PM Healthcare
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JOURNAL

Incorporating *The Journal of Pharmacy Management* and *The Journal of Medicines Optimisation*

Spring 2025 | Issue 12

PM Healthcare Journal – Special Issue

Mental Health in Pharmacy Practice: Awareness, Action, and Impact

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Editorial

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As I am writing this in preparation for release of this special issue journal I am reading the BBC news report about misdiagnosis of bipolar and its significant impact on the lives being 'torn apart by poorly managed extreme suicidal lows or manic erratic highs' (BBC; 1st April 2025) This is not really news to anyone working in mental health, we are aware of the serious impact bipolar can have on individuals, their families and services. Indeed bipolar has been shown to have the highest risk of suicide of any mental illness (bipolarUK; 2025).

In 2023 the number of registered suicides increased in the UK when compared to 2022 (Samaritans; 2025) and we know that the relative risks for suicide are increased if a mental health condition is present (Moitra et al; 2021). Sometimes it is hard to know what to say to someone presenting with low mood, will we say the wrong thing and make it worse? Here at the University of Bradford I have undertaken Mental Health First Aider training (MHFA;2025) which provides an excellent grounding to support people in crisis. Psychological wellbeing practitioners Elizabeth Ruth and Rob Brooks have also provided an expert overview recognising low mood, how to open the conversation and resources for our disposal. I believe it serves as a valuable reminder of the importance of communication skills and it also offers an interesting read for pharmacists who are well-versed in medication but may be less familiar with the psychological support available. We also hear from Graham Newton, who shares his personal and professional insights, experiences, tips and resources to actively engage in conversations about suicide while supporting our own wellbeing and recognising our limitations.

I have had experience of poor mental health and its impact personally and professionally. I worked as a specialist mental health pharmacist for over 13 years and along with many people have been impacted by family poor mental health which can be devastating. And now as an academic I am still as passionate as I was, aiming to reduce the stigma and inequalities associated with poor mental health.

The NHS long term plan (NHS;2019) set out agendas and commitments to transform and improve mental health services for all in England. In 2019, the NHS Mental Health Implementation Plan 2019/20 – 2023/24 (NHS 2019-20) provided targeted deliverables detailing how to achieve some of the Long Term Plan principles. Further insights into this impact are provided by Fatimat (Tolu) Aigbekaen and Beryl Navti in their article within this special issue.

This has gone some way to addressing inequalities and improving patient access, but more is needed. The 2025/6 priorities and operational planning guidance aims to 'improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improve access to children and young people's (CYP) mental health services, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019' and pharmacy professionals will again be key in supporting the delivery of these targets (NHS; 2025).

I was enlightened by Jennifer Southern's article which highlights some outstanding interventions achieved by her and her team. Their journey of 'Mental Health In-Reach' and truly 'Bridging the Gap' is inspiration to not just hospital pharmacy professionals but to those working in any sector. The message is clear, ask someone with mental health expertise and they are happy to help and what a significant difference this can make to patient care and outcomes which aligns nicely with the NHS agenda.

With the recent government announcement referring to changes and the dissolution of NHS England, services are at present more uncertain than previously (BBC; 2025). What does remain the same is the focus and need of staff to ensure mental health is at the forefront of all NHS services. For example, consider the interesting study undertaken by Jenny Scott et.al, and how a quick intervention in community pharmacy can have a significant impact on preventing harm. Substance use and mental health overlap in many conditions (Turning Point; 2004) so I am also delighted to be able to share this powerful recording and initiative involving our own Natalie Finch 'You Can Save a Life' Powerful New Campaign To Prevent Drug Deaths - New Vision Bradford. Natalie has also said she is happy to be contacted for more information N.Finch1@bradford.ac.uk). She is passionate about reducing the incidence of drug-related deaths (UoB News 2025).

As healthcare professionals we cannot help others if we are not looking after ourselves. Without good mental health, holistic well-being cannot flourish. Indeed Ivan Hollingsworth's article provides a personal and professional perspective on improving and sustaining your mental health. Ivan's piece provides a timely reminder of the consequences of long-term stress as well as resources and tools for you to consider for yourself and others. On reading this you may reflect on your own practice, workplace and work-life balance. We often have an awareness and recommend it to our patients, but how often do we prioritise our own mental health?

As guest editor, I am privileged to be part of this special issue, which highlights key mental health and well-being topics. The articles have been written by experts - either working in the mental health field or with experience of mental health- who all share the same passion for improving lives of people who are suffering from poor mental health. This special issue emphasises not only the importance of mental health but also a call to action, encouraging you to get involved in any way you can. Perhaps you will start a new service, engage with mental health patients or create a new way of working with your local specialist mental health pharmacy team. Hopefully you will now feel ready to get more involved in any way you can to support patients and carers with mental health issues and maybe - just maybe - you will consider joining the world of specialist mental health pharmacy. If you are curious about a new role in mental health the 'Evolution of mental health pharmacy' journey by Fatimat (Tolu) Aigbekaen and Beryl Navti will provide some context of the history behind pharmacist mental health services but more importantly what the future holds those who are inspired to move into this worthy area of practice.

Finally, it seems fitting to finish with some thoughts from the one of people who is at the heart of all we do as healthcare professionals. Lynsey is a lived experience patient who is part of our ever-expanding experts by experience group at the university and what she has to say sums it all up perfectly:

'I believe that having good mental health is essential to function at your best. When your mental health is poor, you may be able to function to a certain extent and get through life, but particular aspects of your life are likely to suffer. In any case, trying to muddle through without support is exhausting. I find that the longer people try to function without help for their poor mental health, the more challenging it becomes to get back to a better mental state.

At times when mental health is poor or worsening, it can be even more difficult to prioritise meeting your own needs and can lose sight of the habits that help you to regulate and improve. Your mental health can be helped by prioritising a good diet, staying hydrated, maintaining physical and health relationships with people who build us up, stress management and self-care, but these can be lost when our mental health worsens. We may engage in unhelpful coping strategies such as drinking, over-working or avoiding necessary tasks due to overwhelm. Taking less care of ourselves in these ways makes everyday life more difficult and a cycle forms as consequentially our mental health worsens and our ability to function well is further reduced.'

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NEW VISION BRADFORD
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NHS Long Term Plan Implementation Framework

NHS Mental Health Implementation Plan 2019/20 – 2023/24

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Low Mood: A Pharmacist's Role in Non-pharmacological Treatment and Support

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Introduction

Low mood can affect people at many times in their life, this might be in response to a life event such as bereavement, or for others it may be more persistent and meet the threshold for the diagnosis of depression. As a first point of contact community pharmacists are ideally placed to promote good mental wellbeing and provide early advice and intervention for adults experiencing mental health difficulties (NICE, 2018, 2022). The Royal Pharmaceutical Society (2022) has suggested that pharmacists have a professional responsibly to be alert to mental health issues, to use their professional judgement and to take appropriate action for their patients. Whilst current pharmacy training includes mental health in the curriculum it has been identified that pharmacists can lack confidence in this area (Robinson, 2017). This article will consider how pharmacists can support adults with low mood, guiding you through some of the presenting symptoms, considering what would be good questions to ask, advising on potential non-pharmacological interventions, and exploring where you could refer someone for further help.

Recognising low mood

There are three signs that might help you understand and evaluate someone's mood:

1. The content of speech

Low mood and depression often come with the 'cognitive triad' of distorted beliefs that lead to persistent and negative thoughts about self, the world and the future. You might pick up on patterns of speech that reflect these thoughts. 'I'm rubbish', 'everything is going downhill, it's never getting any better', 'they all think I'm useless'.

2. The manner of speech

If a patient is depressed, rather than just having a bad day, they are likely to be difficult to communicate with. You might feel like you are doing all the work in the conversation. The patient might not volunteer information and might give short and non-committal answers to questions.

3. Behaviours and appearance

Low mood often comes with sleep disruption and low energy which may affect the patient as severe fatigue. You might see someone move slowly or they might show signs of self-neglect. A person with low mood might not look after the details of their appearance, maybe losing routines of washing every day or keeping fingernails trimmed.

Asking further questions

In psychological practitioner training the 'funnelling' method of information gathering is used. Start with an **open question** containing the words 'what, where, when, who, how…' 'Why' is an open question but can feel confrontational so we often avoid it. Rather than firing questions at someone you might want to start with an observation and lead into the question. For example:

- 'You're looking glum/worried/tired/more quiet than usual, how are you doing?'
- I noticed that you look a bit flat in yourself today, what's on your mind?'

- You've been telling me that there's a lot going on in your life, how is all of that affecting you?'

The idea is to open a conversational space that the patient can fill with more information, that you will then sort out and make sense of. It is helpful to '**reflect**' what the patient says back to them, simply re-stating the key part of what they have said. This helps the patient to feel that someone has cared enough to listen to them attentively and understands them accurately, which immediately starts to relieve the sense of disconnection and isolation that comes with low mood. **Summarising** what the patient says helps you to share your understanding with the patient: 'It sounds like when you went back to work after being ill you weren't feeling very confident. You started to worry that they didn't need you and no one really wanted you there, those thoughts have changed how you spend time with your team, and being more isolated has really impacted your mood and brought you down. Now you're struggling to sleep, never feeling happy, and you feel like you can't get out of this state on your own.' The end of a funnel is a **closed question;** you can bluntly ask for the information that will complete the picture that you are building. 'Have you talked to your GP about how you are feeling?' or 'Do you feel like you need some help with this?'.

What advice to give: Self-help

Low mood and mild depression that has started recently can often be effectively treated with Cognitive Behavioural Therapy-Based self-help; the book 'Overcoming Depression' by Paul Gilbert (2009) is highly reputable. Of course, many people feel reassured and helped if they can have support from a practitioner who understands what they are experiencing, so guided self-help is available from the NHS Talking Therapies for Anxiety and Depression (NHS TTAD) programme, where patients can access group, computerised or individual information and evidence based low intensity psychological treatment from registered practitioners.

What advice to give: Behaviour and routines

Activities and routines often stop because the patient experiences barriers to completing them.

Behavioural Activation is a common approach you can use. This intervention recognises that the symptoms of depression can make any activity, even things that patients would usually enjoy, very aversive. Many patients with depression will avoid activity because the thought of doing something is overwhelming and they can only imagine that they will feel bad when they do it or not be able to do that activity well enough. By avoiding the activity, the patient gets short term relief from the dread of doing it, which makes avoidance more likely to happen again. Behavioural Activation reverses this cycle by providing education on the role of avoidance in maintaining depression, then supporting the patient to plan activities that are aligned with their values and setting goals for the patient to do no matter what their mood is like on the day. Saying 'You should go for a two mile walk and then go home and brush your teeth' is likely to make someone with low mood feel worse, not better. Reflecting that you can see how hard things are at the moment and supporting the patient to come up with their own idea of something achievable that gives them an opportunity to experience pleasure, closeness or achievement is likely to be more helpful.

What advice to give: Unhelpful thoughts

Some people can be severely depressed or anxious and still maintain their normal activities. These patients may be affected by the frequency and content of 'negative automatic thoughts' in depression and panic and worry in generalised anxiety disorder. Psychological Practitioners approach these symptoms with a variety of interventions, including Cognitive Restructuring (a process that weighs up a negative belief against factual evidence) and worry postponement. In a very short contact with a patient there are only limited intervention options when the source of distress is cognitive. If you get the sense that worry, or negative self-talk are driving the distress, then it would be a good idea to advise the patient to contact NHS TTAD for an assessment and either a psychoeducation programme or one-to-one support. A non-judgemental attitude and normalising the thoughts as a symptom of a health condition instead of a reflection of the patient's personality can relieve distress. The first step in a psychological intervention for this aspect of a condition is to get into the habit of writing down any thoughts that have an impact on mood. This provides perspective and can quickly reduce emotional distress.

NHS Help for mild-moderate depression

Patients in England can access non-pharmacological treatment for common mental health conditions by self-referral to their local NHS Talking Therapies for Anxiety and Depression (NHS TTAD) programme. Most teams prefer patient self-referral, you can encourage your patient to look up the local team on this website Enter the name of your GP surgery - Find NHS talking therapies for anxiety and depression - NHS.

NHS TTAD follows a national model - There will be easy access to first-line evidence based psychological interventions that can be booked on the website or by calling the local team. First-line interventions might include psycho-education courses delivered by Psychological Wellbeing Practitioners that provide education and support to implement self-help techniques that disrupt the maintenance cycles of depression and anxiety disorders. Many teams will offer a computerised Cognitive Behavioural Therapy (CBT) course that is also supported by regular contact with a Psychological Wellbeing Practitioner who can review progress and advise on how to implement the information to best effect. If more support is needed or you are concerned for the patient's safety, please ask the patient to see their GP who can evaluate if NHS TTAD is the appropriate level of care.

NHS Stages of Support

Step 1: Primary care delivers watchful waiting. At this Step there is identification by a Primary Care Practitioner such as a GP or first contact occupational therapists that the patient is experiencing depression or an anxiety disorder. 'Watchful waiting' is the advised approach at step one. This involves providing some good quality self-help material and booking a review appointment to evaluate if the problem has resolved or is becoming on ongoing difficulty that has a significant effect on the patient's wellbeing for two weeks or more.

Step 2: At this level of psychological care patients receive 'low intensity' interventions. In NHS TTAD this is delivered by Psychological Wellbeing Practitioners (PWPs). This is usually the first point of contact with NHS Talking Therapies services. This workforce is trained to provide a thorough assessment of common mental health difficulties, including initial risk assessment, and to support the patient to establish goals for their treatment. PWPs are trained to provide CBT informed treatment interventions for the simple mild-moderate conditions like uni-polar depression, recent onset obsessive compulsive disorder (OCD), panic attack and panic disorder, and generalised anxiety disorder.

Step 3: More intensive psychological treatment is offered if less intensive treatment isn't effective, or if the patient has a more severe or complex depression or anxiety presentation. For example, Post Traumatic Stress Disorder (PTSD), some specific phobias, and Social Anxiety Disorder are always treated with CBT and not low intensity CBT-informed interventions, because they are more complex than the other anxiety disorders. At Step 3, treatment is delivered by counsellors and Cognitive-Behavioural psychotherapists.

Step 4 and beyond: If a patient has a more severe and complex mental health condition than depression or a common anxiety disorder, psychological care is delivered in specialist mental health teams in secondary care, or through inpatient care.

What if you are concerned for patient safety

Some people with low mood will have suicidal ideation. It is ok to ask directly about the risk of suicide and self-harm, and harm to and from others, at every patient contact. A direct question is much safer for the patient than a 'nice' ambiguous approach. Suicidal ideation occurs in around 40% of patients with depression and varies from the passive 'it would be easier not to be here' to having an active plan on how to end life. Thankfully only around 5-7% of patients are considered high risk for suicide. The statistical risk of suicidal ideation varies with factors like age, deprivation, and ethnicity. When we are working with people who present with low mood, we can expect to meet a lot of people who think that they would be better off dead.

Don't ask: 'are you having dark thoughts?' 'Are you safe?'

Do ask: 'have you ever thought about ending your own life?' or 'in the last two weeks how often have you had thoughts of suicide or hurting yourself deliberately?

> **"Asking in a calm and direct manner takes the mystery and shame out of this element of the experience of low mood. If you suspect any risk of harm, always ask, and be ready to signpost to your local services, making sure that you share information appropriately within your team and with the GP or other services who are involved in the patient's care."**

The University of Glasgow Suicidal Behaviour Research Laboratory provides several useful tools and resources on this topic Tools & Resources – Suicidal Behaviour Research Laboratory.

Signposting

Patients can find their local service and self-refer to NHS Talking Therapies on this link: Enter the name of your GP surgery - Find NHS talking therapies for anxiety and depression - NHS.

A database of good quality free self-help and patient information leaflets on a variety of mental health related topics is available from Cumbria, Northumberland, Tyne and Wear NHS Trust: Home : Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Many local NHS Talking Therapies services have their own websites with a selection of information and resources; it is worth developing links with your local team to support effective signposting.

If self-help information does not feel right for your patient, please do refer them to primary care services. In some GP services First Contact Practitioner Occupational Therapists can offer assessment and intervention for low mood, especially improving return to work (Christie et al., 2021). In addition, many NHS TTAD teams have Employment Advisors whose role is to support any matters related to employment where common mental health problems create barriers to engagement with work.

Summary

Pharmacists should be alert to low mood in their patients. If you have concerns do have a private conversation with someone, be open and supportive in your questioning but also check patient safety and make a clear plan with them. Sign posting to simple self-help can be effective, but for some a referral to local talking therapies or for support in primary care may be needed.

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Suicide–the role of pharmacy

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A winter's tale

*One afternoon last winter, I was walking our dog through the local woods. As I always do, at the brow of the hill, in the wind, I stopped to admire the view over the Mersey estuary. A man was there, seemingly admiring the view too; but as the moments passed, it was clear he was deep in thought and upset. We exchanged acknowledgements, but I felt compelled to ask, "Are you ok?" I can't remember the detail of the conversation, but he shared with me that a relative had "... **committed suicide** ..." the previous day; he didn't understand how it could happen. He said he was "so shocked, I didn't see it coming;" his family were all "... rocked by the news ..." and later that "You're the first person I've been able to tell."*

Our conversation went where he took it. But as we left, he thanked me for listening. I've often wondered how he's doing since our paths crossed ...

Introduction

As a hospital pharmacist, my intuitive response to dealing with suicide is that it's someone else's responsibility – there is always someone better trained, better qualified to ask about, or talk about, suicide. However, the above vignette shows that suicide can be disclosed, almost always unexpectedly, in unexpected situations. This article tries to introduce pharmacy staff to the way to talk with, and listen to, people with suicidal thoughts and signpost support.

Why talking about suicide matters

At a Patient Safety Panel, I've heard countless reports of people, often men, who had taken their own lives. One case has stuck with me over the years:

A young man was feeling depressed and suicidal after the end of his first serious relationship. He had moved back to live with his parents. He was seen by his GP who started a selective serotonin reuptake inhibit (SSRI) antidepressant and referred him to the mental health crisis team because of his suicidal symptoms. The GP continued to prescribe the SSRI as a repeat, and the man was understood to have continued taking the treatment.

He was assessed by the crisis team who signposted him to the local talking therapies service and scheduled a call to review progress in eight weeks.

Eight weeks later, the crisis team called him as scheduled to check his progress. They were told by the young man's parents that he had killed himself 2 weeks previously.