Breaking the Cycle: The System-Wide Impact of Mental Health Medication Non-Adherence on Patients, Prescribers and Healthcare Institutions

Abstract

Medication non-adherence in mental health care is not simply a patient-level challenge; it is a systemic problem that ripples across emergency departments (EDs), inpatient psychiatric units, skilled nursing facilities (SNFs), and community providers. Non-adherence contributes to relapse, repeat hospitalizations, longer inpatient lengths of stay, and compromised regulatory compliance. This paper synthesizes recent evidence (2024–2025) to explore how psychiatric medication non-adherence impacts health systems, influences prescriber decision-making, and creates operational and regulatory risks for hospitals and SNFs. Solutions, including proactive long-acting injectable (LAI) use, measurement-based follow-up, digital adherence supports, and prescriber training, are considered to mitigate these impacts.

Introduction

Medication adherence has long been considered essential to effective psychiatric care. Yet, adherence rates remain discouragingly low. Recent systematic reviews show that approximately 45–50% of patients with psychiatric diagnoses fail to take medications as prescribed (Zewdu et al., 2025). This persistent pattern of non-adherence increases the likelihood of symptom relapse, suicide risk, and preventable hospitalizations (Pruitt et al., 2025). While much of the literature focuses on direct consequences for patients, emerging research highlights the system-level impacts of non-adherence. These include emergency department (ED) boarding, delayed access to beds for other patients, survey deficiencies for skilled nursing facilities (SNFs), and disruptions in hospital compliance with accreditation standards (Ma et al., 2025; The Joint Commission, 2024). This paper expands the lens of analysis beyond individual patients to examine how non-adherence affects healthcare delivery, provider behaviors, and institutional performance.

System-Wide Impacts of Non-Adherence

EDs are frequently the first point of contact for psychiatric crises driven by non-adherence. Studies confirm that psychiatric patients have longer ED lengths of stay (LOS) than medical patients, which intensifies crowding and reduces throughput (Lee et al., 2023; Ma et al., 2025). Prolonged ED boarding delays treatment for all patients, increasing risks such as patients leaving without being seen, prolonged wait times, and missed opportunities for early intervention (Associated Press, 2025). These bottlenecks ripple downstream. Longer ED stays predict longer inpatient LOS, leading to delayed elective surgeries, reduced bed capacity, and higher hospital costs (Ma et al., 2025).

System-Wide Impacts of Non-Adherence cont.

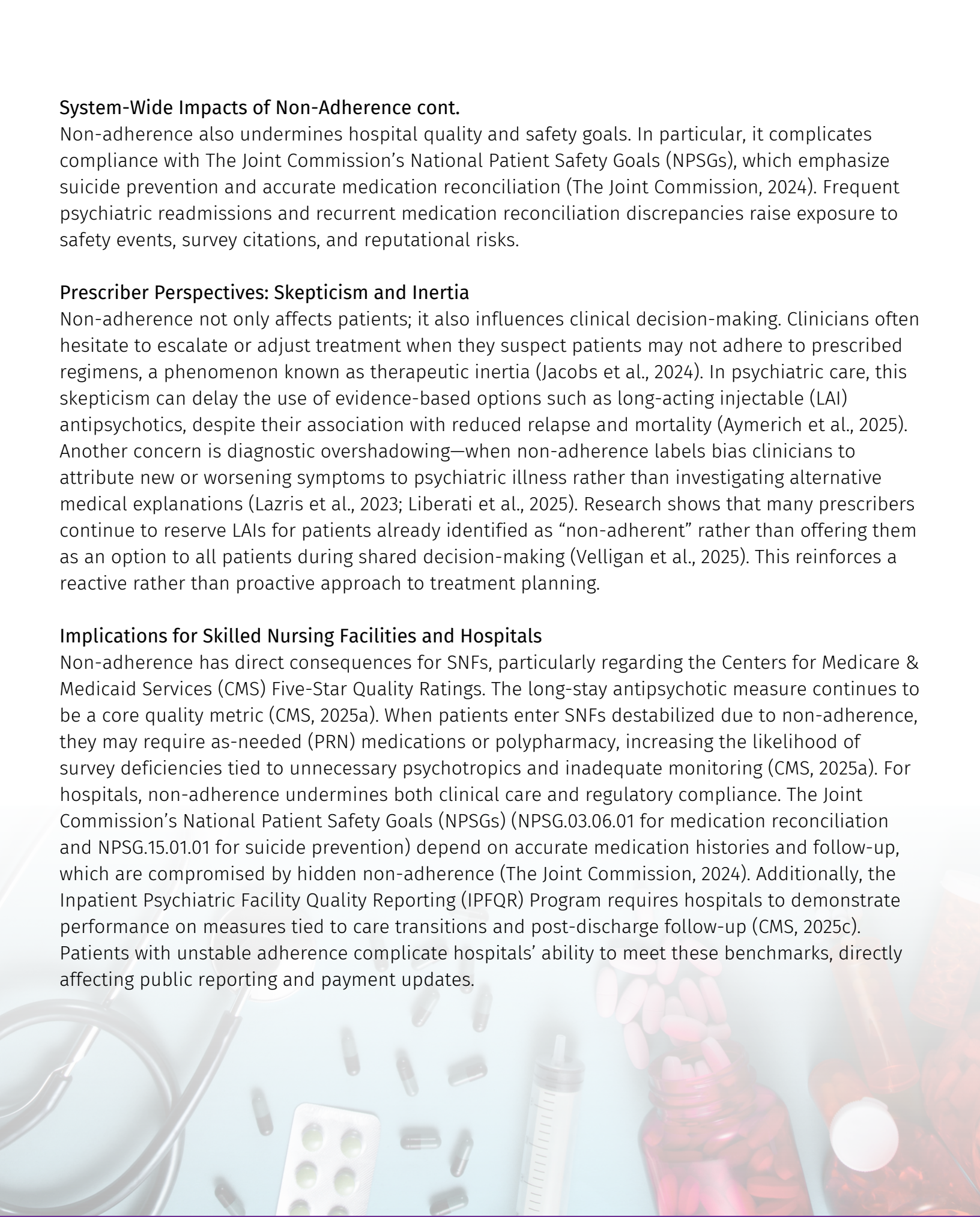
Non-adherence also undermines hospital quality and safety goals. In particular, it complicates compliance with The Joint Commission's National Patient Safety Goals (NPSGs), which emphasize suicide prevention and accurate medication reconciliation (The Joint Commission, 2024). Frequent psychiatric readmissions and recurrent medication reconciliation discrepancies raise exposure to safety events, survey citations, and reputational risks.

Prescriber Perspectives: Skepticism and Inertia

Non-adherence not only affects patients; it also influences clinical decision-making. Clinicians often hesitate to escalate or adjust treatment when they suspect patients may not adhere to prescribed regimens, a phenomenon known as therapeutic inertia (Jacobs et al., 2024). In psychiatric care, this skepticism can delay the use of evidence-based options such as long-acting injectable (LAI) antipsychotics, despite their association with reduced relapse and mortality (Aymerich et al., 2025). Another concern is diagnostic overshadowing—when non-adherence labels bias clinicians to attribute new or worsening symptoms to psychiatric illness rather than investigating alternative medical explanations (Lazris et al., 2023; Liberati et al., 2025). Research shows that many prescribers continue to reserve LAIs for patients already identified as "non-adherent" rather than offering them as an option to all patients during shared decision-making (Velligan et al., 2025). This reinforces a reactive rather than proactive approach to treatment planning.

Implications for Skilled Nursing Facilities and Hospitals

Non-adherence has direct consequences for SNFs, particularly regarding the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Ratings. The long-stay antipsychotic measure continues to be a core quality metric (CMS, 2025a). When patients enter SNFs destabilized due to non-adherence, they may require as-needed (PRN) medications or polypharmacy, increasing the likelihood of survey deficiencies tied to unnecessary psychotropics and inadequate monitoring (CMS, 2025a). For hospitals, non-adherence undermines both clinical care and regulatory compliance. The Joint Commission's National Patient Safety Goals (NPSGs) (NPSG.03.06.01 for medication reconciliation and NPSG.15.01.01 for suicide prevention) depend on accurate medication histories and follow-up, which are compromised by hidden non-adherence (The Joint Commission, 2024). Additionally, the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program requires hospitals to demonstrate performance on measures tied to care transitions and post-discharge follow-up (CMS, 2025c). Patients with unstable adherence complicate hospitals' ability to meet these benchmarks, directly affecting public reporting and payment updates.



Strategies to Address Non-Adherence

Recent evidence highlights several effective approaches.

Proactive use of LAIs: Evidence supports earlier and broader use of LAIs. When incorporated into shared decision-making processes, LAIs reduce relapse, hospitalization, and mortality (Aymerich et al., 2025).

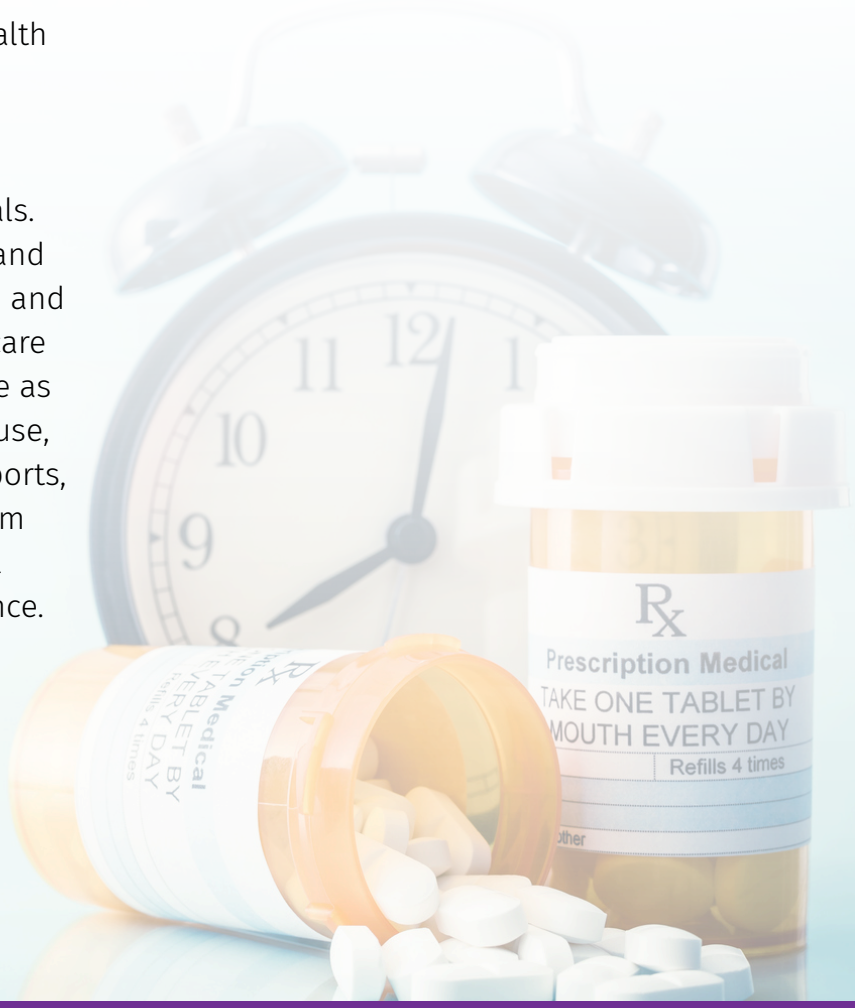
Measurement-based care and follow-up: Structured post-discharge follow-up is critical. Healthcare Effectiveness Data and Information Set (HEDIS) measures such as Follow-Up After Hospitalization for Mental Illness (FUH), and Follow-Up After Emergency Department Visit for Mental Illness (FUM) incentivize continuity of care (NCQA, 2024).

Digital adherence supports: Mobile applications, SMS reminders, and telehealth check-ins have demonstrated measurable improvements in medication adherence (Lanke et al., 2025).

Bias-aware training for prescribers: Training clinicians to recognize diagnostic overshadowing and implicit biases around adherence helps rebuild trust and therapeutic alliance (Liberati et al., 2025).

Conclusion

Medication non-adherence in behavioral health is not simply an individual failure—it is a systemic amplifier that strains ED capacity, complicates hospital throughput, and undermines compliance in SNFs and hospitals. Prescribers, too, are affected, as skepticism and therapeutic inertia alter treatment decisions and delay evidence-based interventions. Healthcare organizations must recognize non-adherence as a shared system risk. Through proactive LAI use, structured follow-up, digital adherence supports, and prescriber training, the healthcare system can reduce both the clinical and operational costs of psychiatric medication non-adherence.



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