Bashir, (2011) stated that education to the family members led to decreased relapse and re-admission to hospital in people with BPAD after an episode of mania as opposed to individual therapy which centres on the affected person only. Similarly Mathew M and Shean Mc, (2013) reported that psychoeducation was effective at improving drug compliance when extended to include the clients caregiver.

Xia (2011) assessed the effects of structured educational intervention (written and verbal method followed by discussion) with standard methods of knowledge provision.

The results revealed that incidence of non-compliance and relapse was lower in psychoeducation groups and promoted better social and global functioning. Intervention delivered at frequent intervals were useful as a part of the treatment programs for people with mental illness. Clients and caregivers who attended multiple session had greater knowledge gains in short term (upto1 month). Hence the author also suggested that multiple education sessions are better than single education session.

Pitkanen (2012) carried out a study to estimate the effectiveness of patient education methods on Quality Of Life (QOL) and functional impairment of patients with schizophrenia. The study group were assigned to computer based information technology and control group with standard leaflets and discussion and standard treatment. The results showed that there is no significant differences between groups in these outcomes. Hence concluded that there is no particular education method as the best way to improve patients QOL or improve functional ability. However computer based patient education remained a suitable alternative for some patients.

Similarly, Valimaki, Hatonen, Lahti, Kuosmanan & Adams, (2012) evaluated the effects of psychoeducation intervention using Information Communication Technology (ICT) as means of educating and supporting people with schizophrenia or related psychosis. The authors found no significant difference in the primary outcome (patient compliance and global state) between psychoeducation intervention using ICT and standard care.

John, Taishiro & Christoph, (2013) reported that traditional randomized controlled trials are not necessarily the best way to study interventions that are thought to work in reducing non compliance and among psychosocial interventions, those combining multiple approaches and involving multiple domains seem to be the most effective. Increasing knowledge about factors affecting drug compliance and leveraging novel technologies can enhance early assessment and adequate management, particularly in clients with psychotic disorders.

Peter et al., (2014) also reported that there is no gold standard approach to the measurement of adherence because all methods have pros and cons. Multidimensional approaches are more effective than unidimensional approaches.

Summary

After an extensive literature search the researcher found that majority of the caregivers were family members and they had lack of awareness and negative attitude towards drug compliance. The risk factors for drug non-compliance were very high among psychotic clients. The reviews supported that caregivers education will reduce the risk factors and promote quality of life among clients with chronic psychiatric illness. The reviews also supported that multidimensional approach is the most effective method for imparting knowledge and attitude among caregivers.

CHAPTER – 3
RESEARCH METHODOLOGY

RESEARCH METHODOLOGY

This chapter deals with the methodology used to assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy.

This phase of study deals with research approach, research design, variables, setting of the study, population, sample, criteria for sample selection, sample size, sampling technique, development and description of the tool, content validity, reliability of the tool, pilot study, procedure for data collection, and procedure for data analysis.

3.1. RESEARCH APPROACH

Quantitative research approach was used in the study.

3.2 RESEARCH DESIGN

Pre experimental one group pre test - post test design was used in the study.

Table 3.2.1: Schematic representation of a Pre experimental design

GROUP	PRE TEST (O_1)	INTERVENTION ($\times$)	POST TEST (O_2)
Caregivers of clients with chronic psychiatric illness.	Assess the pre test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness by using structured knowledge questionnaire and attitude scale.	Multimedia psychoeducation package includes • Lecture cum discussion on meaning of drug compliance, factors affecting drug adherence, importance of drug compliance, strategies to overcome drug non-compliance and counselling for drug adherence for about 30 minutes. • Video show on effects of drug non-compliance and drug adherence for 20 minutes. • Psychodrama on role of caregivers in drug compliance for 15 minutes. • Reinforcement through Digital video disc.	After 7 days assessment of post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness by using structured knowledge questionnaire and attitude scale.

3.3 VARIABLES

3.3.1 Independent Variable

The independent variable of the study was Multimedia Psychoeducation Package regarding drug compliance.

3.3.2 Dependent Variable

The dependent variable of the study was knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

3.3.3 Extraneous variables

Extraneous variables in this study were caregivers age, relationship with the client, duration of stay, education, family monthly income, habits and type of chronic illness and clients insight.

3.4 SETTING OF THE STUDY

The study was conducted in ATHMA Institute of Mental Health and Social Science, Trichy. It is a 80 bedded hospital offering 24hours of high quality service to both psychotic and neurotic clients. It also has separate centres for counselling and therapies, de-addiction and rehabilitation.

3.5 POPULATION

3.5.1 Target population

The target population of the study included all the caregivers of clients with chronic psychiatric illness.

3.5.2 Accessible population

The accessible population were caregivers of clients with chronic psychiatric illness at Athma hospital, Trichy.

3.6 SAMPLE

The study samples were caregivers of clients with chronic psychiatric illness who fulfilled the inclusion criteria.

3.7 SAMPLE SIZE

A total of 60 caregivers of clients with chronic psychiatric illness were selected for the study.

3.8 SAMPLING TECHNIQUE

Non-probability purposive sampling technique was used by the researcher to select the samples.

3.9 CRITERIA FOR SAMPLE SELECTION

3.9.1 Inclusion Criteria

1. Caregivers of clients with chronic psychiatric illness (psychosis and neurosis).
2. Caregivers who could understand Tamil or English

3.9.2 Exclusion Criteria

1. Caregivers with any psychiatric illness.
2. Caregivers who were not willing to participate in the study.
3. Caregivers who had attended teaching on drug compliance of psychiatric illness.

3.10 DEVELOPMENT AND DESCRIPTION OF THE TOOL

The tool was constructed after an extensive review of literature and guidance from the medical and nursing experts and the investigator's personal and professional experience. The tool for the data collection consisted of two parts.

Part A: Data collection tool

Part B: Intervention tool

3.10.1 DATA COLLECTION TOOL

Section A: Demographic variables

Section B: Structured knowledge questionnaire

Section C: Attitude scale

SECTION A: Demographic Variables

The section consisted of demographic variables for the caregivers and clients. The demographic variables for caregivers were age, gender, relationship with client,

duration of care, duration of stay, education, occupation, family monthly income, type of family, number of family members, residence and type of chronic physical illness.

The demographic variables for the clients were age, gender, type of illness, duration of illness and history of relapse.

SECTION B: Structured Knowledge Questionnaire

A structured knowledge questionnaire was developed by the researcher to assess the level of knowledge among caregivers of clients with chronic psychiatric illness with the following components.

S.No.	Components	Questions
1	Meaning	2
2	Importance	3
3	Side effects	1
4	Signs and symptoms	3
5	Complications and recurrence	1
6	Barriers and role of caregivers	5

Each item is a closed ended multiple choice questions with single correct answer. Each correct answer response was awarded with a score of 1 and the wrong answer was awarded with a score of 0. Maximum score is 15 and minimum score is 0.

Scoring and Interpretation:

Score	Percentage	Category
1 – 7	<50	Inadequate knowledge
8 -11	50 – 75	Moderately adequate knowledge
12 – 15	>75	Adequate knowledge

SECTION C: Attitude scale

It is a 3 point likert scale consisting of 10 statements (5 - positive items and 5 - negative items). The researcher has developed this attitude scale based on Drug attitude inventory 30.

Positive statements: always - 3, sometimes - 2, never - 1

Negative statements: always - 1, sometimes - 2, never - 3

Items	Question numbers	Total No. of items
Positive statements	1,3, 5, 7, 10	5
Negative statements	2, 4, 6, 8, 9	5

Scoring and Interpretation:

Score	Percentage	Category
1 - 14	< 50	Unfavorable attitude
15 - 22	50 – 75	Moderately favorable attitude
23 - 30	> 75	Favorable attitude

3.10.2 INTERVENTION TOOL

Multimedia psychoeducation package prepared by the researcher regarding drug compliance focuses mainly on creating awareness and develop a positive attitude among caregivers about the importance of drug compliance and their roles through lecture cum discussion, video show, psychodrama and DVD distribution for about 1hour. The details of the intervention tool are as follows:

1. Lecture cum Discussion

Lecture was given for 30 minutes regarding meaning of drug compliance, factors affecting drug adherence, importance of drug adherence, strategies to overcome drug compliance and counselling for drug adherence

2. Video Show on effects of drug non- compliance and drug adherence for 20 minutes.

3. Psychodrama on role of caregivers in drug adherence for 15 minutes. The researcher was designated as a research trainee in Athma Institute of Mental Health and Social Science, Trichy. The researcher obtained permission from The Principal, Jennys College

of Nursing to involve their students in psychodrama. The researcher trained the students and they enacted psychodrama.

4. Reinforcement through **Digital video disc**.

Preliminary preparation

- Obtained formal permission from the medical director.
- Seating arrangements was done.
- Privacy was maintained.
- Trained the nursing students for psychodrama.
- Informed written consent was obtained.
- A.V.aids was arranged.

During intervention

- Discussed about drug compliance.

After intervention

- Queries were clarified.
- Reinforcement was given.

3.11. CONTENT VALIDITY

The content validity was ascertained from the following field of expertise:

- Psychiatrist - 1
- Clinical Psychologist - 1
- Mental Health Nursing Specialist - 4
- Social Worker - 1

All experts gave their consensus and tool was finalized.

3.12 ETHICAL CONSIDERTAION

The study was approved by the Institutional Ethical Board of International Centre for Collaborative Research (ICCR), Omayal Achi College of Nursing which was held on December 2014 and the ethical principles followed were:

1. BENEFICENCE

The investigator followed the fundamental ethical principles of beneficence by adhering to:

A. The right to freedom from harm and discomfort

The study was beneficial for the participants as it improved their knowledge and attitude regarding drug compliance.

B. The right to protection from exploitation

The investigator explained the procedure and nature of the study to the caregivers and ensured that none of the participant would be exploited or denied fair treatment.

2. RESPECT FOR HUMAN DIGNITY

The researcher followed the second ethical principle of respect for human dignity. It includes the right to self determination and right to self disclosure.

A. The right to self determination

The investigator gave full freedom to the caregivers to decide voluntarily whether to participate in the study or to withdraw from the study and the right to ask questions.

B. The right to full disclosure

The researcher has fully described the nature of the study; the person's right to refuse participation and then the oral and written informed consent was obtained from the participants.

3. JUSTICE

The researcher adhered to the third ethical principle of justice. It includes participants right to fair treatment and right to privacy.

A. Right to fair treatment

The researcher selected the study participants based on the research requirements. No vulnerable or compromised candidates were selected as study participants.

B. Right to privacy

The researcher maintained the study participant's privacy throughout the study.

4. CONFIDENTIALITY

The researcher maintained confidentiality of the data provided by the study participants.

3.13 RELIABILITY OF THE TOOL

The reliability for knowledge questionnaire was done by inter-rater method using the formula,

$$r = \frac{\text{No. of agreements}}{\text{No. of agreement + disagreements}}$$

The reliability for attitude scale was done by split half method using the formula,

$$r = \frac{\Sigma (x - \bar{x}) (y - \bar{y})}{\sqrt{\Sigma (x - \bar{x})^2 \Sigma (y - \bar{y})^2}}$$

The reliability obtained for the structured knowledge questionnaire was 0.98 and for attitude scale was 0.99. The ‘r’ value indicated positive correlation, which showed that the tool was reliable for the researcher for conducting the main study.

3.14 PILOT STUDY

The study was conducted after obtaining ethical committee clearance from International Centre for Collaborative Research (ICCR). A formal written permission was sought from The Principal, Omayal Achi College of Nursing and The Director, Mercy Hospital, Trichy where the pilot study was conducted.

The researcher selected 10 caregivers who fulfilled the inclusion criteria using non-probability purposive sampling technique. A brief explanation was given regarding purpose of the study to the study participants and written consent was obtained.

On 14.05.15 demographic details were obtained from the study participants through the structured profile, then the researcher assessed the pre test level of knowledge and attitude regarding drug compliance by structured knowledge questionnaire and attitude scale. After that the investigator gave multimedia psychoeducation package regarding drug compliance through lecture cum group discussion for 30 minutes, video show for 20 minutes, psychodrama for 15 minutes and DVD for reinforcement. On 21.05.15 post test was conducted by using the same tool.

The result of the pilot study revealed that the assessment and intervention tool was reliable, feasible and practicable to conduct the main study.

3.15 PROCEDURE FOR DATA COLLECTION

The main study was conducted after obtaining a formal written permission from The Principal, Omayal Achi College of Nursing, Ethical Committee Clearance from International Centre for Collaborative Research (ICCR) and The Director, Athma Hospital, Trichy. The researcher was designated as a research trainee. The researcher got formal permission for psychodrama from The Principal, Jennys College of Nursing for involving the B.Sc Nursing III year students who were in Athma Hospital for their mental health nursing clinical posting. The researcher trained the students for psychodrama.

The researcher introduced about self and then gave a brief explanation regarding the purpose of the study. Written informed consent was obtained and confidentiality was reassured.

The researcher selected the in-patient caregivers based on selection criteria and who was accompanying the clients in the hospital for atleast 2 weeks. The demographic variables were collected individually by a structured interview method followed by which the pre test was given using structured knowledge questionnaire and attitude scale. The participants were made to sit comfortably and it took about 20 min for each participants to complete.

After completing the pre test, the researcher gave interventions to the caregivers in the conference hall. The intervention was given between 2pm – 3pm because the clients were made to sleep and the caregivers were free to attend the class. The researcher started with lecture cum discussion, played video show and then the students enacted the psychodrama and finally the session ended with clarification of queries and DVD was given to all the study participants for reinforcement.

After the intervention, 7th day the researcher conducted the post test by using the same structured knowledge questionnaire and attitude scale.

Group	Weeks	Number of members	Procedure		
			Pre test	Intervention	Post test
I	1st & 2nd	30	25.05.15 to 28.05.15	29.05.15	5.06.15 & 6.06.15
II	3 rd & 4th	30	8.06.15 to 11.06.15	12.06.15	19.06.15 & 20.06.15

3.16 PLAN FOR DATA ANALYSIS

The data was analyzed by using both descriptive and inferential statistics.

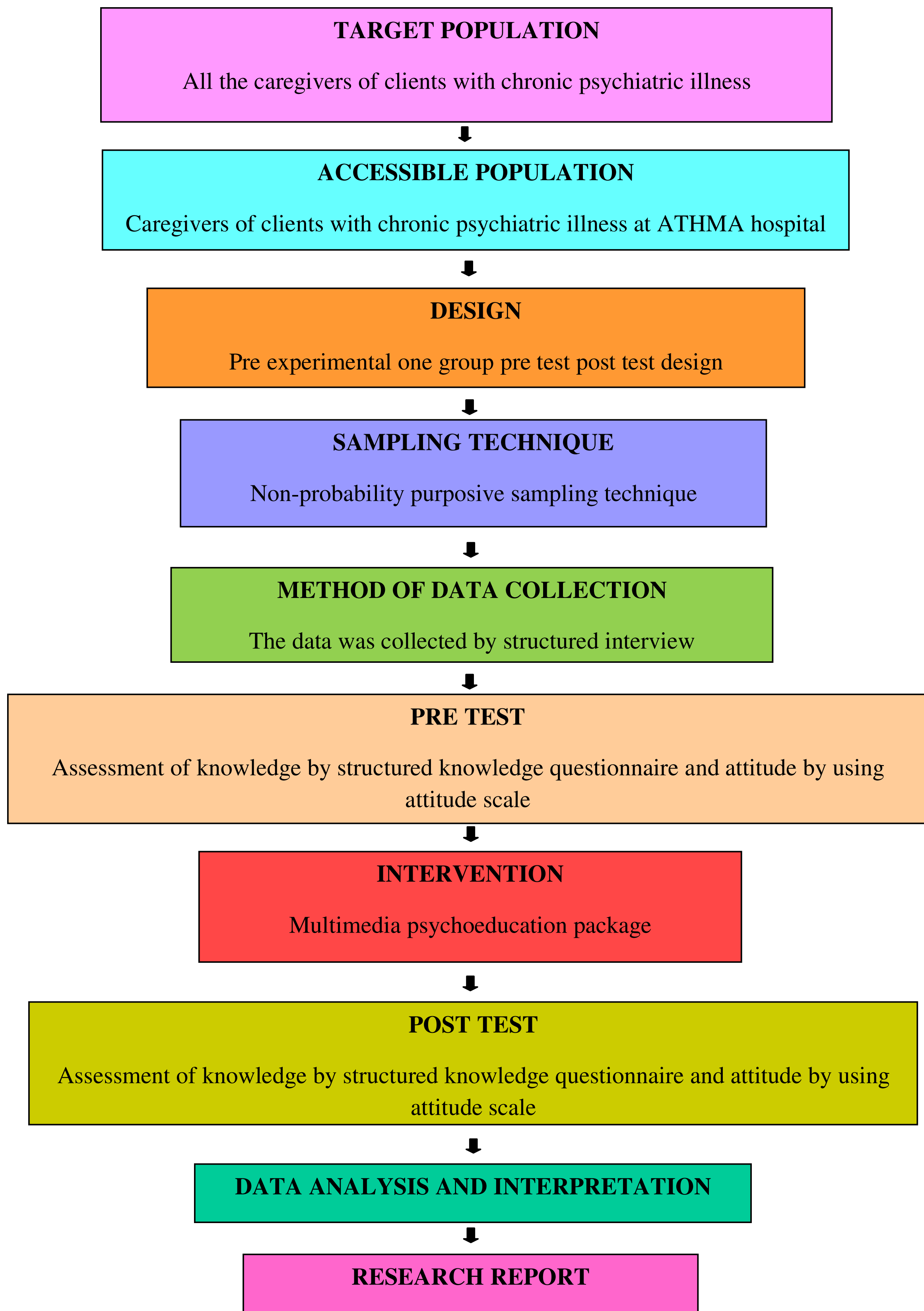
3.16.1 Descriptive Statistics

1. Frequency and percentage distribution was used to analyze the demographic variables.
2. Mean and standard deviation was used to analyze the pre and post test level of knowledge and attitude regarding drug compliance.

3.16.2. Inferential statistics

1. Paired 't' test was used to compare the pre test and post test level of knowledge and attitude regarding drug compliance.
2. Karl Pearson correlation co-efficient was used to study the relationship between the knowledge and attitude of the caregivers regarding drug compliance.
3. One way ANOVA was used to associate the pre and post test mean score of knowledge and attitude with their selected demographic variables.

FIG. 3.1 SCHEMATIC REPRESENTATION OF RESEARCH METHODOLOGY



CHAPTER – 4
DATA ANALYSIS AND INTERPRETATION

DATA ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of the data collected from 60 caregivers of clients with chronic psychiatric illness at selected setting. The data collected was organized, tabulated and analyzed according to the objectives. The findings based on the descriptive and inferential statistical analysis are presented under the following sections.

ORGANIZATION OF THE DATA

Section 4.1: Description of the demographic variables of caregivers of clients with chronic psychiatric illness.

Section 4.2: Description of the demographic variables of clients with chronic psychiatric illness.

Section 4.3: Assessment of pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Section 4.4: Effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Section 4.5: Correlation between post test knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Section 4.6: Association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

SECTION 4.1: DESCRIPTION OF THE DEMOGRAPHIC VARIABLES OF CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS.

Table 4.1.1: Frequency and percentage distribution of demographic variables of caregivers of clients with chronic psychiatric illness with respect to age in years, gender, duration of care (years), duration of stay with the client and education.

N = 60

S.No.	Demographic Variables	No.	%
1.	**Age in years**		
	21-30	10	16.67
	31-40	15	25.00
	41-50	12	20.00
	51-60	20	33.33
	61-70	3	5.00
2.	**Gender**		
	Male	15	25.00
	Female	45	75.00
3.	**Duration of care (Years)**		
	1 – 3	30	50.00
	3 – 6	11	18.33
	6 – 9	7	11.67
	> 9	12	20.00
4.	**Duration of stay with the client**		
	6 months - 1 yr	0	0.00
	1 - 2 yrs	0	0.00
	2 - 3 yrs	3	5.00
	>3 yrs	57	95.00
5.	**Education**		
	Professors / Honours	1	1.67
	Graduate / post graduate	14	23.33
	Intermediate/ post high school diploma	13	21.67
	High school	8	13.33
	Middle school	5	8.33
	Primary school	10	16.67
	Non literate	9	15.00

The above table showed that majority of the caregivers were in their late adulthood, predominantly females providing care for the period of 1-3 years and staying with the chronic psychiatric illness clients for more than 3 years.

Table 4.1.2: Frequency and percentage distribution of demographic variables of caregivers of clients with chronic psychiatric illness with respect to occupation, family monthly income, type of family and number of family members.

N = 60

S.No.	Demographic Variables	No.	%
1.	**Occupation**		
	Profession	8	13.33
	Semi profession	3	5.00
	Clerical/Shop owner/Farmer	8	13.33
	Skilled worker	6	10.00
	Semi skilled worker	1	1.67
	Unskilled worker	5	8.34
	Unemployed	29	48.33
2.	**Family monthly income in Rupees**		
	≥36017	1	1.67
	18000 – 36016	6	10.00
	13495 – 17999	12	20.00
	8989 – 13494	17	28.33
	5387 – 8988	10	16.67
	1803 – 5386	14	23.33
	≤1802	0	0.00
3.	**Type of family**		
	Nuclear family	51	85.00
	Joint family	9	15.00
	Extended family	0	0.00
	Broken family	0	0.00
4.	**Number of family members**		
	<3	6	10.00
	3 – 5	44	73.33
	6 – 10	10	16.67
	>10	0	0.00

The above table depicts that majority of the caregivers were unemployed, belong to lower middle class and nuclear family.

Table 4.1.3: Frequency and percentage distribution of demographic variables of caregivers of clients with chronic psychiatric illness with respect to residence, type of chronic physical illness, marital history and relationship with the client.

N = 60

S.No.	Demographic Variables	No.	%
1.	**Residence**		
	Rural	22	36.7
	Urban	34	56.7
	Semi urban	4	6.6
2.	**Type of chronic physical illness**		
	Yes	13	21.67
	No	47	78.33
3.	**Marital history**		
	Married	48	80.00
	Single	5	8.33
	Widow	7	11.67
	Divorced	0	0.00
4.	**Relationship with the client**		
	Family member	60	100.00
	Friend	0	0.00
	Paid caregiver	0	0.00
	Neighbour	0	0.00

The above table revealed that majority of the caregivers were residing in urban area and most of them had no complaints of chronic physical illness. Majority of the caregivers were married and almost all the caregivers were family members of the clients with chronic psychiatric illness.

SECTION 4.2: DESCRIPTION OF THE DEMOGRAPHIC VARIABLES OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS.

Table 4.2.1: Frequency and percentage distribution of demographic variables of clients with chronic psychiatric illness.

N = 60

S.No.	Demographic Variables	No.	%
1.	**Age in years**		
	21 - 30	16	26.67
	31 - 40	19	31.67
	41 - 50	14	23.33
	51 - 60	9	15.00
	61 - 70	2	3.33
2.	**Type of psychiatric illness**		
	Psychosis	59	98.33
	Neurosis	1	1.67
3.	**Gender**		
	Male	31	51.67
	Female	29	48.33
4.	**Chronicity of illness (years)**		
	1 – 3	27	45.00
	3 – 6	16	26.67
	6 - 9	6	10.00
	>9	11	18.33
5.	**History of relapse**		
	Yes	56	93.33
	No	4	6.67

The above table revealed that majority of the clients were in the age group of 31– 40 years, diagnosed with psychosis and males suffering from psychiatric illness for the past 1-3 years. Majority of the clients had history of relapse, which is the consequence of drug non-compliance that resulted in re-hospitalization.

SECTION 4.3: ASSESSMENT OF PRE AND POST TEST LEVEL OF KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS.

N = 60

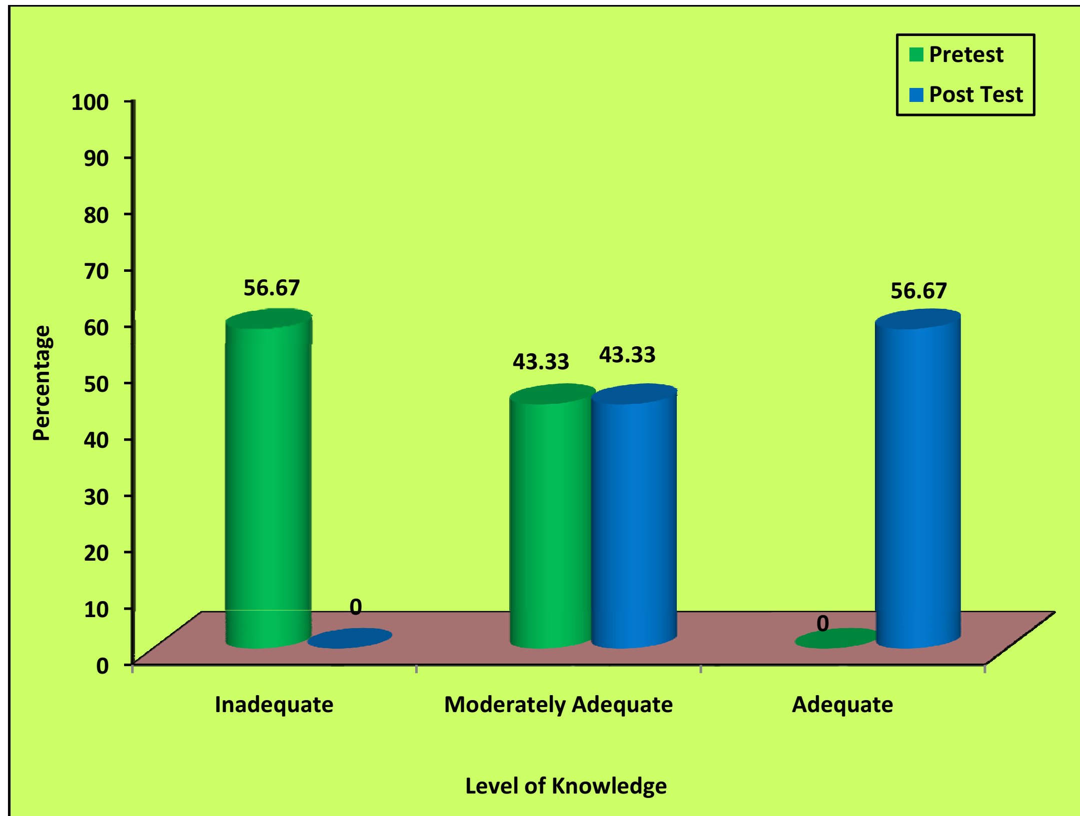


Fig.4.3.1: Percentage distribution of pre and post test level of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness

The overall pretest level of knowledge revealed that majority of the caregivers had inadequate knowledge and few had moderately adequate knowledge whereas after the administration of the multimedia psychoeducation package, the post test scores revealed that majority of the caregivers gained adequate knowledge and few had moderately adequate knowledge.

Nearly half of the caregivers were in the moderately adequate knowledge inspite of administration of the multimedia psychoeducation package because their educational status ranged from non literate to middle school hence the researcher gave DVD for reinforcement.

N = 60

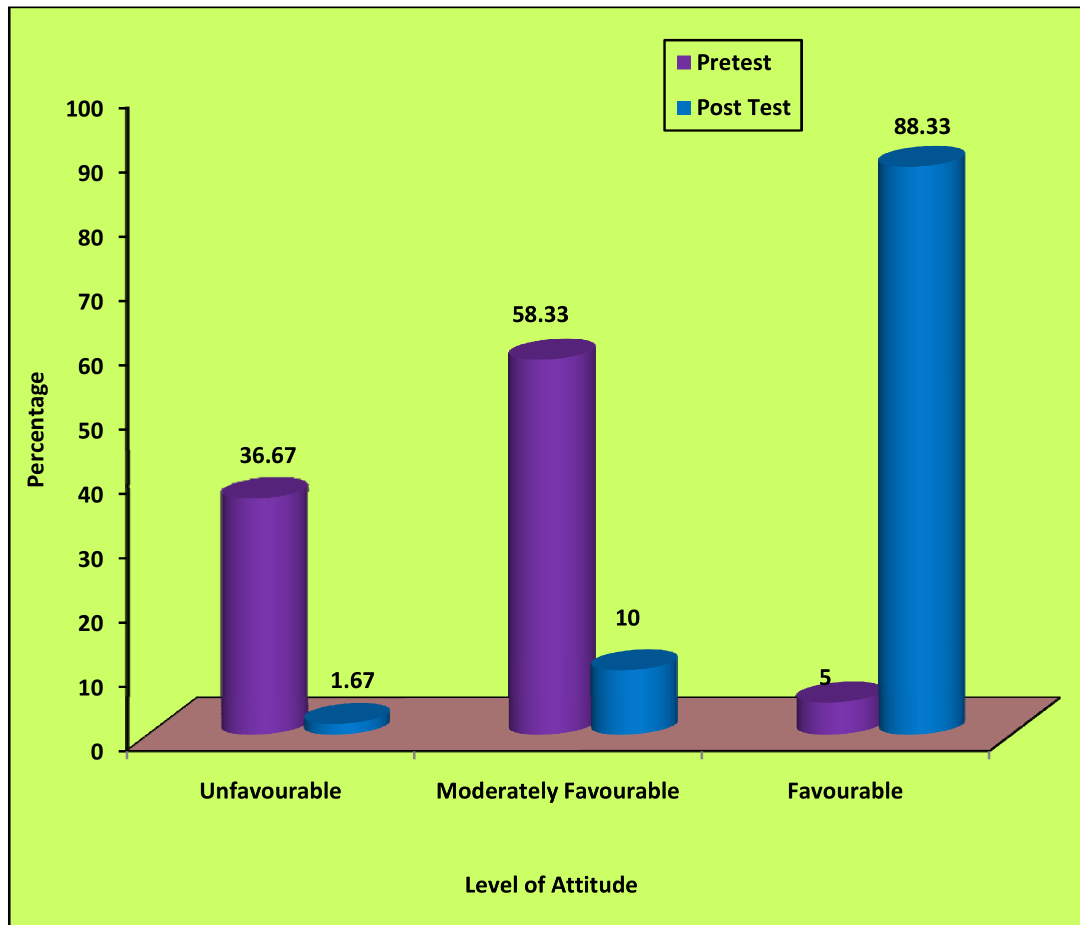


Fig.4.3.2: Frequency and percentage distribution of pre and post test level of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

The figure depicts that in the pretest, majority had moderately favaourable attitude and few had unfavourable attitude. Researcher found that in the post test, after the administration of multimedia psychoeducation package majority of the caregivers developed favourable attitude.

SECTION 4.4: EFFECTIVENESS OF MULTIMEDIA PSYCHOEDUCATION PACKAGE ON KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS.

Table 4.4.1: Comparison of pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Variables	Pre Test		Post Test		Paired 't' Value
	Mean	S.D	Mean	S.D	
Knowledge	6.96	2.38	11.98	1.65	t = 17.438 p = 0.001, S***
Attitude	17.30	4.21	27.0	3.26	t = 27.877 p = 0.001, S***

***p<0.001, S – Significant

The above table depicts that the multimedia psychoeducation package has imparted adequate knowledge and developed favourable attitude regarding drug compliance to the caregivers of clients with chronic psychiatric illness. This change will reduce relapse and re-hospitalization of psychiatric clients and thereby reduces the caregivers burden.

SECTION 4.5: CORRELATION BETWEEN POST TEST KNOWLEDGE SCORE WITH ATTITUDE SCORE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS.

Table 4.5.1: Correlation between post test knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Variables	Mean	S.D	'r' Value
Knowledge	11.98	1.65	r = 0.472 p = 0.001, S***
Attitude	27.0	3.26	

***p<0.001, S – Significant

The table 4.5.1 indicates that when the post test level of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness increases their post test level of attitude also increases. It portrays that the caregivers understood the importance of treatment adherence which prevents relapse and re-hospitalization and improves quality of life of both clients and caregivers.

SECTION 4.6: ASSOCIATION OF SELECTED DEMOGRAPHIC VARIABLES WITH THEIR PRE AND POST TEST MEAN SCORE OF KNOWLEDGE AND ATTITUDE REGARDING DRUG COMPLIANCE AMONG CAREGIVERS OF CLIENTS WITH CHRONIC PSYCHIATRIC ILLNESS.

Table 4.6.1: Association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Demographic Variables of caregivers	Pre test knowledge		Post test knowledge		Pre test attitude		Post test attitude	
	F	Sig.	F	Sig.	F	Sig.	F	Sig.
Age in years	0.693	0.600	2.992	**.026***	1.231	0.309	2.269	0.073
Gender	0.192	0.663	0.732	0.396	0.357	0.552	0.132	0.718
Duration of care (years)	0.565	0.640	1.004	0.398	3.552	**.020***	1.959	0.131
Duration of stay with client (years)	0.599	0.442	0.485	0.489	0.995	0.323	0.293	0.590
Education	1.111	0.368	2.449	**.036***	1.628	0.158	3.029	**0.013***
Occupation	1.042	0.409	1.607	0.163	0.917	0.490	1.355	0.250
Family monthly income	0.690	0.633	1.256	0.296	1.060	0.393	1.144	0.349
Type of family	1.793	0.186	3.939	0.052	0.012	0.912	1.233	0.271
Number of family members	1.022	0.366	3.253	**0.04***	0.130	0.878	1.286	0.284
Residence	2.688	0.077	2.033	0.140	6.356	**0.003***	7.121	**0.002***
Type of chronic physical illness	0.540	0.465	0.022	0.883	2.474	0.121	0.082	0.776
Marital history	0.512	0.602	3.296	**0.04***	0.217	0.806	1.968	0.149
Relationship with the client	1.549	0.172	2.597	**0.02***	1.123	0.363	1.518	0.182

The findings in the above table showed that the demographic variables of caregivers such as age, duration of care, education, number of family members, residence, marital history and relationship with the client had significant association with the pre and post test mean score of knowledge and attitude.

Table 4.6.2: Association of selected demographic variables with their pre test mean score of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Demographic variables of caregivers	Pre test mean score of knowledge	ANOVA	
		F	Sig.
Family monthly income in Rupees		0.690	p =0.633 NS
≥36017	8.25		
18000 – 36016	6.33		
13495 – 17999	7.35		
8989 – 13494	7.83		
5387 – 8988	9.00		
1803 – 5386	6.40		
≤1802	6.41		
Type of family		1.793	p =0.186 NS
Nuclear family	7.13		
Joint family	6.00		
Extended family	0		
Broken family	0		

NS – Nil significant

The above table depicts that none of the variables had significant association with their pre test mean score of knowledge.

Table 4.6.3: Association of selected demographic variables with their post test mean score of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Demographic variables of caregivers	**Post test mean score of knowledge**	**ANOVA**	
		F	**Sig.**
Age in years		2.992	p = 0.026 S*
21-30	13.20		
31-40	12.33		
41-50	11.16		
51-60	11.55		
61-70	12.33		
Education		2.449	p = 0.036 S*
Professors/ Honours	14.00		
Graduate / post graduate	13.07		
Intermediate/ post high school diploma	11.38		
High school	12.12		
Middle school	12.40		
Primary school	11.40		
Non literate	11.22		
Number of family members		3.253	p= 0.046 S*
<3	11.33		
3 – 5	12.29		
6 – 10	11.00		
>10	0		
Marital history		3.296	p= 0.044 S*
Married	11.91		
Single	13.60		
Widow	11.28		
Divorced	0		
Relationship with the client		2.597	p= 0.022 S*
Mother	11.53		
Husband	11.22		
Wife	12.30		
Daughter	13.00		
Son	12.33		
Daughter in law	15.00		
Father	14.00		
Brother	11.50		

S*- significant at $p<0.05$

The above table depicts that after exposure to multimedia psychoeducation package the younger age group has gained ample knowledge comparable with other age group. Similarly, the educational status shows that higher the education greater the knowledge was imparted. Subsequently caregivers with 3 - 5 members in a family had shown improvement in acquiring knowledge. Caregivers who were single showed greater response which indicated that they were highly dedicated and committed in giving care to the clients with psychiatric illness. Almost all the caregivers were the family members, among them the daughter-in-law had been enriched with knowledge comparable with other family members.

Table 4.6.4: Association of selected demographic variables with their pre test mean score of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Demographic variables of caregivers	Pre test mean score of attitude	ANOVA	
		F	**Sig.**
Duration of care (years)		3.552	p = 0.020 S*
1 – 3	18.17		
3 – 6	16.64		
6 – 9	13.00		
> 9	18.25		
Residence		6.356	p = 0.003 S**
Rural	16.05		
Urban	18.68		
Semi urban	12.50		

**p<0.01,*p<0.05, S - Significant

The above table clearly indicates that prior exposure to multimedia psychoeducation package, the caregivers with greater duration of care residing in urban area had positive attitude regarding drug compliance.

Table 4.6.5: Association of selected demographic variables with their post test mean score of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

N = 60

Demographic variables of caregivers	Post test mean score of attitude	ANOVA	
		F	**Sig.**
Education		3.552	p = 0.013 **S***
Professors / Honours	30.00		
Graduate / post graduate	29.21		
Intermediate / post high school diploma	27.46		
High school	27.38		
Middle school	25.60		
Primary school	25.30		
Non literate	24.89		
Residence		7.121	p = 0.002 S**
Rural	25.36		
Urban	28.26		
Semi urban	25.25		

**p <0.01, *p<0.05, S - Significant

The above table indicates that the caregivers residing in urban with higher qualification had developed favorable attitude towards drug compliance rather than others.

CHAPTER – 5
DISCUSSION

DISCUSSION

This chapter deals with the discussion of the findings of the study interpreted from the statistical analysis. The findings are discussed in relation to the objectives specified in the study. It is presented in line with the objectives of the study.

5.1 Description of the demographic variables of caregivers and clients of chronic psychiatric illness.

With regard to age in years, majority of the caregivers 20(33.33%) were in the age group of 51 – 60 yrs, 45(75%) were female, when considering the duration of care 30(50%) were caring the clients for 1 – 3 years, 57(95%) were staying with the client for >3 yrs, the data related to educational status 14(23.33%) were graduates/post graduates, 29(48.33%) were unemployed, 17(28.33%) had a family monthly income of Rs.8989-13494, 51(85%) belong to nuclear family, with respect to family members 44(73.33%) had 3 – 5 family members, 34(56.67%) were from urban area, 47(78.33%) had no chronic physical illness, 48(80%) were married and almost all (100%) were family member of the client.

Whereas for clients, majority of them 19(31.67%) were in the age group of 31 – 40 yrs, 59(98.33%) had psychosis, 31(51.67%) were male, 27(45%) were suffering from psychiatric illness for 1 – 3 yrs and 56(93.33%) had history of relapse.

5.2 The first objective was to assess the pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Fig.4.3.1 showed the percentage distribution of pre and post test level of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness. It revealed that majority 34(56.67%) had inadequate knowledge and 26(43.33%) had moderately adequate knowledge whereas in the post test 34(56.67%) had adequate knowledge and 26(43.33%) had moderately adequate knowledge.

Fig.4.3.2 showed the percentage distribution of pre and post test level of attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness. It revealed that in the pre test, majority 35(58.33%) had moderately favourable attitude, 22(36.67%) had unfavourable attitude and only 3(5%) had favourable attitude regarding drug compliance among caregivers of client with chronic psychiatric illness. In the post test, after the administration multimedia psychoeducation package majority 53(88.33%) had favourable attitude, 6(10%) had moderately favourable and only 1(1.67%) had unfavourable attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

5.3 The second objective was to assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Table 4.4.1 showed the comparison of pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness, the pre test mean score of knowledge was 6.96 with SD of 2.38 and the post test mean score of knowledge was 11.98 with SD of 1.65. The calculated paired 't' value was t = 17.438 was found to be statistically significant at $p<0.001$ level. The pre test mean score of attitude was 17.30 with SD of 4.21 and the post test mean score of attitude was 27.0 with SD of 3.26. The calculated paired 't' value was t = 27.877 was found to be statistically significant at $p<0.001$ level.

This clearly indicates that the multimedia psychoeducation package has imparted adequate knowledge and developed favourable attitude towards drug compliance among caregivers of clients with chronic psychiatric illness. This change in knowledge and attitude will reduce relapse and re-hospitalization of psychiatric clients and thereby reduces the caregivers burden.

The findings were supported by Sagun (2012) conducted a quasi experimental study to assess the efficacy of psycho-educational intervention programme on schizophrenia in relapse prevention among significant caregivers at Tuticorin government hospital using convenience sampling technique. A semi structured knowledge questionnaire and modified attitude scale was used and the results revealed that 93% had adequate knowledge and 7% had moderately adequate knowledge, 18%

had favourable attitude and 82% had most favourable attitude and the intervention tool had significant improvement on knowledge and attitude among caregivers.

Hence the null hypothesis **NH_1** stated earlier that **"There is no significant difference between pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level"** was **rejected**.

The conceptual framework used for this study was based on **J.W.Kenny's open system model**. The open system theory concerned with changes due to interaction between the various factors (variables) in a situation. In human beings, interaction between person and environment change continuously. The key concepts of Kenny's open system model are input, throughout and output. Input refers to the matters and information, which are continuously processed through the system and released as outputs. After processing the input, the system returns output (matter and information) to the environment in a altered state, affecting the environment for information to guide its operation. This feedback information of environment responses to the system output is used by the system in adjustment correlation with the environment. Feedback may be possible, negative or neutral.

The investigator assessed the pre test level of knowledge and attitude of the caregivers of clients with chronic psychiatric illness regarding drug compliance and it is continuously processed information in the environment. Through educating the caregivers regarding drug compliance the investigator changes system and expected outcome after processing the information. The investigator found that through administering the multimedia psychoeducation package the caregivers gained adequate knowledge and developed positive attitude regarding drug compliance.

5.4 The third objective was to correlate the post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness.

Table 4.5.1 showed the correlation between post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness, the mean score of knowledge was 11.98 with SD of 1.65 and the post

mean score of attitude was 27.0 with SD of 3.26. The calculated Karl Pearson's correlation value was r = 0.472 showed a positive correlation which was found to be statistically significant at $p<0.001$ level.

This clearly indicates that when the post test level of knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness increases their post test level of attitude also increases. It portrays that the caregivers have understood the importance of treatment adherence which prevents relapse and re-hospitalization and improves quality of life of both clients and caregivers.

Hence the null hypothesis **NH_2** stated earlier that **"There is no significant correlation between the post level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level"** was **rejected.**

5.5 The fourth objective was to associate the selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

The association between the selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness was done using one way ANOVA test.

The statistical analysis shows that the demographic variables of caregivers age, duration of care, education, number of family members, marital history, residence and relationship with client had shown statistically significant association with their pre and post test mean score of knowledge and attitude among caregivers of clients with chronic psychiatric illness at $p< 0.05$.

This finding was supported by Vijay.P (2012) conducted a study to assess the knowledge and attitude concerning mental illness in adults at Jalgaon. The results revealed that there was a significant difference in knowledge and attitude scores of samples residing in the urban and rural areas. Among the rural participants 78% had poor knowledge and 86% had negative attitude whereas in urban area 82% had knowledge

and 94% had positive attitude towards mental illness. As the knowledge about mental illness increases their attitude towards mental illness also increases simultaneously, which reduced the stigmatization of mental illness in the community area. The results also revealed that the demographic variables such as economical status and education had significant association with knowledge and attitude score among adults.

Hence the null hypothesis **NH_3** stated earlier **"There is no significant association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level"** was **rejected** for the demographic variable of caregivers namely age, duration of care, education, number of family members, marital history, relationship with the client, residence and **accepted** for other demographic variables of caregivers and clients.

Thus the researcher found that multimedia psychoeducation package was an effective intervention in improving knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness which was supported by the review of literature and was proved statistically.

CHAPTER – 6

SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

This chapter deals with the summary, conclusion, implications, recommendations and limitations, plan for research dissemination and plan for research utilization.

6.1 SUMMARY

Clients with chronic psychiatric illness have great difficulty in following drug compliance. Drug non-compliance contributes to relapse and re-hospitalization and it can be devastating for clients and their family members in terms of personal suffering, hospitalization and reduced quality of life.

Caregivers play a crucial role in providing optimal care to the psychiatric clients. They are the persons who are directly and actively involved in the patient's care and they have the responsibility of seeking help for the psychiatric clients. The treatment is more effective when caregivers are equipped with the proper knowledge and attitude regarding drug compliance. In view of improving the knowledge and attitude regarding drug compliance the researcher conducted the study to assess the effectiveness of multimedia psychoeducation package. The study findings revealed that the multimedia psychoeducation package significantly improved the level of knowledge and developed positive attitude regarding drug compliance.

6.1.1 The statement of the problem was

A pre experimental study to assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy.

6.1.2 The objectives of the study were

1. To assess the pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.
2. To assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

3. To correlate the post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness.
4. To associate the selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

6.1.3 The study was based on the assumptions that

1. Caregivers may have some level of knowledge and attitude regarding drug compliance.
2. Multimedia psychoeducation package may improve the caregivers knowledge and develop favourable attitude regarding drug compliance of clients with chronic psychiatric illness.

6.1.4 The Null hypotheses formulated were

NH_1: There is no significant difference between pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

NH_2: There is no significant correlation between the post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

NH_3: There is no significant association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level.

The review of literature was derived from primary and secondary sources along with professional experience and expert's guidance in the field of mental health nursing. This provided a strong foundation for the selection of the problem and also strengthened the ideas for conceptual framework, aided to design the methodology and develop the tool for data collection. The conceptual framework used for this study was based on J.W.Kenny's open system model.

The methodology for this study was pre experimental one group pre test and post test design. The tool used was a structured knowledge questionnaire and attitude scale to assess the knowledge and attitude regarding drug compliance. The tool was validated by

medical and psychiatric nursing experts. The pilot study was conducted to find the feasibility of the study.

The pilot study was conducted at Mercy hospital, Trichy and the study results was found to be practicable and feasible to proceed with the main study. The reliability of the tool was done by inter-rater method and split half method. The reliability obtained for the structured knowledge questionnaire was 0.98 and for attitude scale was 0.99. The 'r' value indicated positive correlation, which showed that the tool was reliable for the researcher for conducting the main study.

The ethical principles were followed throughout the study by obtaining ethical clearance certificate from the International Centre for Collaborative Research (ICCR), formal permission from the respective organization and informed consent from the caregivers. Privacy and confidentiality was maintained throughout the data collection period.

The main study data collection was conducted for a period of 4 weeks. The data collected during the main study was analysed using SPSS version 13.

6.1.5 Major findings of the study were

The analysis revealed that in the pre test, 26(43.33%) had moderately adequate knowledge and 34(56.67%) had inadequate knowledge regarding drug compliance among caregivers of clients with chronic psychiatric illness. The results showed that in the post test, 34(56.67%) had adequate knowledge and 26(43.33%) had moderately adequate knowledge.

The analysis revealed that in the pre test, 35(58.33%) had moderately favourable attitude, 22(36.67%) had unfavourable attitude and only 3(5%) had favourable attitude.The results showed that in the post test 53(88.33%) had favourable attitude, 6(10%) had moderately favourable and only 1(1.67%) had unfavourable attitude.

The analysis of comparison of pre and post test level of knowledge regarding drug compliance among caregivers revealed that the pre test mean score of knowledge was 6.96 with SD of 2.38 and the post test mean score of knowledge was 11.98 with SD

of 1.65. The calculated paired 't' value was t = 17.438 was found to be statistically significant at $p<0.001$ level.

The analysis of comparison of pre and post test level of attitude revealed that the pre test mean score of attitude was 17.30 with SD of 4.21 and the post test mean score of attitude was 27.0 with SD of 3.26. The calculated paired 't' value was t = 27.877 was found to be statistically significant at $p<0.001$ level. Hence the null hypotheses **NH_1** stated earlier that **"There is no significant difference between pre and post test level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level"** was **rejected.**

The correlation between post test level of knowledge score with attitude score regarding drug compliance among caregivers showed that the mean score of knowledge was 11.98 with SD of 1.65 and the mean score of attitude was 27.0 with SD of 3.26. The calculated Karl Pearson's correlation value was r = 0.472 showed a positive correlation which was found to be statistically significant at $p<0.001$ level. Hence the null hypotheses **NH_2** stated earlier that **"There is no significant correlation between the post test level of knowledge score with attitude score regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level"** was **rejected.**

The association of selected demographic variables with their pre and post test mean score of knowledge and attitude showed that the demographic variables of caregivers such as age, duration of care, education, number of family members, residence, marital history and relationship with client had shown statistically significant association. Hence the null hypotheses **NH_3** stated earlier that **"There is no significant association of selected demographic variables with their pre and post test mean score of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at $p<0.05$ level"** was **rejected** for the above variables and was **accepted** for the other variables.

6.2 CONCLUSION

The researcher through the study concluded that after exposure of multimedia psychoeducation package there was a significant difference in the level of knowledge and attitude among caregivers of clients with chronic psychiatric illness. The findings of the study showed that the post test mean knowledge score was 11.98 with SD of 1.65, the calculated paired ‘t’ value was t = 17.438. The attitude post test mean score was 27.0 with SD of 3.26, the calculated paired ‘t’ value was t = 27.877. These values indicated that the Multimedia psychoeducation package was an effective intervention to improve the level of knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness.

6.3 IMPLICATIONS

The investigator has drawn the following implications from the study which is of vital concern for nursing practice, nursing education, nursing administration and nursing research.

6.3.1 Nursing Practice

- Nursing personnel can provide necessary counselling and psychoeducation to the caregivers of psychiatric clients.
- Community mental health nurse can also utilize this multimedia psychoeducation package for educating the psychiatric clients and their caregivers.
- CNE programmes can be planned for the psychiatric nurses regarding drug compliance.
- The psychiatric nurse needs to encourage and motivate the caregivers to follow drug adherence.

6.3.2 Nursing Education

- Nurse educator can teach the importance of drug compliance for psychiatric illness to the family members.
- Nursing students must be prepared to provide psychoeducation on drug compliance to the family members.
- Nurse educator should take initiative to organize psychoeducation regarding drug compliance to the caregivers of clients with psychiatric illness.

6.3.3 Nursing Administration

- Nurse administrator should plan for in-service education programs for staff nurses regarding drug compliance.
- Nurse administrator should plan for mass awareness campaign regarding drug compliance in the psychiatric hospitals and community areas.

6.3.4 Nursing Research

- Nurse researcher communicates these findings to the public sector so as to enhance health care programs.
- Extensive researches can be done in various settings regarding drug compliance to improve the knowledge and attitude of the caregivers of psychiatric clients.
- Nurse researcher can disseminate the study findings to nurses working in psychiatric units to apply it in practice.

6.4 PLAN FOR RESEARCH DISSEMINATION

The findings of the research will be disseminated through paper presentation either in conference or workshop at the national or international level and will be published in psychiatry speciality journals.

6.5 RESEARCH UTILIZATION

The researcher will recommend multimedia psychoeducation package utilization in various settings.

6.6 RECOMMENDATIONS

1. The investigator will recommend the Omayal Achi Community Health Centre to implement this package along with wellness clinic to prevent relapse.
2. Compared with a traditional approach, the combination of multimedia psychoeducation package and a nursing clinic may help clients and their caregivers to achieve and maintain better drug compliance.
3. Further multimedia based interventions should be developed regarding drug compliance to share information among clients and caregivers.

6.7 LIMITATIONS

1. There was no opportunity for a longer period of follow up after the intervention.
2. The researcher found difficulty in gathering the caregivers for interventions.

REFERENCES

REFERENCES

Ahuja, N. (2011). *A Short Text Book of Psychiatry*. New Delhi: Jaypee Publishers.

Attitudes to mental illness-2011 survey report. The Health and Social Care Information Centre.

Bala. (2007). *Fundamentals of Biostatistics*. New Delhi: Anne publications.

Beinart N, Weinman J., & Wade D. (2012). Caregiver burden and psychoeducational interventions in Alzheimer's disease: a review. Dementia and geriatric cognitive disorders. Vol.(2), 636-648.

Bhattacharjee D, Rai AK, Singh NK, Kumar P, Munda SK., & Das B (2011). Psychoeducation: A Measure to Strengthen Psychiatric Treatment. Delhi psychiatric journal vol.(14), No.1, Retrieved on November 2015.

Bhatia, M.S. (2012). *Short Textbook of Psychiatry*. New Delhi: CBS Publications.

Chu-Mei Lan, Shu-Jen Shiau., & Li-Chuan Lin.(2010). Knowledge, Beliefs, attitudes, and drug compliance in schizophrenic patients. Tzu chi med journal 15. No.6. Retrieved on November 2015.

Courts N.F, Barba BE., & Tesh AS.(2010). Family caregivers' attitudes towards aging, care-giving, and nursing home placement. Journal of gerontological nursing. 27(8), 44-50. Retrieved on November 2014 from www. Slackinc.com.

Creswel J.W. (2003). *Research Design*. California: Sage Publications.

Fortinash Worret Haloday.(2012). *Psychiatric Mental Health Nursing*. Missouri: Elsevier Mosby Publications.

Fudith, Schult. (2005). *Lippincott Manual of Psychiatric Nursing Care Plan.* Philadelphia: Lippincott Williams & Wilkins.

Kaplan & Sadock. (2009). *Concise Textbook of childhood and adolescent psychiatry.* New Delhi: Wolters Kluwer Publications.

Griffith,Tacy H. (2012). Caregiver Views on Medication Treatment for Persons with Schizophrenia in a Cultural Context. Retrieved on September 2015.

Hungler & Polit. (2011). *Nursing Research Principles and Methods*. Philadelphia: Lippincott Company.

Iram T.K, Suhaila G, Hanan M., & Abdulbari B.(2014). Treatment non-compliance of psychiatric patients and associated factors: Are patients satisfied from their

psychiatrist? British Journal of Medicine & Medical Research. 4(2), 785-796. Retrieved on November 2015 from www.sciencedomain.org.

John MK, Taishiro K., & Christoph UC.(2013). Non-adherence to medicine in patients with psychotic disorders: epidemiology, contributing factors and management strategies. World psychiatry official journal of the world psychiatry association. Vol.12(3),216-226. Retrieved from www.ncbi.nlm.nih.gov/pubmed.

Johnson, B. M., & Webber, P. B. (2006). *An Introduction to Theory and Reasoning in Nursing*. Philadelphia: Lippincott Williams and Wilkins Publications.

Kazadi NJB, Moosa MYH., & Jeenah FY. (2010). Factors associated with relapse in schizophrenia. American Journal of Psychiatry. Vol.14, No. 2, 52-58. Retrieved on December 2014.

Kenfe T, Eshetu G, Alemayehu N, Markos T., & Sandra D. (2013). Medication non-adherence among adult psychiatric out patients in Jimma university specialized hospital, southwest Ethiopia. Ethiop journal of health science. Vol .23, No. 3, 227-236. Retrieved on November 2015.

Lalitha. (2007). Mental *Health and Psychiatric Nursing*. Bangalore: VBG Publications.

Lua LP. (2014). A brief review on multimedia based health education applications: current trends and future potential. www.eduimed.com.

Lin MF,Moyle W, Chang JH, Chou HM., & Hsu CM(2010). Effect of an interactive computerized psychoeducation system on patients suffering from depression. Journal of clinical nurse. 17(5), 667-676. http://www.ncbi.nim.nih.gov/pubmed.

Mahadeo S, Desai A., & Pawar S.(2012). Cross sectional study to assess the knowledge, attitude and practice among caregivers of schizophrenic clients. International Journal of Science and Research. Retrieved from www.researchgate.net

Maluo magaru. (2012). Knowledge, Attitudes and Practices of caregivers of patients with schizophrenia. Pacific Journal of Medical Sciences.Vol.10, No.1, ISSN: 2072-1625. Retrieved on July 2015 from www.pacjmedsci.com.

Maan, Hussain, Heramani., & Lenin. (2013). Eliminating barriers to the treatment of mental illness. Treatment advocacy centre backgrounds. www.wordpress.com

Marry, Ann Boyd. (2001). *Psychiatric Nursing Contemporary Practice*. Philadelphia: Lippincott Williams and Wilkins.

Martin JL., & Romans SE.(2011). A Community's attitude towards the mental ill. NZ Medical Journal. 108(1013), 505-508. Retrieved from www.ncbi.nlm.nih. gov/pubmed.

Mattew M, Shean MK. (2013). Overcoming medication nonadherence in schizophrenia: Strategies that can reduce harm. Retrieved from www.researchgate.net

Mibeli F. (2013). Non-compliance to medication in psychiatric patients- a literature review. Vol. 101, 119 - 124. Retrieved on September 2014.

Mwanda, Alice O. (2014). The Effectiveness of a Psychoeducational Intervention on Health Promoting Behaviours and Physical Health of Adult Patients on Antipsychotic Medications (2014). Doctoral dissertations paper 23. Retrieved on November 2015 from http://scholarworks.gvsu.edu/dissertations.

National alliance on mental illness: facts about mental illnesses. (2010). Retrieved on December 2014 from http://www.nami.org|Content|NavigationMenu|Inform Yourself| About Mental Illness html.

Neeraja, K. P. (2012). Essentials of Psychiatric and Mental Health Nursing. New Delhi: Jaypee Publishers.

Nora M.(2014). Assess the effectiveness of psychoeducation intervention in improving insight and drug compliance of schizophrenic clients. British journal of medicine and medical research.

Peter MH, Cecilia B., & Jan S.(2014). Non-adherence with antipsychotic medication in schizophrenia: challenges and management strategies. Patient related outcome measures. Vol.5. 43-62. Retrieved from www.ncbi.nlm.nih.gov/pubmed.

Rekha R, Masroor J, Sushma K, Prashant K., & Chakraborty. (2010). Reasons for drug non-compliance of psychiatric patients: A centre based study. Vol.31, No.1-2, 24-28. Retrieved on December 2015.

Roberta S. (2012). Qualitative study about attitudes of caregivers of clients with schizophrenia in relation to drug adherence. Retrieved from www.ncbi.nlm.nih. gov/pubmed.

Satyanarayana. (2006). Biostatistics. New Delhi: Practice Hall of India PVT Limited.

Shaffer, R.D. (2005). Principles and Practice of psychiatric Nursing. Philadelphia: Mosby publications.

Sharmila N, Mounica B., & Rama RN.(2014). Prevalence of medication non-adherence among the psychiatric patients- Results from a survey conducted in a tertiary care hospital. International Journal of Pharmacy and Pharmaceuticals Sciences .Vol 6, issue 4. Retrieved on December 2015.

Sreevani, R. (2010). A Guide to Mental Health & Psychiatric Nursing. New Delhi: Jaypee Publications.

Stuart, W.G. (2011). Principles and Practices of Psychiatric Nursing. Philadelphia: Elsevier Mosby Publications.

Sullivan G, Wells KB, Morgenstern H., & Leake B. (2010). Identifying modifiable risk factors for rehospitalisation: a case-control study of seriously mentally ill persons in Mississippi. American journal of psychiatry. 152(12), 1749-56. Retrieved on November 2014 from http://www.ncbi.nim.nih.gov/pubmed.

Sundar Rao, P.S. (1996). An Introduction to Biostatistics. New Delhi: Practice Hall of India publications

Townsend, C.M. (2012). Psychiatry Mental Health Nursing Concepts of care in Evidence based Practice. New Delhi: Jaypee Brothers Medical Publishers.

Tusaie, K. R., & Fitzpatrick, J. J. (2013). Advanced Practice Psychiatric Nursing. New York: Springer publishing company

Varcarolis, Elizabeth., & Halfer, M. J. (2012). Foundations of Psychiatric Mental Health Nursing- A Clinical approach. Philadelphia: W.B. Saunders.

Wanda, K.M. (2006). Psychiatric Nursing. Philadelphia: Lippincott Williams and Wilkins.

Wood, G. L., Haber., & Judith. (2006). Nursing Research Methods and Critical Appraisal for Evidence based practice. Missouri: Mosby publication.

Xia. (2011). Assess the effectiveness of psychoeducation intervention compared with standard methods of knowledge provision. American Journal of Psychiatry. http://www.ncbi.nim.nih.gov/pubmed.

APPENDICES

APPENDIX – C

LETTER SEEKING EXPERT'S OPINION FOR CONTENT VALIDITY

From

Mrs.A.Sasikala
M.sc (N) I year,
Omayal Achi College of Nursing,
Puzhal, Chennai

To

Respected Sir/Madam,

Subject: Requisition for expert opinion for content validity.

I am Ms.A.Sasikala doing my M.sc Nursing I year specializing in Mental Health Nursing at Omayal Achi College of Nursing under the guidance of Dr.Mrs.S.Kanchana, Research Director ICCR and Speciality Guide Mrs.P.Jayanthi. As a part of my research project to be submitted to the Tamil Nadu Dr. M.G.R. Medical University December 2014 session and in partial fulfillment of the University requirement for the award of M.Sc(N) degree, I am conducting **"A Pre experimental study to assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy" 2015.** I have enclosed my data collection and intervention tool for your expert guidance and validation. Kindly do the needful.

Thanking you,

Yours faithfully,
(Mrs.A. SASIKALA)

ENCLOSURES:

1. Research proposal
2. Data collection tool
3. Intervention tool
4. Content validity form
5. Certificate for content validity

LIST OF EXPERTS FOR CONTENT VALIDITY

MENTAL HEALTH MEDICAL EXPERTS

1. **Dr. M. Peter fernandez**
   M.D., D.P.M., T. D. D., F. I. P. S
   Professor Emeritus (Psychiatry),
   Director, Dr. Fernandez Home for Schizophrenia,
   Mugaliwakam, Chennai – 600 125.

MENTAL HEALTH NURSING EXPERTS

1. **Dr. (Mrs.). Ciby jose, M.Sc.(N)., Ph.D.,**
   Principal,
   Venkateshwara College of Nursing,
   Thalambur, Chennai – 600 130.

2. **Mrs. K. Vijayalakshmi, M.Sc.(N).,**
   Professor & HOD,
   Department of Mental Health Nursing,
   Apollo College of Nursing,
   Ayanambakkam, Chennai – 600 095.

3. **Mrs. Anuradha. C, M.Sc.(N).,**
   Associate Professor,
   Department of Mental Health Nursing,
   Apollo College of Nursing,
   Ayanambakkam, Chennai – 600 095.

4. **Mrs. Neelakshi, M.Sc.(N)., Ph.D.(N)**
   Associate Professor,
   Sri Ramachandra College of Nursing,
   Sri Ramachandra University,
   Porur, Chennai – 600 116.

PSYCHOLOGY AND SOCIOLOGY EXPERTS

1. **Mr.G.Aravindan, M.Sc. M.Phil.,**
   Clinical psychologist,
   Athma Hospital & Research,
   Thillai nagar, Trichy – 620018.

2. **Mrs. Zoraida Samuel, MSW**
   Psychiatric Social Worker,
   Managing Trustee, Rehoboth home for mentally challenged women,
   Kolathuvancherry, Paraniputhur,
   Chennai – 602101.

APPENDIX – F

INFORMED CONSENT REQUISITION FORM

Good morning,

I Mrs.A.Sasikala, M.Sc. (Nursing) student from Omayal Achi College of Nursing, Chennai, conducting **"A Pre experimental study to assess the effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy"** as a partial fulfillment of the requirement for the degree of M.Sc. Nursing under the Tamil Nadu Dr. M.G.R Medical University.

I assure you that information provided by you will be kept confidential. So, I request you to kindly cooperate with me and participate in this study by giving your frank and honest responses to the questions being asked.

Thank you.

Signature of the investigator

Sasikala.A

முன்அறிவிப்பு ஒப்பந்த படிவம்

உமையாள் ஆச்சி செவிலியர் கல்லூரியில் முதுநிலை இரண்டாம் ஆண்டு பயிலும் மாணவி சசிகலா.ஆ அவர்களால் நடத்தபெறும் இந்த ஆய்வில் என்னை பங்கேற்க கேட்டுக் கொண்டதை நான் ஏற்றுக்கொள்கிறேன். இந்த ஆய்வுக்கு நான் ஒப்புக் கொண்டதால் இதனைத் தொடர்ந்து என்னிடம் மருந்து உட்கொள்ளாமை பற்றிய கேள்விகள் கேட்கப்பட்டு அதனை பற்றிய கல்வியும் கற்பிக்கப்படும் என்பதை நான் அறிவேன்.

நான் யாருடைய கட்டாயத்தின் பெயரிலும் ஆய்வில் பங்கு கொள்ளவில்லை என்பதையும் தேவைப்பட்டால் நான் ஆய்விலிருந்து விலகிக்கொள்ளவும் எனக்கு முழு உரிமை உண்டு என்பதையும் அறிவேன்.

என்னைப் பற்றிய அனைத்து தகவல்களும் இரகசியமாக பாதுகாக்கப்படும் என்பதையும் அறிந்து நான் முழு சம்மதமும் அளிக்கிறேன்.

பங்கு கொள்ளுபவரின் கையொப்பம் /கைரேகை: தேதி:

ஆய்வு நடத்துபவரின் கையொப்பம்: தேதி:

INFORMED WRITTEN CONSENT FORM

I understand that I am being asked to participate in a research study conducted by Mrs.Sasikala.A, M.Sc(N) student of Omayal Achi College of Nursing. This study will evaluate effectiveness of multimedia psychoeducation package on knowledge and attitude regarding drug compliance among caregivers of clients with chronic psychiatric illness at selected setting, Trichy. If I agree to participate in the study and no identifying information will be included when it is transcribed. I understand that there are no risks associated with this study.

I realize that the knowledge gained from this study may help me. I realize that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary fashion.

I understand that all study data will be kept confidential. However, this information may be used in nursing publications or presentations. If I need to, I can contact Mrs.Sasikala.A Omayal Achi College of Nursing, 45, Ambattur road, Puzhal, Chennai any time during the study.

The study has been explained to me. I have read and understood this consent form, all of my questions have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form.

Signature of participant Date

Signature of investigator Date

முன் அறிவிப்பு ஒப்பந்த படிவம்

சென்னை புழலில் உள்ள உமையாள் ஆச்சி செவிலியர் கல்லூரியில் முதுகலை மனநல செவிலியர் பட்டம் பயின்று வரும் சசிகலா.ஆ என்னிடம் மனநல நோயாளிகளை மருந்து உட்கொள்ளவைப்பதில் பராமரிப்பாளர்களின் அறிவுத்திறன் மற்றும் மனப்பாங்கை பற்றி ஆய்வு மேற்கொள்ளபோவதை நான் அறிவேன். என்னிடம் நடத்தும் இந்த ஆய்வு முடிவுகள் ஆனைத்தும் பதிவு செய்து பாதுகாக்கப்படும் என்பதையும் நான் அறிவேன்.

என்னைப் பற்றி சேகரித்த சுய தகவல்கள் அனைத்தும் வெளியிடப்படாமல் ஆய்வு மேற்கொள்ளப்படும் என்பதை நான் அறிவேன். இந்த ஆய்வின் மூலமாக எனக்கு எந்த பாதிப்பும் இல்லை என்பதை அறிந்துக்கொண்டேன். எதிர்காலத்தில் இந்த ஆய்வின் முடிவுகள் எனக்கோ அல்லது பிற மக்களுக்கோ பயன்படும் என்பதை நான் அறிவேன்.

நான் எவரின் / யாருடைய கட்டாயத்தின் பெயரிலோ அல்லது வற்புறுத்தலின் பெயரிலோ ஆய்வில் பங்குகொள்ளவில்லை என்பதையும், தேவைப்பட்டால் நான் ஆய்விலிருந்து விலகிக் கொள்ளும்பட்சத்திலும் எப்பொதும் பிறரைப் போலவே நடத்தப்படும் என்பதை அறிவேன்.

என்னைப் பற்றிய அனைத்து தகவல்களும் இரகசியமாக பாதுகாக்கப்படும் என்பதை அறிவேன். தேவைப்படும்போது ஆய்வின் முடிவுகள் செவிலியர் சார்ந்த பத்திரிகைகளிலும், கருத்தரங்குகளிலும் வெளியிட முழு சம்மதம் அளிக்கிறேன். இந்த ஆய்வினை பற்றிய முழு விளக்கமும் எனக்கு அளிக்கப்பட்டிருக்கிறது. அதனை நான் முற்றிலுமாக புரிந்துக்கொண்டு ஆய்வில் பங்குகொள்ள சம்மதம் அளிக்கிறேன்.

பங்குகொள்பவரின் கையொப்பம் அல்லது கைநாட்டு: தேதி:

ஆராய்ச்சியாளரின் கையொப்பம்: தேதி:

APPENDIX – G

RESEARCH TOOL

PART A – DATA COLLECTION TOOL

SECTION A - DEMOGRAPHIC VARIABLES OF THE CAREGIVER

Write your response in the box provided

1. Age in years

2. Gender

A) Male

B) Female

3. Duration of care (years)

A) 1 - 3

B) 3 - 6

C) 6 - 9

D) > 9

4. Duration of stay with the client (years)

A) 6months - 1

B) 1 - 2

C) 2 - 3

D) > 3

5. Education

A) Professors/honours

B) Graduate/post graduate

C) Intermediate/post high school diploma

D) High school

E) Middle school

F) Primary school

G) Non literate

6. Occupation

A) Profession

B) Semi profession

C) Clerical/Shop owner/Farmer

D) Skilled worker

E) Semi skilled worker

F) Unskilled worker

G) Unemployed

7. Family monthly income in Rupees

A) ≥ 36017

B) 18000-36016

C) 13495-17999

D) 8989-13494

E) 5387-8988

F) 1803-5386

G) ≤ 1802

8. Type of family

A) Nuclear family

B) Joint family

C) Extended family

D) Broken family

E) Others

9. Number of family members

A) < 3

B) 3 - 5

C) 6 - 10

D) > 10

10. Residence

A) Rural

B) Urban

C) Semi urban

D) Others

11. Type of chronic physical illness

A) Yes

B) No

if yes specify________

12. Marital history

A) Married

B) Single

C) Widow

D) Divorced

E) Others

13. Relationship with client

A) Family member

B) Friend

C) Paid caregiver

D) Neighbour

if family member specify the relationship with the client ___________.

DEMOGRAPHIC VARIABLES OF THE CLIENT

1. Age in years ________

2. Type of psychiatric illness

A) Psychosis

B) Neurosis

3. Gender

A) Male

B) Female

4. Chronicity of illness (years)

A) 1 - 3

B) 3 - 6

C) 6- 9

D) > 9

5. History of relapse

A) Yes

B) No

if yes, specify the reason ________ and relapse signs and symptoms __________

SECTION – B Structured knowledge questionnaire

Select an option which you feel the best response to the question asked and write your response in the box provided.

1. Psychiatric illness can be treated by

a) physical therapy

b) psychological therapy

c) drug therapy

d) alternative therapy

2. Drug compliance means

a) taking drugs irregularly

b) taking drugs as prescribed by physician

c) taking drugs at recommended dosage

d) taking drugs at regular intervals

3. Relapse and re-hospitalisation of client with psychiatric illness can be significantly prevented by

a) partial adherence

b) treatment resistance

c) diversion therapy

d) treatment adherence

4. Treatment adherence for psychiatric client is found to be effective in

a) increasing mortality

b) decreasing mortality

c) decreasing morbidity

d) increasing morbidity

5. Drug non-compliance occurs mainly due to

a) subsiding of symptoms while on treatment

b) anxiety

c) rehabilitation

d) regular follow-up

6. Personal threat factor for drug adherence is

a) presence of extra pyramidal symptoms

b) cost of medication

c) resistance to accepting the sick role

d) peer influences

7. Relapse is commonly due to

a) discomfort resulting from treatment

b) caregivers burden

c) irregular follow up

d) drug non-compliance

8. Early sign of relapse in a client with drug non-compliance requires

a) immediate hospitalization

b) rehabilitation

c) maintaining rapport with the client

d) home remedies

9. The most significant sign of relapse is

a) headache

b) general weakness

c) worsening of symptoms

d) loss of appetite

10. The relapse sign can be managed by

a) reducing the activity

b) reducing the stressor

c) lowering the medication dose

d) increasing the activity

11. Treatment adherence can prevent complication like

a) HIV

b) diabetes mellitus

c) suicide

d) mental retardation

12. Drug compliance can be managed by

a) using a weekly dose pill box

b) reducing the number of drugs

c) using compliments as reward

d) leaving the responsibility to the client

13. Drug non compliance can be overcome by

a) using traditional home remedies

b) giving medications with routine activity

c) criticising the client

d) placing medications in various places

14. The responsibility of the caregiver in drug compliance is to

a) often check the medication container for renewal dates

b) assist the client in self care activities

c) involve the client in decision making

d) supervise the client

15. Role of caregiver for client with drug non-compliance is to

a) monitor the activities done by the client

b) minimize the dosage by themselves

c) maximize the dosage as required

d) counter check the medication frequency and dosage

Items	Components
1 – 2	Definition
3 – 5	Importance
6	Factors affecting drug adherence
7 – 10	Cause, signs and management of relapse
11	Complication
12 – 13	Strategies to overcome
14 – 15	Role of caregiver

SCORING KEY

SECTION B: Structured Knowledge Questionnaire regarding drug non-compliance

A structured knowledge questionnaire was developed by the researcher to assess the level of knowledge among caregivers of clients with chronic psychiatric illness.

Score	Percentage	Category
1 - 7	<50	Inadequate knowledge
8 - 11	50 - 75	Moderately adequate knowledge
12 - 15	>75	Adequate knowledge

The answer key for the structured knowledge questionnaire furnished below:

1 - C	9 - C
2 - A	10 - B
3 - D	11 - C
4 - B	12 - A
5 - A	13 - B
6 - C	14 - A
7 - D	15 - D
8 - A	

SECTION C: Attitude scale

Place a tick mark against the category which you feel you may fall in.

S.No.	Questions	Always	Sometimes	Never
1.	I feel that I am responsible to administer the drugs.			
2.	I forget to give away the drug to the client.			
3.	I take the client for regular follow-up.			
4.	I give medication because of pressure from other people.			
5.	I feel that I am competent enough to make the client to take the drug compulsorily.			
6.	I stop administering the medicine when I feel the client is better.			
7.	I feel that I am responsible for checking the adequacy of the drugs in the pill box.			
8.	I feel that administering medication to the client is worth the effort.			
9.	I feel irritated while administering the drugs to client.			
10.	I am able to balance my care giving time and other family responsibilities.			

Statement details:

Items	Question numbers	Remarks
Positive statements	1,3, 5, 7,10	5
Negative statements	2, 4, 6, 8, 9	5

Total number of questions = 10

Scoring and Interpretation

Score	Percentage	Category
1 – 14	<50	Unfavorable attitude
15 – 22	50 – 75	Moderately favorable attitude
23 – 30	>75	Favorable attitude

பகுதி – 1

பிரிவு – அ

1.1 பராமரிப்பாளரின் விவரம் சேகரிக்கும் கருவி

உங்கள் பதிலை வழங்கப்பட்டுள்ள பெட்டியில் எழுதுக

1. வயது (வருடங்களில்
2. பாலினம்

   அ. ஆண்

   ஆ. பெண்
3. பாதுகாப்பு காலம் (வருடங்களில்)

   அ. 1 - 3

   ஆ. 3 - 6

   இ. 6 - 9

   ஈ. > 9
4. நோயாளியுடன் இருந்த காலம் (வருடங்களில்)

   அ. 6 மாதம் -1 வருடம்

   ஆ. 1 - 2

   இ. 2 - 3

   ஈ. > 3
5. கல்வித்தகுதி

   அ. தொழில்கல்வி

   ஆ. பட்டதாரி/ முதுகலைப்பட்டதாரி

   இ. மேல்நிலைக்கல்வி

   ஈ. உயர்நிலைப்பள்ளிச் சான்றிதழ்

   உ. நடுநிலைக்கல்விச் சான்றிதழ்

ஊ. தொடக்கக்கல்விச் சான்றிதழ்

எ. படிப்பறிவில்லாதவர்.

6. தொழில்

அ. திறன் மிக்க தொழில்

ஆ. பாதிதிறன் மிக்க தொழில்

இ. எழுத்தர்/ கடை உரிமையாளர்/ விவசாயி

ஈ. திறன் பெற்ற தொழிலாளி

உ. பாதித்திறன்லற்ற தொழிலாளி

ஊ. திறனற்ற தொழிலாளி

எ. வேலையில்லாதவர்

7. குடும்பமாத வருமானம் (ரூபாயில்)

அ. ≥ 36017

ஆ. 18000 – 36016

இ. 13495 – 17999

ஈ. 8989 – 13494

உ. 5387 – 8988

ஊ. 1803 – 5386

எ. ≤ 1802

8. குடும்ப அமைப்பு

அ. தனிக்குடும்பம்

ஆ. கூட்டுக்குடும்பம்

இ. நீட்டிக்கப்பட்ட குடும்பம்

ஈ. பிளவுபட்ட குடும்பம்

உ. மற்றவை

9. குடும்ப உறுப்பினர்களின் எண்ணிக்கை

அ. < 3

ஆ. 3 - 5

இ. 6 - 10

ஈ. > 10

10. குடியிருப்பு

அ. கிராமப்புறம்

ஆ. நகர்ப்புறம்

இ. பாதிநகர்ப்புறம்

ஈ. மற்றவை

11. நாள்பட்ட உடல் நோய்

அ. ஆம்

ஆ. இல்லை

ஆம் என்றால் குறிப்பிடுக----------

12. திருமண நிலை

அ. திருமணமானவர்

ஆ. திருமணமாகாதவர்

இ. துணையை இழந்தவர்

ஈ. விவாகரத்தானவர்

உ. மற்றவர்கள்.

13. நோயாளியுடன் உறவு

அ. குடும்ப உறுப்பினர்

ஆ. நண்பர்

இ. பணியாளர்

ஈ. அண்டை வீட்டார்

குடும்ப உறுப்பினர் என்றால் உறவுமுறை-----------------

1. 2 நோயாளியின் விவரம் சேகரிக்கும் கருவி

1. வயது (வருடங்களில்)

2. மனநலக்கேட்டின் வகை

   அ. சைகோசிஸ்

   ஆ. நியுரோசிஸ்

   இ. சிறப்புக் கோளாறு

3. பாலினம்

   அ. ஆண்

   ஆ. பெண்

4. நோய் காலம்

   அ. 1 - 3

   ஆ. 3 - 6

   இ. 6 - 9

   ஈ. > 9

5. நோய் மீட்சி விவரம்

   அ. ஆம்

   ஆ. இல்லை

ஆம் என்றால் நோய் மீட்சியின் காரணம் மற்றும் அதன் அறிகுறிகள்- -------------

பிரிவு –ஆ

கட்டமைக்கப்பட்ட அறிவுக் கேள்விகள்

கீழ்கண்ட கேள்விகளை கவனமாகப்படித்து உங்கள் மனதிற்கு சரியென்று பட்ட பதிலைத் தேர்ந்தெடுத்து வழங்கப்பட்டுள்ள பெட்டியில் எழுதுக.

1. மனநோயை -------------------------- மூலம் குணப்படுத்தலாம்.

   அ. உடல் சிகிச்சை

   ஆ. உளவியல் சிகிச்சை

   இ. மருந்து சிகச்சை

   ஈ. மாற்று சிகிச்சை

2. மருந்து உட்கொள்ளாமை என்றால்

   அ. மாத்திரையை அவ்வப்போது எடுப்பது

   ஆ. மாத்திரையை மருத்துவர் கூறியது போல்எடுப்பது

   இ. மாத்திரையை சரியான அளவில் எடுப்பது

   ஈ. மாத்திரையை சரியான இடைவெளியில் எடுப்பது.

3. மனநோயினால் பாதிக்கபட்டவர்களை நோய்மீட்சி மற்றும் மருத்துவமனையில் மீண்டும் அனுமதிப்பதை -------------------------- மூலம் தடுக்கலாம்.

   அ. அவ்வர்போது மாத்திரை எடுப்பதின் மூலம்

   ஆ. மாத்திரையை புறக்கணிப்பதின் மூலம்

   இ. கவனத்தை திசைமாற்றுவதின் மூலம்

   ஈ. மாத்திரை எடுப்பதின் மூலம்

4. மனநோயாளி தொடர்ந்து மாத்திரை எடுப்பதின் சிறப்பு ----------------------

   அ. அதிகரித்த நோயுற்ற விகிதம்

   ஆ. குறைந்த நோயுற்ற விகிதம்

   இ. குறைந்த உயிரிழப்பு

   ஈ. ஆதிகரித்த உயிரிழப்பு

5. மாத்திரையை தொடர்ந்து எடுக்க முடியாமல் போவதின் காரணம்

   அ. சிகிச்சையின் போது அறிகுறிகள் தணிந்துவிடுவது

   ஆ. கவலை

   இ. மறுவாழ்வு

   ஈ. சிகிச்சைக்கு தவறாமல் வருவது.

6. மருந்து கடைப்பிடிப்பதின் தனிப்பட்ட அச்சுறுத்தல் காரணி

   அ. தானாக தசை அசைதல்

   ஆ. மாத்திரையின் விலை

   இ. தன்னை நோயாளியாய் ஏற்று கொள்ள முடியாதது

   ஈ. மற்றவர்களின் தாக்கங்கள்

7. நோய் மீட்சியின் காரணம்

   அ. சிகிச்சையினால் ஏற்படும் அசௌகரியம்

   ஆ. பராமரிப்பாளரின் சுமை

   இ. அவ்வப்போது சிகிச்சைக்கு வருவது

   ஈ. மருந்து உட்கொள்ளாமை

8. மருந்து உட்கொள்ளாமையினால் ஏற்படும் அறிகுறிகளுக்கு தேவைப்படுவது

   அ. உடனடியாக மருத்துவமனையில் அனுமதிப்பது

   ஆ. மறுவாழ்வு

   இ. நோயாளியிடம் பரஸ்பர நட்புணர்வு

   ஈ. மருந்து உட்கொள்ளாமை

9. நோய் மீட்சியின் மிக முக்கியமான அறிகுறி

   அ. தலைவலி

   ஆ. உடல்பலவீனம்

   இ. அறிகுறியின் தீவிரம்

   ஈ. பசியின்மை

10. நோய் மீட்சியின் அறிகுறிகளை கையாளும் முறை

    அ. வேலைகளைக் குறைத்தல்

    ஆ. உலைச்சல்களைக் குறைத்தல்

    இ. மாத்திரையின் அளவைக் குறைத்தல்

    ஈ. வேலைகளை அதிகரித்தல்

11. சிகிச்சை தவறாமல் எடுப்பதினால் ----------------- விளைவுகளை தவிர்க்கலாம்

    அ. எச்.ஐ.வி

    ஆ. சர்க்கரை நோய்/ நீரிழிவு நோய்

    இ. தற்கொலை

    ஈ. மனவளர்ச்சி குன்றல

12. மாத்திரை எடுப்பதற்காகக் கையாளும் முறை

    அ. வார மாத்திரை பெட்டி உபயோகித்தல்

    ஆ. மாத்திரையின் எண்ணிக்கையைக் குறைத்தல்

    இ. வாழ்த்துகளை வெகுமதியாக உபயோகித்தல்

    ஈ. பொறுப்புகளை நோயாளியிடம் விட்டுவிடுதல்

13. மாத்திரை உட்கொள்ளாமையை கடக்கும் முறைகள்

    அ. பாரம்பரிய வீட்டு வைத்தியம் முறைகள்

    ஆ. மருந்தை வழக்கமான நடவடிக்கைகளுடன் அளித்தல்

    இ. நோயாளியை விமர்சிப்பது

    ஈ. மருந்துகளை பல்வேறு இடங்களில் வைத்தல்

14. மருந்து கொடுப்பதில் பராமரிப்பாளரின் பொறுப்பு

    அ. அடிக்கடி மருந்துப் பெட்டியின் மறுதேதியை சரிபார்த்தல்

    ஆ. நோயாளிகளுக்கு சுய பாதுகாப்பு நடவடிக்கையில் உதவுதல்

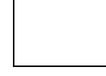
    இ. நோயாளியை முடிவெடுப்பதில் ஈடுபடுத்துதல்

    ஈ. நோயாளியை மேற்பார்வை இடுதல்

15. நோயாளி மருந்து உட்கொள்ளாத நிலையில் பராமரிப்பாளரின் பங்கு

அ. நோயாளியின் நடவடிக்கைகளை கண் காணிப்பது

ஆ. தாங்களாகவே மருந்தின் அளவை குறைத்தல்



இ. மருந்தின் அளவை தேவைக்கேற்ப அதிகரித்தல்

ஈ. மருந்துகளின் கால அளவு மற்றும் அளவுகளை சரிபார்த்தல்

பிரிவு-இ

மனப்பாங்கு அளவுகோல்

குறிப்பு : கீழ்கண்ட வாசகங்களை கவனமாகப் படித்து உங்கள் மனதிற்கு சரியென்று பட்டதை ( ) செய்யுவும்.

மொத்த மதிப்பெண்கள் : 30

வ.எண்	கேள்வி	எப்பொழுதும்	அவ்வப்போது	இல்லை
1	மருந்து கொடுப்பதை என் கடமை என்று நான் உணர்கிறேன்.			
2	நான் நோயாளிக்கு மருந்து கொடுக்க மறந்து விடுகிறேன்.			
3	நான் நோயாளியை மருத்துவர் ஆலோசனைக்கு தவறாமல் அழைத்துச் செல்கிறேன்.			
4	நான் மற்றவர்களின் வற்புறுத்தலின் காரணமாக நோயாளிக்கு மருந்து கொடுக்கிறேன்.			
5	நோயாளியை மருந்து எடுக்க வைக்கும் திறமை என்னிடம் உள்ளது என்று நான் உணர்கிறேன்.			
6	நோயாளிக்கு தவறாமல் மருந்து கொடுப்பதினால் நான் சோர்வடைவதாக உணர்கிறேன்.			
7	மாத்திரை பையில் போதுமான மாத்திரை உள்ளதா என்று கவனிப்பது என் பொறுப்பு என்று நான் உணர்கிறேன்.			
8	நோயாளி குணமடைந்துவிட்டார் என்று உணரும்போது நான் மாத்திரை கொடுப்பதை நிறுத்துகிறேன்.			
9	நோயாளிக்கு மருந்து கொடுக்கும்போது நான் எரிச்சலடைகிறேன்.			
10	என்னால் நோயாளியையும் குடும்பப் பொறுப்புகளையும் சீராக செயல்படுத்த முடிகிறது.			

APPENDIX – H

CODING FOR DEMOGRAPHIC VARIABLES

Demographic Variables	Code No.
1. Age in years	
A) 21 – 30	1
B) 31 – 40	2
C) 41 – 50	3
D) 51 – 60	4
E) 61 – 70	5
2. Gender	
A) Male	1
B) Female	2
3. Duration of care (years)	
A) 1 – 3	1
B) 3 – 6	2
C) 6 – 9	3
D) > 9	4
4. Duration of stay with the client (years)	
A) 6 months – 1	1
B) 1 – 2	2
C) 2 – 3	3
D) > 3	4
5. Education	
A) Professors/Honours	1
B) Graduate/post graduate	2
C) Intermediate/post high school diploma	3
D) High school	4
E) Middle school	5
F) Primary school	6
G) Non literate	7

6. Occupation

A) Profession	1
B) Semi profession	2
C) Clerical/Shop owner/Farmer	3
D) Skilled worker	4
E) Semi skilled worker	5
F) Unskilled worker	6
G) Unemployed	7

7. Family monthly income in Rupees

A) $\geq$ 36017	1
B) 18000 - 36016	2
C) 13495 - 17999	3
D) 8989 - 13494	4
E) 5387 - 8988	5
F) 1803 - 5386	6
G) $\leq$ 1802	7

8. Type of family

A) Nuclear family	1
B) Joint family	2
C) Extended family	3
D) Broken family	4
E) Others	5

9. Number of family members

A) $<$ 3	1
B) 3 - 5	2
C) 6 - 10	3
D) $>$ 10	4

10. Residence

A) Rural	1
B) Urban	2
C) Semi urban	3
D) Others	4

11. Type of chronic physical illness

A) Yes 1

B) No 2

if yes specify________

12. Marital history

A) Married 1

B) Single 2

C) Widow 3

D) Divorced 4

E) Others 5

13. Relationship with the client

A) Family member 1

B) Friend 2

C) Paid caregiver 3

D) Neighbour 4

if family member specify the relationship with the client ___________.

DEMOGRAPHIC VARIABLES OF THE CLIENT

1. Age in year

A) 21 – 30 1

B) 31 – 40 2

C) 41 – 50 3

D) 51 – 60 4

E) 61 – 70 5

2. Type of psychiatric illness

A) Psychosis 1

B) Neurosis 2

3. Gender

A) Male 1

B) Female 2

4. Chronicity of illness (years)

A) 1 – 3	1
B) 4 – 6	2
C) 7 – 9	3
D) > 9	4

5. History of relapse

A) Yes	1
B) No	2

if yes, specify the reason ——— and relapse signs and symptoms ——

APPENDIX – I

BLUE PRINT

S.No.	Topic	Item	No. of items	Percentage
1	Demographic variables	Caregivers: 1 – 13 Clients: 1 – 5	18	100
2	Structured knowledge questionnaire	1 – 15	15	100
3	Attitude scale	Positive – 5 Negative – 5	5 5	50 50
	Total	**43**	**43**	**100**

APPENDIX – J

INTERVENTION TOOL

Multimedia psychoeducation package prepared by the investigator for the caregivers of clients with chronic psychiatric illness, it is an educational programme regarding drug compliance for about 1 hour through lecture cum discussion, video show, psychodrama and DVD for reinforcement.

ஊளவியல நாடகம

பங்கு பெறுவோர்

அம்மா
மகன்
மனோதத்துவ மருத்துவர்
செவிலியர்
அலுவலக உதவியாளர்

(காட்சி -1) – வீட்டில்

மகன் : அம்மா… இவன் தொல்லை தாங்க முடியல, இந்த வீட்டுல ஒன்னு இவன் இருக்கம் இல்லனா நான் இருக்கனும்.

அம்மா: உங்களோட இருக்கிறதுக்கு நான்போய் முதல சேர்ந்தா தெரியும் உங்களுக்கு. இன்னைக்கு எப்படியாவது டாக்டர்கிட்ட போய் இவன admit பண்றதுதான் எனக்கு முதல் வேலை.

மகன் : அத முதல செய்

(காட்சி -2) மருத்துவமனையில்

அம்மா: ஐயா டாக்டர் –ஐ பார்க்கனும்.

அலுவலக பணியாளர் : கொஞ்சம் wait பன்னுங்கம்மா, நான் சொல்றேன்.

அம்மா: மருத்துவமனைக்கு வந்தாலே இது ஒரு பிரச்சனை.

அலுவலக பணியாளர் : அம்மா உள்ளே போங்க.

மருத்துவர்: சொல்லுங்க அம்மா, அந்த அட்டையை கொடுங்க

அம்மா : இந்தாங்க Sir

மருத்துவர்: என்னம்மா போன வருஷம் வந்ததோட இப்பதான் வரிங்களா?

அம்மா : ஆமாம் Sir,

மருத்துவர்: மாத்திரையெல்லாம் ஒழுங்கா கொடுக்கிறிங்களா?

அம்மா : ஆமாம் Sir, ஒழுங்காதான் கொடுக்கிறேன்.

மருத்துவர்: அப்புறம் ஏன் இப்ப வந்திருக்கிங்க.

அம்மா : அது வந்து……. Sir, sorry sir மூணுமாதம் ஒழுங்காதான் கொடுத்தேன. அவன் நல்லாயிட்டான்னு நினைத்து தான் மாத்திரையை நிருத்திட்டேன் Sir.

மருத்துவர்: வர்றவங்க எல்லாம் இது தான் சொல்றிங்க. இதனால பாதிக்கப்படபோறது நீங்க தானு தெரிஞ்சிக்க மாட்றீங்க.

அம்மா : மன்னிச்சிடுங்க Sir.

மருத்துவர்: இரண்டா நம்பர் அரையில் ஒரு செவிலியர் இருப்பாங்க. அவங்கல பாத்துட்டு இங்க வாங்க.

அம்மா : சரிங்க டாக்டர்.

(காட்சி -3) செவிலியர் – ஆலோசனை அறை

அம்மா : வணக்கம் அம்மா, டாக்டர் உங்கள பாத்துட்டு வர சொன்னாங்க.

செவிலியர் : சொல்லுங்கம்மா, என்ன பிரச்சனை.

அம்மா : உன்ன பார்த்தா என் பொண்ணு மாதிரி இருக்க. உன்கிட்ட சொல்றதுக்கு என்ன.

செவிலியர் : சரி, உங்க பொண்ணு மாதிரி நினைச்சிக்கிட்டு சொல்லுங்க.

அம்மா : அம்மா எனக்கு இவன் இல்லாம இன்னும் இரண்டு பசங்க இருக்காங்க ஒருத்தன் படிக்கிறான, ஒருத்தன வேலைக்கு போறான். என் வீட்டுக்காறு உடம்பு முடியாதவறு அதனால நான் தான் இப்ப வயலையும் பாத்துக்கிறேன்.

செவிலியர் : சரிங்க உங்க கஷ்டம் புரியுது, ஆனால் மாத்திரை கொடுப்பதுல என்ன கஷ்டம்.

அம்மா : ஐயோ….. அந்த கொடுமையை ஏன் கேட்கிறிங்க? ஒரு மாத்திரையை கொடுக்கிறதுக்கு நான் படுறபாடு எனக்கு தான் தெரியும். மாத்திரையை கைல கொடுத்தா தூக்கி போட்டுறான் பக்கத்தில என்னால தலையை காட்ட முடியலமா…. இவனால் எனக்கு ஒரே பிரச்சனைதான். கொஞ்சம் டாக்டர் கிட்ட சொல்லி மருத்துவமனையிலே சேத்திடுங்கம்மா. உங்களுக்கு புண்ணியமா போகும்.

செவிலியர் : அம்மா நீங்க நினைக்கிற மாதிரி அவங்க மனசாலையும் அறிவாலையும் வளர்ச்சி கொஞ்சம் கம்மியாதான் இருக்கும். அவங்கள பாத்துகிற ஒரு முக்கியமான கடமை உங்களுக்கு இருக்கு.

அம்மா : புரியுதும்மா… ஆனா இப்ப மனதளவிலும் உடல் அளவிலும் எனக்கு முன்ன மாதிரி தெம்புல்ல.

செவிலியர் : புரியுதும்மா…. நீங்க மட்டும் correct- ஆ checkup க்கும் மாத்திரயும் ஒழுங்கா எடுத்துருந்தீங்கனா இவ்வளவு கஷ்டப்பட்டு இருக்க வேண்டியதுல்ல.

அம்மா : அப்போ மாத்திரயை ஒழுங்கா கொடுத்தா அவனுக்கு இந்த மாதிரி பிரச்சனை வராதா?

செவிலியர் : ஆமாம். பிரச்சனைகளை கண்டிப்பாக குறைக்க முடியும். அது உங்க கைலதான் இருக்கு. நீங்க அவங்களுக்கு மாத்திரையை மற்றவர்களுடைய வர்புருத்தலால் கொடுக்கக் கூடாது.அதை உங்களுடைய கடமையா நினைச்சி செய்யனும். அதுல அன்பும் பாசமும் நிறைந்திருக்க வேண்டும். அவங்கள வேறுபடுத்தி பாக்காதீங்க. அவங்களால செய்ய முடியிற வேலையை அவங்களையே செய்ய விடுங்க.

அம்மா : சரிம்மா…. எனக்கு இருக்கிற வீட்டு வேலைல மாத்திரையும், எப்ப டாக்டர் –அ பார்க்கணும் என்பதையே மறந்திடுறேன். அதுக்கு என்ன பண்றதும்மா?

செவிலியர் : calendar – ல வீட்டுக்கு போன உடனே டாக்டர் அடுத்து எப்ப வரசொல்றாங்க என்ற தேதியை உங்களுக்கு புரியிறமாதிரி குறிச்சி வச்சிடுங்க.

மாத்திரைகளை மூன்று colour – Box ல்; காலைக்கு ஒரு colour Box, மத்திய வேலைக்கு ஒரு colour Box, இராத்திரிக்கு ஒரு colour Box ல போட்டு வச்சிடுங்க. அப்படி இல்லனா அந்த colour Box ல 1,2,3 ன்னு paper- ல எழுதி ஒட்டி வச்சிடுங்க.

அம்மா : சரிங்கம்மா, நான் எப்பாடு பட்டாவது அவனை மாத்திரியை எடுக்க வைச்சிடுறேன். அவன் மாத்திரையை முழுங்கிட்டான்னு பார்த்துட்டு தான் நான் அந்த இடத்தை விட்டே நகருவேன். சரியம்மா.. ரொம்ப நன்றிம்மா, எனக்கு ரொம்ப உதவியா இருந்துச்சி.

செவிலியர் : சரிம்மா…. நீங்க போய் டாக்டர் –ஐ பாருங்க.

(காட்சி -4) டாக்டர் அறையில்

மருத்துவர் : வாங்கம்மா, செவிலியர பாத்திங்களா, அவங்க உங்களுக்கு மாத்திரியை தொடர்ந்து எடுப்பதின் பயனையும், உங்களுடைய கடமையை பற்றியும் சொல்லி கொடுத்தாங்கலா.

அம்மா : ஆமா Sir, ரொம்ப நல்லா சொல்லிதந்தாங்க Sir.

மருத்துவர் : உங்களுடைய வேலைக்கு ஏற்ற மாதிரி நேரத்தை கணக்கு போட்டு வச்சிக் கோங்க அப்ப தான் உங்களால எல்லா கடமைகளையும் செய்ய முடியும். நீங்களும் எரிச்சல் அடையாமல், சந்தோஷமா இருக்கலாம், சரிங்கலாம்மா.

அம்மா : சரிங்க Sir, அடுத்து எப்ப வரனும் Sir.

மருத்துவர் : அடுத்த மாசம் இந்த தேதிக்கு வந்திடுங்கம்மா.

முடிவுரை : மனநோயால் பாதிக்கப்பட்டவர்களை இந்த சமுதாயத்தில் ஒதுக்கி வச்சிடுறாங்க, அப்படி செய்யாமல் அவர்களையும் சராசரி மனிதர்களாக பார்க்கனும். அவங்கள அப்பா, அம்மா, தான் பார்த்துக்கனும்ன்னு கிடையாது, உடன் பிறந்தவர்கள், நண்பர்கள், உறவினர்கள், மனைவி இவர்களுடைய ஊக்குவித்தலும் தேவை.

நேயர்களே இந்த நாடகத்தின் மூலம் நோயாளியின் கவனிப்பாளர்களின் பங்களிப்பு எவ்வளவு முக்கியமானது என்பதை பார்த்தோம். இதன் மூலம் நீங்கள் பலன் அடைந்திருப்பீர்கள் என்று நம்புகிறேன்.

LESSON PLAN ON DRUG COMPLIANCE

Topic : Drug compliance

Group : Caregivers

Place : Athma Hospital

Duration : 30 min

Teaching method : Lecture cum discussion

Instructor : Investigator

Instructional Aids : Power point presentation, video show, Psycho drama

Seating arrangement : Theatre method

General objective : At the end of the session the caregivers will gain adequate knowledge and favourable attitude regarding drug compliance

Specific objectives : At the end of the session the caregivers will be able to,

- define drug compliance
- state the importance of drug compliance
- identify the factors affecting treatment adherence
- list out the side effects of drug non-compliance
- analyze the causes for recurrence
- encounter the strategies to overcome drug non-compliance
- identify the complications of drug non-compliance
- explain the role of caregivers in drug adherence

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
1.	Introduces the topic	5min	**INTRODUCTION** Psychiatric/mental disorders are clinically significant behavioural or psychological syndromes associated with distress or disability. Non-compliance with drug treatment is widespread. When patients are given medication by their doctors, nearly half do not take the drug or do not take it as prescribed, and most will stop the treatment as soon as they are feeling better. A major problem in identifying the non-compliance patient is the unreliability of many of the measures used for assessing compliance.	Teacher introduces the topic with a story	Listening
2	Define drug compliance	5 min	**DEFINITION:** **1. Drug Compliance** to a medication regimen is generally defined as the extent to which patients take medications as prescribed by their health care providers. It includes taking the prescribed number of pills each day and the timing of doses (taking pills within the prescribed period). **2. Drug non-compliance** is defined as failure or refusal to comply with the medication prescribed by the prescriber.	Teacher defines drug compliance	Listening

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			3. **Partial Adherence** is defined as taking an amount that is consistently less than recommended and irregular dosing.		
3	State the importance of drug compliance	5min	**IMPORTANCE:** Drug non-compliance is thought to be a major factor in psychiatric hospitalizations. At home, a large number fail to take their medications properly, if at all. Relapse often occurs and re-hospitalization follows hence, treatment adherence • Prevents relapse and re-hospitalization • Strongest modifiable protective factor against suicide • Effective in reducing mortality	Teaches the importance of drug compliance	Listening
4	Identify the factors affecting treatment adherence	10 min	**FACTORS AFFECTING TREATMENT ADHERENCE:** ➢ Psychological problems, especially depression ➢ Cognitive impairment ➢ Treatment of asymptomatic disease ➢ Inadequate follow up/discharge planning ➢ Medication side effects ➢ Patient's lack of belief in benefits/treatment ➢ Patients lack of insight into the illness ➢ Poor provider- patient relationship	Teaches the factors that affect treatment adherence	Listens and actively participating in discussion

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			➢ Cost of medication ,co-payment or both ➢ Complexity of treatment ➢ Barriers to care or medications ➢ Missed appointments **4.1 PATIENT CHARACTERISTICS** 1. Very young or very old. 2. Low education. 3. Hostility and aggression. 4. Living alone. 5. Fear and paranoia. 6. Lack of transportation. 7. Personality disorder. 8. Lack of knowledge of illness. 9. Substance abuse. 10. Therapeutic effects not understood. 11. Poor judgment and insight. 12. Resistance to accept the "sick" role. 13. Paranoid delusions about content or effects of medication.		

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			14. Change in lifestyle or habits required. 15. Prefers delusional sick life to depressing well life. 16. Resistance to mind-controlling medication. **4.2 DRUG-RELATED FACTORS** 1. Presence of extra-pyramidal side effects (involuntary movements). 2. Presence of dysphoric response (feels less alive). 3. Presence of other side effects. 4. Medication not very effective. 5. Need to continue medication in absence of symptoms. 6. Complicated drug regimens. 7. Cost of medication. 8. Inadequate information about how to take medication. 9. Feels best when first stops medication; feels worst when first starts medication. **4.3 INTERPERSONAL FACTORS** • Patient-physician relationship.		

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			• Family relationships. • Peer influences. • Resistant to authority. • No alliance toward patient goals.		
5	List out the side effects of drug non-compliance	5 min	**SIDE EFFECTS:** • Sleep disruption • Dry mouth • Constipation • Weight changes • Sexual dysfunction • Aggressiveness • Withdrawal symptoms • Seizure • Death • Psychomotor disturbances	Teaches the side effects	Listening
6	Analyze the causes for recurrence	5 min	**RECURRENCE:** **6.1 SIGNS OF POTENTIAL RELAPSES** Are different for each person. The most common signs in order of frequency are:	Teaches the causes for recurrence	Listening

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			1. Increased interpersonal sensitivity, suspiciousness, paranoia. 2. Sleep disturbance worse than usual pattern. 3. Anger or hostility of an unusual type or amount. 4. Hallucinations of increased intensity or intrusiveness. 5. Actions based on or preoccupation with delusions. 6. Increased fearfulness, anxiety, or feeling threatened. 7. Increased depression with withdrawal and eating less. **<u>6.2 IDENTIFYING EARLY SIGNS OF RELAPSE</u>** For your ill relative, identify the specific signs which lead to a serious relapse. Differentiate between • Behaviours which are troubling for the patient and problematic for the family, but which do not result in re-hospitalization and • The specific behaviours whose presence uniquely predict or the earliest signs of a relapse which may require re-hospitalization.		

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			<u>6.3 RESPONDING TO WARNING SIGNS OF AN IMPENDING RELAPSE</u> 1. Temporarily increase medication. 2. Temporarily reduce stress by: a. Lowering demands and activity level. b. Keeping a routine (minimizing changes), and c. Providing a safe, calm, predictable environment. 3. Do the specific things which calm and reassure your relative. **Alternatives include:** a. Low stress activities or hobbies, b. Social support, c. Allow alone time, and d. Relaxation techniques. 4. Remain calm and in control. 5. Use your urgency and emergency plans as needed.		
7	Encounter the strategies to overcome drug	10 min	**STRATEGIES TO OVERCOME DRUG NONADHERENCE: HEALING ENVIRONMENTS** • Recognize that the illness is no one's fault.	Teaches the strategies to overcome drug	Listens and contributes the ideas

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
	non-adherence		• Have clear and appropriate expectations, understanding the limits of the illness and the extent of the person's control over his behaviour. • Are simple and structured with predictable routines. • Are quiet with calm voices and limited stimulation. • Are consistent and change seldom and gradually. • Include the patient in life in ways that are not over stimulating. • Offer opportunities to have major personal, social, activity, and competence needs met. • Provide lots of praise and encouragement. • Teach and reward the use of daily living, social, and vocational skills. • Utilize medication and treatment programs as resources to help the ill person move toward his goals. • Are prepared for and manage minor system worsening to minimize disruption and prevent major relapse.	non-adherence	

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			7.1 INVOLVE THE PATIENT IN MEDICATION AND TREATMENT DECISIONS BY: • Tracking his own symptoms and side effects. • Taking an experimental approach (incorporate blood levels and symptom tracking by the patient and others). • Helping him to learn to gain control over symptoms and side effects (medication and symptom management classes). • Negotiating a shared treatment contract. • Using the lowest possible dose of medication that the patient prefers (if appropriate). • Helping the patient do a cost benefit analysis of therapeutic versus side effects. **7.2 HELP THE CLIENT MINIMIZE SIDE EFFECTS BY:** • Preparing patient for potential side effects. • Contacting patient frequently by telephone when beginning a new medication. • Selecting medications and dosages to minimize side effects.		

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
			• Teaching patient to cope with side effects. **7.3 MAKE IT EASY TO COMPLY** • Smart phone alarms/reminders • Combining medications together in one place-pill box • Put medications with another routine activity (i.e.-toothbrush) • Chart medications and symptoms • Use intangible rewards like attention, praise, compliments, hugs, smiles, etc. • Using long acting injectables • Using a weekly dose pill box. • Putting in with vitamins		
8	Identify the complications of drug non-compliance	5 min	**COMPLICATIONS:** • Lower quality of life • Relapse • Re-hospitalization • Homelessness • Delays the restoration to full health • Physical aggressiveness	Teaches the complications	Listening

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
9	Explain the role of caregivers in drug adherence	10 min	**ROLE OF CAREGIVERS:** 1. Display patience and empathy when interacting with patients. 2. Be mindful of the number of medications prescribed and their frequency and dosages. 3. Think of the consequences of non- adherence and act appropriately. 4. Periodically review patient's medication containers, noting renewal dates. 5. Provide emotional support. 6. Practice active listening. 7. Address fears and concerns. 8. Empower patients to self manage their condition. 9. Provide rewards for adherence. Do not give praise and criticism at the same time. If you wish the person to try again, you must only praise effort and the parts of the task that he did well. Any constructive criticism must wait. Before the next try you can provide helpful suggestions.	Teaches the role of caregivers	Listens and contributes the ideas

S.No.	SPECIFIC OBJECTIVES	TIME	CONTENT	TEACHER'S ACTIVITY	LEARNER'S ACTIVITY
10			**CONCLUSION:** Non-adherence to medication is widespread and caregivers clearly play a major role in the life of a person with psychiatric illness. They provide direct assistance, advocate for services and provide financial and emotional support. Caregivers can have enormous influence on the ability of persons with psychiatric illness to live productive, integrated lives in their communities. Caregivers also play a key but relatively unexplored role in assisting their relatives in taking their medications and maintaining stability in the community. Strong social supports, including family and community supports and a good relationship with the care team, reportedly exert a positive influence on medication adherence. Studies also have shown that when a family member acts as a caregiver, this has a positive effect on patients taking their medications.	Concludes the topic with evaluation	

மனநோயில் மருந்து உட்கொள்ளாமை குறித்த பாடத்திட்டம்

தலைப்பு : மருந்து உட்கொள்ளாமை
குழு : பராமரிப்பாளர்கள்
இடம் : ஆத்மா மருத்துவமனை
காலம் : 30 நிமிடம்
பாடம் நடத்தும் முறைமை : போதித்தலும் குழு விவாதமும்
பாடம் நடத்தத் தேவையான உபகரணங்கள் : PPT, வீடியோ காட்சி, உளவியல் நாடகம்
பங்கேற்பாளர்களை அமர்த்தும் முறை : தியேட்டர் முறை

பொதுவான நோக்கம் : மருந்து உட்கொள்ளாமை குறித்த குழு விவாதங்களின் முடிவில உறுப்பினர்கள் ஆழமாக அறிந்து கொள்வதோடு அதனைக் குறித்து நேர்மையான மனோபாங்கினையும் வளர்த்துக் கொள்வார்கள்

பிரத்தியேகமான நோக்கங்கள் : பராமரிப்பாளர்கள் கீழக்கண்டவற்றை செயல்படுத்துபவர்களாக இருக்க வேண்டும்.

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
1	தலைப்பைக் குறித்த முன்னுரை	5 நிமிடம்	**முன்னுரை:** மனநலக் கோளாறால் பாதிக்கப்பட்டவர்களின் நடத்தை, அறிகுறிகள் துன்பம் மற்றும் இயலாமையுடன் சம்பந்தப்பட்டதாகும். (மனநோயில் மருந்துகளைத் தவிர்ப்பது எல்லாரிடத்திலும் உள்ள இயல்பாகும்) மருத்துவரால் கொடுக்கப்படும் மருந்துகள், பாதிக்கும் மேற்பட்டோறால்பின்பற்றப் படுவதில்லை. மேலும் மருத்துவர் குறித்துக் கொடுப்பது போல் எடுக்கப்படுவதுமில்லை. அதிலும் பெரும்பாலோர் மருந்தை நிறுத்திவிடுகிறார்கள்.	போதிப்பவர் தலைப்பைப் பற்றி உரைக்க, குழுவினர் கவனிப்பது
2	மருந்து உட்கொள்ளாமையின் பொருள்	5 நிமிடம்	**வரையறை:** 1. **மருந்து உட்கொள்ளல்:** மருந்து உட்கொள்ளல் என்பது மருத்துவரால் பரிந்துரைக்கப்படும் மருந்துகளை நோயாளிகள் தவறாமல் எடுத்தல் ஆகும். மேலும் மருந்துகளை சரியான அளவு மற்றும் சரியான நேரத்தில் எடுப்பதாகும். 2. **மருந்து உட்கொள்ளாமை:** மருந்து உட்கொள்ளாமை என்பது மருத்துவரால	போதிப்பவர் பொருளை விளக்கிக் கூற, குழுவினர் கவனிப்பது

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			பரிந்துரைக்கப்படும் மருந்துகளை பின்பற்ற மறுத்தலாகும். 3. **மருந்தைப் பகுதியாக உட்கொள்ளல்:** மருத்துவரால் பரிந்துரைக்கப்படும் மருந்துகளை அவ்வப்போது எடுப்பது ஆகும்.	
3	மனநோயாளி மருந்து உட்கொள்வதின் முக்கியத்துவம்	5 நிமிடம்	**முக்கியத்துவம்:** **நாம் மருந்துகளை சரியாக எடுப்பது என்பது** 1. நோய் மீட்சி மற்றும் மீண்டும் மருத்துவமனையில் அனுமதிக்கப்படுவதை தடுக்கிறது. 2. தற்கொலைக்கு எதிராக வலுவான பாதுகாப்புக் காரணியாக விளங்குகிறது. 3. நோயின் வீரியத்தை குறைக்கிறது.	போதிப்பவர் மருந்து உட்கொள்வதின் முக்கியத்துவத்தை விளக்கிக் கூற, குழுவினர் கவனிப்பது
4	மனநோயாளி சிகிச்சை எடுப்பதை பாதிக்கும் காரணிகளை கண்டறிதல்	10 நிமிடம்	**சிகிச்சை எடுப்பதை பாதிக்கும் காரணிகள்:** • உளவியல் பிரச்சினைகள் (எ.டு) மன அழுத்தம் • அறிவாற்றல் குறைபாடு • எந்த அறிகுறியும் இல்லாமல் நோய் சிகிச்சை • போதிய பின்பற்றலின்மை	போதிப்பவர் வீடியோ உதவியுடன் விளக்கி கூற, குழுவினர் கவனிப்பது

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			• மருந்துகளின் பக்க விளைவுகள் • சிகிச்சைகள், மருந்துகளின் மீது நம்பிக்கை இல்லாமை • நோய் உட்பார்வை இல்லாதது • நோயாளிகள் மற்றும் பராமரிப்பவர்களின் உறவு • மருந்தின் செலவு • சிக்கலான சிகிச்சை முறை • உரிய நேரத்தில் மருத்துவரை சந்திக்கத்தவறுவது 4.1 **நோயாளி பண்புகள்:** • இளம்வயது அல்லது முதியவர் • குறைந்த கல்வி - விரோதம் மற்றும் ஆக்கிரமிப்பு • தனியாக வாழ்வது • பயம் • போக்குவரத்து வசதி இல்லாதது • ஆளுமை கோளாறு • நோயினை பற்றி போதுமான அறிவு இல்லாமை	

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			• குடிப்பழக்கம் • சிகிச்சையின் நன்மைகளை புரிந்துகொள்ளாதது • வாழ்க்கை மாற்றம் • மருந்துகளை எடுக்க மனது எதிர்ப்பு 4.2 மருந்து தொடர்பான காரணி • தானாக தசைகள் அசைவு • குறைவான உயிருடன் இருப்பது போல் உணர்வது • மற்ற பக்க விளைவுகள் • மருந்துகள் பயனற்று போவது • மருந்தின் மிக உயர்ந்த விலை • சிக்கலான சிகிச்சை முறை • மருந்தினை எடுத்து கொள்வது பற்றிய போதுமான தகவல இல்லாதது • மருந்தினை நிறுத்தும்போது சிறப்பாக உணர்வதும், • அதனை மீண்டும் தொடரும்போது மோசமாக உணர்வதும்	

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			4.3 உளப்பகுப்பாய்வினை காரணிகள்: • நோயாளி - மருத்துவர் உறவு • குடும்ப உறவு • நண்பர்களின் தூண்டுதல் • பராமரிப்பவர்களிடம் எதிர்ப்பு • நோயாளியிடம் இலக்கை நோக்கி எந்த முயற்சியும் இல்லாதது.	
5	பக்க விளைவுகளை எடுத்துக் கூறுதல்	5 நிமிடம்	**மனநோயில் மருந்து உட்கொள்ளாமையின் பக்க விளைவுகள்:** • தூக்கத்தில் இடையூறு • வாய் உலர்தல் • மலச்சிக்கல் • எடை மாற்றங்கள் • பாலியல் பிறழ்ச்சி • கோபம் கொள்வது • மீளப்பெறும் அறிகுறிகள் • பக்கவாதம்	போதிப்பவர் விளக்கிக் கூற, குழுவினர் கவனிப்பது

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			• உள இடையூறு • இறப்பு	
6	மருந்து உட்கொள்ளாமையின் விளைவுகளைக் கண்டறிதல்	5 நிமிடம்	**மனநோயில் மருந்து உட்கொள்ளாமையின் விளைவுகள்:** • குறைவான வாழ்க்கைத்தரம் • நோய் மீட்சி • மீண்டும் மருத்துவமனையில் அனுமதிக்கப்படுவது • வீடற்ற நிலை • முழுமையாக குணமடைவதில் தாமதம் • தங்களை வருத்திக் கொள்வது	போதிப்பவர் விளைவுகளை விளக்கிக் கூற, குழுவினர் கவனிப்பது
7	நோய் மீட்சியின் காரணிகளை பகுத்தறிதல்	5 நிமிடம்	**7.1 மனநோய் மீட்சியின் அறிகுறிகள்:** • அதிகரித்த உளப்பகுப்பாய்வினை உணர்திறன் • சந்தேகப்படுவது • இடையூறான தூக்கம் • வழக்கத்தை விட அதிகமாகக் கோபம் கொள்வது • முன்பை விட அதிகமாகக் காதில் அல்லது நேரில் யாருடனோ பேசுவது போல் உணர்வது	போதிப்பவர் விளக்கிக் கூற, குழுவினர் கவனிப்பது

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			• மாயை நினைப்பு • அதிகரித்த பயம் • கவலை • மன அழுத்தத்தினால் தனிமைப்படுவது மற்றும் குறைவாக உண்ணுவது **7.2 மனநோய் மீட்சியினை கண்டறியும் முறைகள்:** • நோயாளிக்கும் அவரது குடும்பத்தினருக்கும் பிரச்சினை தரக்கூடிய நடத்தைகள் • நோயாளியின் பிரத்தியேக நடவடிக்கையில் மாற்றம் **7.3 மனநோய் மீட்சியின் அறிகுறிகளை கையாளும் முறைகள்:** 1. தற்காலிகமாக மருந்தின் அளவினை அதிகரித்தல் 2. தற்காலிகமாக மன அழுத்தத்தைக் குறைக்க a. கோரிக்கைகளைக் குறைப்பது மற்றும் வேலைகளைக் குறைப்பது b. வழக்கமானதைத் தொடர்வது	

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			c. பாதுகாப்பான அமைதியான சூழலை வழங்குவது 3. நோயாளியை அமைதியாக்கும் மற்றும் உத்திரவாதம் கொடுப்பதை போல் நடந்து கொள்ளுதல் a. குறைந்த அழுத்த நடவடிக்கைகள் (எ.டு) பொழுதுபோக்கு b. சமூக ஆதரவு c. தனியாக இருப்பதற்கு அனுமதித்தல் d. ஓய்வெடுக்கும் நுட்பம் 4. அமைதியாக மற்றும் கட்டுப்பாட்டில் தொடர்ந்து வைத்திருத்தல் 5. தேவையான உங்கள் அவசர மற்றும் அவசரநிலை திட்டங்களை பயன்படுத்துதல்	
8	மருந்து இணக்கம் மேற்கொள்ளும் முறைகளை அறிதல்	10 நிமிடம்	**மருந்து இணக்கம் மேற்கொள்ளும் முறைகள்:** 1. நோய் வருவது தனிப்பட்டவருடைய தவறில்லை என்பதை உணர்தல் 2. நோய் எல்லையைப் புரிந்து கொள்ளுதல் 3. நோயாளியை எளிய மற்றும் கட்டமைக்கப்பட்ட நடைமுறைகளில் ஈடுபடுத்துதல் 4. அமைதியான சூழலை ஏற்படுத்திக் கொடுத்தல்	போதிப்பவர் விளக்கிக் கூற, குழுவினர் கவனிப்பது

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			5. நோயாளியை தூண்டுதல் செய்யும் வழிகளை அகற்றல் 6. தனிப்பட்ட, சமூக மற்றும் தொழில் திறன் வாய்ப்புகளை வழங்குதல் 7. பாராட்டு மற்றும் ஊக்கம் நிறைய வழங்குதல் 8. அன்றாட வாழ்க்கை, சமூக மற்றும் தொழில் திறன்களை பயன்படுத்தக் கற்றுக் கொடுப்பதோடு 9. மருந்தை நோயாளியின் இலக்கை நோக்கி நகர்த்தும் ஒரு கருவியாக பயன்படுத்துதல் **நோயாளியை மருந்துகள் மற்றும் சிகிச்சை குறித்த முடிவுகளை எடுக்க வைக்கும் முறைகள்:** 1. தன் அறிகுறிகளையும் பக்க விளைவுகளையும் கண்காணிப்பது 2. இரத்த அளவுகள் மற்றும் அறிகுறிகளை நோயாளியும் பராமரிப்பவரும் கண்காணிப்பது 3. பக்க விளைவுகள் மற்றும் அறிகுறிகள் மீது கட்டுப்பாடு பெற கற்றுக்கொடுத்தல் 4. சிகிச்சை ஒப்பந்தம் கொள்ளுதல் 5. மிகக் குறைவான அளவில் மருந்தைப் பயன்படுத்துதல்	

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			6. நோயாளியை பக்க விளைவுகளுக்கு எதிராக சிகிச்சை செலவு பயன் பகுப்பாய்வு செய்ய உதவுதல் **நோயாளியின் பக்க விளைவுகளை குறைக்கும் முறைகள்:** 1. புதிதாக மருந்து ஆரம்பிக்கும் போது அவ்வப்போது தொலைபேசியில் நோயாளியை தொடா்பு கொள்ளுதல் 2. மருந்துகளை தொடா்ந்து எடுப்பது 3. மருந்து மற்றும் அதன் அளவுகளை பக்க விளைவுகளை குறைப்பது போல் தோ்வு செய்தல் 4. பக்க விளைவுகளை சமாளிக்க நோயாளிகளுக்கு கற்றுக் கொடுத்தல் **எளிதாக இணங்க** • அலாரம் அல்லது நினைவூட்டல்கள் வைத்தல் • ஒரே இடத்தில் ஒன்றாக மருந்துகளை வைத்தல் • மருந்தினை மற்றொரு வழக்கமான நடவடிக்கையுடன் வைத்தல் (எ.டு) பல்துலக்கம்	

வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			• மருந்து மற்றும் அறிகுறிகளை பட்டியலிடுதல் • வெகுமதிகளை பயன்படுத்துதல் (எ.டு) புன்னகை, கை குலுக்கல் • வாராந்திர மாத்திரைப் பெட்டி பயன்படுத்துதல் • வைட்டமின் மாத்திரையுடன் இணைந்து எடுத்தல்	
9	மருந்து உட்கொள்ளலில் பராமரிப்பவர்களின் பங்கினை விளக்கிக் கூறுதல்	10 நிமிடம்	**பராமரிப்பவர்களின் பங்கு** 1. நோயாளியிடம் உரையாடும்போது பொறுமை மற்றும் அனுதாபம் காட்டுதல் 2. பரிந்துரைக்கப்பட்ட மருந்துகளின் எண்ணிக்கை, மற்றும் அவற்றின் கால அளவு மற்றும் மருந்தளவு கவனத்தில் இருத்தல் 3. மருந்தினை சரியாக கொடுக்காததால் ஏற்படும் விளைவுகளை மனதில் கொண்டு பொறுப்பாக நடந்து கொள்ளுதல் 4. சரியான கால இடைவேளையில் நோயாளிகளின் மருந்துப் பெட்டிகளையும் மறுதேதிகளையும் நினைவு கொள்ளுதல் 5. நோயாளியின் உணர்ச்சியை புரிந்து கொள்ளுதல் 6. நோயாளியின் பிரச்சினைகளை கேட்டறிதல்	போதிப்பவர் விளக்கிக் கூற, குழுவினர் கவனிப்பது

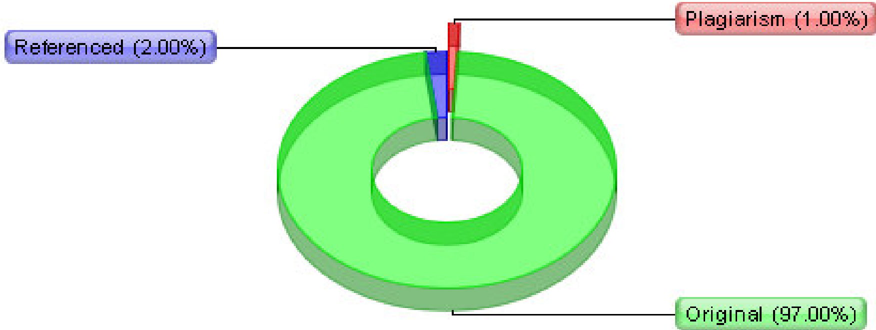
வ. எண்	பிரத்தியேகமான நோக்கங்கள்	காலம்	கருப்பொருள்	போதிக்கும் / கற்றுக்கொள்ளும் செயல்திட்ட முறைமை
			7. நோயாளியின் பயத்தைப் போக்குதல் 8. தனது நிலைமைகளை சமாளிக்கும் திறனை நோயாளிகள் வளர்த்துக் கொள்ள உதவுதல் 9. நோயாளி மருந்தினை சரியாக எடுத்தால் வெகுமதி அளித்தல். பாராட்டு மற்றும் விமர்சனம் ஒரே நேரத்தில் கொடுக்க கூடாது.	
10			**முடிவுரை:** பராமரிப்பாளர்கள் மனநல நோயாளிகளின் வாழ்க்கையில் ஒரு முக்கியப் பங்கு வகிக்கிறார்கள். அவர்கள் நேரடி உதவி வழங்குவர். நிதி மற்றும் உணர்ச்சி ஆதரவு அளிப்பவர். அவர்கள் நோயாளியை மருந்து எடுக்க வைக்கும், ஒரு முக்கிய பொறுப்பினையும் உடையவர்கள். மேலும் பராமரிப்பாளர்கள் நோயாளிகளின் சமூக நிலையை வலுப்படுத்துபவர்களாகவும் விளங்குகின்றனர். உறுதியான சமூக மற்றும் குடும்ப ஆதரவும் மருந்தினை தொடர்ந்து எடுக்க ஒரு முக்கியமான காரணியாகவும் விளங்குகின்றனர்.	

APPENDIX – K

Plagiarism Detector - Originality Report

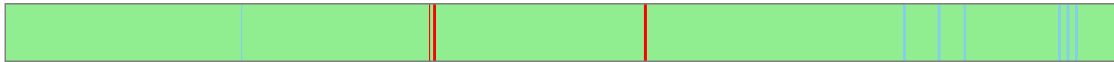
Analyzed document:
"plagiarism report Sasikala A.docx"

Core version:	895
Size:	86563 words
Registered to:	Yayathee Subbarayalu
Generated:	1/23/2016 10:36:38 PM
License type:	Plagiarism Detector
Core version:	895



Processed Resources List: [click below to open] **Processed Ok: 42 Failed: 7**

Distribution graph:



Signature of the Candidate **Signature of the Principal**

APPENDIX – M

PHOTOGRAPHS

APPENDIX – L

M.Sc (N) DISSERTATION EXECUTION PLAN – GANTT CHART

GANNT CHART																			
S.NO	**CALANDER MONTHS**	**Nov '14**	**Dec '14**	**Jan '15**	**Feb '15**	**Mar '15**	**Apr '15**	**May '15**	**June '15**	**July '15**	**Aug '15**	**Sep '15**	**Oct '15**	**Nov '15**	**Dec '15**	**Jan '16**	**Feb '16**	**Mar '16**	**Apr '16**
A	**Conceptual phase**																		
1	Problem identification																		
2	Literature review																		
3	Clinical fieldwork																		
4	Theoretical framework																		
5	Hypothesis formulation																		
B	**Design & planning phase**																		
6	Research design																		
7	Intervention protocol																		
8	Population specification																		
9	Sampling plan																		
10	Data collection plan																		
11	Ethics procedure																		
12	Finalization of plans																		
C	**Empirical phase**																		
13	Data collection																		
14	Data preparation																		
D	**Analytical phase**																		
15	Data analysis																		
16	Interpretation of results																		
E	**Dissemination phase**																		
17	Presentation or report																		
18	Utilization of findings																		
	Calendar months	**11**	**12**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**01**	**02**	**03**	**04**