

Pharmacist's Role in Mental Health and Emotional Well Being

Background Paper Prepared for the 2018-2019 APhA Policy Committee (not yet copyedited)

*Nathaniel M. Rickles, PharmD, PhD, BCPP
Associate Professor of Pharmacy Practice
University of Connecticut School of Pharmacy*

Issue

The American Pharmacists Association (APhA) Board of Trustees has directed the 2018-2019 Policy Committee to recommend policy to the APhA House of Delegates related to a pharmacist's role in a mental health crisis. The Board's guidance on this topic included -but was not limited to- review of the impact of mental illness, pharmacist training in and provision of mental health first aid services, barriers to patient's seeking care for mental illness, and the impact of mental health stigma on patients obtaining care.

Background

Mental health can be thought of along a continuum evaluating the severity and presence of symptoms (Figure 1).¹

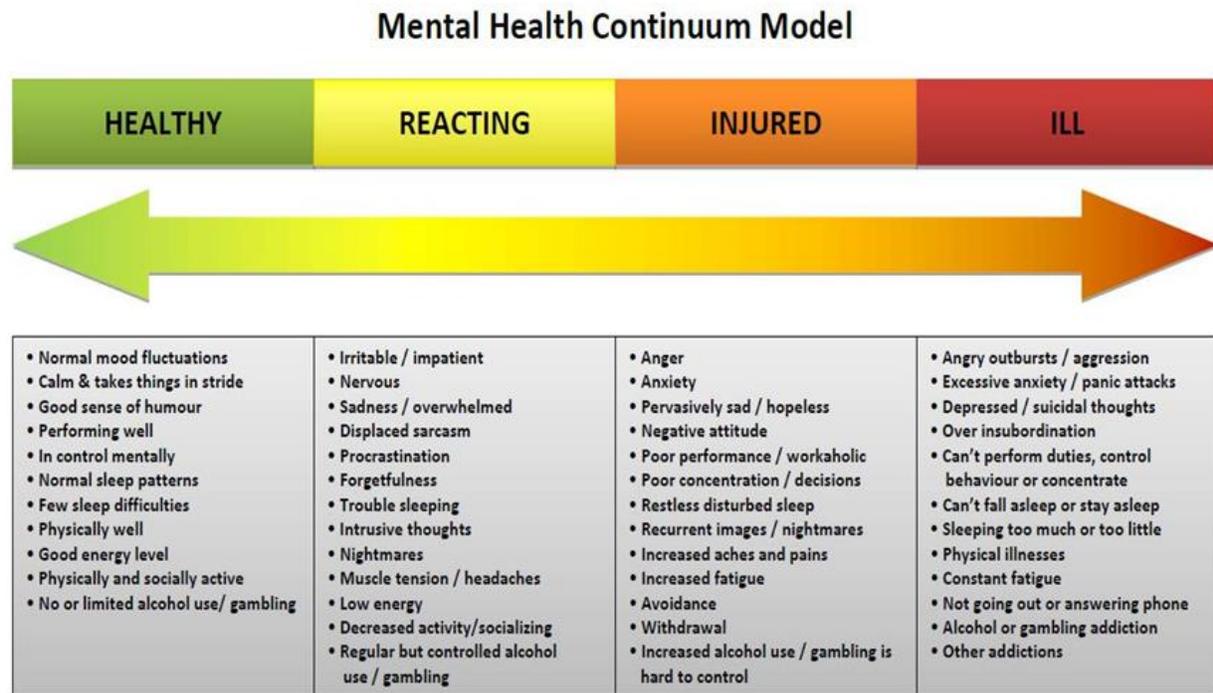


Figure 1 adapted from: Mental Health Commission of Canada. Home | Mental Health Commission of Canada. <https://www.mentalhealthcommission.ca/>

Patients presenting at different stages within the continuum are in need of different levels of care. Thus, the continuum acts as a useful resource to clarify the severity of impairment of those suffering from mental illness, and what resources these patients will benefit from.¹

The continuum also illustrates the distinction between mental health and mental illness. Mental health represents our psychological and social well-being. It encompasses how we feel about ourselves and subsequently interact with others. While poor mental health can lead to poor physical health and mental illness, it is possible to have poor mental health with no comorbid mental illness.² For example, a person going through a hard life experience may have poor mental health during this time period without necessarily having a mental illness. Thus, feeling miserable or isolated may be red flags that your mental health requires attention and improvement. In these cases, it is important to utilize support from friends/families/other groups, focus on healthy lifestyle habits such as eating regularly and appropriate sleep hygiene, and even seeking support from a therapist can be beneficial.

At the one end of the continuum of mental illness, there are at least 43.8 million individuals afflicted in the US by mental illness every year.³ There are several more millions of individuals who likely fall under the reacting and injured aspects of the continuum. These are often those undertreated, who should be diagnosed and properly treated for mental illness, or that need brief and temporary support to help them return to the healthy end of the continuum. While 1 in 5 adults in the US are afflicted by mental health conditions in a given year, only 41% of those adults receive mental health services. Among adults with a diagnosed serious mental illness, 62.9% received mental health services in the past.³ Additionally, just over half (50.6%) of children with a mental health condition aged 8-15 received mental health services in the previous year.³ In addition, we recognize that there are numerous other individuals that do not meet criteria for a diagnosis of mental illness or require treatment but experience episodes where they are unable to optimally cope or manage their temporary thoughts, feelings, and behaviors.

There are clear individual and societal consequences to inadequate identification and management of mental health symptoms. Individuals are at greater risk for poor psychological, social, occupational, and physical functioning that affects their quality of life, morbidity, and mortality.³ Suicide is also the 10th leading cause of death in the U.S., the 3rd leading cause of death for people aged 10–14, and the 2nd leading cause of death for people aged 15–24.³ Inadequately treated mental illness has also contributed to \$193.2 billion in lost earnings per year.³

For a variety of reasons, whether it be those already diagnosed with mental illness, those who need to be diagnosed and/or treated, or those with more transient/temporary mental health symptoms, these groups of individuals face significant challenges obtaining resources to help them initiate and/or remain consistently engaged with a support system that can provide the needed support to help them resolve their temporary or long-term difficulties. Needed support might include the identification of strategies to manage and monitor symptoms, connecting with formal (i.e., therapists, prescribers, etc.) and informal support systems (i.e., peers, family, and religious groups), identification of treatment approaches including psychotherapy and/or medications, the use of available specific community programs and resources. Key reasons why these groups of individuals struggle to initially reach out for support or consistently engage in support include (1) the stigma experienced by all these groups that are afflicted with different levels of mental health challenges, and (2) the lack of convenient access to individuals trained to provide temporary supportive management of specific mental health challenges and know when and what types of additional support is needed for such individuals. The stigma associated with mental illness reflects the general societal belief that those with mental health concerns are often

dangerous, unstable, and incompetent because they are not fully able to function in their communities and communicate.⁴ Even insurance companies have been shown to offer greater coverage for physical illness over mental illness.⁵

The National Alliance on Mental Illness (NAMI) and many other mental health advocacy groups and organizations have promoted anti-stigma campaigns to target the first reason for the lack of initiation or continued engagement to seek support services by those with ongoing and new mental health needs. Clearly, there is still much work to do to make individuals with a variety of mental health symptoms feel more comfortable reaching out and having someone help them through their symptoms. Mental health organizations continue to focus on facilitating cultures at work places, health care environments, and other areas of the community that avoid judgement and distance away from the individual suffering from ongoing or temporary mental health symptoms. Rather, the focus of this anti-stigma work is to help bring the affected individual together with a community resource and together support the individual towards improved mental health management.⁶

Role of the Pharmacist

As valued, trusted members of the community, pharmacists are at the frontlines of primary health care and thus regularly interact with individuals that have a diagnosed mental illness, not yet diagnosed mental illness, or less severe symptoms not meeting a diagnosis. While pharmacy school curriculums and continuing education programs typically cover the clinical management of diagnosed conditions, students and practicing pharmacists are often not exposed how to screen, provide brief supportive intervention, and/or offer referral to further management of mental health symptoms. If pharmacy staff were equipped with such knowledge and skills, they may be able to facilitate a significant population of individuals struggling with mental health symptoms to get needed attention to effectively manage their symptoms. The College of Psychiatric and Neurologic Pharmacy (CPNP) and National Alliance on Mental Illness (NAMI) collaborated on a 2012 national survey and assessed the opinions of 1,031 individuals with mental health concerns, or their caregivers, regarding their relationship with their pharmacist. 91% felt very comfortable going to their community pharmacy and 83% felt like the pharmacist respected them.⁷ Studies show mixed findings with regards to pharmacists' comfort level and willingness to provide services to those with mental illness^{4,7,8,9}. For example, several studies show pharmacists having greater discomfort with providing services to those with mental health conditions than those with physical illnesses such as asthma.⁸ Further, a recent study reported that willingness/interest to provide services to those with mental illness was greater than comfort/confidence in doing so.⁹ Such discomfort appears to be reflected in the finding that individuals with mental illness have been reported to receive less counseling, monitoring, and follow-up from pharmacists, compared with patients who have corporeal health conditions.⁸ In the 2012 NAMI and CPNP survey presented previously, a little over half of the survey respondents reported having a strong professional relationship with the pharmacist, and 40% reported no relationship with their pharmacist. Furthermore, 75% reported not receiving effectiveness and/or safety monitoring assistance from the pharmacist.⁷ These mixed findings about the collaboration between individuals with mental health needs and community pharmacists highlights, as noted earlier, there is a potential need for greater education and support for pharmacists to gain greater comfort and confidence in engaging patients with mental health needs.

Mental Health First Aid

Mental Health First Aid (MHFA) is a training program offered to the general public aiming to increase mental health literacy and impart the participant with the skills required to provide an immediate response to a person suffering from an acute mental health crisis. The program originated in Australia, and was designed by Betty Kitchener, a nurse specializing in health education, and Anthony Jorm, a mental health literacy professor, in 2001. The program runs eight hours, often split into two four-hour sessions. During this time, participants obtain the skill set necessary to not only intervene in a mental health crisis, but to identify those at risk and suffering from mental illness and direct them to the help they require. Many consider MHFA analogous to the CPR of mental illness.

The program focuses on depression and mood disorders, anxiety disorders, trauma, psychosis, and substance use disorders. Participants in the training learn the program's "Mental Health First Aid Action Plan," and are taught to apply the plan to many different scenarios – specifically guiding interactions with others experiencing suicidal thoughts or behaviors, panic attacks, nonsuicidal self-injury, overdose or withdrawal from substance use, and reaction to a traumatic event. The plan consists of five simple steps:

1. Assess for risk of suicide or harm
2. Listen non-judgmentally
3. Give reassurance and information
4. Encourage appropriate professional help
5. Encourage self-help and other support strategies

While no requirements exist for the training, it is available to anyone within the general public. The company providing the training strongly encourages professions whose daily interactions include frequent encounters with those at risk or experiencing mental illness/crisis to participate. Specific examples listed on the MHFA website include police officers, human resource workers, primary health care workers, schools, community faith organizations, friends and family of someone suffering from mental illness, and many more.¹⁰

Mental Health First Aid: Review of Existing Literature

With an apparent need to alter pharmacists' perceptions and increase knowledge base regarding mental health, a few pharmacies have adopted the use of MHFA training. With much talk regarding how to improve the outcomes of our patients with a mental illness, researchers have begun investigating the results and attitudes of those successfully completing MHFA.

One study took place in 8 rural Australian community pharmacies and entailed a survey assessing barriers to applying training as well as pharmacists' attitudes toward MHFA. Pharmacists identified and supported the need for MHFA and had low confidence in their ability to handle an acute mental health crisis without the additional training. The majority (72%) of pharmacists agreed that it is their role to provide MHFA, but less than half (48%) were comfortable in providing this support. All participants agreed that more training is required in MHFA and they further stated they would be prepared to undertake this training. 32% thought the training should be administered during their intern year, 24% thought training should be administered during their pharmacist years, and the majority (76%) preferred administration of training as a one-day course with an online component. The major barriers identified by pharmacists included time, geographic location, and resources.¹¹ This shows that pharmacists have both identified the need for

and are willing to undertake MHFA training in order to decrease the health disparities found in the mental health population.

A controlled trial was conducted assessing 60 third year pharmacy students at the University of Sydney who were randomly chosen to complete two 12-hour sessions of MHFA and complete a follow up survey. The survey (administered before and after the training) evaluated mental health literacy, the 7-item social distance scale, and 16 items related to self-reported behavior. Survey results showed that MHFA training reduced the student pharmacists' mental health stigma, improved recognition of mental disorders, and improved confidence in providing services to consumers with a mental illness in the pharmacy setting.¹² Another randomized controlled study of 262 members of the Australian public demonstrated that students (not just in pharmacy school) who participated in an online MHFA course responded better to measures of stigma reduction compared to those that used a written manual.¹³ This indicates that completing a training program such as the MHFA is more valuable than just offering educational materials to the pharmacist.

A meta-analysis was performed estimating the effects of the MHFA program in participants of any occupation, both for adults and young people, based on results published up to March 2014. MHFA was found to be effective in increasing knowledge regarding mental health problems and effectively decreasing negative attitudes toward individuals suffering from mental health problems. The program was also shown to increase help-providing behavior.¹⁴ Another publication reviewed 3 published trials and found improved concordance with health professionals about treatments, improved helping behavior, greater confidence in providing help to others, and decreased social distance from people with mental disorders.¹⁵ This culmination of data goes to show that taking a course in MHFA significantly improves confidence, decreases stigma, and sets the participant up for a more successful interaction when reaching out to those with mental illnesses.

Important Considerations

Although studies have reported on the opinions of those taking the Mental Health First Aid program, little research has been done following patient outcomes. While one can certainly appreciate its impact on participants' attitudes and confidence regarding mental health and crisis situations, we don't have any data on how this relates back to the patient. This poses the question of whether these trainings really help prepare people to identify and communicate with those with mental health concerns or if participants are simply receiving a false sense of confidence. More research must be done exploring the outcomes of those receiving help from trained MHFA participants.

Mental Health First Aid is also designed for administration to the general public – it may be prudent to give healthcare professionals a more intensive program, tailored to their education and background, than the public receives. Pharmacists may also benefit from a focus on consultation, in addition to conversation, and how to incorporate both into their patient interactions.¹⁶ One study, taking place at University of Sydney, evaluated the differences in confidence and attitudes of their student pharmacists towards suicidal crisis in three groups of students: the first group simply completed MHFA training, the second group completed MHFA training and observed a simulation of a patient and pharmacist interaction with a person undergoing suicidal crisis, and the third completed the MHFA training and participated in the live simulated interaction. Results displayed a clinically significant increase in confidence in all students who participated (due to the MHFA training) but showed greater increases in students participating in the

live interaction.¹⁷ This could indicate that participating in a live simulation of a crisis situation may be a valuable addition to the MHFA curriculum for pharmacists.

In addition, MHFA is not the only program available to train participants on how to deal with mental health crisis and communicate effectively with those suffering. Other programs include options such as “Psychological First Aid (PFA)” and “Emotional CPR (eCPR).” PFA usually focuses more on protocol following a disaster, while MHFA is broader.¹⁸ Thus, mental health first aid would likely be a more appropriate choice to administer as training since it has a more realistic and applicable scope. eCPR, however, is another training geared toward the general public to assist a person experiencing an emotional crisis using three components:

1. **C** = Connecting with Compassion and Concern to Communicate
2. **P** = emPowerment to experience Passion, Purpose and Planning
3. **R** = Revitalize through Re-establishing Relationships, Routines and Rhythms in the community¹⁹

No head to head studies exist comparing the different available trainings, so one cannot confidently say that MHFA is the best program offered in preparing pharmacists, or even the general public, for these interventions.

Additional Points for Policy Consideration

There are other areas beyond education and training for pharmacists and student pharmacists that may also need to be considered when developing policy. The role of other pharmacy staff members, professional liability, and integration of services into the pharmacy workflow are other topic areas that need to be considered.

Other pharmacy staff members such as a technician or clerk may have interactions with patients who have a mental illness and could prevent a mental health crisis if knowledgeable on appropriate procedures. Or, perhaps it is the responsibility of the pharmacy staff member to notify another individual who has training to intervene during a mental health crisis. Regardless of the situation, pharmacists and student pharmacists are not the only individuals in a pharmacy setting who may be able to have a positive impact on a patient’s outcome should a mental health crisis situation develop.

Professional liability is another subject that needs to be considered. When identifying a patient who is having a mental health crisis or may be a danger to themselves or others, what is the responsibility of the pharmacist? Could the pharmacist be held liable if they do not refer the patient to an appropriate healthcare provider? What documentation within a medical record or the pharmacy record would be needed to ensure the pharmacist documents their interaction? Technology barriers prevent some pharmacists from being able to document directly into a patient’s electronic health record (EHR) and APhA has existing policy that calls for this type of integration. What then would be the required documentation or the appropriate referral when a pharmacist does not have access to broader information or the ability to document their current interaction.

Conclusion

Although we do not have enough evidence suggesting that Mental Health First Aid improves patient outcomes, we do have overwhelming evidence that it decreases existing stigma regarding mental illness, which is one of the leading barriers to patients seeking care. It also increases pharmacists' confidence in approaching and interacting with a patient who is undergoing a mental health crisis, and aids pharmacists in identifying these patients. These are both huge steps in improving access to care for patients suffering from mental illness. However, with no head to head studies comparing Mental Health First Aid to other programs, we cannot confidently say this is the only program recommended for adequate training. With the pharmacist being the most accessible and most frequently visited healthcare professional, community pharmacists are an incredibly underutilized tool in bridging the gap between those suffering from mental illness and the treatment and support they need to begin the healing process. In conclusion, pharmacists acknowledge the need to augment their knowledge regarding mental health crisis and can be an excellent tool in reaching out to patients suffering from mental illness. Training programs exist that may help to abolish stigma and increase confidence and awareness of pharmacists to encourage greater access to care for patients who need it but may not know how to ask for it.

Related APhA Policy

2018 Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

2016, 2003, 1987 Substance Use Disorder Education

APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.

(Am Pharm. NS27(6):424 June 1987) (JAPhA NS43(5): Suppl. 1:558 September/October 2003) (Reviewed 2006)(Reviewed 2011) (JAPhA 56(4); 369 July/August 2016)

2011 The Role and Contributions of the Pharmacist in Public Health

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

(JAPhA NS51(4) 482; July/August 2011)(Reviewed 2012)(Reviewed 2016)

2004, 1965 Mental Health Programs

APhA supports pharmacists' participation in the development and implementation of all aspects of mental health programs so that the special needs and problems of the mentally ill can be effectively met.

(JAPhA NS5:274 May 1965) (JAPhA NS44(5):551 September/October 2004)(Reviewed 2010)(Reviewed 2011)

2003 Drug Addiction/Chemical Dependency Education

APhA urges pharmacists and pharmacy students to become educated in the recognition and treatment of drug addiction and chemical dependency.

(JAPhA NS43(5):Suppl. 1:557 September/October 2003) (Reviewed 2006)(Reviewed 2011)(Reviewed 2016)

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