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PROGRESS THROUGH PARTNERSHIP

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

Contents

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PROGRESS THROUGH PARTNERSHIP

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

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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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 ...

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.

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:

The guidance for reviewing a person newly prescribed an antidepressant is not simple, but generally people should be reviewed after two weeks treatment; this may be reduced to after one week for younger people (usually in the range of 18 to 30 years), where a selective serotonin reuptake inhibitor (SSRI) or selective noradrenergic reuptake inhibitor (SNRI) is prescribed, or if there are other risk factors, such as a history of suicide or self-harm, or social predictors such as loss of relationship or employment.[1,2,3]

"The investigation for this case showed that he was not reviewed by either the GP or the mental health crisis team. The investigation did not follow through this theme, but it left me wondering if the GP made the referral to the crisis team and assumed they would make the necessary follow-up review; while the crisis team believed that the GP would arrange the necessary review because they were continuing to prescribe the SSRI. "

Or was no review arranged because reviews are rarely arranged?

How could your pharmacy team do differently in the future?

Our human reaction to suicide - reasons for reluctance

Whether we think about this as a non-professional or as pharmacy staff, most of us are uncomfortable by the thought of suicide and by the prospect of having to talk about it.

We retain this reluctance to discuss certain topics. And that is despite our training being essentially about how to communicate with people about their health, ill health, and medications; yet, discussing mental health and ill-health often feels a step too far. In the experience of the author, suicide is just one of a range of difficult conversations that we are prone to avoid, others including safeguarding, sexual matters, substance misuse, and money.

Mental health consultations

There is a lot of advice available about how to run a consultation with a person who is presenting with mental health problems, for example the CPPE *Consultation skills for pharmacy practice* distance learning pack.[4]

General approaches for starting a conversation with someone with symptoms of depression or anxiety include:

- Wherever possible, have consultations **face-to-face** – you will detect so much more nuance from talking with someone directly. If you must have telephone consultations, then try to reserve these for follow-up consultations. If you have any concerns about any element of a telephone/remote consultation, then don't hesitate to re-arrange a face-to-face consultation later at an appropriate time
- Give yourself **sufficient time** – these consultations take longer than expected. Be aware that a conversation with a person can take an unexpected turn just as you are trying to draw the conversation to a close: they may have needed the first 10-mintues of the conversation to trust you. In these situations, you will always want to make sure you have understood the new topics and managed them appropriately. You may need to pop out to the waiting room or dispensary and let them know you are running late and will need another 10-minutes
- **Anticipate:** have a box of tissues ready in case the person needs them
- Make sure **you** have support *after* the consultation – you can come away from these discussions emotionally drained. Your support may simply be someone to chat with (in confidence) about how you feel about the situation, or in a more formal sense (e.g. clinical supervision) to explore how you approached the consultation and what you could have done

differently. When work is pressured, these important conversations for you are easily overlooked or deferred, but **you** are losing the benefit of that space to reflect on your work and patient care (see later)

Here are some suggestions to structure your consultation:[5]

- Use very broad open questions to understand the person perspective.
- Be patient waiting for replies – some people with depression can take (a very) long time to reply – be content to say nothing while they hear your question and prepare their reply – even a wait of just 5-seconds can feel like eternity! Some people can take 20-30 seconds or longer to begin their replies.
- Use the actual words and phrases the person uses; reflect these words back to the person
  - Ask for clarification where necessary. Reflect the last few words or last phrase the person used back to them as a question.
- Listen - aim to listen more than you talk.
- Use active listening – help the person to understand that you are listening and understanding what they are saying, nodding can help, eye contract, you are interested in what they are saying
- Avoid language that can be judgemental – we can often use "ok" as evidence of active listening – but this response to a comment such as "no one cares about me" could re-affirm a person's negative beliefs about their situation.
- Ask your questions in a clear, direct and unambiguous way – even about difficult or embarrassing topics, like suicide.

Talking about suicide

It is understandable that many people find the prospect of discussing suicide upsetting and scary. However, we should also be aware that the person experiencing these feelings, whether for the first time or after multiple occasions, is likely to be more scared than you are.

We also need to recognise that suicide is associated with depression and with a wide range of medications, including antidepressants.[6,7] Therefore, as pharmacy professionals, we have a responsibility to be confident to engage in these conversations. We are not expected know how to manage the situation, but that must not stop us having the conversation.

It is important to recognise that when we explore a person's feelings of suicide, we are not doing it in isolation - we are part of a wider team of healthcare professionals, and *we all* find these conversations difficult and unsettling – you are not alone. But we are, also, all here to support each other after these conversations (see later).

"Yeah, I'm ok"

We've all had conversations where we ask how someone is feeling and they say *"Yeah, I'm ok"* but there is a dissonance: their eye contact is missing, the tone of voice is flat, the smile lies, or their spark is missing. At one level you know something isn't quite right; however, we think *"I don't have the headspace to ask"* or *"I don't have the time to talk about this now"* or *"That's a shame but pull yourself together and stop being so miserable!"*

Exactly these situations could be the start of our conversations about suicide! These are the passing comments that give us a window into *how* someone is really feeling; these will be the conversations that show that we care.

How to talk about suicide

As pharmacy staff, it is important that we are confident enough to start conversations with people about their suicidal thoughts. However, we are not experts in this field. We should not think that we have to help manage these situations. There are others much better placed to support people with suicidal thoughts. But we can help get people with suicidal thoughts to get the right care.

There are a wide range of training resources available to staff supporting those with suicidal thoughts; see *Further Reading* below:

DOs of talking about suicide[8,9]

1. Use open questions.
2. Use simple, direct language – ask directly about whether someone is suicidal.
3. Take people seriously – the person will have taken a lot of courage to start to talk to you about their suicidal feelings.
4. Listen – just listen calmly, without interrupting; let the person talk.
5. Try to stay calm – we know this will be difficult for you in the situation, but it will help you think clearly, and it will also help the person you're talking with know that you are genuine.

DON'Ts of talking about suicide

1. Don't avoid asking about suicide – you will not trigger a suicide attempt because you have asked about it.
2. Don't make assumptions based on your perspective – about what is causing the person to feel suicidal or what will help.
3. Don't avoid asking directly about suicide: ask "have you ever tried to take your life?" rather than something like "have you ever tried to hurt yourself?" .
4. Don't use phrases like *"committed suicide"* – the origins of the words *"commit suicide"* can be traced back to when suicide was illegal (before 1962). Some people find this language can reinforce the stigma associated with suicide. Another phrase to avoid is 'a positive' or '(un)successful' suicide attempt: no suicide can be positive or successful. A less stigmatising phrase might be "died by suicide" or "took their own life."
5. Don't use judgemental language. You may feel shocked or frightened having this conversation with someone, but don't blame the person for how they feel.
6. Don't use dismissive language, such as *"You're not going to do anything silly are you?."* Such language can sound dismissive and invalidating of a person's genuine feelings. We do, though, understand why using this kind of response can feel protective to you as the questionnaire – it gives us permission to stop asking questions about someone's feelings – but it is only protecting **us,** the questioner, from further difficult questions; it does nothing to protect or support the person experiencing the suicidal thoughts.

Having these difficult conversations about suicide are difficult. They need regular and frequent practicing before you can begin to feel confident using this language. You need to give yourself a safe space and sufficient time to practice what you will say and how you will say it.

A suggested structure for talking to someone about suicide[8,9]

A useful structure to conversations about suicide can be to follow these steps:

See	• Think about what you know, like
	  o someone's relationship difficulties that you are aware of
	• Think about what you see, like
	  o they appear short tempered and irritable or fed up
	  o they are not their usual self or isolating from their usual group of friends
	  o how much people drink

Say	• Reflect back to the person what you hear, use ***their*** words • Directly, ask "Do you feel suicidal?"
Signpost	• Ask where the person could go for support • Ask permission to talk with an advice service on behalf of the person

Signposting and safety netting according to current risk

When someone presents to you with suicidal thoughts, you are **not** expected to deal with and resolve their feelings. This is not a skill that pharmacy staff are usually trained for.

However, it is reasonable for you to be able to signpost the person to appropriate services.

A useful question is *"Are you able to keep yourself safe at the moment?"* and explore how they can do that. Encourage the person to problem solve a solution with you rather than you giving them the answers.

As a general rule, if someone feels they can keep themselves safe and they have fleeting thoughts of suicide, their risks may be lower than if they have regular, frequent and intrusive thoughts of suicide with clear plans that they have started to put into practice.

The following table suggests a range of referral points that will be available locally to you:

Fewer immediate safety concerns	More immediate safety concerns
Encourage them to ring GP and make appointment	Make the call to the mental health crisis team *with* the person Encourage them to visit A&E
Do they have family or friends they could reach out to and talk with? Self-referral to local mental health crisis team: Where to get urgent help for mental health - NHS or Check your mental health symptoms - NHS 111 or NHS 111 Self-help, e.g. What can I do to help myself cope? | Mind - Mind Samaritans 116 123 Other local or national helplines, like Shout (by text message) or Papyrus 0800-068 41 41 You may have other local services near you that are also available or veterans support	Ring 999 to request ambulance You may want to stay with (or arrange for someone else to stay with) the person until the ambulance arrives

Wherever you signpost or refer the person, that service will have staff who are trained and experienced in providing a comprehensive assessment and safety plan for them.[10,11]

Some NHS Talking Therapies services will exclude people from CBT and other therapies if they have current, active suicidal thoughts. This is because these services don't have the required staffing levels and/or clinical experience to support the assessment and management of active suicidal thoughts. Your local Mental Health Crisis Team may be best placed in these acute situations.

Safeguarding

When you are working with someone who is describing suicide thoughts, you will probably need to make a safeguarding report. Your referral could be directly about the person who is feeling suicidal; or it could be indirect about one of their dependents. Review your organisation's safeguarding training and contact your safeguarding lead for more advice.

There is DHSC guidance to support healthcare professionals with issues of consent, confidentiality, and safeguarding.[12]

Documentation

Irrespective of where you work, any challenging conversations should be documented in the person's clinical records; this is exactly the same for a conversation with someone about suicide. Your records should include a summary of:

- The circumstances of the contact, e.g. how the contact arose.
- The person's presentation and relevant information they disclosed.
- Any signposting you provided, e.g. arranged for practice mental health nurse to review the person, signposting to local Crisis Team or accompanied person to A&E, any Safeguarding referral.
- Any following up or review you suggest, e.g. safety netting, who, when, objectives, next steps, etc.

Support for the professional

Throughout this article, we have emphasised the difficulty of talking about suicidal thoughts for all parties: the person experiencing the suicidal thoughts and their family and loved ones. We mustn't overlook the impact these discussions also have on the healthcare professional: we have acknowledged that these are not conversations that pharmacy staff are usually trained in or expect to routinely have. Having these conversations are stressful for the pharmacy professional because they are unfamiliar territory.

Therefore it is important that you have the right support available. The following are worth considering:

- Ensure you have access to, and complete, appropriate suicide awareness training.
- Ensure you have regular informal 'check ins' with your local team/colleagues – share your experiences and describe the difficult cases you have been dealing with – such simple peer support may be sufficient to check on your health and wellbeing and reflect on the support you provided.
- You should have routine clinical supervision with a peer or manager to help you reflect on your work. These valuable and confidential sessions help you explore what has gone well and what could be done differently. You may want to reach out to your local mental health trust's pharmacy team to explore the challenges you experience in your role.
- As a healthcare professional, you provide care: this has an emotional toll. You may want to self-refer to your organisation's occupational health team to discuss the feelings this case has had on you. You may be able to access a staff counselling service. · If you area pharmacist, you can self-refer to Homepage - Pharmacist Support.
- If you are directly or indirectly involved in a significant incident, then a formal debrief should be available to you and anyone else in your team that wants (or needs) to engage.

If you have contact with someone who has recently experienced the suicide of someone close to them, the booklet *Help is at Hand* is available.[13]

Training to raise suicide awareness for pharmacy staff

Neither Pre-registration Training Pharmacy Technician (PTPT) (including apprentices) nor undergraduate pharmacist training require suicide awareness training, although both training pathways requires the knowledge of basic physical first aid.[14,15]

> **"Anecdotally, some undergraduate pharmacist courses include brief suicide awareness training, such as Zero Suicide Awareness (see *Further Information*); a very limited number provide Mental Health First Aid training."**

e-Learning such as Health Education England's *We need to talk about suicide* and the Zero Suicide Alliance *Suicide Awareness Training* both provide brief training (typically 30 – 60 minutes) with simple strategies to encourage talking with those who have suicide thoughts. In contrast, Mental Health First Aid (MHFA) training typically takes 2-days and additionally provides repeated role play opportunities to practice these conversations. See *Further Information*.

Investing in collaboration at both technological and workforce levels would enhance the transfer of information between primary and secondary care, minimising delays in treatment and improving continuity of care. By integrating access to shared health records, the NHS can strengthen the connection between care sectors, enabling a more cohesive and patient-centred approach to addressing healthcare needs.[14]

Future developments in pharmacy to support people with suicidal thoughts

CPPE is developing a Focal Point package to support the New Medicines Service for newly prescribed antidepressants. This package will provide opportunities to develop and explore conversations about suicide, for example when people start an antidepressant.

The Lifeguard Pharmacy project was a pilot project that operated in Lincoln. It developed and delivered training for selected community

pharmacy staff to support people self-presenting with either domestic abuse or suicidal thoughts.[16,17]

Conclusions

Talking to people about suicidal thoughts remains one of the most difficult conversations we may have to engage in: but they should be easier for us, as health professionals, than the person experiencing the suicidal thoughts.

> **"As pharmacy staff we dispense and oversee the use of medication that appears to cause suicidal thoughts: we are also well placed to ask about suicide when we regularly supply medications. "**

Looking back at the story at the start of this article: firstly, the person I spoke to talked about a relative who *"... committed suicide ..."* the previous day. We now know that there is some language that, as health professionals, we are encouraged to avoid; we now know suitable alternatives. Secondly, often it is the *listening,* the genuine hearing someone's angst, that matters the most. As pharmacy staff we are already good at listening. Let's commit to listening to, rather than avoiding, these difficult conversations in future.

Suggested priorities for pharmacy staff

- When you make a first supply of any antidepressant, ask the person when their first scheduled review is and with whom. Most people should expect a review after no more than two weeks of treatment; people at higher risk should expect a review after one week.
- People at higher risk of suicide will tend to live in isolation, have recent financial difficulties, have a history of drug or alcohol abuse, and may have a history of self-harm. They may not be engaging with mental health services. Monitor for those who are at risk and engage with them.
- Understand your local points of referral.
- Explore and complete the free suicide awareness training (see further reading).

Suggested strategic priorities for the pharmacy profession

- The General Pharmaceutical Council should consider whether the Learning Outcomes for Pharmacy Technician and Pharmacist training should include mental health first aid.

Further information, reading and training resources

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8 https://zerosuicidealliance.com/suicide-awareness-training

9 Helping someone talk about suicidal feelings - Mind

10 National Institute for Health and Care Excellent (NICE). NICE guidelines 225: Self-harm: assessment, management and preventing recurrence. Published 7 September 2022. Available at: Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE Accessed on 1st April 2025

11 NHS England. Staying safe from suicide (date published 4 April 2025). NHS England » Staying safe from suicide (Date accessed 7th April 2025)

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14 General Pharmaceutical Council. Standards for the initial education and training of pharmacy technicians (October 2017). GPhC: Standards Initial EandT PTs (Date accessed 1st April 2025)

15 General Pharmaceutical Council. Standards for the initial education and training of pharmacists (January 2021). GPhC: Standards Initial EandT Pharmacists (Date accessed 1st April 2025)

16 Lifeguard Pharmacy (Date accessed 3rd April 2025)

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Evolution of mental health pharmacy - improving outcomes for people living with mental illness

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Introduction

In England, evidence suggests that 1 in 4 adults will experience a mental health related problem at some point in any given year, whilst 1 in 5 children are estimated to be living with a mental health problem.[1] In 2024, NHS Business Services Authority (NHSBSA) recorded an increase in prescribing of psychotropic medication as well as patients receiving these medicines.[2] There is need for a rational approach to supporting people living with mental illness and treated with psychotropic medication, and for comprehensive medicines optimisation strategies to promote cost-effective and appropriate prescribing of psychotropic medication.

Pharmacists are trained health professionals who play a crucial role in patient care, from managing medication supply, providing essential health advice, and conducting medication reviews, to being integral members of multidisciplinary healthcare teams managing complex patients to improve overall health outcomes. Their expertise is particularly significant in managing complex medication regimens for patients with mental health conditions, highlighting the importance of psychiatric pharmacy.

In the context of the UK's healthcare sector, pharmacists and pharmacy technicians contribute to improving health outcomes, enhancing patient safety, and promoting public health initiatives. They are integral to multidisciplinary teams, collaborating with doctors, nurses, and other healthcare providers to ensure that patients receive comprehensive care. The role of pharmacy was further emphasized during the COVID-19 pandemic, where pharmacists stepped up to deliver essential services, including vaccination programs and medication management, thereby alleviating pressure on the NHS.

The NHS Long Term Plan outlines a vision for a more integrated and accessible healthcare system, with a strong focus on mental health services. Within this framework, psychiatric pharmacy has gained prominence, as pharmacists are increasingly recognized for their ability to optimise pharmacotherapy for mental health disorders. This evolution reflects a broader shift towards collaborative healthcare, where pharmacists and pharmacy technicians are not only dispensers of medication but also key players in the management of mental health, ensuring that patients receive holistic and individualized care.

This article will delve into the historical context, current practices, and future directions, particularly in light of the ongoing challenges posed by mental health issues and the overarching goals of the NHS.

Historical context and evolution of mental health pharmacy

Psychiatric pharmacy, also known as mental health pharmacy, is an established field where pharmacy professionals work in various settings within the public and private healthcare sectors. Though it is a recognised speciality, it is relatively new and is continuously evolving.

The origins of psychiatric clinical pharmacy can be traced back to the 1960s and early 1970s in the USA where in 1971, a pharmacist was assigned to a psychiatric unit in Alaska by the US Public Health Service, marking the location of the first documented instance detailing the role of a psychiatric pharmacist.[3]

In the UK, in 1970, a small group of pharmacists working in some of the large mental institutions of the time met to discuss concerns that pharmacy services to in-patients living with serious mental illness were, at that time, generally provided by unsupported, under-resourced staff frequently working in isolation with no peer support and with no opportunity for further training in mental health. This culminated in the formation of an informal group which became known as United Kingdom Psychiatric Pharmacy Group (UKPPG) with the overall aim 'to promote better pharmaceutical care for people with mental health needs through education, liaison and accreditation'.[4] In the year 2000, the UKPPG established one of the first specialist pharmacist accreditation bodies when it commissioned the College of Mental Health Pharmacists, and in 2010 a formal merger between the College of Mental Health Pharmacists and UKPPG led to the formation of the College of Mental Health Pharmacy (CMHP) to focus on education, accreditation and research in the field of mental health pharmacy. To date, the CMHP runs several annual training courses, offers education bursaries, and convenes yearly at annual conference to adhere to their aim of promoting knowledge and skills for mental health pharmacy professionals. Aston University, Birmingham runs postgraduate qualifications in psychiatric therapeutics that are open to pharmacists and pharmacy technicians.

> **"In 2014, a comprehensive review of the impact of clinical pharmacy services on patient outcomes in mental health found that pharmacists do provide a variety of services and play a significant role in inpatient mental healthcare but concluded that evidence of clinical outcomes was lacking.[5]"**

However, the Royal Pharmaceutical Society (2018) in their 'No health without mental health' publication, acknowledged the crucial role pharmacists were already playing in mental health services through their expertise in mental healthcare and training of other health professionals.[6] The document also called for effective collaboration between pharmacists in

different sectors particularly with joining up pathways between specialist mental health services, GP practices and community pharmacy.

> **"In 2022, the RPS launched the 'Core advanced pharmacist curriculum' with a credentialing assessment for pharmacists working in any patient focused role to demonstrate their ability to practice at advanced level."**

More recently, following several years of the RPS and CMHP working together to develop a joint advanced mental health credentialing curriculum for pharmacists in the UK,[7] joint credentialing was launched involving the two organisations bringing their credentialing processes together to form one consolidated method for credentialing as advanced pharmacists within the speciality of mental health across the UK.

Current practice

Mental health pharmacy has undergone significant evolution over the past five decades, transitioning from a primarily medication supply role to a more integrated clinical practice. This shift is reflected in the numerous guidelines, reports, and frameworks that have been published, emphasising the essential contributions of pharmacists in various capacities.[6,8-9] These include screening, initiating, and maintaining treatment regimens, enhancing medication adherence, and providing comprehensive medication information across both primary and secondary care settings.[10]

Several specialist roles have been identified in which pharmacy professionals contribute to promoting better outcomes for individuals living with mental illness. These include pharmacy technicians working in clozapine clinics, advanced specialist pharmacists in various mental health services such as child and adolescent mental health services (CAMHS), adult community mental health and wellbeing teams (MHWT), early intervention in psychosis (EIP), crisis and home treatment teams, perinatal mental health services, learning disabilities, psychiatric liaison within acute hospitals, and forensic services. In these roles, pharmacy professionals (many with independent prescribing qualifications) offer assessment, advice, and consultation for mental health problems; evidence-based pharmacological treatments; physical healthcare; access to mental health information and online resources; and run specific support groups.[11]

Growth of pharmacist roles in psychiatry could be attributed to the shift from institutionalising people with mental illness to caring for them within the community, necessitating collaboration between healthcare professionals in a multidisciplinary manner to enable holistic care.[12]

However, whilst it is recognised that medication constitutes a key, often effective intervention for people living with mental illness, and that pharmacists who are the experts in optimising medication use are well-positioned to improve physical and mental health of this population, it is not often clear what the impact of their role is in mental health, nor is there much documented evidence that convinces mental health services to commission psychiatric pharmacist roles.[12,13] This has meant pharmacy provision is inconsistent across mental health services and considerable effort is often required to acquire funding for such roles.[14]

Nevertheless, over 500,000 patients in England alone are living with serious mental illness and it is acknowledged that these patients face well-documented health inequalities that lead to them dying 15-20 years earlier than the general population, mostly from co-morbid physical health conditions which could be prevented by appropriate treatment and support.[15,16]

Medicines management for patients with serious mental illness is one of the goals stated in the plan for newly established integrated models of care in NHS England, as they are typically prescribed multiple medicines. Therefore, the 'NHS mental health implementation plan 2019–2024', which provides a framework to deliver the mental health commitments of the 'NHS long-term plan', identified a need for 260 pharmacist posts in integrated community care teams which was meant to be in place by 2024.[17] Whilst this effort is commendable, it is not nearly enough provision to

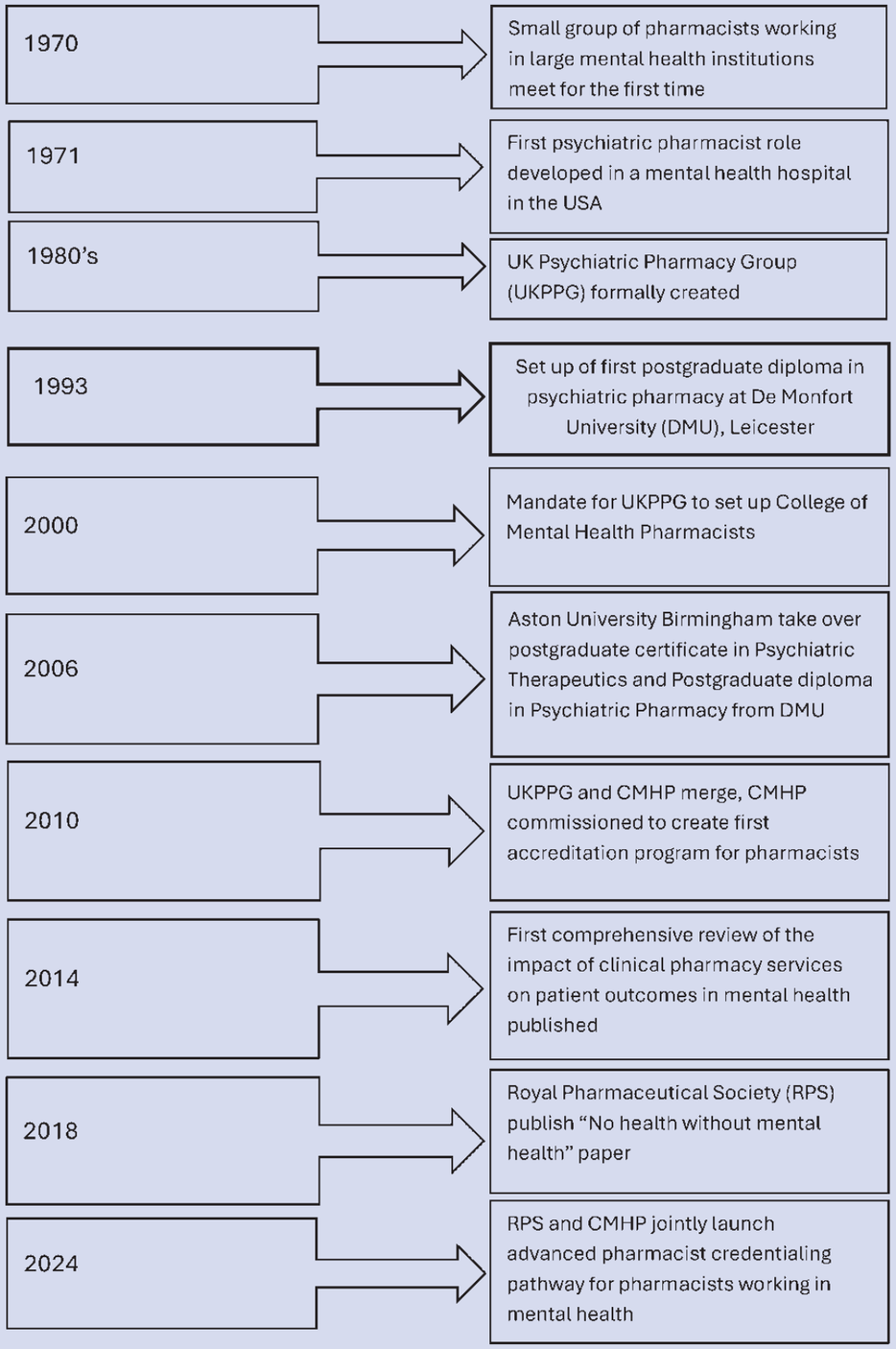

Figure 1 outlines some milestones in the evolution of psychiatric pharmacy as a growing sector

cater for the number of patients with mental illness who can often fall between the cracks as they do not meet the criteria for inpatient admission and require care in the community.

It is only by making adequate provision of pharmacy professionals in integrated mental health roles that more evidence of impact and measurable outcomes can be demonstrated.

> **"Notwithstanding the inadequate funding of mental health roles for pharmacists, it is still a fulfilling option for early career pharmacists looking for an area to specialise in, as evidenced by pharmacists who have undertaken rotations in psychiatry who described the experience as eye-opening and insightful.[18]"**

Despite the profession evolving significantly, there is much to be done to define service specifications, clarify pathways for early career pharmacists to develop in these roles, and define outcome measures to demonstrate impact of each role.

Challenges and Barriers

Although considerable progress has been made in mental health pharmacy practice training, challenges remain. Training should not be limited to speciality roles but should also be integrated as a fundamental component of foundation level competency development.[19,20] This includes closing the training gaps in community pharmacy practice as pharmacy staff within these roles are well placed to have major impact on improving wellbeing of mental health patients including suicide prevention, managing physical health and comorbidities.[19,21-24] An example could be the inclusion of certain psychotropic medications, such as antidepressants, in the New Medicines Service (NMS). NHS England and NHS Improvement are currently running a pilot on this with Centre for Pharmacy Postgraduate Education (CPPE) providing necessary training.[25] Training can also be provided by specialist mental health pharmacists within their localities to primary care pharmacists. This however needs to be coordinated and resourced to ensure it is embedded in practice and there is continuity. Upskilling all pharmacists with mental health skills would build confidence to support patients better including improving adherence to medication. Pharmacists taking a lead on pharmacological intervention would free up other clinicians' time to use their area of expertise more effectively.[26]

There is need for community pharmacy staff to have access to records to support initiatives such as the NMS and advancement in technology with a robust governance process would facilitate this. A joined up clinical service that ensures clinicians involved in the patient's care have access to appropriate and up to date information will reduce risks to the patient and enable timely interventions improving outcomes for patients and potentially preventing need for specialist service or secondary care which reduces the healthcare cost. It is important that technology is accessible, affordable and its potential maximised in pharmacy practice as this would also ease pressure on staff apart from enhancing care delivery.

Community pharmacy staff also require adequate time and space for private consultation and counselling. Ensuring staffing levels are proportionate to workload would be a key factor in enabling this. Staff shortages in both community and hospital sectors compounded by stress and burnout from workload is a challenge that needs to be addressed to enable optimal care for patients.[27-30] Workforce planning is essential to this, and it is important to include secondary school students, particularly A level students, in efforts to promote the profession and specialist areas. Innovative ways of demonstrating and showcasing the impact and value pharmacy professional offer within mental health space would generate interest. This needs to be backed with more work placement opportunities including paid roles.

As already mentioned, funding continues to be a barrier to achieving the goal of improving mental health pharmacy practice and cuts across all areas from education and training to renumeration.[31] In the UK, national investment made available to improve equality in mental health care usually is

allocated to other priority areas as Trusts and Integrated Care Services are not mandated on the specific areas within mental health service that this should be spent.[19] Where funding is made available for pharmacy roles, this usually is not protected and so the roles are not established as integral part of the teams.[19] Funding also needs to reflect the level of expertise expected for the roles. The recent announcement of the dissolution of NHS England and plan to reduce Integrated Care Boards (ICBs) cost by fifty percent is likely to impact current funding arrangements and the hope is that mental health pharmacy roles will be a critical part of the reinvestment plan for frontline services. More studies and sharing of data from established services including data from ongoing projects and initiatives will provide evidence and highlight the impact and outcomes of mental health pharmacy staff on patient care, which would be crucial in developing and advancing these specialist roles within mental health services.[24,32-33]

Additionally, targeted support is required to upskill more pharmacists to become independent prescribers which includes mental health pharmacists to ensure their preparedness to facilitate development of pharmacists who will be graduating with prescribing qualifications from 2026. It will equip prescribing pharmacists with the skills to become Designated Prescribing Practitioners (DPP) to support foundation trainee pharmacists. This also entails strategic planning on how the skills will be used within services to deliver patient centred care. More needs to be done with stakeholders such as medics to facilitate this as though pharmacists are valued as part of the multidisciplinary teams (MDTs) gaps such as ability to diagnose, clarity around legal responsibility for errors and prescribing models remain.[34] A resolution to this would mean all mental health pharmacist skills including prescribing can be harnessed to improve patient care.

Other challenges include medicine shortages that have worsened in recent years, and require considerable time and resources spent looking for suitable alternatives.[29] This has a significant impact on patients as can lead to deterioration in mental state for those who have only responded well to that particular medicine and been on it for long time or withdrawal symptoms when there is insufficient supply to cross taper or wean off and make a switch safely. Teams with no dedicated pharmacist struggle to meet the needs of patients requiring reassurance and support to switch to available alternatives.

Future Directions

Pharmacogenomic testing enables individualised therapy as it involves the assessment of the effect of differences in gene on the pharmacokinetics and

pharmacodynamics of a drug to determine its efficacy so treatment can be tailored, and patient outcomes can be improved.[35,36] The ability to improve treatment of mental health conditions with targeted treatment regimens that can be optimised for efficacy and reduction of serious side effects would have significant impact in patient care. Although there is evidence to support this, uptake is slow and limited.[37,38] There is need to develop training and knowledge in this area as well as studies to demonstrate cost effectiveness. This should build confidence within multidisciplinary teams and enable integration into clinical practice. While there are some resources currently available that offer valuable information on pharmacogenomics, the results from ongoing studies and pilot projects would be essential for developing guidelines and facilitating implementation within the NHS in the UK.[35-36,39] Further research in this field is required to build a stronger evidence base for use in practice and pharmacy professionals with focus on mental health possess the expertise and capability to lead pharmacogenetic and other medicines related research so patients can achieve optimal outcomes with medication.[36,37,40] This is especially vital given the growing number of new therapies in psychiatry, which is constantly evolving.

Artificial intelligence (AI) has significantly impacted various areas of life, including in healthcare, with its influence becoming even more apparent during the pandemic. The technology is advancing rapidly, reshaping how services are both provided and delivered. Mental health care is not an exception to this, and a number of AI technologies are currently in use to provide personalised therapy.[41] It is important that psychiatric pharmacy professionals take advantage of these innovative technologies and engage in the development to enhance clinical service and outcomes for patients. AI has to be recognised for its potential to improve efficiencies within services and not as a threat to the profession as the human interaction with patients is particularly important in mental health. For example, teletherapy could be quite effective in ensuring reach to patients in isolated areas or that are inaccessible.[41] Monitoring of treatment, adherence and for side effects are also areas where AI can be used to reduce incidents of adverse drug reactions.[42]

Though there are variations currently in service models with specialist mental health pharmacy roles, the ongoing work by the Royal Pharmaceutical Society (RPS) and College of Mental Health Pharmacy (CMHP) to develop curriculums to support the development of mental health pharmacy practice will have a positive impact in shaping and ensuring high standards are achieved and maintained irrespective of the model of service delivery. Next steps would be to ensure buy-in and engagement of decision makers to encourage, promote and support pharmacy professionals to achieve the developmental goals on an ongoing basis. This should also encompass the ability to apply prescribing skills, as these can be further developed to support services and enable psychiatry pharmacists to address current gaps in medication optimisation. Mental health pharmacists can be equipped to run clinics such as Attention Deficit Hyperactive Disorder (ADHD) where there is currently a large backlog across the UK.[43] They can also run clinics for high risk medicines such as clozapine, lithium and deprescribing clinics including for medicines with risk of dependence e.g. benzodiazepines. Their expertise in consultation, active listening, and counselling makes them highly suited for these roles.

With the potential and possibilities in mental health pharmacy practice highlighted including the positive impact on patient care, this is a speciality worth diversifying into as there is a wide range of opportunities to utilise clinical skills and expertise. It is a unique area of practice due to nature of the illness and management as routine bloods and treatment options are not standard practice in comparison to most physical health conditions for example. There is growing interest as more mental health trusts are taking on foundation trainees and recruiting newly registered pharmacists which was previously not commonplace. It is important to build on this and provide more opportunities and avenues for pharmacists to have experience of psychiatric pharmacy for example through shadowing schemes and cross sector rotational programmes. The exposure would provide valuable insight, deeper understanding, and interest in the practice. It will demystify what it entails, open up growth within the sector, and improve skill mix within multidisciplinary teams (MDTs) across mental health services.

Conclusion

Mental health pharmacy practice has grown over the years and is making a profound impact in patient care and improving outcomes for patients. Systems are in place to support pharmacists and pharmacy technicians to develop specialist mental health skills to optimise patients' treatment and outcomes. Specialist roles up to consultant level are now becoming established. There is room for more of these roles and upskilling of general pharmacy workforce due to the growing number of patients. Mental health pharmacy practice has played a significant role in the progress that has been made in bridging the gap and ensuring parity of esteem in care for mental health patients as with physical health. The expertise is valued and backed by MDTs, promoting growth. However, more still needs to be done to build on successes and improve mental health patients access to support from pharmacists with mental health training and expertise.

Acknowledgement

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Mental Health In-Reach – Bridging the Gap

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About the author

Jennifer has worked in mental health pharmacy for over twenty years and was awarded the College of Mental Health Pharmacy Fellowship in 2022. In May 2023 she published her MSc research in BMC Psychiatry 'What are patients' experiences of discontinuing clozapine and how does this impact their views on subsequent treatment?'.

She is currently employed as a senior clinical pharmacist and independent prescriber in community mental health teams at Cheshire and Wirral Partnership NHS Foundation Trust. She also uses her expertise to provide education and support as a mental health in-reach pharmacist at Wirral University Teaching Hospitals NHS Foundation Trust.

Introduction

In 2019 the pharmacy teams at Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Wirral University Teaching Hospital Foundation Trust (WUTH) decided to take a new approach to improve pharmaceutical care to people taking mental health medicines in the general hospital setting.

An initial scoping period by the pharmacy teams identified how the teams worked currently and put in place plans to provide higher quality care to patients with mental health conditions presenting at WUTH, in line with The National Confidential Enquiry into Patient Outcome and Death (NCEPOD), Treat as One 'Bridging the gap between mental and physical healthcare in general hospitals'.[1]

The NCEPOD Report highlighted:

- Only 72% of patients had their mental health drugs prescribed during the initial assessment
- Discharge notification lacked the mental health medication in 29% of patients
- 58% of healthcare staff had no training in psychiatric medicine
- All general hospital pharmacy departments should be able to undertake medicines reconciliation of medications for mental health conditions within the first 24 hours of admission
- Communication between general hospital and mental health hospital pharmacists should be encouraged

(WUTH did not have access to specialist mental health pharmacy support at this time).

Aims and objectives of the service change

- To improve patient outcomes by ensuring they receive optimal treatment options relating to their mental health
- To create links and relationships with pharmacy Mental Health Services via Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
- To upskill current WUTH pharmacy clinical staff with respect to treatment pathways, medicines and other services used within mental health. This will be completed by:
  - Patient reviews
  - Departmental education sessions
  - 1:1 training sessions

- Case based education
- Support to produce guidance and patient information
- Creating links to external organisations and other useful resource

- To provide both WUTH and CWP pharmacy services with a two-way communication channel relating to medicines optimisation for individual and appropriate patients
- To provide specialist input and advice on the investigation of incidents involving psychotropic agents

"Education and support about mental health was to be delivered by the specialist pharmacist to the WUTH pharmacy team to enable them to provide optimal pharmaceutical care to any inpatients at WUTH requiring mental health-related interventions."

Targeted interventions were to be made for those identified through Cerner reports to be receiving:

- Clozapine
- Other antipsychotics
- Lithium
- Valproate (females only)

Mental health advice and support to be provided one day a week by a CWP specialist mental health pharmacist to pharmacy staff at Arrowe Park Hospital.

Scoping exercise

Locally agreed goals were formulated from discussions between mental health and acute trust pharmacy representatives and through reflection of local incidents involving mental health medicines.

Locally agreed goals:

1. Patients identified to be reviewed and teaching provided to the WUTH pharmacists for psychotropic medicines
2. Provide pharmacological advice and interventions for identified inpatients prescribed antipsychotics, antidepressants and complex psychotropic polypharmacy from a mental health and physical health perspective
3. Maintain a log of clinical queries and responses provided to the WUTH pharmacy team and use this for the annual report and to drive service development
4. Provide training to pharmacists and pharmacy technicians working at ward level and maintain a record of training
5. Maintain a directory of psychotropic online resources on the pharmacy shared drive at WUTH. Review on a six-monthly basis
6. Supervise and co-develop one audit annually, focusing on psychotropic medicines for implementation by pre-registration and diploma students at WUTH using QI methodology
7. Deliver a minimum of four 'Clinical Bites' learning sessions over a 12-month period

Baseline questionnaire

A questionnaire was prepared to gauge peoples' baseline knowledge and confidence in mental health and understand what the training needs were. The questionnaire included questions on a range of clinical topics including:

- Antipsychotics
- Antidepressant
- Anticholinergic burden
- Alcohol withdrawal
- Restarting medicines following overdose
- Cardiac risks
- Serotonin syndrome
- Lithium monitoring

Questionnaire

The final question, about how confident the person felt about mental health pharmacy, was scored separately to the clinical questions.

Thirty-eight people returned completed questionnaires with the following points of note:

- No-one felt confident about their answers being correct
- Five people (13%) thought they knew the correct answers but were not sure of the reasons why
- The remaining 87% felt they had guessed at least half of the answers
- 55% did not feel confident talking to people on mental health medicines or mental health medicines made them feel nervous
- Questions about anticholinergic effects of medicines, cardiac effects, clozapine and treating agitated or aggressive patients had least correct answers

Interventions in the first three months

Initially a report was run weekly to identify patients on medicines related to aims, which were: valproate annual risk assessment forms, physical health monitoring for those on antipsychotics, clozapine and lithium prescribing.

At a regular weekly meeting, the CWP mental health (MH) pharmacist highlighted her availability to support with mental health issues and also shared a mental health fact.

On ward visits, the CWP MH pharmacist:

- Introduced herself and her role to members of the pharmacy team
- Used reports to identify patients in line with the indicators agreed at the outset of the programme
- Shared knowledge of mental health pharmacy from a general perspective
- Provided patient-specific guidance.

In the first three months fifty-seven patients from the reports were reviewed, additional interventions were made during ward visits for other patients. The main interventions total of 150 are summarised in Table 1 below:

Intervention required	Number of patients
Physical health monitoring implemented due to psychotropic medicines	28
Contact required with CMHT or liaison psychiatry	23
Support with adherence to medication to prevent relapse	21
Medicines reconciliation required more information about mental health medicines	13
Identifying medicines needed a more complex review including a specialist	11
Stopping or starting medicines	9
Lithium book was not identified/given	8
Documentation of PPP for Valproate as not in situ	7
Adverse drug reaction/side-effects	7
Lithium monitoring or brand check not completed	5
Choice of medicines	5
Interventions requiring further documentation of information	4
Potential drug interactions	4
Management of medicines following overdose	4
Clozapine	1
Total number of interventions	**150**

Table 1 – Summary of interventions May - July 2019

Interventions

Details of some of these interventions include the following:

1. A patient admitted on lithium, mirtazapine and venlafaxine with diagnosis of serotonin syndrome, differential diagnosis of lithium toxicity and the medicines had been stopped.

The pharmacists discussed contributing factors:

- Signs of lithium toxicity and serotonin syndrome
- The importance of giving lithium at night and taking the level in the morning as this had not been done correctly on admission
- Formulating a plan for the restarting of medicines
- Ensuring the patient has a lithium booklet
- Patient counselled about drinking plenty of fluids

2. Four interventions involving overdoses which included two patients admitted to ITU following overdose. Interventions by CWP MH pharmacist and ward pharmacist:

- One patient was unknown to CWP service and had overdosed on foxgloves. ITU pharmacist and MH pharmacist able to discuss risks of foxglove OD and properties of aripiprazole to reach a safe medication plan
- Second patient had taken a mixed overdose, the prescription had potential for rationalisation which was discussed between the two pharmacists
- MH pharmacist emailed the psychiatrist who quickly responded with a plan to stop lithium, propranolol and procyclidine, which was in agreement with the pharmacists' discussion. It was helpful to discuss the physical health issues and mental health needs together to find the best overall treatment. This also demonstrated that the psychiatrist would provide prescribing advice and support when provided with the relevant information.

Training

Four lunchtime sessions of 30-45 minutes were delivered between May and July 2019. Topics were:

- An introduction to Mental Health Services
- Clozapine as two sessions, covering blood tests (routine FBC and plasma levels), interactions, effects of smoking and adverse effects
- Suicide awareness and prevention (specialist guest speaker)

Presentations in power point were saved in the WUTH pharmacy folder for reference and to allow for sustainability. The target of delivering four presentations per year was met within the scoping period.

Between August 2019 and March 2020 a further 171 interventions were recorded. It is impressive to see pharmacists making sure plans are communicated regarding de-prescribing of benzodiazepines or antipsychotics for which there is not a satisfactory indication, some examples are given here:

- A patient with a high BMI and no mental illness was gradually taken off olanzapine 5mg daily with input from liaison psychiatry to reduce his hunger and dietary intake
- After taking trifluoperazine since the 1970s, with no symptoms or mental health follow up for decades the prescription needed review. Following discussion with the patient, relative, MH pharmacist, GP practice and an older people's psychiatrist, the WUTH pharmacist and medical team were able to commence a slow reduction of trifluoperazine by 1mg every 3-6 months
- In September 2020 a WUTH pharmacist made a brilliant intervention and instigated de-prescribing of zolpidem and diazepam, with the agreement of the patient, to reduce risk of further falls. The patient had been taking the medicines for nearly 10 years. Negotiation with the patient and plan for reduction was made just as a mental health pharmacist would.

A further seven lunchtime sessions of 30 -45 minutes were delivered during this time about Lithium, Antidepressants (Case study), Introduction to Mental Health, Clozapine and Benzodiazepines. Clozapine and Introduction to Mental Health were repeated sessions for new starters. The Benzodiazepine presentation was developed in response to a medicines incident which identified a knowledge gap.

Evaluation forms show the presentations to be well received, stimulating, helpful, interesting, and useful to know about monitoring. All the presentations were rated as excellent and professional. Communication between the CMHT and WUTH pharmacy had been encouraged by explaining how to find out whether the patient is under a CWP service and how to contact the CMHT (also covered in the lunchtime presentation 'Introduction to Mental Health').

Understanding that CMHT staff, psychiatrists and care coordinators will respond to emails and that information can be exchanged (now we all use nhs.net email) helps address communication and lack of shared patient records. Contact with the CMHT by email was initiated by the MH pharmacist, copying in the WUTH pharmacy member to demonstrate that this is effective.

Post pandemic developments

Rerunning the staff questionnaire at a later date was hampered by the advent of Covid 19 and WUTH had a key role in treating people returning from Wuhan.[2] The repeat questionnaire was sent out in March 2020 but was not a priority for completion. The questionnaire returns were insufficient to draw conclusions but did indicate an increase in knowledge and confidence.

The project was paused and the pandemic changed working patterns – even the structure of departmental meetings affected how mental health in-reach was delivered. On restart the decision was made to take the focus away from looking for patients on specific medicines and to maximise the support, training and interaction with pharmacy staff.

With significant changes in the pharmacy workforce over the last five years or so, it has been necessary to repeat and update core training about clozapine, for example, and we have introduced a

mental health awareness session to the pharmacists' induction training.

During the pandemic we discovered much more about the effect of infection on both clozapine blood levels and reduction of white blood cells and neutrophil counts. We now check plasma levels and make dose adjustments to clozapine doses as we would for patients who have stopped smoking. Learning to order plasma levels and extending the list of red flags with clozapine has been embraced by the pharmacy team at WUTH.

In November 2024 we demonstrated how we have improved management of clozapine in the acute hospital setting by co-presenting on this topic at the CPC North conference, showing what a little knowledge and some support can do.

The QR Code below, 'In conversation with the ITU pharmacist' highlights learning and the importance of making interventions jointly, utilising our expertise.

In conversation with the ITU pharmacist

What worked? The author's experience

Where are we now?

As the MH pharmacist I can only record those interventions that are communicated to me or that occur when I am at the acute hospital. I may also see a notes entry about lithium or clozapine management or receive emails from the CMHT about clozapine supplies; I therefore know that interventions are happening without my direct involvement.

What I have seen is that confidence in handling mental health queries has increased dramatically, which was a main objective – that the acute hospital pharmacy team have enough confidence and knowledge to make interventions, whilst also providing a route to support for more complex cases.

There are many impressive examples of interventions which demonstrate improvement in care for people receiving mental health medicines, for example questioning why a patient with dementia is taking clomipramine 25mg at night as well as citalopram 20mg in the morning, a seemingly simple observation but one that had not been made before. Such an intervention could make a significant difference in the risk of falls and in reducing the anticholinergic burden to gradually discontinue clomipramine.

I am proud to be part of the WUTH pharmacy team, which has successfully taken on board key messages about critical medicines like clozapine and lithium and handling ever more complex interventions (e.g. how to stop propranolol and venlafaxine in pregnancy from one of the WUTH PCN pharmacists).

My role as the MH in-reach pharmacist is now considered to be 'business as usual'. I am embedded in the pharmacy team and can assess mental health incidents from different perspectives, allowing the team to respond quickly, putting support and education in place where needed.

In the last twelve months training topics have been:

- Talking to patients
- Autism
- Dementia
- Lithium

The various strands have been drawn together in a case studies session to embed learning.

My appreciation of the demands on the acute hospital team and listening to what pharmacy and liaison psychiatry are finding as sticking points has helped me to tailor the support I provide. Occasionally a team member has mental health concerns of their own or for a family member and I can direct them to the wellbeing resources provided by WUTH and in the wider community.

What's next?

We have been exploring how to formalise the use of clozapine for psychosis in Parkinson's disease, having successfully initiated clozapine for two patients.

Having jointly supported a patient recently, we are discussing how the best service can be provided to people with serious mental health issues with palliative care needs.

Plans are in place for a presentation from liaison psychiatry, to encourage the pharmacy team to make direct referrals to liaison psychiatry and foster the good relationship and mutual respect that already exists.

Two trainee pharmacists have undertaken field work looking at nurses' understanding of clozapine and missed doses, in response to some incidents identified by the pharmacy team. This is a preliminary piece of work to inform an action plan.

We continue to share mental health in-reach good practice, which is to demonstrate the benefits of sharing expertise and improving patient outcomes through a relatively simple idea.

Conclusion

Mental health in-reach was not something I initially wanted to take part in. This was partly because of existing commitments and because, personally, I am not an extrovert person so the challenge of going into a big department to try and make a difference was not my idea of 'fun'. However, with appeals to my enjoyment of sharing expertise and helping patients I was persuaded to try and now I am fully committed, even suggesting that I go back to in-reach after a break.

The response to in-reach has been overwhelmingly positive, perhaps because it helps bring together people who are trying to deliver their part of patient care, sometimes in challenging situations, creating an understanding of each other's role and taking a holistic view of the patient.

The success of the project depended upon the team at WUTH responding to my enthusiasm for mental health care. It is a pleasure to hear other people being passionate about a missed dose of clozapine and, when I see an intervention about laxatives and clozapine, I know my teaching has made a difference. Communication with the mental health clinical pharmacy team at CWP, the community mental health teams and liaison psychiatry has been essential to what has been achieved.

My overall conclusion is that the experience has been positive and beneficial for all involved, staff and patients, so do please get to know your local mental health pharmacy team and consider giving in-reach a try.

A key message I give to the WUTH team is that if you have a mental health query, no matter how small or how uncertain you may be, the best thing to do is to ask – help can only be provided if we know it is needed.

Further information can be found in the poster we presented at the CMHP and CPC North conferences in 2023, below:

Poster

Feedback

The following feedback was received from pharmacists with some of the most challenging patients:

> *'Thank you again for your help with patients over the last few weeks – it makes a huge difference to myself and our medical teams when we can sort problems through yourself. We have been able to manage such patients much better and optimise their treatment more effectively – better for them and for us!'*

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Optimising an intervention used to provide take home naloxone from community pharmacies

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Abstract

Introduction

Opioid related deaths are a public health crisis in the UK. Reducing the number of fatalities is a key priority. Supply of the opioid antagonist naloxone through community pharmacies could increase reach into the community, especially in areas of greatest deprivation. However, work is needed to optimise pharmacy naloxone supply models.

Methods

A qualitative interview study was conducted, using thematic analysis, with secondary deductive analysis using the COM-B framework to identify important intervention components.

Results

Twenty one pharmacists were interviewed, ten with experience of naloxone supply and eleven interested to do so. Four themes were identified:

- Components of success
- Barriers to supply
- Operational issues
- Training and support

Under each, the successful behaviours and other relevant factors related to those successfully supplying are identified. These and their related behavioural constructs were mapped out and a suggested optimised pharmacy take home naloxone intervention delivery model is given.

Discussion

The findings show successful pharmacy naloxone supply requires its own adapted model of delivery suitable for the needs of the target recipients. Basing pharmacy supply models on other reactive, more lengthy intervention models is unlikely to maximise opportunity for supply. In keeping with previous work the importance of involving counter staff and taking a proactive approach to offering naloxone was identified. However other findings, such as the importance of a brief (2-5 minute) intervention, supplying akin to an over-the-counter medicine, and being flexible on use of the consultation room offers new learning.

Conclusion

An optimised model for community pharmacy supply of naloxone has been developed based on qualitative research and secondary analysis using established intervention development frameworks.

Shortened intervention times in the community pharmacy (five minutes reduced from 15 minutes) have the potential to reduce time pressures and workloads, which could have a positive impact on workforce mental health and on patients through improved engagement.

Keywords

community pharmacy, take home naloxone, overdose, intervention development.

Introduction

Substance use disorders are diagnostically classified as mental and behavioural disorders e.g. DSM-V, ICD-10. Estimates suggest 70% of people accessing community drug services have a co-existing mental health issue (Weaver et al, 2003). Drug overdose deaths are an escalating public health crisis in the UK. Latest figures show drug poisoning deaths at 90.8 per million in England and Wales, with nearly half involving opioids (ONS, 2024). In Scotland, the rate is higher (224 per million), with 80% linked to opioids (NRS, 2024). Drug-death rates vary by location; in England, the North East has the highest (175 per million) and London the lowest (59 per million) (ONS, 2024). In Scotland, people in the most deprived areas die at rates over 15 times higher than those in the least deprived (NRS, 2024).

Addressing the root causes of overdose deaths is complex and requires long-term socio-economic change. In the short term, preventing fatalities is critical. Since 2015, naloxone, a first-aid medicine, has been available in the UK without prescription through commissioned drug treatment services, including pharmacies providing needle exchange (NX) and opioid substitution therapy (OST). In December 2024, legislation expanded non-prescription supply to specific professionals, including pharmacists and pharmacy technicians.

Pharmacies are accessible without appointments, open long hours and frequently engage with people who use drugs (PWUD) (Craine, 2010). Their distribution aligns with a positive care law – 99.8% of people in high-deprivation areas live within a 20-minute walk of a pharmacy (Todd et al., 2014). However, pharmacy take-home naloxone (THN) programs remain patchy (Carre, 2018).

Neilson and Van Hout's (2016) scoping review identified five key issues in pharmacy naloxone supply:

1. Pharmacists Perceptions of Naloxone
2. Identification of at-risk people and recruitment
3. Supply Systems and Cost
4. Legal Issues
5. Training of Pharmacists and Recipients

Since then, most pharmacy research has focused on North America, particularly changes to federal law and supply data (e.g., Vascimini et al., 2024), with less emphasis on effective implementation models. Grindrod and Beazley (2016) present a pharmacy THN advisory infographic, though its development or implementation is not reported. Eldridge et al. (2023) detail the iterative development of PharmNET, a pharmacy-based harm reduction intervention including THN. Their development process addresses points of concern, but the focus is not on detailing the intervention. Differences between UK and US pharmacy public health funding further highlight the need for UK-specific approaches.

"The Centre for Pharmacy Postgraduate Education provides support in England. It directs pharmacy professionals to Addiction Professionals naloxone training module. This focuses on administration but not supply, revealing a training gap. Anecdotally, some pharmacies use THN delivery models akin to other interventions, requiring proforma-driven consultations in private lasting about 15 minutes (one location in this study found such an approach results in low engagement and supply levels)."

Study aim

This study aimed to optimise a THN intervention model for the community pharmacy setting.

Objectives

(i) Explore factors that pharmacists feel are important in community pharmacy THN, including operational, educational and support

matters, from the perspective of those experienced in supply and those keen to supply.

(ii) Identify capability, opportunity and motivation of pharmacists that make pharmacy THN successful or inhibit supply and use these to describe a model of optimal delivery.

Methods

Study design

This study followed Medical Research Council guidance on intervention development (Skivington et al., 2021; Craig, 2006). Qualitative interviews explored participants' opinions and experiences of pharmacy THN provision. Stakeholder discussions with senior drug and alcohol service pharmacists informed recruitment in Wiltshire, Suffolk, Birmingham, and Glasgow (existing THN schemes) and Somerset (planning a scheme).

Participants

Community pharmacists either involved in the provision of THN or had expressed interest in doing so.

Recruitment

Local Pharmaceutical Committee officers and drug service senior pharmacists acted as gatekeepers. They shared study information and returned contact details of pharmacists who expressed interest. The researcher made contact to establish the extent of involvement in THN. Those who agreed were sent a Participant Information Sheet. From the 36 who shared their contact details, 10 with an interest in supplying naloxone but no current experience of doing so, and 11 with THN experience were interviewed, with recruitment biased towards extensive experience.

Data collection

Fourteen participants identified as male and seven as female. Table 1 summarises demographics:

Participant number	Experience of THN scheme?	Gender	Pharmacy type	Experience of services for PWUD[b]	THN experience
1	Yes	M	Independent	NX; OST	Extensive[c]
2	Yes	M	Independent	NX; OST	Extensive
3[a]	Yes	F	Large multiple	NX; OST	Extensive and has administered
4	Yes	M	4Independent	NX; OST	Extensive
5	Yes	M	Independent	NX; OST	Extensive
6[a]	Yes	M	Large multiple	NX; OST	Extensive and has administered
7	Yes	M	Large multiple	NX; OST	Extensive
8	Yes	M	Small multiple	OST[d]	Offered not supplied
9	Yes	F	Supermarket pharmacy	OST	Offered not supplied
10	Yes	F	Large multiple	NX; OST	Supplied once in current pharmacy and extensively in previous job
11	Yes	F	Large multiple	NX; OST	Extensive supply in previous job
12	No	M	Independent	NX; OST	None
13	No	F	Large multiple	NX; OST	None
14	No	F	Independent	NX; OST	None
15	No	F	Independent	NX; OST	None
16[a]	No	M	Locum	NX; OST	None
17	No	M	Locum	NX; OST	None
18	No	M	Locum	OST	None
19	No	M	Large multiple	OST	None
20[a]	No	M	Small multiple superintendent	NX; OST	None
21	No	M	Independent	NX; OST	None

Table 1: Participant demographics

Table 1: Participant demographics

a. These pharmacists were qualified non-medical prescribers, one also worked in substance use services.
b. People who use drugs.
c. Extensive experience for the purpose of this study was arbitrarily defined as self-reported supply of naloxone more than 10 times. Participants 12 -21 were interested to supply naloxone but did not currently do so.
d. In process of joining needle exchange (NX) scheme but had not yet begun supply.

Thirteen interviews were face to face and eight by telephone, allowing for participants' convenience and remote distance. With consent, interviews were recorded.

The topic guide was informed by Neilson & Van Hout (2016) scoping review and explored barriers and facilitators to pharmacy THN. For those with experience of THN, there was additional exploration of their experience and practice. A dummy intramuscular naloxone kit was used to aid discussion during face-to-face interviews. Interviews lasted 16 to 40 minutes, typically around 30 minutes.

Reflexivity

The researcher came from the perspective of a pharmacist with specialist clinical experience in substance use and academic expertise on overdose prevention. Field notes were made to aid reflexivity and capture the context of each interview. These were referred to when theming and interpreting the data.

Analysis

Recordings were transcribed, checked for omissions, re-read and imported into NVivo v.12-Pro for coding. Primary analysis took a reflexive thematic approach, using deductive codes based on Neilson & Van Hout (2016) and inductive codes. Codes were grouped under themes, then overarching themes.

Intervention model optimisation

Secondary analysis was undertaken on the themes using constructs from the COM-B behaviour change model as deductive codes (Michie et al, 2011, West & Michie, 2023). Interpretation was aided by use of the OSOP method (Ziebland & MacPherson, 2006), undertaken by hand to sketch links with literature, behaviour change theory and findings and then design an optimised model of how to deliver pharmacy THN.

Ethics approval

The study was approved by REACH (Research Ethics Approval Committee for Health), University of Bath (EP 17/18 248), where the author was based at the time of this work.

Results

Analysis resulted in four overarching themes:

1. Components of success

Explains successful pharmacy THN delivery. Proactively offering naloxone rather than waiting for a request was critical. This is contrary to many pharmacy services which are reactive i.e. respond to a request. Pharmacists who used proactive approaches reported reactive supply as less effective:

''We do have stickers up to say supplying naloxone here and sometimes people have had a recent overdose incident you know, from a family member, a friend, and they will ask the question, or they will come in and they will say 'have you got any of this stuff', but I would say kind of, eight out of ten times, it is us that initiate it'' [P6].

Pharmacists who had made no or few supplies and some not in a THN scheme expected the service to be reactive. Central to making a proactive offer was recognising an opportunity, showing reflective motivation. Pharmacists described using a 'hook', usually a request for NX or an OST prescription. This hook engaged people in conversation about naloxone and was considered an effective way to promote uptake. If naloxone was refused, some described 'sowing the seed' and then raising it another time.

''We did needle exchange, so as part of the add on to that service sometimes we offered it [naloxone], especially if it was someone new that didn't come in routinely... [We] suggested that they have it and would they like to take one away and usually they would say 'I have already got one' or 'yes' '' [P11].

"Supply by all pharmacy staff was central to managing time and workload pressures. Getting staff motivated, in terms of attitudes towards and backing for THN, was vital. Linked to this was the importance of pharmacist leadership."

All-staff training was critical. Pharmacists who did not supply THN wanted to feel confident in order to train and support others before they would consider supply. Those who were experienced in THN talked with confidence about their abilities to supply and challenge the reasons people give for refusing naloxone. In contrast, those in schemes reporting no or little supply were less confident in challenging refusals. Experienced participants described how momentum had gathered. Once a person had used or witnessed naloxone used, motivation to have it increased and they were likely to request more. Two participants had administered naloxone and both felt once 'word got round' about their actions engagement increased.

Relationships with PWUD were important, good rapport being central to engagement in discussions and a barrier to not. Being nonjudgmental, compassionate and respectful were key.

2. Barriers to supply

Those who did not supply naloxone envisaged undertaking a seated consultation according to a framework, spending time akin to other interventions, estimated at 15 minutes. Participants with experience talked about clients not being keen to engage that way. Some had trimmed the intervention down to 'two or three minutes' or 'less than five minutes', focusing on key points, in order to address this, and to meet the time pressure demands of the pharmacy, sometimes delivering it 'over the counter'.

These pharmacists prioritised getting naloxone to the person. For them, resupply did not necessitate the same advice level as first supply, checking the person was comfortable with instructions instead of repeating all advice. This adaptation resulted in greater uptake. Those who reported low uptake highlighted lack of time of the client as a barrier but had not adapted their consultation.

''....I have got the consultation down to a bit of a T, so I can get them in, give them the proper training but do it quite effectively, quite quick so I can get them in and out and sometimes you need to make a judgement call, if you have only got ...3 or 4 minutes sometimes you do have to make that 'What kind of information is the most important here?' because them not having naloxone is worse''. [P3]

Pharmacist time pressures were a barrier that meant opportunity to supply was sometimes missed. These were mitigated by having other staff trained to supply and by being efficient, for example, in data entry. Adequate remuneration was central, considered likely to influence pharmacists' involvement decisions and could mitigate time pressures.

Little stigma towards PWUD was evident, but participants believed attitudes and stigmas held within other pharmacy professionals could be a barrier. Self-stigma by clients was seen as a reason why THN was refused. It was felt pharmacies can be fewer stigmatising environments than drugs services. which could facilitate THN uptake.

'' I believe we're trusted more because it's an informal sort of consultation...they don't see it as a consultation, [we] say 'how you doing? have you got you an injection?' then they'll be like... [reply] ...it's very informal''. [P7]

The fear of offending people on OST was a barrier to offering naloxone in those with no or little experience. Although people on high dose prescription opioids for pain were recognised as possible candidates for THN and could be easily identified through dispensing records, concerns about causing offence were expressed. It was easier to offer to people requesting NX because their drug use was obvious and they were perceived to be aware of overdose risks. Confidentiality concerns were a barrier in offering to family and carers. When the participant could be confident that person was aware of their loved one's drug use, there was willingness to offer THN.

3. Operational issues

Data entry and payment claims had to be quick. Pharmacy layout including adequate space and a confidential area for conversations was important but not always wanted. Adequate support for locums was expressed.

4. Training and support

Perceived capability to work with PWUD was strong. Participants saw THN as an appropriate role. Those who had supplied felt capable of

doing so, demonstrated in their descriptions of how they interacted with clients, their confidence and empathy and their recognition of naloxone as a first aid response.

"...I think it's a great idea, I'm 100% for it, I think whoever is using [drugs], who is on methadone or potentially using like heroin or what have you, or any other opioid, should potentially have one of those at home or on them actually..... I guess that shouldn't be a problem in actually approaching these people and saying, 'look we are providing this, would you like to have that in your cupboard and use it just in case'. I think that would go down well " [P3].

Pharmacists who supplied felt adequately trained with no further needs. There was a strong emphasis on training importance ahead of supply in order to feel competent to answer questions. Those who supported staff being involved highlighted the importance of them being trained, but a barrier to this was the necessity for evening/own time training sessions for pharmacists. Some felt that staff would not want to be involved or did not have the background to be competent, seeing it as role that should be limited to pharmacists. Alternative models of staff involvement were described from being fully involved in supply, to initiating the conversation then referring to the pharmacist.

COM-B analysis

The output from the secondary analysis is given in figure 1, showing constructs from the COM-B model, mapped onto the identified facilitators (blue hexagons) and barriers (pink boxes) to successful pharmacy THN, detailed in the themes above:

The identified key components of how the pharmacy THN intervention should be delivered, drawn from the facilitators and other information in the themes, is shown in figure 2:

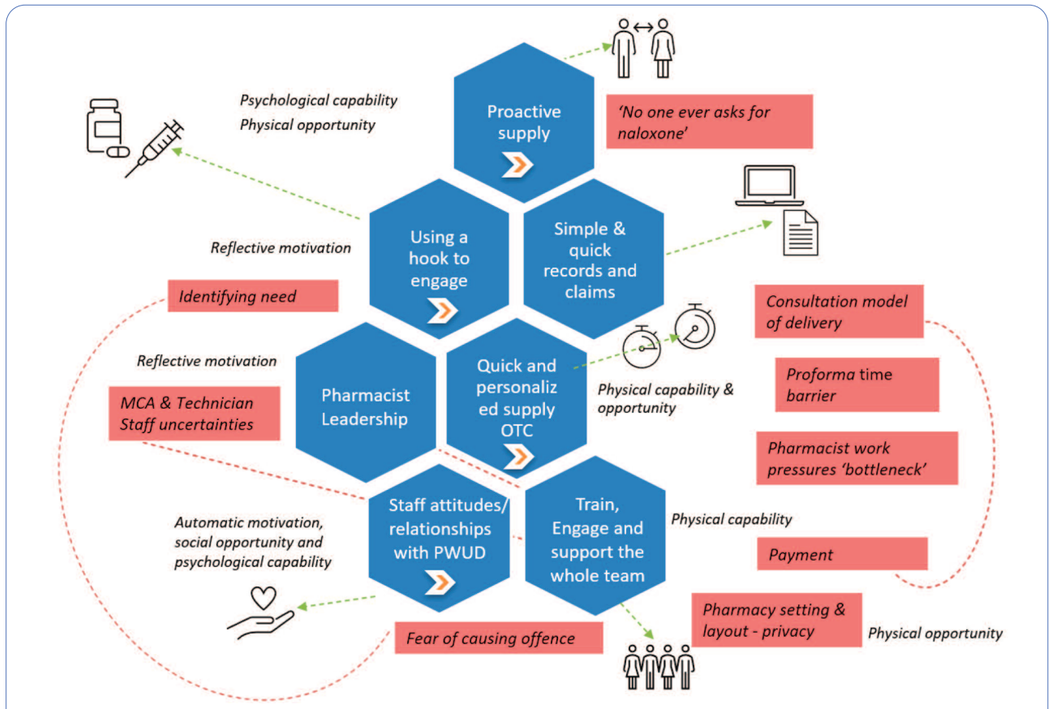

Figure 1: Components needed for successful pharmacy THN supply, showing related constructs of the COM-B. MCA = medicines counter assistants. The red broken lines indicate related factors.

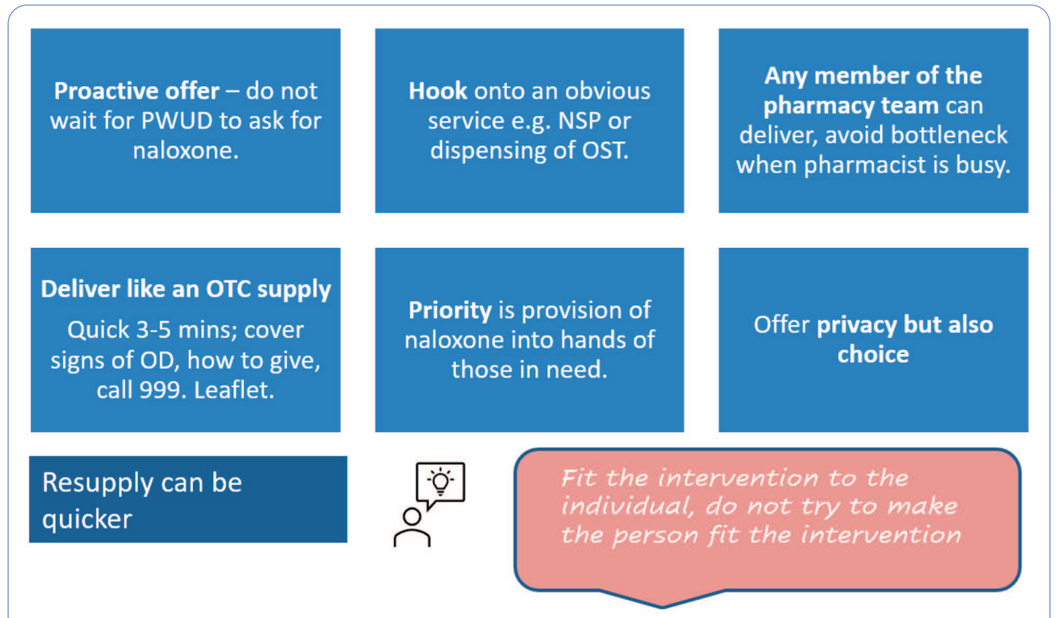

Figure 2: Key components for delivery of an optimised pharmacy take home naloxone intervention. OTC = 'over the counter'. The illustrative quote is from P3.

Discussion

This study explored delivery of pharmacy THN, identifying factors relating to capability, opportunity and motivation of pharmacists that make pharmacy THN successful or not. This aids understanding of how to increase pharmacy supply and identifies key intervention components (figure 2). Participants extensive experience of providing services to PWUD gave confidence to supply. Pharmacists felt capable both psychologically and physically, with recognition of the importance of adequate training. Amongst those with experience of THN supply, a proactive approach was a mechanism to create opportunity, linked with reflective motivation to distribute naloxone. Reactive supply, reflecting automatic motivation, was felt unlikely to create opportunity by those with experience, but for some with no or little experience it was expected, mirroring other pharmacy interventions. This supports the findings of Eldridge et al (2023) who state the importance of proactively offering their PharmNET intervention, and findings on other sensitive topics in pharmacy (Alhusein, et al. 2021).

Participants felt that factors relating to physical opportunity, such as their frequent contact with PWUD and the informal, easily accessible environment of community pharmacy were conducive to providing THN. Time pressures, both from workload and from PWUD not wishing to wait in the pharmacy, were barriers, restricting physical opportunity, mitigated by adapting the THN intervention to a few minutes, over the counter. Ensuring all pharmacy staff can supply reduced pressures. This is also advocated by Eldridge et al (2023). Participants felt that the relationship and rapport they had with PWUD created the social opportunity to deliver THN, although they recognised that stigma and judgement held by other pharmacists could limit scheme expansion. Pharmacy staff stigma is a serious barrier to the provision of services to PWUD (Lloyd, 2013, Ibragimov et al, 2017, Paquette, Syvertsen and Pollini, 2018, Carlisle et al, 2023). Some findings from Neilson and Van Hout (2016), such as concerns about staff attitude, time pressures, training and remuneration are echoed here, but others were not evident, such as ethical objections or the fear of encouraging drug use.

There was support for providing naloxone to family and carers, providing this could be done without breaching confidentiality or causing offence. However, uncertainties around supplying people on high-dose prescription opioids e.g. for pain existed. More consideration should be given to developing a bespoke intervention for this group. Participants did not highlight the need for external support, for example from a naloxone scheme co-ordinator. This contrasts with some earlier literature on pharmacy services for PWUD. Matheson and Bond (2003) place value and importance on support systems. The contrast here may be because services are now well established, so confidence has grown, or it may be because such roles have disappeared in England, reducing expectations.

Limitations

This work does not intend to generalise about UK pharmacy practice. Participants were drawn from a willing group of volunteers likely to have more positive attitudes towards PWUD and naloxone than pharmacists who did not volunteer. As the aim was to optimise a THN intervention for the pharmacy setting, positive attitudes were a strength, but if the model was rolled out to community pharmacies in general more to address stigma may be need. As an example, pharmacists with more negative attitudes may be less willing or suitable to make proactive offers of THN.

Conclusion

This study identified barriers and facilitators to pharmacy THN provision (the themes). Deductive analysis using the constructs of the COM-B model (figure 1) identified important factors regarding pharmacy staff behaviour when supplying THN. Synthesis drew key components needed for optimised pharmacy THN delivery (figure 2) . These are: all staff proactively offering THN to encourage uptake, using a 'hook' such as NX or OST to lever the opportunity to raise discussion; quick intervention, delivered in a few minutes to fit with PWUD, sometimes conducted over the counter instead of in private, prioritising getting naloxone into the hands of those who need it. The findings show pharmacists felt capable of supplying THN, can create the opportunity to do so and recognised that they work in an environment conducive to supply. Next steps are to test the optimised intervention delivery model.

Acknowledgement

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Protecting the Mental Health of our Healthcare Professionals: Coping Strategies for Identifying and Tackling Burnout

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About the author

Ivan Hollingsworth is the founder and director of Centric Consultants – a business founded in a bid to tackle 'culture-washing' and support organisations to build strong, sustainable, high-performing teams based on trust and psychological safety.

A former elite athlete and award-winning fundraiser, Ivan brings his lived experience of how culture and trust affect mindset when it comes to reaching goals. After 16 years working in senior roles in the pharmaceutical industry, Ivan combines his in-depth research and knowledge with on-the-ground experience of a wide range of different team dynamics, both in the private and public sector. He creates an inclusive, open and engaging atmosphere tailored to individual or team dynamics and shares strategies and tools that can be applied right away.

Ivan isn't just a leadership expert, he's also a dad to Seb, now 16, who faced open-heart surgery not once but twice, first as a baby, and again as a teenager. Those long, emotional stretches spent on hospital wards gave Ivan a deep, first-hand view into what makes healthcare teams truly effective. What struck him most wasn't just the incredible skill of the professionals; it was the way they worked together. Ivan saw that it was the *culture* of the team, their psychological safety, openness to learning and vitality that made the real difference.

Ivan believes this culture not only created a positive and resilient work environment that helped reduce burnout among staff but played a vital role in Seb's extraordinary recovery.

Today, Seb is a thriving, healthy teenager and Ivan credits the power of team culture for helping make that possible and uses their journey to empower other people to thrive.

For more insights on what company culture truly means, and how to implement change across your business follow Centric Consultants on LinkedIn or email Ivan directly at ivan@centric-consultants.com

Introduction

In recent years, the mental health challenges faced by healthcare professionals, especially pharmacists and frontline workers, have become more and more prominent. These challenges have exacerbated a problem that was already causing issues in healthcare settings across the UK - *burnout.* Staff shortages, growing waiting lists, and the persistent pressure to perform in a system that is often stretched thin are all taking their toll, and it is no surprise that our healthcare workers are increasingly vulnerable to stress and emotional exhaustion.[1,2]

In 2019, the WHO officially included burnout in its International Classification of Diseases, describing it as a state of emotional, physical, and mental exhaustion caused by prolonged and unmanaged stress.[3]

Though in the past burnout might have been seen as a sign of weakness, it is now regarded more as a reflection of problematic workplace conditions rather than the individual's capacity to cope. It underscores the importance of addressing systemic issues within the work environment to prevent burnout, rather than attributing the problem solely to the person experiencing it.

Feelings of stress, sadness, and anger do not just affect our mental wellbeing but also our physical health too. Over time, chronic stress, loneliness, and negative emotions can lead to a cascade of biological changes in the body, affecting multiple systems and leading to significant health issues.

Cortisol and the stress response

When we are in the thick of a stressful situation, the primal part of our brains has difficulty distinguishing between a workplace threat, like a missed deadline or busy workload, and more immediate danger, like a lion attack. When our bodies perceive a threat, whether physical, emotional, or psychological, our brain activates the fight, flight or freeze response, leading to the release of cortisol to help prepare the body to deal with immediate danger.

> **"In the short term, cortisol serves essential functions; it increases glucose availability for energy, enhances memory and alertness, and increases the heart rate, among other things. However, when cortisol levels remain elevated over long periods, it begins to have detrimental effects on the body."**

One of the most significant consequences of prolonged cortisol production is its impact on the cardiovascular system. When cortisol remains elevated, it contributes to the hardening of the arteries through atherosclerosis, causing blood vessels to narrow and stiffen, which can lead to high blood pressure and increase the risk of heart attacks and stroke. Over time, chronic stress and accompanying high cortisol levels can lead to severe cardiovascular diseases, making cortisol a literal killer if unchecked.[4,5]

Cortisol and Metabolic Health: The Risk of Type 2 Diabetes

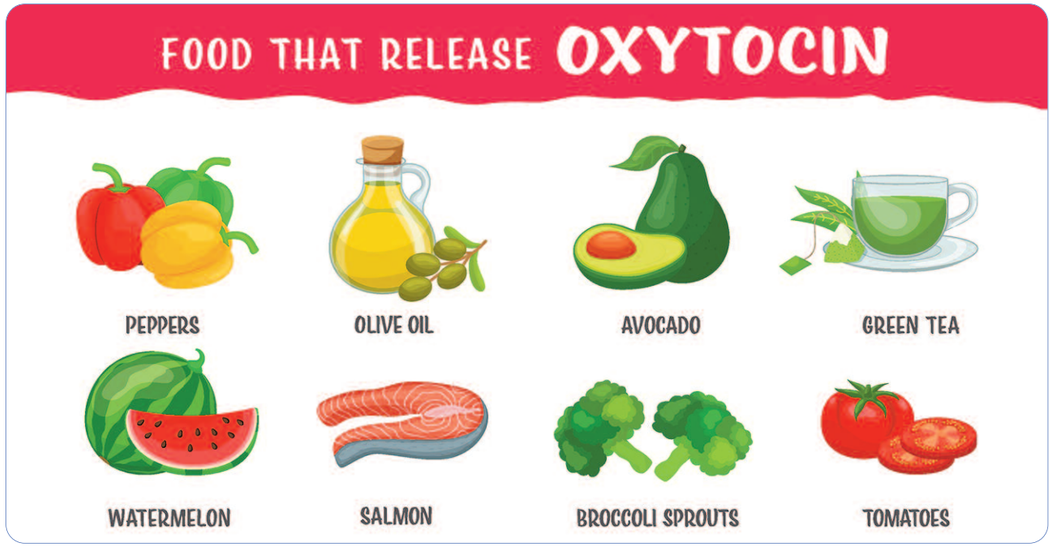
Another alarming effect of cortisol is its ability to increase glucose levels in the bloodstream. Under stress, the body releases glucose as part of the fight, flight or freeze mechanism, to provide a quick source of energy to allow us to escape. However, when cortisol is constantly high, it repeatedly floods the bloodstream with glucose. This creates a situation where the body's ability to use and store glucose properly is impaired, leading to insulin resistance. Over time, this chronic state of elevated blood sugar can contribute to the development of Type 2 Diabetes. This happens because the body's metabolic processes become disrupted, making it harder for cells to absorb glucose, which can result in chronic high blood sugar levels and eventually lead to the onset of Type 2 diabetes.[6,7,8]

Cortisol and Cognitive Function: The Impact on Learning

Cortisol also has significant effects on the brain, particularly the hippocampus, which is responsible for memory formation, learning, and emotional regulation. Chronic exposure to high cortisol levels can damage the hippocampus, leading to impaired cognitive function. Studies have shown9 that individuals experiencing high levels of stress have a reduced ability to retain information and learn new things and over time, this chronic cortisol production can even contribute to cognitive decline and is considered one of the risk factors for Alzheimer's disease and other neurodegenerative conditions.

The Impact of Stress and Testosterone on Oxytocin

On top of the physiological impacts of cortisol, chronic stress also inhibits the production of oxytocin, a hormone that plays a crucial role in social bonding and our emotional regulation abilities. When oxytocin is released it promotes feelings of trust, empathy, and connection and is essential for building and maintaining healthy relationships as well as for mitigating the negative effects of stress.



However, when cortisol is elevated, particularly in high-stress situations, oxytocin production is inhibited. In men, this effect is often compounded by elevated testosterone levels, which can also suppress oxytocin release. This results in a vicious cycle: stress increases cortisol, which inhibits oxytocin, leaving individuals feeling more isolated, anxious, and disconnected. This cycle can intensify feelings of loneliness, stress, and emotional pain, leading to a further increase in cortisol and perpetuating the cycle of emotional dysregulation.

The Importance of Normalising Loneliness and Stress

Given the severe health implications of stress, loneliness, and anger, it is critical that we address these issues in a more compassionate and open way. For many, these emotions are often accompanied by feelings of shame and self-judgment. We may feel that loneliness is a personal flaw or that we are somehow failing if we experience stress or sadness. However, the first step toward mitigating the long-term damaging effects of stress is to normalise and accept these feelings.

Acceptance of loneliness and stress is not about resigning ourselves to a state of helplessness but about acknowledging that these feelings are part of the human experience. Everyone struggles with emotional challenges at some point, and by recognising this commonality, we can break free from the isolation and self-criticism that often accompanies difficult emotions. When we stop blaming ourselves for feeling overwhelmed or alone, we can take the first steps toward healing and emotional resilience.

Additionally, talking openly about these feelings with others is one of the most effective ways to reduce the immediate physiological impact of stress. When we share our experiences of stress, sadness, or loneliness with others, we increase oxytocin levels, which counteract the harmful effects of cortisol. Meaningful connection and empathy not only improve emotional well-being but also help protect our physical health by reducing the stress hormones in our bodies.

Moving Away from Self-Judgment to Connection

In practical terms, this means creating spaces where people feel safe to express vulnerability and share their struggles. Whether in personal relationships or within the workplace, fostering environments that prioritise empathy, compassion, and mutual support can help individuals navigate the darker moments of stress and loneliness without the damaging consequences. Self-compassion and shared humanity are essential tools for combating the adverse health effects of chronic stress.

The health implications of burnout cannot be overstated. However, by accepting and normalising these feelings, we can begin to mitigate their effects. Creating a culture of open dialogue, empathy, and connection is essential in helping individuals reduce stress and improve their overall wellbeing. When we move from self-judgment and isolation to acceptance and connection, we not only improve our emotional health but also protect our physical health in the long term.

As we continue to grapple with these challenges, it's important to not only learn to recognise the signs of burnout but to equip leaders and colleagues with strategies to protect their overall mental health.

Understanding Burnout in Healthcare Professionals

Unlike stress, burnout is commonly understood as a state of emotional exhaustion, cynicism and physical depletion, due to chronic workplace stressors that have not been successfully managed. In healthcare, burnout is particularly dangerous as it not only impacts the mental health and well-being of professionals but also affects the quality of care provided to patients. The consequences of which can lead to poor decision-making, increased errors, decreased empathy, and lower job satisfaction.

Dr. Christina Maslach, a pioneer in the study of burnout, identified several factors contributing to burnout, many of which are on the rise in an increasingly busy healthcare sector:[10]

1. **Workload:** Excessive demands, long hours, and insufficient staffing are contributing to physical and emotional exhaustion
2. **Perceived Lack of Control:** Healthcare professionals often face rigid systems and protocols, leaving them with little control over their work
3. **Lack of Reward or Recognition:** The feeling of being unappreciated or under-compensated for the demands of the job can lead to frustration and disillusionment
4. **Poor Relationships:** Conflict with colleagues or a lack of support can exacerbate stress
5. **Lack of Fairness:** Perceived inequities in workload distribution or organizational decision-making can create resentment
6. **Values Mismatch:** When a healthcare worker's personal values are at odds with the culture or practices of their workplace, it can lead to burnout

In this environment, it is easy to see how burnout becomes not just an individual issue but one rooted in broader workplace conditions.

What can healthcare professionals do to combat it?

1. Self-Compassion

One of the most powerful tools for managing stress and avoiding burnout is self-compassion. This concept, popularised by Dr. Kristin Neff, encourages individuals to treat themselves with the same kindness, care, and understanding that they would offer a friend or loved one in times of difficulty.[11]

Self-compassion is composed of three key elements:

- **Mindfulness:** Being present with your feelings and experiences without judgment. It's about acknowledging and accepting your emotions rather than suppressing them
- **Common Humanity:** Recognising that suffering, imperfection, and failure are part of the shared human experience. You are not alone in your struggles.
- **Self-Kindness:** Responding to your own pain and difficulties with warmth and care, rather than with criticism

It is important to take a moment to acknowledge when you are feeling overwhelmed and be gentle with yourself. This doesn't mean giving up on your responsibilities but rather recognising that your well-being is equally important. Psychotherapist Dr. Julia Samuel emphasises that self-compassion involves listening to your own needs and avoiding self-criticism, especially in challenging situations.[12] This is particularly relevant in healthcare, where professionals are often expected to perform at their best despite overwhelming circumstances.

2. Physical Activity

Physical activity is a powerful tool in combating burnout. It is not so much about intense gym sessions or long runs but about finding something you enjoy and can do regularly. Even an activity that

involves small movements like a 20-minute walk or stretching can help reduce stress levels.

Exercise helps regulate the stress hormone cortisol and boosts the production of endorphins, which are natural mood elevators. Physical activity also signals to the body that it has survived a stressor, helping to return the body to a more balanced state.

If time is short, small actions can be just as beneficial:

- Stand up from your chair periodically, stretch, and take deep breaths
- Try tensing all of your muscles for 20 seconds and then releasing the tension with a big exhale

Even a brief physical break can be a game-changer when dealing with burnout.

3. Building Supportive Networks

In the demanding world of healthcare, building strong, supportive relationships with colleagues can be a critical buffer against stress. Studies have shown that even brief moments of connection can significantly reduce anxiety and increase feelings of safety.

> **"Engaging in casual conversations with colleagues can create a sense of belonging and foster a supportive environment. Research by John Hopkins found that even 40 seconds of compassionate interaction could significantly reduce anxiety levels.[13]"**

Creating a 'crew' at work, whether through informal chats during breaks or structured support groups, can help pharmacists and other healthcare professionals feel more connected and less isolated in their work.

4. Breathing Techniques to regulate stress in real time

Breathing exercises can be a simple yet highly effective tool for managing immediate stress. Techniques such as box breathing (popularised by yoga and military practices) can help regulate the nervous system and lower stress levels in real-time.

Here is how box breathing works:

1. Inhale deeply through your nose for a count of 4
2. Hold the breath for a count of 4
3. Exhale slowly through your mouth for a count of 4
4. Hold the empty breath for a count of 4
5. Repeat steps 1 to 4 through 4 times

This simple exercise can help you to remain calm and focused during stressful interactions with patients or while dealing with high-pressure situations.

5. Laughter and Affection

Laughter is not only enjoyable but also a natural way to manage stress. According to neuroscientist Sophie Scott, laughter activates ancient social bonding systems, promoting relaxation and emotional regulation.[14]

This means that finding moments to laugh, whether with a colleague or by watching a funny video, can help ease the weight of stress.

Affection is another powerful stress-reliever. A warm hug or friendly touch in a safe, trusting environment can trigger the release of oxytocin, a hormone that promotes feelings of safety and trust, helping to reduce cortisol levels.

6. Creative Expression and Emotional Release

Sometimes, the best way to deal with stress is through finding time for creative expression. Writing, painting, music, or other forms of creative activities can provide an outlet for emotions and help release built-up stress. It is also a way of reframing negative feelings in a more positive light, helping to put a new lens on the situation and promote healing.

Although it may feel uncomfortable, crying is also an effective emotional release. Allowing yourself to cry can help regulate emotions and lower stress, and finding a way to express your emotions is a critical component of managing mental health in high-pressure workplace environments like healthcare.

Organisational Support for Healthcare Workers

While individual strategies are essential, it is equally important for organisations, particularly in the NHS, to provide systemic support to help protect the mental health of their staff. Here are some recommendations:

1. **Mental Health Training for Staff:** Providing training on mental health awareness and stress management can help workers identify the signs of burnout in themselves and others
2. **Access to Mental Health Resources**: Ensure healthcare workers have access to mental health support, employee assistance programs, and peer support networks
3. **Fostering a Positive Work Environment:** Encouraging open communication, team collaboration, and recognition of achievements can help reduce the risk of burnout
4. **Regular Breaks and Downtime:** Ensure that colleagues have regular breaks to rest and recharge, reducing the pressure to work through exhaustion
5. **Promotion of Work-Life Balance:** Encouraging a healthy balance between professional responsibilities and personal time is crucial in preventing burnout. Flexible working arrangements, where possible, can help employees manage their workload more effectively

Here are some ideas that you could adopt to help manage workplace stress:

- Breaking down tasks using lists, mind maps and diaries
- Prioritise difficult tasks (especially when your energy levels are highest)
- Look for quick wins and easy morale boosters (tasks you can batch together and clear quickly)
- Build support networks as well as work networks

- Find a mentor who can share their experiences of what works – don't reinvent the wheel
- Don't forget self-care - stress reduction, as described above, exercise, sleep and good nutrition

With a focus on self-care, meaningful connections, and creating a supportive work environment, healthcare organisations can help alleviate burnout and create a more sustainable and resilient workforce, future proofing healthcare provision in the UK by creating a healthy and resilient workforce.

Ultimately, when healthcare professionals are supported in protecting their own mental health, they are better equipped to care for others.

Additional resources and signposting to further information

Burnout

'Employee Burnout, Part 1: The 5 Main Causes', Ben Wigert and Sangeeta Agrawal. Gallup survey examining the main causes of burnout.

The Burnout Epidemic: The Rise of Chronic Stress and How We Can Fix It, Jennifer Moss. Analyses the phenomenon of burnout and provides simple, researched-based solutions for minimising stress and building thriving workplaces.

Burnout: Solve Your Stress Cycle, Emily Nagoski, Amelia Nagoski. Explains why women experience burnout differently than men and provides a simple, science-based plan to help women minimise stress, manage emotions and live a more joyful life.

Self-Compassion

'Mindfulness, Self-Compassion, Posttraumatic Stress Disorder Symptoms, and Functional Disability in U.S. Iraq and Afghanistan War Veterans', Katherine Dahm, Eric C Meyer, Kristin Neff, Nathan A Kimbrel, Suzy Bird Gulliver, Sandra B Morissette. Self-compassion decreasing functional disability in returning war veterans with PTSD symptoms.

Self-Compassion: The Proven Power of Being Kind to Yourself, Kristin Neff. Identifies three core components that help to heal destructive emotional patterns.

Managing Stress

'A meta-analytic review of anger management activities that increase or decrease arousal: What fuels or douses rage?' Sophie L. Kjærvik, Brad J. Bushman. Clinical Psychology Review, Volume 109, April 2024. Does high-intensity exercise decrease arousal when feeling anger? The effect of calming exercises such as deep breathing yoga, mindfulness and meditation.

'Transient decreases in blood pressure and heart rate with increased subjective level of relaxation while viewing water compared with adjacent ground', Richard G. Coss, Craig M. Keller, Journal of Environmental Psychology, Volume 81, June 2022.

Podcast

Why You Should Always Look Into Someone's Left Eye!, Dr Tara Swart Bieber, 'Diary of a CEO'. Includes discussion of a wide range of topics including the impact of unmanaged stress and how neuroscience can contribute to stress management

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9. https://pmc.ncbi.nlm.nih.gov/articles/PMC4561403/
10. https://hbr.org/2019/07/6-causes-of-burnout-and-how-to-avoid-them
11. https://self-compassion.org/wp-content/uploads/publications/SCCoping.pdf
12. https://www.juliasamuel.co.uk/pillars-of-strength/relationship-with-oneself
13. https://pubmed.ncbi.nlm.nih.gov/10458256/
14. https://pubmed.ncbi.nlm.nih.gov/25439499/

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