

Mental Illness Counseling: Communication Strategies and Resources for Pharmacists

Brooke K. Kinast and Allyson H. Wexler, PharmD Candidates, The Ohio State University; and Michelle Maguire, R.Ph., PharmD, Clinical Pharmacist Specialist, Southeast, Inc. Mental Health

Brooke Kinast, Allyson Wexler, and Michelle Maguire have no relevant financial relationships to disclose.

Goal. The goal of this lesson is to define mental illness, identify barriers to patients receiving treatment, and provide communication strategies for pharmacists to help patients overcome these obstacles. Clinical pearls of antipsychotics and mood stabilizers will also be discussed, in addition to resources available for mental health patients and healthcare providers.

Objectives. At the completion of this activity, the participant will be able to:

1. define mental illness and its prevalence in the U.S.;
2. identify current barriers in communication between pharmacists and patients with mental illnesses;
3. demonstrate an understanding of approaches to improve pharmacists' confidence in discussing mental health conditions and medications with patients;
4. list key counseling points of antipsychotics, mood stabilizing medications, and antidepressants that may be utilized during counseling sessions; and
5. list communication tools and resources for pharmacists to counsel and educate patients with mental illness.

Background

Serious mental illness (SMI) is

defined as a mental illness resulting in behavioral or emotional distress. This distress leads to serious functional impairment that substantially interferes with, or limits, at least one activity of daily living, such as the ability to maintain employment. SMI includes schizophrenia, bipolar disorder and severe depression. SMI affects 9.6 million adults, representing 4.1 percent of the adult population in the United States.

Any mental illness (AMI), a broader category, includes mental illnesses that cause more mild impairment and affects an even larger population. In the U.S., 43.7 million or 18.6 percent of the adult population are affected with AMI. SMI and AMI are most effectively treated with antipsychotics, antidepressants, and mood stabilizers.

Medication Non-Adherence

Medication non-adherence is a major factor in the recurrence of psychiatric symptoms, relapse, and rehospitalization, compromising the patient's health and well being. The Bipolar Evaluation of Satisfaction and Tolerability Study, a large national survey of 1,052 outpatients ages 18- to 65-years-old with bipolar disorder, found that nearly half (49.5 percent) of the study's participants were non-adherent with prescribed psychotropic medications as measured by the Morisky Medication Adherence Scale. The increased number of medications being taken, cost, side

effects and the perception that they aren't "working" as expected are major causes of medication non-adherence.

Pharmacists have the potential to help patients with mental illness improve their adherence to treatment. Pharmacists can help reinforce what the medications are for and how they work. Patients need constant reinforcement to continue to take their medications as directed and not stop therapy once they are feeling "better."

Pharmacists can work with psychiatric prescribers to discuss serious side effects, avoid drug-drug interactions, recommend dose form changes to improve side effects, and communicate cost-related barriers. Patients can also be reminded by pharmacists of the importance of following through on laboratory testing and continued evaluation by their prescribers.

Barriers to Treatment and Communication

Factors that interfere with patients seeking appropriate mental health care include lack of perceived need for treatment, the self-stigma associated with mental illness, and negativity toward the effectiveness of treatment. Also, patients may lack access to healthcare due to financial or other barriers, such as difficulty with transportation to doctors' appointments.

Research has shown that both clinicians and society associate a negative stigma with individuals

who have mental illness, including the perception that these patients are incompetent, unpredictable and dangerous. Effective communication from healthcare providers can help patients understand their illness and the importance of treatment. Treating patients as individuals, helping them feel respected and not stigmatized, and providing a safe environment to talk about health concerns and invite questions can help minimize this gap in mental health treatment.

Healthcare providers should identify and work toward overcoming their own biases against patients with mental illness. A study based on the results of surveys completed by 292 community pharmacists in 2006 looked at pharmacists' attitudes toward patients with mental illness, and how attitudes affected their willingness to counsel patients on mental health medications. Pharmacists with less negative attitudes toward patients with mental illness and who valued the importance of counseling were more likely to provide services to these patients. Pharmacists reported the need for additional training on how to effectively educate and monitor patients with mental illness. This was reported as one of the factors affecting the pharmacists' decision to provide services to patients with mental illness.

Communication Techniques

Verbal Immediacy. A systematic, yet genuine, approach by healthcare providers is key to communicating with patients about mental illnesses. Verbal immediacy was introduced in 1968 by Wiener and Mehrabian as a model of communication that analyzes the words used by people. Verbal immediacy analyzes messages that appear to say the same thing, but with different words. The verbal immediacy model can be used to minimize degrees of separation between the speaker and subject, in order to establish teamwork between practitioners and patients in managing their disease.

Table 1
Examples of verbal immediacy

	Non-immediate	Immediate
Symbols of non-immediacy	"Remember, <i>it</i> said your medications were too early until the 20 th of the month."	"Remember, <i>we</i> called your insurance and this medicine will go through the 20 th of this month." (<i>most immediate</i>)
<i>Us</i> versus <i>Them</i>	" <i>The</i> medication is ready."	" <i>Your</i> medication is ready."
Time	"Did you feel comfortable <i>when people</i> talked about your medications?"	"Would you feel comfortable if <i>we</i> talk about your medications today?"

Pharmacists' choice of words when interacting with patients can reveal their true attitudes and feelings toward patients and their illness. Immediacy implies a direct involvement of the pharmacist, along with the patient, in their treatment plan, which assists in building an environment where the patient feels comfortable articulating concerns. For example, "we" demonstrates immediate communication, while "you and I" implies non-immediate communication. Although "we" and "you and I" refer to the same subjects, "we" implies more immediacy and supports a patient-pharmacist unit, while "you and I" continues to designate the pharmacist and patient as two separate entities. Examples of verbal immediacy can be found in Table 1 above.

Literature has shown that both patients and healthcare providers use non-immediate language when dealing with certain persons or discussing a difficult topic, such as mental illness. Immediate language may not be natural, but it can be taught using three simple steps.

Step one to more immediate language is identifying specific topics and issues that make you, the pharmacist, uncomfortable. The next step is to make a list of groups and individuals with whom you find it difficult to communicate. Finally, begin to identify degrees of immediacy used and opportunities to incorporate verbal immediacy

into patient communication.

There are three categories that have been used to identify non-immediate language: (1) symbols of non-immediacy, (2) "us" versus "them," and (3) time. Symbols of non-immediacy refer to using "I" or "we" statements rather than the less specific "everyone" or "it." Use of "I" statements allows pharmacists to deal with patients on a personal level.

"Us" versus "them" theorizes that better rapport is built when there is less degree of separation between the communicator and recipient. For example would be, "Our mutual patient is out of their medication and needs a refill" is more immediate than "the patient is out of their medication and needs a refill."

The last category of non-immediacy is time, which looks at the temporal relationship between the speaker and the object. Speaking in terms of the present is more immediate, than referring to the past or future. This would be similar to, "Did anyone ever tell you how to take this?" A more immediate approach would be, "Let's talk about how you should take this medicine." Additional examples can be found in Table 1. Using these methods can help establish a relationship in which patients feel comfortable to discuss healthcare concerns, specifically mental illnesses.

Motivational Interviewing.

An effective approach to communi-

cating with all patients, specifically patients with mental illness, is to use motivational interviewing (MI) techniques, as shown in Table 2. Motivational interviewing is based on the Transtheoretical Model for Change, a step-wise approach to assess patients' acceptance and readiness for behavioral change in five sequential steps. Pharmacists can utilize MI to improve medication adherence in patients with SMI such as schizophrenia, bipolar disorder, and depression. This type of patient-centered approach has been shown to increase patients' insight and attitude toward treatment of their mental illness. MI allows patients to set their own goals, develop the goals, and become an active participant in their treatment.

MI uses four general principles to facilitate the process of behavioral change: (1) express empathy, (2) develop discrepancy, (3) roll with resistance, and (4) support self-efficacy. Expressing empathy encourages an open dialogue between the healthcare provider and the patient, which promotes understanding of the patient's situation and motivation to change. Recognizing a discrepancy between patients' current situations and their goals will help them see what needs to be done to get where they want to be. Resistance from patients should be welcomed, rather than challenged, by the healthcare provider. Resistance should be used to develop ideas and solutions to barriers of change. Self-efficacy is a significant motivator for change. Patients need to believe that this change is possible and that they are capable of taking the necessary steps to reach their goals.

There are four communication techniques with MI that should be used to promote the stages and principles of change: (1) open-ended questions, (2) affirmations, (3) reflective listening, and (4) summaries. *Open-ended questions* allow for discussion to occur between the patient and the healthcare provider, allowing patients to elaborate and explore change. For example,

"Tell me about what's happened since I've last seen you at the pharmacy."

Affirmations are statements that identify the patient's strengths, as well as validate the patient's feelings toward change. This would be similar to, "I understand it is difficult to stay on track with all of your appointments. I admire you for managing your busy schedule, you're doing a great job."

Reflective listening is used to keep the conversation moving forward in order for the patient to reach their goals. For instance, "It seems as if you are trying to change, but you are concerned your work schedule is keeping you from your appointments."

Providing *summaries* can be used to demonstrate that the healthcare provider is listening to the patient, and that the provider is interested in what the patient is saying. An example would be, "Let me summarize what I'm understanding. You have a new job since I've last seen you and your new schedule is making it hard to manage doctors' appointments. Let me help by at least setting all of your medications for the same pick up date." These techniques are effective in promoting change, as well as facilitating the development of a relationship between the patient and the provider. An additional example of motivational interviewing can be found in Table 2.

There are some adjustments that can make MI more effective in the SMI population. Patients with schizophrenia often have poor insight into their mental illness. Inadequate insight, e.g., lack of awareness and social consequences of a disease, often leads to poor treatment adherence and outcomes. Insight implies that patients are aware of their conditions and the possibility of successful treatment. Effective MI techniques in this population include repetition of information, breaking more lengthy behavioral goals into shorter steps, and using educational handouts to limit demands on memory and attention.

Table 2 Motivational interviewing dialogue

RPh (*open-ended question*): "What concerns do you have about taking your Seroquel?"

Patient: "I've never had to take a medication every day."

RPh (*affirmation*): "I understand it is an adjustment to have to take a medication every day. **Your commitment really shows** by coming into the pharmacy and asking questions about your medication."

Patient: "Thanks, I'm trying to make improvements in my life but I am not sure I can."

RPh (*reflective listening*): "I'm hearing that there is a lot of pressure on you to change, and you are not sure you can do it because of the difficulties you had when you tried in the past."

Patient: "Yes, I am concerned that I will stop taking my medication if I begin to notice side effects."

RPh (*summary*): "It sounds like you are concerned about taking your new medication daily because it may be difficult to remember to take your medications. That, along with the unwanted side effects may make it difficult to continue working toward change. I would suggest putting your Seroquel on your nightstand and take it right before going to bed. That will help you develop a routine and avoid the side effect of drowsiness."

By using MI techniques, pharmacists can help patients develop insight and form an adherence plan. Bipolar patients may resist change because they often experience pleasure from their symptoms. For example, bipolar patients often report increased self-esteem and energy as a result of a manic episode. This pleasure can lead to ambivalence when it comes to medication adherence. Using MI, the patient is able to express his concerns and resolve them with the assistance of the healthcare provider. Reinforcement of the patient's

Table 3
Dealing with anxious and hostile patients

Patient Behavior	Appropriate Response
Beginning stages of anxiety	<ul style="list-style-type: none"> • Safe body language: stand at an angle (not eye-to-eye), with arms uncrossed and face relaxed • Safe tone of voice: remain calm, rational, and professional • Change the scene: go to a more quiet or private area • Bring in a supervisor or different staff person: this helps to redirect the patient and convey the importance of the situation.
Escalating language	<ul style="list-style-type: none"> • Do not take it personally: matching anger or anxiety will worsen the situation. • Clarify and reflect: listen for the real message and feelings. Ask reflective questions, use silence and restatements, e.g., “I am hearing you are upset that you can’t get your medicine today. Let’s figure out how we can get this covered.” • Ignore challenging questions: redirect away from challenging your authority or a facility policy. Avoid power struggles. • Be clear and concise: give concrete answers, e.g., “Your insurance will pay for this next Tuesday. Do you have enough medicine at home?” is better than “You cannot get this until next week. What did you do with the rest of your medicine?”
Extreme venting and hostile behavior	<ul style="list-style-type: none"> • Allow venting: if possible, briefly let the patient release energy and frustrations. Do not match the tone of voice or volume. • Set reasonable limits: provide clear choices and consequences, e.g., “I can see you are very upset. If you lower your voice and let me look into the situation, we can figure this out now. Or you can come back later, if you are not able to calm down.”
After anxiety has subsided	<ul style="list-style-type: none"> • Resolve the issue: find the root problem, resolve quickly, and identify resources to help if necessary. • Build therapeutic rapport: summarize the situation and validate the patient’s concerns.

Strategies adapted with permission from the Crisis Prevention Institute. This is intended to be informative, and is not intended to take the place of formal training on crisis situations.

motivation and readiness to change is a powerful way of decreasing ambivalence toward medications and supporting change.

The Anxious or Hostile Patient

More than 50 percent of patients with mental illness have a concurrent anxiety disorder. This anxiety can manifest into hostile or aggressive behavior, negatively impacting a patient’s ability to receive appropriate care. In a community pharmacy setting, hostile behav-

ior or language from patients can disrupt other patients’ care, cause staff stress, and prevent patients from getting their critically needed medications. Pharmacists and support staff can use the communication strategies outlined in Table 3 in order to defuse these situations and prevent potential crises.

Pharmacists should also identify the root causes of patient anxiety. Many SMI patients have low health literacy and cognitive impairments, making it difficult for them to understand medication-

related problems such as co-pays, prior authorizations, and early refills. Explaining things in simple terms with concrete answers can assist with this. Patients may also struggle with social phobias, making a crowded and noisy pharmacy waiting room a difficult situation. Staff can try to redirect patients to a quiet or more private area in the pharmacy to interact in a calmer environment.

Additionally, patients with mental illness are often not “taken seriously” by healthcare providers. Pharmacists should try to remove their personal biases and remain empathetic to the patient’s concerns.

Resources

In addition to psychiatric medication management, patients with SMI can benefit from case management and other services to aid in medication adherence and treatment satisfaction. Many patients face additional barriers including low literacy, poverty, homelessness, and lack of phones or transportation. Case managers and social workers can help patients understand and obtain available resources. Social workers can help patients determine eligibility for Medicare, Medicaid, and other types of insurance, helping them gain access to prescription medications. Social workers, counselors, and peer groups also assist patients with setting and working toward their own treatment goals.

Across the country there are many national, state-funded, and non-profit organizations that can assist healthcare providers and patients find treatment services and information. The National Alliance on Mental Illness (NAMI) is the largest mental health organization in the United States. NAMI is the foundation for many statewide organizations, including NAMI of Ohio. NAMI advocates for patients with mental illness by focusing on providing access to services, treatment, support, and research. Along with patient resources, they provide education on mental ill-

ness for healthcare providers and caregivers. Information regarding the courses offered can be found at www.nami.org.

In Ohio, for example, the Ohio Department of Mental Health & Addiction Services (OhioMHAS) provides mental health and addiction prevention, treatment, and recovery resources for all Ohio citizens. They operate Central Pharmacy which provides free psychiatric medications to indigent patients with SMI. Their website provides patient-directed information about institutions for mental health and addiction treatment, prevention resources, and support services to maintain a positive life. The OhioMHAS website is also a great resource for pharmacists to learn about current legislation, initiatives, and funding resources. Additional information can be found at www.mha.ohio.gov.

OHIOCARES is a collaboration of state and local agencies that provide community behavioral health services for returning veterans and their families. The purpose of the organization is to enhance the community of behavioral health services available for military personnel and their families. OHIOCARES is available to complement the services through the Department of Veterans Affairs. This resource can be helpful for returning veterans to deal with the transition from active duty back to civilian life. Additional information can be found at ong.ohio.gov/ohiocares/index.htm.

Pharmacists in other states can explore similar resources through state and local health departments, as well as the federal organization Substance Abuse and Mental Health Services Administration (SAMHSA). Additional information can be found at www.SAMHSA.gov.

Lastly, pharmacists should be prepared to discuss suicide with patients and help patients in need get connected to the appropriate resource: physician, suicide hotline, or crisis center. Pharmacists should observe if patients are

significantly “different” than when previously seen, and approach the patient in a non-judgmental, open-ended format. NAMI promotes the crisis line of the American Association of Suicidology, 800.273.TALK (8255). Their website, www.suicidology.org, provides a listing of state-by-state suicide crisis lines. More pharmacist-specific information can be found at Pharmacists Preventing Suicides, Inc., www.pharmacistspreventing suicides.com.

Key Counseling Points for Antipsychotics

The following will focus on medication counseling points to include when communicating with patients. Antipsychotics are the main pharmacologic treatment for schizophrenia, and are also an important treatment for bipolar disorder. First generation antipsychotics (FGAs) are dopamine antagonists, and second generation antipsychotics (SGAs) work to antagonize both dopamine and serotonin. All antipsychotics are equally effective if used in therapeutic doses.

Major side effects of all antipsychotics include sedation, anticholinergic side effects, extrapyramidal symptoms and tardive dyskinesia, prolactin elevation, orthostasis, QTc prolongation, and metabolic side effects such as weight gain, and glucose and lipid abnormalities. SGAs tend to cause fewer extrapyramidal symptoms (EPS), less tardive dyskinesia, and less prolactin elevations compared to FGAs. However, they come with the burden of more metabolic side effects. Pharmacists should educate patients on the importance of monitoring metabolic effects and seeing a primary care provider to obtain appropriate lab testing including A1c and lipid panels. Other key considerations of the SGAs are presented below.

SGAs include aripiprazole, asenapine, iloperidone, lurasidone, paliperidone, clozapine, olanzapine, quetiapine, risperidone, and ziprasidone.

Aripiprazole, or Abilify, has a dosage range that varies greatly based on indication, but can range from 2 to 30 mg as a daily maximum dose. Aripiprazole is available as both a tablet, and long-acting Abilify Maintena intramuscular injection with a dose of 400 mg monthly. It is usually dosed in the morning because it can cause insomnia. Side effects for aripiprazole are generally mild in terms of metabolic effects, however patients often experience akathisia (a movement disorder characterized by a feeling of inner restlessness). The dose of aripiprazole may need to be decreased when administered with strong CYP2D6 and CYP3A4 inhibitors or inducers.

Asenapine, marketed as Saphris, is available as an oral disintegrating tablet in 5 and 10 mg dosage forms to be taken twice daily. Patients should be told to place the tablet under the tongue to dissolve, and to not swallow the tablet. Patients should avoid eating and drinking within 10 minutes of taking the medication to avoid a drug-food interaction. A strong CYP1A2 inhibitor, such as fluvoxamine, and strong CYP2D6 inducer and inhibitor like paroxetine should be administered cautiously.

Iloperidone, marketed as Fanapt, should be titrated slowly due to the dizziness and orthostatic hypotension associated with its alpha-adrenergic properties. The recommended starting dose is 1 mg twice daily, but should be increased to a target dose of 6 to 12 mg twice daily (12 to 24 mg/day). Dose adjustments should be made daily and should not exceed increases greater than 2 mg twice daily (4 mg/day). Patients should be informed that while the titration is occurring, they may not see resolution of symptoms. Iloperidone has the potential to enhance the effect of antihypertensive agents. Iloperidone is metabolized by CYP3A4 and CYP2D6; therefore, drugs that inhibit these enzymes such as paroxetine and fluoxetine can increase concentrations of iloperidone.

Lurasidone, or Latuda, has a

starting dose of 20 to 40 mg daily depending on the indication, but can be increased to a maximum dose of 160 mg daily. Common side effects associated with lurasidone include akathisia, somnolence, and extrapyramidal symptoms. Lurasidone should be taken with food, at least 350 calories, to increase absorption. Lurasidone is metabolized mainly by CYP3A4; therefore, its use is contraindicated when taking concomitant strong CYP3A4 inducers or inhibitors.

Paliperidone, marketed as Invega, is available in a tablet form, dosed from 3 to 12 mg daily, as well as a long-acting intramuscular injection, Invega Sustenna, which is dosed once monthly. Before Invega Sustenna is started, tolerability of the oral form of paliperidone or risperidone must be established. When initiating Invega Sustenna, a loading dose should be given to get the patient to therapeutic levels. Without this loading dose, patients will not reach steady state and will remain subtherapeutic for the duration of treatment. Paliperidone has been associated with orthostatic hypotension, and may cause an additive effect with other drugs. Carbamazepine may decrease the concentration of paliperidone, and divalproex may increase its concentration, which may require dosage adjustments.

Clozapine, or Clozaril, is approved for treatment-resistant schizophrenia. Dispensing of clozapine is restricted to pharmacies participating in the risk evaluation and mitigation strategies (REMS) program due to risk of agranulocytosis. Before initiating therapy, a white blood cell count $\geq 3,500/\text{mm}^3$ and absolute neutrophil count $\geq 2,000/\text{mm}^3$ must be confirmed and monitored regularly. Clozapine is initiated at 12.5 mg once or twice daily, and increased in 25 to 50 mg daily increments to a maximum tolerated dose. Dose limitations include hypotension and bradycardia. Typical doses are 300 to 450 mg daily administered in divided doses. Subsequent increases should be done in 100 mg incre-

ments once or twice weekly. The maximum approved daily dose is 900 mg. This medication should be used with caution in patients with a history of seizures or cardiovascular disease, due to the increased risk of seizures and cardiovascular complications. The most common side effects include metabolic effects, hypotension, anticholinergic side effects, and sedation. Clozapine should be reduced to one-third of the original dose when used with strong CYP1A2 inhibitors, such as fluvoxamine or ciprofloxacin. CYP3A4 inducers should not be used with clozapine due to risk of decreased clozapine effectiveness. Clozapine dose reductions should be considered when discontinuing CYP1A2 inducers, including smoking and CYP3A4 inducers such as carbamazepine.

Olanzapine, marketed as Zyprexa, has a typical maintenance dose ranging from 10 to 20 mg daily. Olanzapine is also available in oral disintegrating tablets and short- and long-acting intramuscular injections. The use of the intramuscular formula is limited due to rare but serious adverse effects including hypotension, orthostasis, and post-injection delirium/sedation syndrome, requiring clinicians to enroll in a national registry and observe patients for three hours after every dose. The most common adverse effects include metabolic effects and anticholinergic side effects. Therapeutic alternatives should be considered in patients taking strong CYP1A2 inducers or inhibitors.

Quetiapine, or Seroquel, is available in immediate and extended-release formulations. Low doses should be used upon initiation of therapy and titrated daily to tolerable doses. Adverse effects include metabolic effects, sedation, and hypotension. The dose should be decreased to one-sixth of the original dose when used in combination with a strong CYP3A4 inhibitor such as ketoconazole, itraconazole, indinavir, ritonavir, or nefazodone. The dose of quetiapine should be increased up to five times

the original dose when used long term with a CYP3A4 inducer such as carbamazepine, phenytoin, or rifampin. Quetiapine should be titrated slowly in patients who have been off therapy for more than one week.

Risperidone, marketed as Risperdal, is available in oral and intramuscular formulations. Common adverse effects include sexual side effects as a result of increased prolactin levels, dose-related EPS, and metabolic side effects. Risperidone is a substrate of CYP2D6 and CYP3A4. The use of risperidone with CYP3A4 and CYP2D6 inducers and/or inhibitors should be monitored. Therapeutic modifications should be considered with strong CYP2D6 inhibitors.

Ziprasidone, marketed as Geodon, is available as oral capsules or as an intramuscular injection. Ziprasidone should be administered with a meal consisting of at least 500 calories to improve absorption. The most notable adverse effect is QTc prolongation; EPS, tardive dyskinesia, sexual side effects, sedation, and hypotension can also be seen.

Key Counseling Points for Mood Stabilizers

Mood stabilizers, including lithium, carbamazepine, valproic acid, and lamotrigine, have been shown to be effective in treating acute manic or mixed episodes associated with bipolar I disorder in adults. SGAs and mood stabilizers are used for a variety of FDA-approved and off-label indications. Pharmacists should refer to the package insert for more information on approved indications.

Lithium doses should be initiated at ≤ 300 mg orally three times daily, and adjusted based on serum concentration and clinical response. Serum lithium levels should be monitored twice weekly until lithium levels and clinical status are stable, then repeated every one to three months, or as clinically indicated. Most patients are treated successfully at 0.6-1.0 mEq/L. Lithium levels greater

than 1.5 mEq/L carry a greater risk of toxicity, however toxicity may vary among patients. Serum lithium levels should not exceed 2.0 mEq/L during the acute treatment phase. Lithium toxicity can lead to coma, seizures, and cardiovascular collapse. Patients should be educated about early toxicity symptoms including drowsiness, confusion, coarse hand tremor, and ataxia. Due to urinary excretion, creatinine should be monitored, and consistent water and sodium intake should be encouraged in order to prevent fluctuating lithium levels. Common side effects include hypothyroidism, nephrotoxicity, tremor, polyuria, and diarrhea. Pharmacists may be able to help patients identify and recommend pharmacological treatment to manage these adverse effects. NSAIDs, ACE inhibitors, thiazide and loop diuretics, verapamil and diltiazem can increase lithium concentrations; caffeine, theophylline, sodium bicarbonate, and dialysis can decrease lithium concentrations. Increased neurotoxicity risks should be noted with the addition of lithium to anticonvulsants and antipsychotics.

Carbamazepine, or Tegretol, is a potent inducer of CYP3A4, and also auto-induces its own metabolism, usually requiring a dose increase after five to six weeks of therapy. The dose is generally initiated at 200 mg orally twice daily. Chronic use of carbamazepine has been shown to elevate homocysteine and serum lipoprotein concentrations, biomarkers of cardiovascular disease. Carbamazepine should also be used with caution in patients with an abnormal electrocardiogram. Patients should be warned about the risk of rash, including potentially fatal Stevens-Johnson syndrome. If a rash occurs, patients should be instructed to seek immediate medical attention.

Valproic acid is available in a variety of dosage forms including capsules, sprinkle capsules, liquid, and extended-release. The maximum recommended dose of

valproic acid is 60 mg/kg/day, but should be titrated slowly to prevent gastrointestinal upset. Common side effects with valproic acid are weight gain, tremor, thrombocytopenia, hepatotoxicity, and alopecia. Valproic acid is classified as pregnancy category D for use in bipolar disorder. Patients considering pregnancy should consult with their physicians. Valproic acid is metabolized mainly via glucuronidation and oxidation, with minor impact of the CYP450 system.

Lamotrigine, marketed as Lamictal, should be initiated at 25 mg daily and slowly titrated to a therapeutic dose of 200 mg daily, due to the risk of rash, including Stevens-Johnson Syndrome. Lamotrigine when used in combination with carbamazepine, phenytoin, phenobarbital, primidone, or valproic acid requires a dose adjustment. Patients should be informed that lamotrigine decreases the effectiveness of oral contraceptives and nonhormonal methods of birth control should be used.

Key Counseling Points for Antidepressants

The most commonly prescribed drug classes for major depressive disorder are selective serotonin reuptake inhibitors (SSRIs) and selective serotonin norepinephrine reuptake inhibitors (SNRIs). SSRIs include fluoxetine, fluvoxamine, sertraline, paroxetine, citalopram, and escitalopram. SNRIs include venlafaxine, desvenlafaxine, and duloxetine.

Side effects associated with these classes of antidepressants include, but are not limited to, weight gain, fatigue, drowsiness, and sexual dysfunction. Citalopram and escitalopram can cause QTc prolongation; daily doses should, therefore, be limited to 40 mg and 20 mg respectively. Blood pressure should be monitored regularly in patients taking venlafaxine and desvenlafaxine due to effects on blood pressure. Patients should be informed that it can take about two weeks to see an improvement in somatic symptoms after starting

an SSRI or SNRI, and up to four to six weeks to see effects on psychological symptoms after initiating treatment. Patients should contact their physician if they have worsening of symptoms or suicidal ideation.

Conclusion

Pharmacists have important roles in the care of patients with mental illness. Verbal immediacy and motivational interviewing are techniques that can bridge the barriers to communication and improve care. There are many resources available to patients in the community, at both a local and national level, that pharmacists should be familiar with to support their patients. Confidence when counseling patients on mental health medications can develop when better communication techniques are implemented and important counseling points for each medication are understood. Pharmacists can help improve medication adherence and patient outcomes by communicating with and counseling patients effectively.

•••••

The authors, the Ohio Pharmacists Foundation and the Ohio Pharmacists Association disclaim any liability to you or your patients resulting from reliance solely upon the information contained herein. Bibliography for additional reading and inquiry is available upon request.

This lesson is a knowledge-based CPE activity and is targeted to pharmacists in all practice settings.

Program 0129-0000-15-004-H01-P

Release date: 4-15-15

Expiration date: 4-15-18

CE Hours: 1.5 (0.15 CEU)

The Ohio Pharmacists Foundation Inc. is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.



continuing education quiz

Mental Illness Counseling: Communication Strategies and Resources for Pharmacists

- Serious mental illness includes all of the following EXCEPT:
 - schizophrenia.
 - anxiety.
 - bipolar disorder.
 - severe depression.
- All of the following are major causes of medication non-adherence EXCEPT:
 - side effects.
 - cost.
 - drug interactions.
 - perception of not "working."
- Which of the following techniques minimizes degrees of separation between the speaker and subject?
 - Verbal immediacy
 - Transtheoretical model for change
 - Motivational interviewing
- Which of the following language implies more immediacy and supports a patient-pharmacist unit?
 - We
 - You and I
- All of the following general principles are used in motivational interviewing EXCEPT:
 - support self-efficacy.
 - roll with resistance.
 - develop discrepancy.
 - force opinions.
- Statements that identify the patient's strengths and validate his feelings toward change are referred to as:
 - open-ended questions.
 - affirmations.
 - reflective listening.
 - summaries.
- The percentage of patients with mental illness who have a concurrent anxiety disorder is more than:
 - 10 percent.
 - 25 percent.
 - 50 percent.

.....
Completely fill in the lettered box corresponding to your answer.

- | | | |
|--------------------|---------------------|---------------------|
| 1. [a] [b] [c] [d] | 6. [a] [b] [c] [d] | 11. [a] [b] [c] [d] |
| 2. [a] [b] [c] [d] | 7. [a] [b] [c] | 12. [a] [b] [c] [d] |
| 3. [a] [b] [c] | 8. [a] [b] [c] [d] | 13. [a] [b] [c] [d] |
| 4. [a] [b] | 9. [a] [b] [c] | 14. [a] [b] [c] [d] |
| 5. [a] [b] [c] [d] | 10. [a] [b] [c] [d] | 15. [a] [b] [c] [d] |

I am enclosing \$5 for this quiz made payable to Ohio Pharmacists Association.

- Rate this lesson: (Excellent) 5 4 3 2 1 (Poor)
- Did it meet each of its objectives? yes no
If no, list any unmet _____
- Was the content balanced and without commercial bias?
 yes no If no, why? _____
- Did the program meet your educational/practice needs?
 yes no
- How long did it take you to read this lesson and complete the quiz? _____
- Comments/future topics welcome.

Please print.

Program 0129-0000-15-004-H01-P
0.15 CEU

Name _____

Address _____

City, State, Zip _____

Email _____

NABP e-Profile ID _____ Birthdate _____ (MMDD)

**Return quiz and payment (check or money order) to
Correspondence Course, OPA,
2674 Federated Blvd, Columbus, OH 43235-4990**

- In Ohio, the following resource provides behavioral health services to returning veterans and their families.
 - NAMI
 - Central Pharmacy
 - OhioMHAS
 - OHIOCARES
- The main pharmacologic treatment for schizophrenia is:
 - antipsychotics.
 - mood stabilizers.
 - antidepressants.
- With which of the following drugs should patients be counseled to avoid eating and drinking within 10 minutes of dosing to avoid a drug-food interaction?
 - Aripiprazole
 - Asenapine
 - Lurasidone
 - Clozapine
- Which of the following drugs should be taken with at least 350 calories to increase absorption?
 - Aripiprazole
 - Asenapine
 - Lurasidone
 - Clozapine
- Which of the following antipsychotics is restricted to pharmacies participating in the REMS program due to the risk of agranulocytosis?
 - Aripiprazole
 - Asenapine
 - Lurasidone
 - Clozapine
- All of the following drugs increase lithium concentrations EXCEPT:
 - NSAIDs.
 - verapamil.
 - theophylline.
 - loop diuretics.
- With which of the following side effects should a patient on carbamazepine seek immediate medical attention?
 - Rash
 - Confusion
 - Tremor
 - Weight gain
- The daily dose of citalopram should be limited to 40 mg to avoid the risk of:
 - hypotension.
 - sedation.
 - weight gain.
 - QTc prolongation.

.....

To receive CE credit, your quiz must be received no later than April 15, 2018. A passing grade of 80% must be attained. CE credit for successfully completed quizzes will be uploaded to the CPE Monitor. CE statements of credit can be printed from the CPE Monitor website. Send inquiries to opa@ohiopharmacists.org.