• Continuing Education •

TECH talk CE

THE NATIONAL CONTINUING EDUCATION PROGRAM FOR PHARMACY TECHNICIANS 1.5 CE Units FREE

ANSWER ONLINE FOR INSTANT RESULTS AT WWW.ECORTEX.CA NOVEMBER 2020

APPROVED FOR 1.5 CE Units

Approved for 1.5 CE units by the Canadian Council on Continuing Education in Pharmacy. File no. 1329-2020-3114-I-T. Please consult this course online at eCortex.ca for expiry dates.

Answer this CE online for instant results and accreditation. Visit eCortex.ca

CE JUST FOR TECHNICIANS

Tech Talk CE is the only national continuing education program for Canadian pharmacy technicians.

As the role of the technician expands, use Tech Talk CE as a regular part of your learning portfolio. Note that a passing grade of 70% is required to earn the CE credit.

Tech Talk CE is generously sponsored by Teva. Download back issues at www.CanadianHealthcareNetwork.ca. The author has no competing interests to declare.

INSTRUCTIONS

1. After carefully reading this lesson, go to eCortex.ca to complete the questions.

2.Answer the test online at eCortex.ca. To pass, a grade of at least 70% (11 out of 15) is required.

3. Complete the required feedback for this lesson online at eCortex.ca.

CE FACULTY

CE Coordinator:
Rosalind Stefanac

Clinical Editor:
Lu-Ann Murdoch, BScPhm

Authors:
Melanie McLeod BSP, ACPR, PharmD, BCPP

pharmacy PRACTICE + BUSINESS

eCortex.ca

Anxiety and Mental Health Awareness:

The role of the pharmacy technician

by Melanie McLeod BSP, ACPR, PharmD, BCPP

Learning objectives

After completing this lesson, the pharmacy technician participant will be able to:

1. Describe how stigma and discrimination may impact individuals with mental illness and society as a whole
2. Define “anxiety” and explain how it differs from an anxiety disorder
3. Compare and contrast the subtypes of anxiety disorders in terms of their prevalence, common clinical presentations and approach to treatment
4. Recognize the role pharmacy technicians play in identifying individuals who may benefit from further interaction with a pharmacist to address concerns related to anxiety
5. Employ strategies within your scope of practice to reduce stigma and prejudice toward patients living with mental illness and substance-use disorders

Introduction:

What is mental health?

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”[1] They subsequently define Mental Health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruit-

fully, and is able to make a contribution to his or her community."[2-4] Mental health and well-being is an integral part of one's overall health; good health is not possible without good mental health.[4] Mental health and well-being contributes to our quality of life and influences our ability to enjoy life.[4]

What is mental illness?

Mental illnesses (also known as mental health disorders) are characterized by alterations in thinking, mood or behaviour and are often associated with significant distress and impaired functioning.[4-5] There are many different types of mental health disorders; the clinical presentation may range from a single, short-lived episode to a chronic disorder with multiple relapses and recurrences.[4-6] Furthermore, symptom severity and the degree of functional impairment may differ among episodes of illness and are subject to individual variability.[4-6]

Criteria to establish the presence of a mental illness are listed in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V).[6] The manual, produced by the American Psychiatric Association, serves as a key resource for clinicians specializing in the diagnosis and treatment of patients with mental illness.[6] The DSM-V contains descriptions, symptoms and other criteria about specific mental health disorders in an effort to improve consistency surrounding diagnoses and terminology, sub classifications, severity of illness, and degree of functional impairment.[6]

When an illness first presents or is initially diagnosed, it may be difficult for the patient and those close to them to manage. However, with effective treatment and support, many people can return to previous levels of mental health and function.[4] Regaining mental health or the achievement of "mental wellness" or recovery is an integral focus of treatment for individuals with mental health disorders.[4] Effective treatment strategies differ among individuals and are influenced by the severity of illness and availability of local resources.[7] Treatment may involve the use of medication, psychological therapy or a combination of both.[7] In Canada, treatment and supports for individuals with mental illness are provided across many settings, including family physicians' and psychiatrists' offices, hospitals, outpatient programs and clinics, and community agencies.[5] In some cases, several clinicians may be involved in an individual's care in the form of a coordinated multidisciplinary team.[5]

Mental illness is multifactorial in etiology; biological, psychosocial, economic and genetic factors all play a role in its development.[5] Stressful life events can serve as precipitating or aggravating factors to the development of mental health disorders and may influence the propensity for an individual to relapse.[5] Regardless of the cause, mental illness influences one's overall health and well-being, and should be acknowledged and discussed in a similar manner to other chronic medical conditions- such as hypertension or diabetes.[3]

BOX 1 - Use the STOP criteria to recognize attitudes and actions in yourself and others that promote stigma and discrimination of individuals with mental illness[12, 16]

If you SAY or HEAR actions that:

Stereotype mental health disorders and/or persons with mental illness by making generalized and incorrect statements or assumptions:
- "All persons prescribed antipsychotic medication hear voices"
- "All persons with schizophrenia are dangerous"

Trivialize or belittle people with mental illness or minimize the disorder itself:
- "What does she have to be depressed about? She has everything going for her!"
- Blaming the patient for their illness- for e.g. "if only she took care of herself or lost weight, she'd feel better"
- "That person is moody today, they must be bipolar!"

Offend people with mental illness by insulting them:
- Using potentially offensive language, even unintentionally (Refer to Table 1 for examples of phrases to avoid)

Patronize people with mental health conditions by treating them as if they were not as good as other people:
- Making patient A wait longer because she is not as important as patient B
- Avoiding direct interactions with patients with mental illness

Do something!

Start with yourself. Be thoughtful about your own choice of words and phrases.
- Use accurate, respectful phrasing when speaking to patients and also when speaking about them to your fellow colleagues
- Speak up if you hear or observe stigmatizing language or discrimination
- Help educate others about how their choice of words may affect people with mental health disorders

BOX 2 - How can I reduce stigma and discrimination within my pharmacy practice environment?

- Educate yourself about mental illness and substance use disorders
  - Look into designated training programs to learn more about mental illness and, in doing so, develop skills to help better support patients. An example program is Mental Health First Aid Canada (link: https://www.mhfa.ca/)[19]
- Keep a current list of community mental health supports and referral agencies in the pharmacy
- Place signage in the pharmacy indicating it is a safe environment to ask about mental health concerns and substance use disorders
- Arrange mental health awareness events in your pharmacy

Set the standard for positive professional behaviour:
- Approach ALL patients in a similar and respectful manner
- Encourage patients to discuss concerns regarding their mental health in a similar manner that you would ask about physical concerns. This serves as an opportunity to "normalize" conversation about mental health
- Confront stigma and discrimination if you hear or see it (Refer to Box 1)
  - Challenge myths and stereotypes about mental illness
  - Use patient-centred language in your interactions (see Table 1)

TABLE 1 - Mind your language[19-22]

Instead of	Consider saying	Why this is important
"mentally ill person" "suffering from or afflicted by mental illness" "person who is mentally ill"	Living with mental illness	• Suffering implies the patient is unwell and unhappy • People with mental illness can live fulfilling, healthy lives • The use of language is critical to ensuring a recovery-oriented and person-centred approach • It is important that people are seen first as people and not seen as their mental health condition • Individuals are far more than their illnesses • To accept someone as a person first is far more respectful and honours many other parts to them outside their illness
person with mental health "issues"	Living with mental illness	• Referring to the patient's "issues" trivializes the patient's illness • It doesn't really offer much information to reflect what the patient is dealing with • It demonstrates a lack of mental health awareness and knowledge about mental illness
Schizophrenic; psychotic; disturbed; crazy	Person living with schizophrenia	• People should be identified as people—not by their illnesses
"normal behaviour"	"Usual behaviour" for this individual or typical behaviour for this person	• There is no clear definition of "normal." It can cause others to feel judged if their experience is classified as not fitting in to a category of normal. Usual or typical is less critical.
Substance abuser; addict, alcoholic Person who "suffers" from addiction	Person with a substance use disorder Can be further broken down to reflect a particular drug: Person with a cannabis use disorder, alcohol use disorder or polysubstance use disorder	• The use of language is critical to ensuring a recovery-oriented and person-centred approach • It is important that people are seen first as people and not seen as their mental health condition • Suffering implies the patient is unwell and not recovery-focused • Recovery involves increasing a person's ability to make the changes they want in their life—the power to get better, to identify their goals, to develop the ability to accomplish their goals, and provide the supports needed to attain their goals
"Committed" suicide	Died by suicide	To say someone committed suicide suggests blame The individual died as result of their illness and we need to acknowledge that mental illness can be associated with mortality We would never blame someone from dying from cancer

Mental illness is highly prevalent in Canada; in any given year, one in five Canadians will personally experience a mental illness or substance use disorder.[7-8] During one's lifetime, mental illness is experienced by at least one in three Canadians and is a leading cause of disability.[8-9] Additionally, many Canadians are affected indirectly by mental illness- through family, friends or colleagues.[4, 9] Due to factors possibly influencing the underreporting of mental health disorders in Canada (e.g., homelessness, stigma and under-diagnosis), the actual prevalence of mental illness is believed to be even higher.[9]

Further to this, the COVID-19 pandemic has triggered a parallel anxiety pandemic;[10] the fear associated with coronavirus has spawned widespread anxiety, panic and worry about one's health and the health of loved ones.[10-11] The pandemic is likely to challenge the stability of patients with existing mental illness and may contribute to new illness in others—possibly due to the phenomenal stress it has brought with it.[10-11]

Mental Health Awareness

Too many people with mental health disorders experience shame and marginalization due to their diagnosis.[12] What will it take to change attitudes and shape a world where people with mental illness receive the level of care they need and deserve?[12] It has been proposed that increased awareness and knowledge[13-14] about mental health and mental health stigma may improve a healthcare provider's confidence in providing effective care to individuals with mental illness.[15-16]

This module provides pharmacy technicians with an opportunity to become more aware of mental health, anxiety disorders and their management. In doing so, it serves as an opportunity for the pharmacy technician to self-reflect on their own use of (or exposure to) potentially offensive and stigmatizing language surrounding mental illness. It also defines, explores and challenges some of the reasons why individuals may not feel comfortable disclosing mental health concerns, seeking help or accepting treatment.

The community pharmacy team is a readily accessible resource for patients. Pharmacy technicians, in collaboration with pharmacists, are ideally positioned to play an essential role in the ongoing support of individuals with mental illness and substance use disorders. Furthermore, due to the COVID-19 pandemic, patients may increasingly call or present to the pharmacy with concerns relating to their mental health or the mental health of others. Ultimately, this lesson serves to empower pharmacy technicians to identify patients who may require further assessment and involvement of the pharmacist.

Stigma and discrimination

Individuals with mental health disorders are

TABLE 2 - Types of Anxiety Disorders[6,24-28]

	Description	Lifetime Prevalence[24]
Separation anxiety disorder	• Individuals are fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate • Persistent fear about harm coming to an attachment figure (e.g., a parent) • Often develops in childhood, but can be expressed in adulthood • The most prevalent anxiety disorder in children < 12 years	4.8%
Selective mutism	• Consistent failure to speak in social situations in which there is an expectation to speak (e.g., school) even though the individual speaks in other settings • Duration of at least one 1 month • May result in significant consequences on academic, social and occupational achievement • More likely to manifest in young children (< 5 years) than in adolescents and adults	(0.11%–2.2%)
Specific phobia	Individuals are fearful or anxious about or avoidant of specific objects or situations • Examples: - Animals (e.g., spiders, insects, dogs) - Natural environment (e.g., heights, storms, water) - Blood, injection-injury (e.g., needles, receiving an injection, seeing blood) - Situational (e.g., airplanes, elevators, enclosed spaces) - Other (e.g., costumed characters, such as a clown) • The object or situation usually provokes immediate fear or anxiety • The fear or anxiety is out of proportion to the actual danger posed	7.4%
Social anxiety disorder (SAD), also called Social phobia	• Marked fear or anxiety about social situations in which the individual is exposed to possible scrutiny by others and is judged to be out of proportion to the actual risk. Individuals are afraid of situations in which they are the centre of attention and may be criticized • Examples: - Social interactions (e.g., meeting unfamiliar people, making conversation) - Being observed (e.g., eating or drinking) - Performing in front of others (e.g., public speaking) • The social situations are avoided or endured with intense fear or anxiety • Causes marked distress or impairment in social, occupational and other important areas of function	10%
Panic disorder	• Recurrent unexpected panic attacks (refer to Box 4 for a description) • Persistent concern about having another panic attack, worrying about the implications of the attack or its consequences • Significant change in behaviour related to panic attacks • May co-occur with agoraphobia	2%–5%
Agoraphobia	Fear of places where it might be difficult or embarrassing to escape if a panic attack should occur (crowds, on public transport, or enclosed spaces [e.g., elevators]). Individuals are fearful and anxious about 2 or more of the following situations: • Using public transportation • Being in open spaces (e.g. parking lots, bridges, marketplaces) • Being in enclosed places (shops, theatres, cinemas) • Standing in lines or being in a crowd • Being outside the home alone	2%
Generalized anxiety disorder (GAD)	• Persistent and excessive anxiety and worry about various domains that the individual finds difficult to control and persists for at least 6 months • Patients experience emotional and physical anxiety symptoms (e.g., tremor, palpitations, nausea, muscle tension, etc.) Individual experiences physical symptoms including: - Restlessness - Feeling keyed up or on edge, or excessive fatigue - Difficulty concentrating or mind going blank - Irritability - Sleep disturbance • GAD is often a chronic condition that requires long-term treatment	3%–5%

often plagued by stigma and discrimination.[13-14] Stigma is a negative stereotype or "mark of shame" that sets one apart from others.[12] Stigma is holding negative attitudes or beliefs about people who are viewed as different and making inaccurate generalizations and assumptions about these individuals.[16-17]

Stigma differs from discrimination; stigma is the negative stereotype and discrimination is the behaviour that results from this negative stereotype.[15-17] Discrimination involves acting on these ideas or beliefs and treating individuals differently due to the persons' identity.[15-17] Avoiding direct communication

with a patient who has a mental illness is one example of discrimination.

"Discrimination is unfair treatment due to a person's identity, which includes race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability, including mental disorder."[15] Acts of discrimination can be overt or systemic.[15-17] Individuals with a mental illness are often faced with multiple, intersecting layers of discrimination as a result of their mental illness identity.[15-17]

Discrimination can affect all areas of living.[7,16] It can prevent people from meeting their basic needs, for instance: obtaining a job, finding a place to live, feeling loved and accepted by family and friends, getting insurance, going to school, immigrating to another country or contributing to society.[16]

Healthcare professionals are not immune to prejudicial attitudes and beliefs about mental illness, displaying rejection or avoidant behaviours, and making offensive comments and remarks to patients or about patients among their colleagues in all types of clinical settings.[18] Self-reflect on your own attitudes surrounding mental health stigma and discrimination by conducting a self-evaluation using Box 1.

The media and entertainment industries play a key role in shaping public opinions about mental health and illness.[12, 16-17] It is not uncommon for individuals with mental health disorders to be depicted as dangerous, violent, strange or unpredictable in movies and television series or news reports, further contributing to fear, prejudice and discrimination.[12]

Impact of stigma and discrimination

Stigma is a reality for many people with a mental illness, and many individuals report that how others judge them is one of their greatest barriers to living complete and satisfying lives.[13] Stigma profoundly changes how people feel about themselves and the way others see them.[13] Some have characterized stigma and discrimination as having worse consequences than the mental illness itself.[13, 15-17]

Mental health stigma is not only an interpersonal issue: it is a health crisis.[13] Sadly; individuals with mental illness receive less overall primary care for physical health and preventive care than those without.[4, 12, 16-17] Individuals with serious mental illness die decades earlier than those without, due to increased suicides or injuries and poor physical health.[4, 12, 16]

Healthcare professionals are not immune to contributing to or tolerating stigma and discrimination within their workplace.[17, 18] For these reasons, it is possible that some patients may have a negative experience when they call or present to a pharmacy. For suggestions for how pharmacy technicians can identify and address stigma and discrimination, refer to Box 2.

Anxiety

Anxiety is a usual reaction to stress and can be beneficial in some situations.[23] For instance, it may alert us of imminent danger or harm by suggesting we prepare and pay attention.[23] Anxiety symptoms may present in various ways depending on the individual and the stressor. Anxiety symptoms may also occur in anticipation of a future event—such as a job interview, performance review or public speaking engagement.[23-24]

Anxiety disorders

What separates "anxiety symptoms" from an anxiety disorder is the amount of distress that is felt by the individual and the extent to which this distress interferes with their everyday life.[24] Anxiety disorders are the most common type of mental health disorders with an estimated lifetime prevalence of 31%.[24-28] Despite the high prevalence, anxiety disorders are frequently underdiagnosed,[28,29] especially in primary care.[30] Anxiety disorders are associated with a high burden of illness [13, 26-28] due to significant functional impairment and subsequent impacts on one's overall physical and mental well-being.[13] There are several different types of anxiety disorders[6] (see Table 2); prevalence rates for individual disorders vary widely.[30]

Risk factors

Anxiety disorders tend to run in families; genetics likely play an important role in their etiology and response to certain treatments.[28] Individuals meeting diagnostic criteria for an anxiety disorder are four to six times more likely to have a first-degree relative with a mood or anxiety disorder.[24-28] Other risk factors include childhood adversities, such as abuse and neglect.[28] It is common for anxiety disorders to initially present in childhood, suggesting that childhood adversities may increase one's vulnerability to developing an anxiety disorder.[24-28]

Stressful and traumatic life events likely play a role in contributing to anxiety disorders, perhaps through the development of excessive or maladaptive activation of the "threat circuitry" of the brain.[24] Females are twice as likely to develop anxiety disorders as males, but it is unclear if this is caused by biological factors, a higher likelihood for females to seek help or environmental factors.[24-28]

Complicating factors

Anxiety disorders commonly co-occur in

BOX 3 - How can I reduce stigma and discrimination within my pharmacy practice environment?

The DSM-V defines a panic attack as: an "abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and ends within 10 minutes from onset." It may occur without any particular warning or trigger.[3] Not everyone who develops a panic attack has panic disorder.

A panic attack is an abrupt period of intense fear or discomfort accompanied by 4 or more of the following 13 symptoms:

1. Palpitations, pounding heart or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sense of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Derealization or depersonalization (feeling detached from oneself)
9. Fear of losing control
10. Fear of dying
11. Numbness or tingling sensations
12. Chills or heat sensations
13. Feeling dizzy, unsteady, lightheaded or faint

patients with other medical conditions (such as epilepsy, heart disease and diabetes) and other psychiatric disorders.[26-28,31] Furthermore, an individual may be diagnosed with more than one type of anxiety disorder at the same time; more than half of patients with an anxiety disorder have multiple types.[28]

The presence of an anxiety disorder is associated with an increased risk of developing a comorbid major depressive disorder,[28, 30-31] as well as an increased risk of developing other health conditions such as high blood pressure, thyroid disease, respiratory disease, arthritis and migraine headaches.[28, 30-31] Patients with psychiatric comorbidities tend to have more severe symptoms, poorer treatment outcomes, greater functional impairment, poorer quality of life, and an increased risk of suicide.[28, 30, 31]

Aggravating factors

Stimulants, such as amphetamines, ecstasy, cocaine or caffeine, can worsen anxiety symptoms.[24-28, 32] Over-the-counter stimulants (such as pseudoephedrine) and herbal products (e.g., green tea) can also contribute to anxiety symptoms.[32] Prescription medications- such as corticosteroids, anabolic steroids, certain antidepressants (e.g., bupropion) and anticholinergic medications- have been shown to aggravate or precipitate anxiety symptoms in some individuals.[24-28,32]Missed doses of medications (especially those medicines used to treat anxiety disorders) may contribute to rebound anxiety symptoms.[30]

Unfortunately, some individuals may reach out to substances (such as alcohol or cannabis) in an effort to self-manage their symptoms related to a diagnosed or undiagnosed anxiety disorder.[28] Substance use disorders commonly co-occur with anxiety disorders.[28, 31]

COVID-19

The viral pandemic poses new challenges for the community pharmacy practice environment. Stress associated with the pandemic will likely contribute to the overall prevalence rate of anxiety disorders but the true impact of this is not yet captured or reported.[33] It is likely that the pharmacy technician will more frequently encounter patients expressing higher than usual stress and anxiety levels.[10] Some of this is due to a "real" fear posed by the virus and also by the difficult adjustments and restrictions that are currently in place.[10] People may feel disconnected from their supports, feel socially isolated, be afraid to interact socially with others, and struggle to balance the challenges and demands between home and work.[10]

Though the evidence on the consequences of COVID-19 disruptions is still emerging,[33] there have been data and reports from jurisdictions across Canada suggesting increased numbers of substance use-related morbidity and mortality from non-fatal and fatal drug poisonings[34] and an increase in cases of domestic violence.[35] The pandemic will likely have a profound impact on mental health and requests for services to support a large influx of individuals with mental health decompensation.[33]

Types of Anxiety Disorders[6]

Table 2 outlines the different types of anxiety disorders described in the DSM-V.[6]

- Some conditions listed as anxiety disorders in previous editions of the DSM are now categorized as different disorders. For instance, the classification of obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) has changed. The former is now classified as an Obsessive-Compulsive & Related Disorder and the latter is classified as a Trauma and Stressor-Related Disorder. For this reason, these disorders are not discussed in this article.
- Each anxiety disorder is diagnosed only when the symptoms are not attributable to the physiological effects of a substance or medication, to another condition or not better explained by another mental disorder.
- Unless otherwise indicated, the diagnosis requires symptom duration of at least six months.
- Some anxiety disorders run a chronic course, with symptoms fluctuating in severity between periods of relapse and remission. Others, especially phobias, may be more transient in nature.

Management of Anxiety Disorders

General Principles[28]

Not all anxiety disorders have to be treated when symptoms are mild, transient and without associated impairment in social and occupational function. Furthermore, some anxiety disorders (e.g., specific phobias) may benefit more from psychotherapy-focused treatments than medication.

Treatment is indicated when a patient shows marked distress or suffers from complications resulting from the disorder, for example, secondary depression, suicidal ideation (thoughts about suicide) or concurrent substance use disorder. Generally, treatment of an anxiety disorder involves the use of medication and/or psychotherapy. The choice of treatment depends on patient preference, the availability of and accessibility to psychological resources (and wait times), and costs, as well as individual factors including comorbidities and the severity of illness.

Anxiety disorders can usually be treated on an outpatient basis. Indications for hospitalization include acute suicidality, and lack of response to standard treatment in the context of severe impairment.

Treatment goals[24-28, 30]

- Reduce acute anxiety symptoms
- Facilitate remission of symptoms and complete functional recovery
- Prevent relapse and recurrences
- Treat comorbid disorders

Psychoeducation[28]

- All patients should receive psychoeducation from their physician—about their diagnosis, possible contributing factors and an explanation of treatment options.
  - Psychoeducation can occur in different formats:
    - It can be a simple discussion between the patient and their physician that provides the patient with information about the causes, symptoms, prognosis, and treatments of their diagnosed condition
    - It may also include the patient and their family members—in an effort to educate the family about the illness, ways they can help and early signs of relapse to report
    - Support groups may provide additional information

- Other important components to discuss with patient regarding medication include:
  - The purpose of medication
    - This may include realistic and non-realistic expectations of what the medication can help with
  - How medication may help and how long it may take to expect improvement
  - How the medication is to be taken (i.e., every day or only when needed) and why that is important

TABLE 3 - Common medications used in the treatment of anxiety disorders[24-28, 32]

Class of medications	Mechanism of action	How it may help the patient	Common adverse effects
Selective serotonin reuptake inhibitors (SSRIs) Examples include: escitalopram- GAD* SAD* sertraline -PD* SAD* paroxetine-PD* ,SAD* fluoxetine- PD* *denotes Health Canada-approved indications	• Inhibit the reuptake of serotonin • Increase the presynaptic reuptake of serotonin resulting in increased production of serotonin	• Used for maintenance treatment • Gradual onset of action • May take several weeks to show a response • Important to take regularly and to not stop abruptly	• Initial worsening of anxiety due to activation of serotonin; start with smaller doses initially to help prevent this • Nausea, somnolence, insomnia, sexual dysfunction, loose stools, sweating and headache
Serotonin and norepinephrine reuptake inhibitors (SNRIs) Examples include: venlafaxine XR- *PD,* SAD,*GAD duloxetine- *GAD *denotes Health Canada-approved indications	• Inhibit the reuptake of serotonin and norepinephrine	• Used for maintenance treatment • Gradual onset of action • May take several weeks to show a response • Important to take regularly and to not stop abruptly	• Initial worsening of anxiety due to activation of serotonin and norepinephrine; start with smaller doses initially to help prevent this • Nausea, somnolence, insomnia, sexual dysfunction, loose stools, sweating and headache, and elevated blood pressure (with venlafaxine XR)
Buspirone*GAD *denotes Health Canada-approved indications	• Buspirone has a high affinity for serotonin 5-HT1A and 5-HT2 receptors and moderate affinity for dopamine D2 receptors • It may increase production of serotonin, norepinephrine and dopamine, but the exact mechanism of action of buspirone is unknown	• Must be taken every day to be effective • Has a similar onset of action to SSRIs and SNRIs	• Dizziness, nausea, insomnia, headache
Adjunctive Agents – for anxiety disorders			
Benzodiazepines Examples include: alprazolam lorazepam diazepam clonazepam	• Bind to GABA-A receptors to increase release and effects of GABA (an inhibitory neurotransmitter)	• Offer short-term, rapid relief from acute symptoms • Can be useful in the first 1-2 weeks when starting an anxiolytic, to combat transient increase in symptoms • Not recommended for long-term management	• Drowsiness, fatigue, memory impairment, dizziness; can cause dependence and withdrawal symptoms

CNS–central nervous system; GABA–gamma aminobutyric acid; GAD–general anxiety disorder; SAD–social anxiety disorder; PD- panic disorder

- What to do if certain concerning side effects occur
- How long to continue medication for

- Situations and substances to avoid due to potential exacerbation of symptoms
- Pharmacists are well positioned to provide additional education to the patient – especially about the role of medication

Pharmacotherapy[28]

Table 3 summarizes the first-line, second-line and adjunctive agents, including their mechanism of action, benefits of use and common adverse effects.

Why are antidepressants prescribed for anxiety?

Most of the primary medication treatments for anxiety disorders are actually classified as antidepressants. However, many of the agents will have additional indications for treating anxiety disorders. Pharmacists play an essential role in explaining this to patients as the patient information leaflet provided may confuse the patient.

Assess for "information overload"

Due to the nature of the illness, some patients may be more sensitive to side effects and more fearful when provided with patient information. They may ask many questions and feel overwhelmed with information and fear getting every side effect listed. If this occurs, pharmacy technicians should refer patients to speak to the pharmacist to provide reassurance, accurate probability of feared side effects and clinical context to the information they are reading.

How do medications improve symptoms of anxiety?

Antidepressants are believed to focus on neurotransmitters that mediate anxiety symptoms.

Serotonin, norepinephrine and gamma

aminobutyric acid (GABA) are the primary neurotransmitters involved in anxiety disorders and its treatment.[24-28, 32] There are four primary classes of medications used to treat anxiety disorders.[24, 30] Table 3 outlines the different treatment options and their proposed mechanisms of actions.

Adjunctive therapies[28]

Medications may be added on to primary treatments to help improve response, to help counter side effects or to help with short-term anxiety before therapeutic benefit from the primary treatment sets in. An example of this includes the use of a benzodiazepine. Ideally, the adjunctive medication is intended to be used for a short time only.

Benzodiazepines alleviate anxiety symptoms more quickly than the primary agents prescribed, but these effects are short-lived and with continued use, the patient may develop a tolerance to the benzodiazepine's effects.[28] Furthermore, benzodiazepines, if relied upon too significantly, can lead to maladaptive coping behaviours (e.g., reaching for a pill instead of working through anxiety symptoms), rebound anxiety, dependency and unnecessary side effects.[27] Benzodiazepines can cause rebound anxiety when their effects wear off and misuse of benzodiazepines can occur. [27-28]

Nonmedication therapies:

- Cognitive behavioural therapy (CBT) is a type of psychotherapy that aims to stop negative thought cycles. CBT that is specifically tailored to the primary diagnosis is preferred.[28, 36] This type of psychotherapy is delivered by a CBT-trained psychologist or therapist and can be delivered face to face or online via Internet delivery (ICBT).[28,36]
- Exposure therapy may be useful for the treatment of phobias, especially if avoidance of feared situations is prevalent. Exposure therapy involves exposing the patient to the anxiety source gradually in an effort to help them overcome their anxiety or distress.[28-36]
- Mindfulness-based CBT combines the ideas of cognitive therapy with meditative practices and attitudes based on the cultivation of mindfulness.[37]
- Encouraging stress reduction techniques such as meditation, yoga and deep breathing can be recommended and may help to reduce some anxiety symptoms.[38]

Encourage healthy activities:[24-28]

- Aerobic exercise
- Encourage healthy sleep hygiene
- Avoid agents that worsen anxiety
- Avoidance of alcohol is important—especially if it is being used to control anxiety symptoms.

Opportunities for pharmacy technicians to intervene:

As patients often first turn to their pharmacy team for advice, it is important to be able to identify cues suggesting a patient may have new concerns. The better you know your patients, the easier it may be to screen your patient for changes and identify problems.

It is important that a pharmacy technician reports observed changes and concerns to the pharmacist. For instance, if the patient is:

- No longer coming into the pharmacy due to expressed fear to leave their home
- Demonstrating symptoms suggestive of anxiety or expressing concerns to you about their mental health
- More confused than usual, slurring their speech or appearing intoxicated when you check in on them
- Persistently presenting with complaints about aches, pains and poor sleep
- Not filling medications as regularly; missing doses or has stopped taking a medication without direction to do so.

It may be useful for the pharmacy technician to consistently ask patients if there are barriers or problems to taking medications such as side effects or cost. If so, refer them to the pharmacist

If is also important to be discreet and respectful when asking patients questions. Patients may not want to discuss a mental health disorder in a pharmacy while others are around. Make use of private counselling areas, if available, when asking personal questions—especially if you sense that a patient feels uncomfortable.

Be cognizant of benzodiazepine use and alert the pharmacist if a patient is requesting early refills. It is possible that some patients may overuse and over-rely on benzodiazepines for their anxiety. These patients may benefit from different medications (e.g., antidepressants) to manage their chronic condition.

When individuals request sleep aids or over-the-counter or herbal stimulants, be sure to refer them to the pharmacist to ensure these agents are safe to combine with their prescribed medications and to allow for more questions in an effort to intervene.

Become familiar with available community mental health resources so the pharmacist can provide information and refer patients when appropriate. Keep a list of such resources in the pharmacy and if possible, make connections with the mental health team in your own community. Normalizing interactions with the mental health community may help reduce stigma and discrimination within the pharmacy.

Recognize your limitations

Set boundaries within your patient encounters. Be careful about taking on other people's problems unnecessarily or trying to take on the responsibility to "fix" problems. Sometimes all we can do is listen and make every effort not to make someone feel worse. Talk to someone if you are having difficulty disconnecting from work stress and are taking people's problems home with you.

Conclusion

Although anxiety is one of the most commonly diagnosed psychiatric disorders, adequate treatment is often obstructed by the effects of stigma. By increasing knowledge and awareness surrounding mental health disorders and their management, pharmacy technicians can help reduce stigma and discrimination while providing patients with a safe environment to receive optimal care.

Due to the increased stress associated with the COVID-19 pandemic, there is no better time for pharmacy technicians to step up and adapt. Pharmacy technicians are in a unique position, being on the front line of care, to help make a positive impact in the lives of people with mental health disorders.

The author thanks Jessianne Grimard and Jori Wright, fourth-year PharmD students at the University of Saskatchewan, for their input on this lesson.

REFERENCES

1. World Health Organization: Mental health: strengthening our response- Fact sheet No. 220. Available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response. Accessed September 9, 2020

2. World Health Organization constitution: Available at: https://www.who.int/about/who-we-are/constitution. Accessed September 9, 2020

3. Vigo D, Thornicroft G, Riffat A. Estimating the true global burden of mental illness. Lancet Psychiatry; 2016: 3(2): 171-178.

4. Mental Health Commission of Canada. Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada. Mental Health Commission

of Canada; 2009 Nov. 129 p. ISBN: 978-0-9913795-0-0 Available at: https://www.mentalhealthcommission.ca/sites/default/files/FNIM_Toward_Recovery_and_Well_Being_ENG_0_1.pdf. Accessed September 9, 2020
5. Government of Canada. Report from the Canadian Chronic Disease Surveillance System: Mental Illness in Canada, 2015: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/report-canadian-chronic-disease-surveillance-system-mental-illness-canada-2015.html. Accessed August 2020.
6. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th ed. Arlington, VA: American Psychiatric Association; 2013.
7. Smetanin P, Stiff D, Briante C, et al. The life and economic impact of major mental illnesses in Canada: 2011-2041. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica; 2011 https://www.mentalhealthcommission.ca/sites/default/files/MHCC_Report_Base_Case_FINAL_ENG_0_0.pdf. Accessed August 2020.
8. CAMH. Mental Illness and Addiction: Facts and Statistics. https://www.camh.ca/en/driving-change/the-crisis-is-real/mental-health-statistics. Accessed August 2020.
9. Institute for Health Metrics and Evaluation (2015). Global Burden of Diseases, Injuries, and Risk Factors Study, 2013. Data retrieved from http://www.healthdata.org/data-visualization/gbd-compare. Accessed September 28, 2020.
10. Nasrallah, HA. From the editor: During a viral pandemic, anxiety is endemic: The psychiatric aspects of COVID-19. Curr Psychiatry 2020; 19:4 e3-5.
11. Pfefferbaum B and North CS. Mental Health and the Covid-19 Pandemic. N Engl J Med 2020; 383:6:510-12.
12. CAMH. Addressing Stigma. https://www.camh.ca/en/driving-change/addressing-stigma. Accessed August 2020.
13. Lancet Editorial: The health crisis of mental health stigma. The Lancet; 2016: 387(10023):1027-1028. https://doi.org/10.1016/S0140-6736(16)00687-5
14. Thornicroft G, Mehta N, Clement S, et al. Evidence for effective interventions to reduce mental health related stigma and discrimination. Lancet 2016; 387: 1123-32.
15. Yanos PT, Lucksted A, Drapalski AL et al. Interventions targeting mental health self-stigma: a review and comparison. Psychiatr Rehabil J 2015; 38(2): 171-178.
16. Canadian Mental Health Association. Stigma and Discrimination. https://ontario.cmha.ca/documents/stigma-and-discrimination/#:~:text=Help%20them%20realize%20how%20their,people%20with%20mental%20health%20conditions. Accessed August 2020.
17. Unger T, Knaak S. The hidden medical logic of mental health stigma. Aust N Z J Psychiatry 2013; 27:611-2.
18. Rubio-Valera M, Chen TF, O'Reilly CL, et al. New roles for pharmacists in community mental health care: a narrative review. Int J Environ Res Public Health 2014; 11(10):10967-90.
19. Mental Health Commission of Canada: Mental Health First Aid Accessed at: https://www.mhfa.ca/ August 2020
20. Mental Health America. Person-Centered Language. https://www.mhanational.org/person-centered-language. Accessed August 2020.
21. Anxiety and Depression Association of America. Watch Your Words: Why Mental Health Awareness Should be Year Round. https://adaa.org/learn-from-us/from-the-experts/blog-posts/consumer/watch-your-words-why-mental-health-awareness. Accessed August 2020.
22. Granello DH, Gibbs TA. The power of language and labels: "The Mentally Ill" versus "people with Mental Illnesses". Journal of Counseling and Development 2016; 94:31-40.
23. https://www.psychiatry.org/patients-families/anxiety-disorders/what-are-anxiety-disorders. Accessed September 28, 2020.
24. Giacobbe P, Flint A. Diagnosis and Management of Anxiety Disorders. Continuum 2018(3); Behavioural Neurology and Psychiatry: 893-919.
25. Bandelow B, Michaelis S, Wedeking D. Treatment of anxiety disorders. Dialog Clin Neuroscience 2017; 19(2):93-106.
26. Craske MG, Stein MB. Anxiety. Lancet 2016; 388:3048-3059.
27. Shah AA. Anxiety. Continuum 2015; 21(3):772-82.
28. Katzman MA, Belau P, Bilier P et al. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive compulsive disorders. BMC Psychiatry 2014; 14 (Supp1): S1
29. Vermani M, Marcus M, Katzman MA. Rates of detection of mood and anxiety disorders in primary care; a descriptive, cross-sectional study. Prim Care Companion CNS Disord 2011; 13 (2).
30. Thibaut F. Anxiety Disorders: A review of current literature. Dialogues Clin Neurosci. 2017 Jun; 19(2): 87–88.
31. Latas M, Latas DV, Stojakovic MS. Anxiety disorders and medical illness comorbidity and treatment implications. Current Opin Psychiatry 2019:32; 429-434.
32. Jensen B, Regier L. RxFiles Comparison Chart-Anxiety Disorder Medication April 2020
33. https://www150.statcan.gc.ca/n1/daily-quotidien/200527/dq200527b-eng.htm. Accessed September 28, 2020.
34. https://www.publichealthontario.ca/-/media/documents/ncov/main/2020/08/substance-use-related-harms-disruption.pdf?la=en. Accessed September 28, 2020.
35. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00065-eng.htm. Accessed September 28, 2020.
36. Hofmann SG, Smits JA. Cognitive-behavioural therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. J Clin Psychiatry 2008; 69 (4)621-32.
37. Roemer L, Williston SK, Eustis EH et al. Mindfulness and acceptance-based behavioural therapies for anxiety disorders. Curr Psychiatry Rep 2013; 15 (11): 410.
38. Dupuis G, Laurence JR, Tourjman Sv. Relaxation, hypnosis, mediation In Lalonde JR et al. Psychiatrie Clinique 4th edition. Montreal, Quebec: Cheneliere; 2016.

QUESTIONS

Please select the best answer for each question and answer online at eCortex.ca for instant results.

1. Stigma is often experienced by patients with mental illness and substance use disorders. All of the following statements are true EXCEPT:

a) Stigma is a negative stereotype
b) Stigma is equated to a "mark of shame"
c) Stigma is unfair treatment due to a person's identity
d) Stigma makes inaccurate generalizations and assumptions about individuals who are viewed as different

2. Examples of discrimination include:

a) Not hiring an individual because they have a mental illness
b) Avoiding talking to a customer because he has a mental health disorder
c) Refusing treatment due the different colour of someone's skin
d) All of the above

3. The STOP criteria may be used to recognize attitudes and actions in yourself and others that promote stigma and discrimination. STOP stands for:

a) Stereotype, Trivialize, Offend and Patronize
b) Stereotype, Traumatic, Offend and Patronize
c) Stigma, Trivialize, Offend and Patronize
d) None of the above

4. An example of a patronizing action includes which of the following:

a) Blaming the patient for their illness
b) Viewing individuals with mental illness as weak
c) Using offensive language to describe the patient
d) Making patient A wait longer because she is not as important as patient B. Patient A has a mental illness.

5. Which of the following actions can help a pharmacy technician reduce stigma and discrimination within their pharmacy environment?

a) Complete Mental Health First Aid Certification
b) Place signage in the pharmacy indicating it is a safe place to talk about mental health concerns
c) Use patient-centred language with all patient interactions
d) All of the above

6. All of the following statements about anxiety disorders are correct EXCEPT:

a) Anxiety disorders are the most prevalent mental health disorder
b) Anxiety disorders are associated with a high burden of illness
c) Anxiety disorders usually present for the first time in adulthood
d) More than half of patients with anxiety disorders have multiple types

7. Anxiety differs from anxiety disorder in the following way:
a) The frequency of anxiety symptoms
b) The degree of distress the patient feels and the extent that it interferes with everyday life.
c) Anxiety may occur without a stressor
d) Anxiety involves both physical and emotional symptoms

8. The most prevalent mental health disorder(s) is/are:
a) Depression
b) Anxiety disorders
c) Schizophrenia
d) Bipolar disorder

9. Which of the following disorders is no longer classified as an anxiety disorder?
a) Panic disorder
b) Social anxiety disorder
c) Obsessive compulsive disorder
d) Generalized anxiety disorder

10. Which of the following statements about anxiety disorders is TRUE?
a) Separation anxiety disorder is the most prevalent anxiety disorder in children < 12 years
b) Specific phobias often require long-term medication
c) An individual cannot have more than one type of anxiety disorder at the same time
d) Agoraphobia involves a fear of animals.

11. The pharmacy technician can play an essential role in the identification of patients who may benefit from further interaction and assessment by the pharmacist. Examples of these scenarios include:
a) Frequent requests for sleeping pills and/or benzodiazepines
b) When a patient expresses concerns about paying for their medications recently prescribed for anxiety
c) If a patient is switching from one antianxiety medication to another
d) If you notice that patients are not filling or picking up their prescriptions, especially if this is a change from usual
e) All of the above

12. The COVID-19 pandemic is likely to have the following impact on the demands for mental health resources:
a) Increase
b) Decrease
c) No change
d) None of the above

13. Examples of patient-centred-language include all of the following EXCEPT:
a) Person with a substance use disorder
b) The schizophrenic patient
c) The individual with depression
d) The patient living with mental illness

14. The following substances may worsen or aggravate anxiety symptoms and should be avoided if possible:
a) Caffeine
b) Corticosteroids
c) Pseudoephedrine
d) All of the above

15. Anxiety disorders are commonly treated with the following group of medications
a) Antidepressants
b) Muscle-relaxing agents
c) Antipsychotics
d) Mood stabilizers

TECH talk CE

Presented by pharmacy PRACTICE + BUSINESS

Sponsored by teva

Anxiety and Mental Health Awareness: The role of the pharmacy technician

1.5 CE Units • NOVEMBER 2020
To find this lesson, enter the CCCEP number 1329-2020-3114-I-T

Please consult this course online at eCortex.ca for specific expiry dates.

***REFERENCE ONLY: PLEASE SUBMIT YOUR ANSWERS ONLINE**

1. a b c d	**4.** a b c d	**7.** a b c d	**10.** a b c d	**13.** a b c d
2. a b c d	**5.** a b c d	**8.** a b c d	**11.** a b c d e	**14.** a b c d
3. a b c d	**6.** a b c d	**9.** a b c d	**12.** a b c d	**15.** a b c d

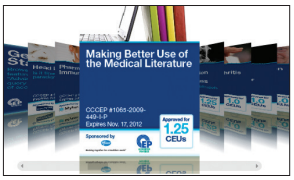
Accredited by the Canadian Council on Continuing Education in Pharmacy

FOR IMMEDIATE RESULTS, ANSWER ONLINE AT eCortex.ca

> Sign in and click on **eCortex.ca**
OR click on **Education** and then **ECortex**.

> To find this lesson, enter the CCCEP number (**1329-2020-3114-I-T**) in the **Quick Search ECortex**, and hit **Go**.

Canadian HealthcareNetwork.ca



For information about CE marking, please email canadianhealthcarenetwork@halldata.com.
All other inquiries about Tech Talk CE should be directed to Vicki Wood at 437-889-0615, ext. 1254 or vwood@ensembleiq.com.