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Experiences in Teaching and Learning

Student pharmacist experiences as inpatient psychiatry medication education group leaders during an early immersion program

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ABSTRACT

Background and purpose: While research suggests that pharmacists generally hold positive attitudes toward consumers of psychiatric medications, they often feel less comfortable talking about these medications and providing services for patients with mental illness. The purpose of this program was to train second and third year student pharmacists as psychiatry medication education groups leaders and to examine resulting student self-efficacy and mental health stigma.
Educational activity and setting: In partnership with the University of North Carolina (UNC) Eshelman School of Pharmacy, the inpatient psychiatry service at UNC Medical Center expanded weekly medication education groups with the help of trained student pharmacists. All second- and third-year student pharmacists were invited to participate. Pre/post surveys and reflection statements were collected from 13 students that received training, provided informed consent, and participated in one or more medication education groups. Data were analyzed with a mixed methods approach.
Findings: Student responses revealed an increase in student self-efficacy ($p < 0.05$), improved understanding of mental illness, and new strategies for engaging in direct patient care.
Discussion and summary: Results from this study suggest that students gained an appreciation for pharmacists and the workplace while developing self-efficacy and strategies for engaging with patients with mental illness as a part of medication education groups.

Background and purpose

Suicide is the tenth leading cause of death in the United States, with a marked increase in reported cases from 1999 to 2014.[1] Over the course of a year, at least half of patients on psychotropic medication will fail to adhere to prescribed medication regimens.[2] In the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) trial, for example, 74% of enrolled patients self-discontinued medication therapy within 18 months.[3] Access to mental healthcare is paramount to alter this trend, and pharmacists are in an advantageous position to optimize treatment of patients with mental illness.[4]

The World Health Organization (WHO) has identified stigma as the greatest impediment to the provision of effective mental

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healthcare, advocating for strategies that reduce mental health stigma.[5,6] While research suggests that pharmacists generally hold positive attitudes toward consumers of psychiatric medications, they often feel less comfortable talking about these medications than other types of non-psychiatric medications and are less able or interested in providing services to patients with mental illness.[7–9] In pharmacy education, research suggests that traditional practices of lectures and clinical rotations are not enough to reduce mental health stigma among student pharmacists.[10] Although studies demonstrate the positive impact of instructional models that engage student pharmacists with mental health consumers, there is a gap in the literature concerning student immersion in direct patient care for this patient population.

Medication education groups in psychiatry are a cost-effective means to treat a large number of patients at the same time that can instill hope, develop socializing techniques, foster cohesiveness, and promote substance abuse prevention.[11,12] Research has shown significant decreases in medication adverse effects and number of prescribed medications in patients who received drug monitoring and participated in pharmacist-led medication groups.[12] Despite the demonstrated effectiveness of pharmacist-led medication education groups, the integration of these interventions into clinical practice can be a challenge due to limited provider resources.

A growing number of studies demonstrate positive outcomes associated with student engagement in direct patient care early in the pharmacy curriculum.[13–15] McLaughlin and colleagues[13] for example, found that direct patient care experiences promoted student self-efficacy (i.e., belief in one's ability to accomplish a task) and an appreciation for real-world pharmacy practice. Accreditation Council for Pharmacy Education (ACPE) accreditation guidelines state that introductory pharmacy practice experiences (IPPEs) should “expose students to common contemporary US practice models, including …direct patient care activities.”[16] In addition, the Practice Advancement Initiative (PAI, formerly called the Pharmacy Practice Model Initiative (PPMI) Summit) emphasized the importance of working collaboratively with health systems to prepare student pharmacists for emerging and ongoing health care challenges, specifically noting that “curricular changes are required in colleges of pharmacy to prepare students for a significantly larger role in drug therapy management than is currently achieved in most hospitals and health systems.”[17]

In partnership with the University of North Carolina (UNC) Eshelman School of Pharmacy, the psychiatry service at UNC Medical Center expanded the weekly medication education groups across additional units with the help of trained student pharmacists. The Psychiatry Medication Education Group (PMEG) program was designed to provide second- and third-year student pharmacists with real-world experience in an academic medical center through the design and implementation of medication education groups for psychiatric inpatients. While the literature to-date provides some insight into the impact of providing direct contact with mental health consumers,[18–21] there is a gap in the literature concerning the early immersion of student pharmacists in inpatient psychiatry medication education groups. The purpose of this program was to train second and third year student pharmacists as psychiatry medication education group leaders and to examine resulting student pharmacists' development, including self-efficacy[22] and mental health stigma.[23]

Educational activity and setting

The PMEG program was offered in the spring and fall semesters of 2015 to second and third professional year students in the doctor of pharmacy degree program at the UNC Eshelman School of Pharmacy. Students were not required to have completed the psychiatry/neurology pharmacotherapy course prior to participating. All second and third year students were invited to attend an information and training session for the PMEG program via email to all students by a non-teaching member of the faculty. Although researchers were prepared to randomly select participants from volunteers, there were enough program slots for all volunteers to participate. Training was led by two pharmacists from UNC Medical Center that also served as adjunct faculty for the school. Material was provided primarily in the form of a slideshow and handouts. Training lasted 45 min and included a description of medication education groups, strategies for building therapeutic relationships, tips for engaging patients with mental illness, and ideas for designing fun and interesting medication education group sessions.

Following the program training, students were asked to volunteer and sign up for medication education groups at the hospital. In the spring and fall, groups were offered weekly on three services: adolescent, adult psychotic disorders, and eating disorders. Students were required to observe at least one medication education group prior to volunteering to lead a group. The observed group was led by a pharmacist or pharmacy resident. Each group session lasted approximately 45 min. While the goal was for students to lead at least two medication groups, students were allowed to participate in fewer or more groups. When leading a group, students were tasked with preparing and facilitating all activities for the group. These plans were discussed and reviewed by a pharmacist or pharmacy resident prior to leading the group. A pharmacist or pharmacy resident was also present at all medication education groups to provide oversight and support.

Student consent and all data for the study were acquired by a non-teaching member of the faculty. Prior to the program training, students were asked to complete a pre-program survey about their prior experience with medication education groups, their self-efficacy associated with leading medication education groups, and their perceptions of patients with mental illness as measured by twelve items from the Opening Minds Scale for Health Care Providers (OMS) and seven items from the Social Distance Scale (SDS). The OMS is a validated instrument that measures the attitudes of health care providers towards people with mental illness using a five-point Likert agreement scale ranging from strongly disagree to strongly agree.[24] The SDS is a widely-used validated instrument that measures how much social distance an individual would maintain from a former psychiatric patient on a four point scale from definitely willing to definitely unwilling.[25] Student self-efficacy items associated with designing and leading the medication education groups were developed by the research team according to Bandura's guidelines.[22] Namely, the research team identified the tasks associated with the activities associated with PMEG and then asked student participants to rate on a scale of “0” (cannot do at all) to “10” (highly certain can do) the certainty with which they can perform specific tasks. Following completion of the program,