Community Pharmacists' Attitudes Toward and Professional Interactions With Users of Psychiatric Medication

Vinay Phokeo, M.Sc., B.Sc.Phm.
Beth Sproule, Pharm.D., B.Sc.Phm.
Lalitha Raman-Wilms, Pharm.D., B.Sc.Phm.

Consumers of psychiatric medications or services may be stigmatized by health care providers. The authors surveyed community pharmacists (N=283) in the greater Toronto area to determine their attitudes toward and professional interactions with patients who used psychiatric medications and those who used cardiovascular medications. Despite generally positive attitudes, pharmacists reported feeling more uncomfortable discussing symptoms and medications with patients who have mental illness than with patients who have cardiovascular problems. Patients with mental illness appeared to receive fewer pharmacy services than patients with cardiovascular disorders. Barriers to receipt of counseling included a lack of privacy and inadequate training. Adequate training in mental health may be key in improving the professional interactions of community pharmacists toward patients who use psychiatric medication. (*Psychiatric Services* 55:1434–1436, 2004)

Health care providers have been known to stigmatize patients who use psychiatric medications or services by offering discouraging advice, disparaging remarks, and rejecting behavior (1). This form of discrimination may have a negative impact on patients' self-esteem (2) and the way they seek help (3) or adhere to prescribed medical treatments (4).

As one of the primary health care providers in the community, pharmacists have the opportunity to influence patients' perception of their mental illness. Consequently, negative attitudes that manifest as apprehension or discomfort during patient interactions may lead to ineffective counseling or the lack of essential medical services.

To our knowledge, no study has directly examined the attitudes of community pharmacists toward patients who use psychiatric medications. In this study we used a survey to assess community pharmacists' attitudes toward and professional interactions with patients who use psychiatric medications and patients who use cardiovascular medications.

Methods

A 69-item questionnaire was developed on the basis of other related studies (5,6). It encompassed five domains: attitudes; level of comfort when counseling; barriers to providing professional services; counselor role orientation, as defined by pharmacists' overall attitude toward communicating with patients; and professional interactions, as defined by acts involving counseling about new and ongoing medications and following up with patients to monitor for medication adherence, side effects, and treatment efficacy. Counseling was defined as the provision of patient-specific information about medication or health to patients. Survey items about cardiovascular medications corresponded to mental health items except that the words "mental health" were replaced by the word "cardiovascular." Except for two open-ended questions, the survey was assessed with a 5-point Likert scale, in which 1 indicated "strongly agree" and 5 indicated "strongly disagree." Demographic data for respondents were also obtained. The questionnaire was evaluated for content by four senior academic pharmacists, pretested with 14 community and academic pharmacists, revised for wording, and finalized. This study received approval from the research ethics board of the Centre for Addiction and Mental Health before it was conducted from May to August 2002.

A random sample of 800 pharmacies was chosen from 1,400 community pharmacies located in the greater Toronto area. Two faxed notices informed pharmacies of the survey's arrival and encouraged the prompt return of the completed survey. Each survey included a cover letter stating the purpose of the survey, instructions, and a definition of terms. Any pharmacist at the pharmacy could complete and return the anonymous questionnaire by fax or by mail in the postage-paid envelope included. The survey took approximately 20 minutes to complete, and

The authors are affiliated with the faculty of pharmacy at the University of Toronto. Dr. Sproule is also with the department of clinical research at the Centre for Addiction and Mental Health in Toronto. Send correspondence to Dr. Sproule at 33 Russell Street, Toronto, Ontario, Canada M5S 2S1 (e-mail, beth_sproule@camh.net).

financial incentives were not offered.

Data were analyzed with SPSS 11.0. Descriptive statistics were calculated for demographic variables. Wilcoxon signed-rank tests (two-tailed) compared ordinal responses for mental health items with the corresponding cardiovascular items for all respondents.

Results

Of the 800 questionnaires sent, 283 were returned (35 percent response rate). Fifty-eight percent of respondents (164 of 282 respondents) were male. Nearly half the pharmacists had graduated more than 20 years ago (132 of 283 respondents, or 47 percent). Most had a bachelor of science degree in pharmacy as their highest professional degree (258 of 282 respondents, or 92 percent). Most participants received their highest degree from a school in Ontario, Canada (165 of 280 respondents, or 59 percent); some received this degree from another country (77 of 280 respondents, or 28 percent). Most pharmacists had known someone with a severe mental illness (182 or 278 respondents, 66 percent), and many had visited a patient in a psychiatric hospital (81 of 278 respondents, or 29 percent).

Respondents generally endorsed positive attitudes in their interactions with patients who used psychiatric medications; a majority of pharmacists agreed with positive statements. Exceptions to this finding and other items of interest were identified.

For the section of the survey on attitudes, 21 percent of pharmacists (59 of 279 respondents) disagreed with or were neutral about the statement, "anyone can develop a mental health problem," whereas only 11 percent (31 of 279 respondents) disagreed with or were neutral about the statement, "anyone can develop a cardiovascular problem" ($Z=-2.46$, $p=.014$). Only 55 percent of pharmacists (155 of 280 respondents) agreed that substance use disorders are mental health problems.

For the section on level of comfort, 36 percent of pharmacists (100 of 275 respondents) stated that they felt awkward asking patients the reason for using psychiatric medications, whereas only 7 percent (18 of 275 respondents) felt the same way when asking those using cardiovascular medications ($Z=-9.88$, $p<.001$). Seventy-one percent of pharmacists (200 of 280 respondents) felt comfortable discussing symptoms of mental illness, compared with 93 percent (261 of 280 respondents) of pharmacists who felt comfortable discussing cardiovascular symptoms ($Z=-6.28$, $p<.001$).

For the section on counselor role orientation, 47 percent (131 of 282 respondents) agreed with or were neutral about the statement that patients with mental health problems do not want to talk to a pharmacist about their mental health symptoms, whereas only 6 percent (17 of 281 respondents) agreed with or were neutral about the corresponding statement about cardiovascular symptoms. Only 8 percent of pharmacists (22 of 281 respondents) agreed that patients who use psychiatric medications receive all the necessary drug information from their physician or psychiatrist.

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For the section on professional interactions, pharmacists tended to agree that they monitored patients with mental illness less frequently than patients with cardiovascular problems. For example, fewer pharmacists agreed that they routinely monitor patients with mental illness for medication side effects (93 of 277 respondents, or 34 percent, compared with 144 of 277 respondents, or 52 percent, who monitored cardiovascular patients for side effects; $Z=-6.57$, $p<.001$) or for compliance with psychiatric medications (86 of 280 respondents, or 31 percent, compared with 135 of 280 respondents, or 48 percent, who routinely monitored cardiovascular patients for compliance; $Z=-6.42$ $p<.001$).

For the section on barriers to counseling, only 57 percent of pharmacists (159 of 280 respondents) agreed that their work environment provided adequate privacy for counseling patients with mental health problems. Even fewer indicated that they had received adequate education about mental health during undergraduate pharmacy training (65 of 275 respondents, or 24 percent, compared with 168 of 275 respondents, or 61 percent, who indicated having received adequate education about cardiovascular issues; $Z=-9.96$, $p<.001$).

Two open-ended questions asked pharmacists (N=379) to list barriers to counseling mental health patients or factors that make counseling easier. In general, the responses to these questions were inversely related to each other. Some pharmacists listed multiple barriers to counseling these patients, which yielded a total of 379 responses. The most frequently cited barriers included communication difficulty caused by patient symptoms—for example, hostility, inattentiveness, irritability (67 responses, or 18 percent); time constraints (57 responses, or 15 percent); lack of patient information—for example, drug indication or treatment goals unknown (52 responses, or 14 percent); and lack of a private counseling area in the pharmacy (45 responses, or 12 percent).

Discussion

Our study demonstrated that community pharmacists in the greater Toronto area generally embrace positive attitudes toward psychiatric medication users. Previous studies have

found similar attitudes reported, from hospital pharmacists toward mental health inpatients (7) and community pharmacists toward mentally challenged patients (8).

However, the most significant findings were that community pharmacists felt uncomfortable discussing symptoms of mental illness and indicated reduced follow-up monitoring for drug-related problems among these patients, compared with the monitoring of patients using cardiovascular medications. Because the pharmacists also perceived a lack of adequate undergraduate training in mental health, these differences may indicate an increased level of discomfort in a therapeutic area in which they are undertrained. Schools of pharmacy and continuing education providers should consider additional emphasis in this area.

The perceived lack of private space for counseling that was reported by pharmacists is likely an important factor in limiting their interactions with patients. The barriers identified in our study are congruent with the results of a previous study involving community pharmacists (9). The pharmacists in our study stated that patients with mental illness do not receive adequate information about their medications from their physicians. Because these patients may also receive less attention from pharmacists than other patients, it raises concerns that their drug-related needs are not being adequately met.

Another interesting finding was that only 55 percent of respondents agreed that substance use disorders are mental health problems. This finding may reflect the perception that addictions represent poor self-control or are self-inflicted problems rather than disorders like other mental health problems. More extensive pharmacist-patient interactions may help improve these negative attitudes (10).

This study had several limitations. The survey responses were self-reported and not validated by other measures. The study did not differentiate among different classes of psychiatric medications (for example, antipsychotics or benzodiazepines) or different mental illnesses (for example, schizophrenia or anxiety). Use of cardiovascular medication users as the comparison group was arbitrary, and these patients may not represent other populations using medications. The low response rate from our population, which was restricted to a single, urban geographic area, makes it difficult to extrapolate the results to a wider population. Generalizability of the results may also be limited to health systems that are similar to that of Ontario, which provides universal coverage.

Conclusions

Continuing education and undergraduate training programs for pharmacists should consider enhancing mental health curriculums and heightening the awareness of potential stigmatizing behaviors in pharmacy practice to improve pharmacists' ability to meet the drug-related needs of this population. ♦

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