American Pharmacists Association
Academy of Student Pharmacists

Report of the 2019
Resolutions Committee

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2019.1 — Addressing Professional Burnout

APhA-ASP recommends that all pharmacy practice settings and educational institutions develop and implement programs targeted at the prevention, identification, and reduction of professional burnout in the pharmacy profession, including among pharmacists, student pharmacists, and pharmacy technicians.

Background Statement:
Burnout is a common problem that affects the emotional well-being of a pharmacist, causing a depersonalization, exhaustion, and reduced productivity. “It is not an acute condition but rather a culmination of the effects of professionalism responsibilities and work environment.” Some symptoms include: decreased satisfaction of job, irritability, inattention to work and may lead to health problems if not addressed.³

According to the Agency for Healthcare Research and Quality, burnout experienced by healthcare workers is associated with “characteristics of the healthcare environment, including time pressure, lack of control over work processes, role conflict, and poor relationships between groups and with leadership, combine with personal predisposing factors and the emotional intensity of clinical work to put clinicians at high risk for burnout.”² A 2017 study on assessing burnout Hospital Clinical Pharmacy practitioners in the US found that 61.2% pharmacists experienced burnout and causes of burnout included inadequate administrative and teaching time, uncertainty of health care reform, too many non-clinical duties, difficult pharmacist colleagues, and feeling that contributions are underappreciated.³

Even the APhA House of Delegates recognized the significance of burnout in the profession. In 2018, the APhA House of Delegates supported the development of programs and educational resources to address burnout and support resiliency. This was also a discussion during the APhA-APPM Open Business Meeting with the Special Interest Group (SIG) currently developing programs for preceptors to support students’ and residents’ well-being.⁴

Quality of care for patients can be directly affected by pharmacist burnout. It is reported that “Patients receiving care from a provider suffering from burnout were also doubly likely to report low provider professionalism or low satisfaction with the care encounter.” Patient safety is a major concern that is affected by the wellbeing of the healthcare provider. A systematic study review was conducted and results showed that 16 of the 27 studies that measured the wellbeing of pharmacist resulted in a significant relationship to declined patient safety.⁵ Burnout among pharmacy technicians also negatively impacts patient safety. A study was conducted to assess the effects of mental demands induced by pharmacy workload while dispensing, showed that external demands such as interruptions, rushing and divided attention caused a negative impact on medication safety and the wellbeing of the employee.⁶ In addition, burnout has long been recognized in the healthcare field but continues to be a struggle for many professionals and has continually been identified as a potential source of medication error.⁵

The prevention of burnout is the first step in ensuring optimal patient care in our profession. The AMA (American Medical Association) has created the “AMA STEPS Forward” program to help with prevention of and address physician burnout. The AMA STEPS Forward program is an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment by working smart, not harder. The program is a free online module that shows you how to measure and respond to burnout in your practice. The program recommends 7 steps to implement at any healthcare practice setting to reduce the risk of and prevent burnout.⁷

Identification of burnout is another key piece in this puzzle. A 2018 JAMA article identified some characteristics associated with higher risk of burnout in physicians: female (relative risk 1.17 [95% CI, 1.07 to 1.28]) and higher
reported levels of anxiety during medical school (relative risk 1.08 per 1-point increase [95% CI, 1.06 to 1.11]).\textsuperscript{8} Furthermore, an EPMA 2018 article emphasized associations of negative self-esteem and negative emotionality with vulnerability for burnout. Greater understanding on evidence-based risk factors and identifying them proactively in colleagues may contribute to the impact on burnout.\textsuperscript{9}

In aiming to address burnout in the profession of pharmacy, there are examples of programs in place to reduce burnout. The National Academy of Medicine supports an Action Collaborative, comprised of over fifty organizations, that focuses on resiliency. Cited examples of individual steps that can be taken to reduce work-related stress include mindfulness exercises along with medication. Organization level approaches include workload reduction and schedule changes along with communication and workflow improvement. The action coalition also provides resources for measurement of burnout among staff members. Action taken by both individual and organization play a key role in increasing resiliency of employees and, in turn, decreasing burnout levels.\textsuperscript{7}

As employers look to assist their pharmacy staff members, it is important to note that validated tools do exist to evaluate an employee’s burnout level.\textsuperscript{1,10} Furthermore, numerous strategies can be implemented with little change to an organization, such as avoiding rapid staff turnover, limiting work hours, and allowing time for reflection amongst staff. Burnout does span beyond just pharmacists, and can impact students even while in training. Thus, incorporation of burnout awareness and resiliency training are called for in didactic and practical training in order to decrease professional burnout in the long-term.\textsuperscript{1} By addressing this issue, it is the hope to keep highly qualified professionals in the pharmacy profession and enable them to provide high-quality patient care to all patients.

In addition to direct patient care, those who are training to become or involved in the training of future pharmacists may be impacted by burnout as well. In a survey looking at burnout in student pharmacists, many were very or extremely much in agreement with indicators of burnout.\textsuperscript{11} An assessment of risk factors among pharmacy practice faculty in the United States was conducted among 758 pharmacy faculty members looking at three different factors related to burnout exhaustion, depersonalization and personal accomplishment. Results showed 41.3% reporting high emotional exhaustion, while 10% has high depersonalization and 24% with low accomplishment scores.\textsuperscript{12}

Additionally, it is recognized that pharmacy staff burnout can lead to suboptimal patient care. Thus, this resolution also aims to address the mental wellbeing of pharmacy staff and students with the intent to promote both awareness of burnout and resiliency tactics in the workplace and educational areas.

References:


2019.2 — Amendment to APhA-ASP Resolution 2015.4 (Increased Access to Opioid Reversal Agents)

APhA-ASP supports the amendment of Resolution 2015.4 to read:
2015.4 – Increased Access to Opioid Reversal Agents
  1. APhA-ASP supports state and federal legislation to increase access to opioid reversal agents.
  2. APhA-ASP encourages pharmacists and student pharmacists to provide public education about opioid reversal agents, including proper administration in situations of opioid-related drug overdose.
  3. APhA-ASP encourages all schools and colleges of pharmacy to incorporate opioid reversal agent training as a requirement prior to completion of the pharmacy program. APhA-ASP recommends this training includes a live, hands-on component, identification of high-risk patients, and recognition of the stigma surrounding opioid use disorder.

Background Statement:
The opioid epidemic is a major concern in the United States. According to the U.S. Department of Health and Human Services, in 2017 there were on average more than 130 deaths every day due to an opioid-related overdose.1 With opioid death rates rising every year since 2002, 48 states and the District of Columbia have implemented legislation to increase access to opioid reversal agents, such as naloxone. As the number of opioid overdoses continue to grow, the pharmacist’s role expands in response.

In some states, pharmacists have standing order with local physicians in order to dispense naloxone, while in 46 states, pharmacists are authorized to dispense naloxone without a prescription.2 Throughout 2007-2016, there was a 79% average increase in the amount of naloxone dispensed from retail pharmacies as a result of these efforts.3 However, there remains a disparity between initiatives to increase access of opioid reversal agents and actual implementation of increased accessibility within pharmacy settings. A 2018 study found that 2 years after California authorities passed legislation to allow pharmacists to dispense naloxone without a prescription, only 25% of 1,100 pharmacies surveyed would provide naloxone without a prescription. Furthermore, only 50% of those pharmacies that would provide naloxone without a prescription actually had nasal spray naloxone in stock.4 Similar results can be seen across other states as well; researchers found that 32 months after a standing order was enacted, 84% of Texas pharmacies would dispense naloxone without a prescription and only 69% of those pharmacies had naloxone stocked.5 In Indiana, 58% of pharmacies had stocked naloxone after 30 months of passed legislation6 and in New York, 37.5% of pharmacies reported to have naloxone stocked and would dispense it without a prescription 3 years after the standing order had been enacted.7

Many barriers cause the lack of accessibility to pharmacist-furnished naloxone, including confusion regarding dispensing protocols, low demand for naloxone or lack of inventory space, comfort level of a pharmacist counseling and educating patients, and pharmacist stigma surrounding opioid use disorder and its associated population. Opioid use disorder is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress and is often referred to as opioid addiction.8 Unfortunately, Opioid Use Disorder can have negative connotations within the community and healthcare population. Often the understanding of opioid use disorder as a medical illness is still overshadowed by its misconception as a moral weakness or willful choice. Some pharmacists have concerns that opioid reversal agents will serve as “safety nets” that encourage more drug misuse.9,10 However, research has demonstrated that increased access to opioid reversal agents is associated with lower rates of opioid overdose deaths and promotion of entry into drug addiction programs.11 Increased pharmacist education on opioid harm reduction and opioid reversal agents is pertinent to addressing these barriers. As advocates of patient safety, pharmacists need to be more adequately trained in counseling and administration of naloxone in order to provide patient education and increase public awareness regarding opioid reversal agents.

Currently, schools and colleges of pharmacy are not required to provide naloxone training as part of their curricula. However, due to the heightened number of opioid-related deaths, student pharmacists should be required to gain the knowledge and training on the dispensing, counseling, and administration of opioid reversal agents. This training will allow student pharmacists to properly counsel patients, family members, and other members of the community on risks and causes for opioid overdose, the different formulations of naloxone, and how to administer.
naloxone. In addition, student pharmacists should be trained on the latest protocol in response to an emergency overdose situation. In a 2018 study conducted by the University of Minnesota, 92% of first year student pharmacists expressed needing more training before feeling confident to help someone who has overdosed and 70% expressed that they would be unable to assist an overdosed patient beyond calling emergency authorities, among other results displaying general feelings of uncertainty in regards to responding to an overdose situation. These results affirm the necessity of naloxone training within pharmacy curricula to better prepare student pharmacists in cases of emergency opioid overdose situations and, as future pharmacists, prepare others within the community to their fullest capability.

Furthermore, it was found that 93% of first year pharmacy students, at the University of Maryland School of Pharmacy, who participated in the naloxone training and took the Objective Structured Clinical Examination (OSCE) had improved confidence in counseling and administering opioid reversal agents. In the study at the University of New Mexico College of Pharmacy, it was found that live (in-person) training was critical to provide students with sufficient knowledge to improve their confidence level in effectively interact with real patients. Additionally, they found that before the training, P1 students had negative opinions on advertising the availability of naloxone; however, post-training survey showed a statistically significant change in this attitude. This further proves that incorporating an opioid-reversal program as part of the pharmacy curriculum is an effective method to prevent the barrier of naloxone availability through pharmacists.14

Alongside obtaining new responsibilities in dispensing naloxone, pharmacists must take an active role in educating the public, building awareness about opioid misuse and embracing their role as health educators who strive to provide information about opioid medications, overdoses and stewardship. In addition, being that pharmacists are the most accessible healthcare professionals, this creates urgency and emphasizes their role in providing better health outcomes and patient outreach services. Furthermore, the Centers for Disease Control (CDC) has now implemented recommendations on the assessment of risk of overdose for patients on chronic opioid therapy. According to the CDC, high risk patients that are at risk for opioid overdose include history of overdose, history of substance use disorder, higher opioid dosages (>50 morphine milligram equivalents/day), or concurrent benzodiazepine use. This creates a greater responsibility for pharmacists to be properly trained on opioid reversal training and emphasizes the obligation that student pharmacists acquire the proper education and training within their pharmacy curricula. This will ensure properly trained pharmacists entering the workforce in the near future who can effectively and confidently counsel patients and identify risk factors of an opioid overdose as well as the use, administration, duration, side effects, and storage of opioid reversal agents.

References:
3. Jing Xu, Corey S. Davis, Marisa Cruz and Peter Lurie, State naloxone access laws are associated with an increase in the number of naloxone prescriptions dispensed in retail pharmacies, Drug and Alcohol Dependence, 10.1016/j.drugalcdep.2018.04.020, 189, (37-41), (2018).

10. Ludmila N. Bakhireva, L, Bautista, A., Cano, S., Shreshtha, S., Bachyrycz, A., Cruz, T. Barriers and facilitators to dispensing of intranasal naloxone by pharmacists, Substance Abuse, DOI: 10.1080/08897077.2017.1391924


2019.3 — Role of Pharmacists and Pharmacy Education in Patient Care Involving Cannabis

1. APhA-ASP encourages the resolution of any conflict between federal and state regulations regarding the legality of cannabis and any cannabis-derived products.
2. APhA-ASP supports the standardization of cannabis-derived products in order to optimize patient safety and to ensure clinical efficacy.
3. APhA-ASP encourages all colleges and schools of pharmacy to expand curricula on cannabis and any cannabis-derived products, including pharmacologic effects, adverse drug reactions, interactions with other medications and current pharmacy law regarding cannabis at both a federal and state level.
4. APhA-ASP encourages the expansion of postgraduate education regarding cannabis and cannabis-derived products, including relevant pharmacy law at both a federal and state level, in order to better serve our patients.
5. APhA-ASP supports pharmacists keeping an updated patient profile regarding use of cannabis and any cannabis-derived products to ensure proper patient care.
6. APhA-ASP supports continued research, development, and implementation of clinical guidelines to inform appropriate therapeutic use of cannabis-derived products to improve patient care.

Background Statement:
The use of cannabis and its related products in the United States has continued to increase within recent years. Over 22 million Americans reported using the drug within the past month according to a 2015 survey. The continued utilization of cannabis and cannabis-derived products has created an increased need for additional education, research, standardization, and regulations regarding cannabis. Cannabis is defined as any part of hemp plant that marijuana is derived from. Cannabis-derived products include medications containing purified extracts from cannabis plants. An example of a cannabis-derived product would be cannabinoids, which are chemicals related to Δ9-tetrahydrocannabinol (THC). Currently, there are two cannabinoids from the marijuana plant that have been researched for medical use, THC and cannabidiol (CBD). While the medicinal use of cannabis and cannabis-derived products can be a controversial topic, it is important for both pharmacists and student pharmacists to be aware of and properly educated about the use, regulation, and research of cannabis on the federal level and in their respective states.

The current variation between federal and state law has led to confusion about the legal regulations and standardization of cannabis. While over 30 states have legalized the distribution and medical use of cannabis, cannabis is still considered a schedule I substance by federal law regulations. Due to the lack of clarity in the legality, many pharmacists and student pharmacists have apprehensions about discussing cannabis use with patients. Pharmacists interact with patients who use cannabis and cannabis derivatives, and in order to properly treat and manage the diseases of these patients, the discrepancies of the regulations regarding cannabis and its derivatives must be resolved. In addition, standardization of cannabis derived would assist pharmacists in knowing potential interactions that may exist between prescription medications and cannabis derivatives.

In a 2017 study, student pharmacists were surveyed anonymously on their current knowledge and concerns about the use of cannabis. The authors found that there were significant misconceptions about the current indications of medical cannabis among student pharmacists. When asked if they felt confident in their ability to talk about the risks of medical cannabis’ use with patients who use medical cannabis, 72% of students reported that they felt not confident. Additionally, a study of pharmacists in a state that was legalizing cannabis for medical use within a year found that pharmacists were uncertain of the laws and regulations surrounding cannabis in their state of practice. These studies, indicate a definite need for an increase in education about cannabis in all schools and colleges of pharmacy as well as improving postgraduate education materials.

In order to provide adequate care to our patients using cannabis and cannabis derivatives, it is imperative that pharmacists and student pharmacists have the most recent data regarding medication and substance use. While there is still much research in progress regarding THC and CBD, we are aware of some interactions with other medications such as warfarin, theophylline, clobazam and central nervous system (CNS) depressants, including...
alcohol products. Additionally, the use of cannabis and cannabis derivatives is not recommended in patients with unstable psychiatric conditions, severe cardiovascular, immunological, liver, or kidney disease and can even exacerbate an arrhythmia.

In order to address the safety concerns and quantify the effectiveness of cannabis and its derivatives, further evidence is needed. The British Medical Journal defines evidence based medicine as, “the conscientious, explicit, and judicious use of current, best evidence in making decisions about the care of individual patients.” With evidence-based medicine being currently accepted in practice, further research of the medical uses of cannabis and its derivatives is needed in order for pharmacists to reasonably recommend for or against its use, along with address any safety concerns associated with the use of cannabis and its derivatives. Furthermore, with concerns about drug interactions, noting cannabis and derivative use among individuals in a medication profile can assist a pharmacist in making reasonable interventions to ensure patient safety with other prescribed medications.

As the use of cannabis and its derivatives continues to expand, the need for pharmacists and student pharmacists’ awareness heightens. This resolution is intended to address any barriers hindering the opportunity for pharmacists and student pharmacists’ involvement with the use of medical cannabis. In order to create an environment for pharmacists to properly manage patients that use medical cannabis, additional education, unambiguous regulations and standardizations, and improved documentation must become a priority.

References:
2019.4 — Technicians’ Immunization Administration Authority

APhA-ASP supports the advancement of pharmacy technicians’ roles in public health and disease prevention through immunization administration authority (under pharmacist supervision) to include, but not be limited to, appropriate technician certification and/or state licensure, immunization training/certification, and basic life support.

**Background Statement:**
The profession of pharmacy is continually evolving. Therefore, it is critical that pharmacists are equipped with an environment that allows for full utilization of their clinical training. Historically, pharmacy technicians have held and continue to hold a vital role in ensuring efficiency in pharmacy services. Entrusting pharmacy technicians with additional advanced responsibilities such as immunization administration, allows for improved public health outcomes, increased preventative care, and the pursuit of the highest quality of patient care.

Idaho was the first state to provide a training course on immunization administration for pharmacy technicians. Idaho provided a 6-hour training from Accreditation Council for Pharmacy Education-accredited course for pharmacy technicians in immunization. Those who completed the immunization course and basic life support training, such as that provided by American Heart Association, were able to take part in immunization administration under the supervision of a licensed pharmacist. According to Dr. Alex Adams, the executive director of the Idaho State Board of Pharmacy, pharmacists use their professional judgment in the workplace daily; therefore, they should be able to use their professional judgment to delegate this technical task of immunizing to qualified technicians who are certified in immunization administration. Additionally, Dr. Adams reported the following: “We found that pharmacists are generally supportive of expanded technician roles, as long as the technician has the requisite training to perform the duty. Pharmacists report variability in technician qualifications, and thus it is critical to ensure the assignment of function ultimately rests with the supervising pharmacist even when the technician has completed a task-specific training.” This re-emphasizes the importance that when pharmacy technicians are administering immunizations they must be properly trained, and this authority should always be exercised under the supervision of a pharmacist.

This Idaho driven pilot program encouraged additional research studies evaluating the effectiveness of pharmacy technician focused immunization programs. After receiving the live training course, the majority of pharmacy technicians felt comfortable administering an immunization, locating the correct injection site and selecting supplies, documenting the immunization, and responding to a vaccine reaction emergency. Six months after Idaho implemented legislation allowing technicians to immunize patients, 953 immunizations were administered by pharmacy technicians and resulted in zero vaccination-related incidents. The most current data from Idaho indicates that approximately 25,000 immunizations have been administered by pharmacy technicians and the vaccination-related incident rate still successfully remains at zero.

Furthermore, similar pilot programs in states beyond Idaho have followed suit. Following implementation in Idaho, in October 2018 Rhode Island joined Idaho in passing legislation allowing pharmacy technicians to perform vaccine administration. Additionally, the Utah Board of Pharmacy has demonstrated interest in pharmacy technician administration authority, in addition to several other states also discussing this change.

Pharmacy technicians have and will continue to play an integral role in the advancement of pharmacy practice. Pharmacies are found to be the second most common health-care institution for vaccine administration; however, immunization rates still fall short of Healthy People 2020 goals. Based upon data collected from pharmacy technician focused immunization administration training in Idaho, when pharmacy technicians are properly immunization trained/certified, complete training in basic life support, and are working under the supervision of a pharmacist, there is the potential for expanded opportunities in efficiency and patient care. Additionally, entrusting pharmacy technicians to administer immunizations could help minimize ongoing health disparities and could improve immunization rates overall.
References:
2019.5 – Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians

1. APhA-ASP strongly believes that all student pharmacists, pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA-ASP strongly recommends that schools and colleges of pharmacy, residency programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA-ASP strongly believes student pharmacists and pharmacists should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA-ASP encourages student pharmacists, pharmacists, and pharmacy technicians who are victims of firearm-related violence to seek the help of counselors and other trained mental health professionals.

Background Statement:
The numbers of firearm-related injuries and fatalities have increasingly become a public health problem, with the Centers for Disease Control and Prevention’s WONDER database demonstrating over 600,000 firearm-related deaths in from 1999 to 2017. In 2017 alone, nearly 40,000 individuals were killed due to firearms. Firearm-related incidents are non-discriminatory in terms of environmental impact, with a 2011 study finding that both rural and urban areas are impacted by firearm-related violence. Firearm-related violence is expensive in another key way as well: medical costs for firearm injuries total more than $70 billion in direct medical care and loss of productivity.

The passing of a pharmacy resident at Mercy Hospital and Medical Center, Dayna Less, further creates a necessary and timely opportunity for the American Pharmacists Association-Academy of Student Pharmacists to initiate an informed, multifaceted conversation about firearm-related safety in places of work and learning.

Firearm in common parlance refers to any portable gun. More specifically, firearms that are regulated by the National Firearms Act (NFA) include the following: “(1) a shotgun having a barrel or barrels of less than 18 inches in length; (2) a weapon made from a shotgun if such weapon as modified has an overall length of less than 26 inches or a barrel or barrels of less than 18 inches in length; (3) a rifle having a barrel or barrels of less than 16 inches in length; (4) a weapon made from a rifle if such weapon as modified has an overall length of less than 26 inches or a barrel or barrels of less than 16 inches in length; (5) any other weapon, as defined in subsection (e); (6) a machinegun; (7) any silencer (as defined in section 921 of title 18, United States Code); and (8) a destructive device.”

Active shooter preparedness programs are not new in educational and work settings. Existing guidelines, such as the one from the Washington Office of Superintendent of Public Instruction, outlines readiness programs and resources available for K-12 programs. The Readiness and Emergency Management for Schools program (REMS) also outlines recommended steps for response to an active shooter, such as respond immediately, run, and hide. The Joint Commission similarly issued recommendations in 2014 in regard to planning for active shooter situations in healthcare facilities. Hospital-based violence intervention programs have begun to work on reducing firearm violence-related recidivism rates as well. A 2016 study pinpoints three components of an effective institution-based strategy: addressing risks associated with violent injury, introducing services at the time of acute injury and hospital care, and providing culturally competent case management. With all these best practice recommendations published and programs being built, there is still room for improvement. A survey from the Education Week Research Center found that one in five school law enforcement officers does not feel their respective schools are prepared to handle an active shooter situation. Furthermore, not every school and college of pharmacy has a published active shooter protocol or related training – such as the protocol at Presbyterian College School of Pharmacy and drills conducted at Samford University – readily available to student pharmacists, pharmacists, and pharmacy technicians.
A 2013 report from the American Psychological Association (APA) defines the following groups at high risk for firearm-related violence: domestic violence offenders, persons convicted of violent misdemeanor crimes, and individuals with mental illness who have been adjudicated as being a threat to themselves or to others. Note that the APA does not categorize all individuals who have been diagnosed with a mental health condition or exhibiting behaviors such as suicidal ideation as being dangerous. However, there is an emphasis in recommendations in all age groups to develop interventions or programs — such as those involving psychologists — to promote emotional and mental health. Carter and colleagues in 2015 found that youth in emergency departments with at least one prior incident of firearm-related assault are at higher risk for subsequent firearm-related violence; the authors advocate for interventions including those addressing substance use and mental health needs. American Association of Colleges of Pharmacy (AACP) Curricular Guidelines for Pharmacy (Substance Abuse and Addictive Disease) promote foundational and elective curricular opportunities to help student pharmacists be able to identify “characteristics of addiction and related disorders and patterns of abuse and dependence... to allow pharmacists to assist in early identification and assistance where appropriate,” as well as be well-educated about “methods of prevention, intervention, referral, withdrawal, treatment, and recovery support.” While the AACP recommends at least four hours of training be focused on “the identification, intervention, and treatment of addiction and related disorders,” a 2017 survey of pharmacists regarding perceived readiness of mental health-related medication issues indicates a greater need for training in this area. It is important to continue to identify and develop opportunities to expand learning for mental health and substance abuse — such as in curricula in schools and colleges of pharmacy, continuing education programs, and post-graduate residency and fellowship programs — for student pharmacists and pharmacists. A 2015 study by O’Reilly and colleagues demonstrated that pharmacists “are capable of performing screening and risk assessment services for depression in primary care... and community pharmacies.” Additionally, there has been support — such as by the National Community Pharmacists Association — for pharmacists to be trained in existing programs such as the Mental Health First Aid program, thus enabling pharmacists “to identify when an individual is experiencing a mental health issue or crisis, and to start the intervention process, which includes referring out to help.”

Firearm-related violence is a traumatic experience. The American Psychological Association points to a number of possible reactions of those involved in a firearm-related incident: post-traumatic stress, depression, anxiety, substance abuse. The Substance Abuse and Mental Health Services Administration (SAMHSA) further categorizes three stages of healing after a firearm-related incident: acute phase — denial, shock, disbelief; intermediate phase — fear, anger, anxiety, depression, trouble sleeping; long-term phase (months afterward) — solidification of behavioral health reactions into mental health or substance use disorders. A 2008 study at Northern Illinois University completed after a mass shooting on the campus found that 12% of survivors reported PTSD, higher than the average incidence of PTSD among trauma survivors. A later study in 2018 similarly found that armed robberies increased posttraumatic stress in victims. With the potential for developing sequelae post-firearm-related incident, there is a large need for continued promotion of trained mental health professionals available to help student pharmacists, pharmacists, and pharmacy technicians access evidence-based pharmacological treatments and psychosocial interventions — such as exposure-based interventions and cognitive-based therapies — that have been proven effective for conditions such as PTSD.

Firearm-related violence is devastating — physically, psychologically, financially — regardless of the scope or environment. Many healthcare professional associations have taken a stand on proactive and reactive recommendations to reduce the harmful impacts of firearm-related violence. APhA-ASP aims to accomplish these same goals ultimately to improve the safety of student pharmacists, pharmacists, and pharmacy personnel.
References:
