Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice

College of Pharmacists of Manitoba
November 23, 2021
Manitoba’s Overdose Crisis in the Era of COVID-19

Dr. Marina Reinecke
MBChB, CCFP(AM), ISAM, Medical Consultant, Prescribing Practices Program, College of Physicians and Surgeons of Manitoba
Manitoba’s Overdose Crisis in the Era of Covid-19

A CPhM Professional Development Event

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Faculty: Marina Reinecke

CPSM employee – Consultant to the Prescribing Practices Program, CPSM

Medical Director – OHA OAT program, OCN, MB

Member of the MMDRC and AIRC

Former HSC Medical Director of Addiction Services

Relationships with commercial interests: None
Faculty/Presenter Disclosure

- **With thanks to:** Erin Knight (Co-author – health system recommendation slides)

- **Relationships with commercial interests:** None

- Medical Director, Addiction Services - Health Sciences Centre
- Medical Co-Lead, Rapid Access to Addiction Medicine (RAAM) Hub - Shared Health
- Program Director, Addiction Medicine Enhanced Skills Residency Program - University of Manitoba
- Medical Director, Island Lake Addiction Program - Four Arrows Regional Health Authority
- Addiction Physician, OAT clinic – Opaskwayak Health Authority
- Family Physician, Aboriginal Health and Wellness Centre
We wish to recognize and thank:

- The Office of the Chief Medical Examiner of Manitoba.
- Dr John Younes, Chief Medical Examiner
Learning Objectives

- At the conclusion of this activity, participants will be able to:
  - Discuss historic and recent trends/changes in MB overdose death data reported by substance.
  - Recognize shifting overdose death data trends in the context of the pandemic.
  - Demonstrate how existing frontline addiction services that can impact survival are strained, despite recent investments.
  - Propose an appropriate health system response to address the overdose crisis by applying accepted evidence-based & cost-effective interventions.
Polling Questions:

1. Between 2013-2018 in Manitoba, which opioid is responsible for the largest number of overdose deaths, either as primary cause or as a major contributing factor?

   a) Fentanyl
   b) Carfentanil
   c) Codeine
   d) Tramadol
   e) Oxycodone
2. In 2018 in Manitoba, which benzodiazepine contributed to the largest number of overdose deaths?

a) Alprazolam
b) Diazepam
c) Temazepam
d) Bromazepam
e) Lorazepam
Polling Questions:

3. In Manitoba, most opioid overdose deaths can be attributed to:

a) A single prescribed opioid
b) Multiple prescribed opioids
c) A single illicit opioid
d) One or more opioids combined with multiple other drugs
e) Opioids in combination with alcohol
Polling Questions:

4. In Manitoba between 2014-2017, which two drug classes were the top contributors to opioid overdoses?

a) Alcohol and benzodiazepines  
b) Antipsychotics and antidepressants  
c) Benzodiazepines and antidepressants  
d) Statins and antihypertensives  
e) Benzodiazepines and Z-drugs
Polling Questions:

5. In Manitoba in 2018, which two over-the-counter ingredients contributed to the largest number of deaths?

a) Acetaminophen and ASA
b) Acetaminophen and pseudoephedrine
c) Diphenhydramine and dextromethorphan
d) Dextromethorphan and acetaminophen
e) Ibuprophen and desloratadine
6. In Manitoba, in 2020, which two individual drugs were the most common contributors to drug and alcohol overdose deaths according to the OCME?

a) Diphenhydramine and dextromethorphan
b) Fentanyl and alcohol
c) Fentanyl and Methamphetamine
d) Dextromethorphan and methamphetamines
e) Methamphetamines and alprazolam
7. In Manitoba, between 2017 and 2020, which individual drug was the most consistent primary cause of drug and alcohol overdose deaths according to the OCME?

a) Diphenhydramine  
b) Fentanyl  
c) Alcohol  
d) Dextromethorphan  
e) Methamphetamines
8. In Manitoba, between 2017 and 2020, which individual prescription drug was the most consistent primary cause of drug and alcohol overdose deaths according to the OCME?

a) Zopiclone  
b) Fentanyl  
c) Codeine  
d) Methadone  
e) Alprazolam
CPSM Prescribing Practices Program
Department of Quality

- Chief Medical Examiners’ Death Review
- OAT Prescriber Training, Mentoring and Auditing
- Benzodiazepine and Z-drug Prescribing Standard Implementation and Resource Development
- Individual Informal Case Support/Mentoring
Chief Medical Examiners’ Death Review
Chief Medical Examiners’ Death Review
- Joint process with CPhM!!

- Relationship initiated by the previous ME who was concerned regarding the number of prescription drug related deaths
- Reviewers: Historically 4 medical consultants with extensive primary care experience in the management of pain, addiction and mental health concerns. Currently and new: Pharmacist
- **Adult Inquest Review Committee**
- All deaths involving prescription medications undergo detailed review
- No chart information unless we ask for it (high volume and educational process and meant to prompt self-reflection)
- Methadone; buprenorphine/naloxone deaths
Chief Medical Examiners’ Death Review

- Prescribers receive standard cover letter plus relevant resources if needed
- Plus summary of the ME report highlighting the manner of death, cause of death, notable circumstances of death, toxicology findings and summary of relevant DPIN data
- Feedback to prescribers in 3 categories:
  - FYI
  - Prescribing falls outside of guidelines, best practices (standardized evidence-based quality indicators, e.g. concomitant opioids and benzo’s); includes resources
  - Significant concerns (rare)
Historically there has been a lack of meaningful safe prescribing education on undergrad, postgrad, and CPD level.
Big Pharma & OXYCONTIN: Historically physicians have been exposed to aggressive pharmaceutical marketing techniques.
Number* of Unique Patients in Manitoba with “Average Morphine Equivalent Per Day”**

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<td># Unique Patients</td>
<td>Proportion of Unique Patients</td>
<td># Unique Patients</td>
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<td>0 to 50</td>
<td>4,203</td>
<td>45.2%</td>
<td>1.8%</td>
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<td>50 to 90</td>
<td>2,305</td>
<td>25.5%</td>
<td>4.0%</td>
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<td>90 to 200</td>
<td>1,937</td>
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<td>&gt;200</td>
<td>787</td>
<td>8.5%</td>
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*Data source is DPIN, excludes Long Term Care & Palliative Care clients; does not include drugs dispensed in hospital. Includes fentanyl.
** MME Per Day Calculated by taking Total MME divided by Days Supply.
The pandemic and non-prescription fentanyl

- Fentanyl smuggled in from China via west coast.
- Different fentanyl analogues with varying strengths (carfentanil)
- Attainable from internet pharmacies – 1 kg goes a long way (100K street value)
- Adulterated into other drugs:
  - West coast heroin 70% +
  - Local – adulterated into powdered cocaine, crystal meth, fake oxys.
- Blotter tabs
Drug and Alcohol Overdose Deaths (primary or contributing cause) 2013-2015
source: OCME Nov 3, 2016
Drug and Alcohol Overdose Deaths Contributing Cause 2016 - 2018
Source: OCME April 3rd, 2019
Important changes in 2018

- Opioid deaths have leveled off.
- **Stimulant-related deaths are climbing rapidly.** Alprazolam and gabapentin, as well as diphenhydramine, have become significant drugs of abuse.

- Note that more than one drug is often involved in a given death where a drug is given as a “contributing” cause.
- Overall, **138 drug-related deaths in 2018.** This does not include deaths where drug intoxication led to death by other means (MVAs, suicides, homicides, etc.), or where death occurred due to the effects of chronic drug use (cirrhosis, etc.).
Drug and Alcohol Overdose Deaths
Primary Cause 2018 – 2019
Sources: OCME Feb, 2021

Bar chart showing the primary causes of drug and alcohol overdose deaths in 2018 and 2019.
Drug and Alcohol Overdose Deaths
Primary Cause 2019 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021
Drug and Alcohol Overdose Deaths
Contributing Cause 2019 – 2020 (9/12 of data for 2020)
Sources: OCME Feb. 2021
Drug and Alcohol Overdose Deaths
Primary Cause 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021
Drug and Alcohol Overdose Deaths
Contributing Cause 2017 – 2020 (9/12 of data for 2020)
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Drug and Alcohol Overdose Deaths
Contributing Cause: 2017 – 2020 (9/12 of data for 2020)
Source: OCME Feb, 2021
2019..

- **TOTAL NUMBER OF DRUG-RELATED DEATHS:** 191

- Deaths due to single opioid toxicity: 6
- Deaths with one or more opioids contributing: 87
- Total opioid-related deaths: 93 (49% of all drug-related deaths)
- Fentanyl-related deaths: 41 (44% of all opioid-related deaths, 21% of all drug-related deaths)
2020 and 2021

- TOTAL NUMBER OF DRUG-RELATED DEATHS:
  - 259 total drug-related deaths in 9 months!
  - Primarily due to toxic street supply of fentanyl, cocaine, and methamphetamine
  - Final total was 372 deaths in 2020 - most of them young with many years of work and life left to live!
  - 2021 is of grave concern: 199 drug-related deaths in Manitoba from January to June 2021
Important changes in 2019-2021

- Drug supply coming from the U.S. land border, has been disrupted by the pandemic border closures to non-essential traffic. Mail carried drug supply has become more expensive (supply and demand), more toxic and containing higher concentrations of fentanyl and additional substances are being added in.

- Concurrent changes in prescribing and regulation may contribute?

- Toxic supply and contaminated drugs are now commonplace in Winnipeg and surrounding areas e.g., "down" which can be a combination of fentanyl, heroin as well as other CNS depressants.
How should we respond?

Overview of our services & limitations

- Within the health sector
  - RAAM
  - Opioid Agonist Therapy
  - Withdrawal management
  - Hospital based services

- Outside the health sector
  - Residential & non-residential treatment programs
  - Peer & community-based supports

Common limitations among services:
- capacity
- wait lists
- accessibility, especially rural/remote
- stigma
Clinical trends in 2020-2021

- Significant increase in opioid related presentations at RAAM
  - Most significantly “down”, a potent fentanyl analogue (+- benzo +- meth)
- Highest volume RAAM clinic in Winnipeg, located at CRC:
  - “re-directing” on average 30% of people who present due to high volumes
    - January - March 2021 at CRC RAAM:
      - 249 people NOT SEEN due to capacity, on average 6.6 people per drop-in clinic
      - opioids account for 73% of presentations

- Similar trends noted through in-hospital services
  - Increase in opioid related consults requiring OAT
  - More patients with difficulty stabilizing on traditional OAT
What evidence-based interventions we don’t (but should!) have

1. **Specialized OAT service providing Sustained Release Oral Morphine (SROM) and Injectable Opioid Agonist Therapy (iOAT)**
   - Increases retention in treatment, improves social outcomes, reduces illicit drug use and related harms
   - Allows engagement in care for people who have been unsuccessful or are not prepared for treatment with 1st line OAT

2. **Managed Alcohol Programs (MAPs)**
   - Improves social outcomes, reduces use of acute care services (e.g. EMS, emergency, contact with police)

3. **Supervised consumption/overdose prevention sites**
   - Strong evidence-base, repeatedly shown to be cost effective
     - Reduces harms including overdose and medical consequences (HIV, HCV, SSTI)
     - Increases engagement in care
What you may be hearing about, but where the evidence is unclear...

- Safe supply ???
  - Medications (generally opioids) prescribed by a physician to allow people to use drugs without needing to resort to the toxic illicit drug supply
  - Need to study and understand unintended consequences
    - Iatrogenic Opioid Use Disorder (OUD)
    - Overall impacts on fatal and non-fatal overdose
  - Larger discussion re: decriminalization vs. legalization
    - Removing opioid prescribing from medical oversight, similar to cannabis trajectory
  - ? Applicability of safe supply discussion to non-opioids
    - Benzodiazepines
    - Stimulants
    - Other sedatives (e.g. gabapentin, ketamine, GHB)
Where decision makers could start to effect change

1. **Addressing stigma within our existing systems & services**
   - Mandate ALL publicly funded treatment programs to support opioid agonist therapy (OAT)
   - Require EIA to recognized Substance Use Disorders (SUDs) as a disability
   - Develop standardized, transparent & evidence-informed Child & Family Services (CFS) practices for parents with SUDs
   - Declare governmental support for harm reduction practices including Managed Alcohol and Supervised Consumption

2. **Facilitating easier access to buprenorphine (+ methadone)**
   - Provincial plan for supporting patients in northern/remote communities, leveraging long-acting formulations (Sublocade, Probuphine)
   - Formalizing support for existing (and needed expansion!) of in-hospital addiction consult services
   - Enhancing capacity within primary care – billing codes, access to supports
     - resources: Point of care UDS, harm reduction services including intranasal naloxone
     - staffing: Nursing/case management, counseling (CBT, DBT, MI)

3. **Developing specialist-led programs employing SROM & iOAT**
   - to increase the menu of options, and engage more people in care, especially those with severe disease and substance related harms

4. **Establishing Supervised Consumption/Overdose Prevention Sites and Managed Alcohol Programs**
   - integrated with health care and social supports
Example: PHS (Portland Hotel Society) Community Services Society

- Focused on housing, healthcare, harm reduction & health promotion
- Multiple funding streams including the health sector – a whole system approach!
- Programs include:
  - Multiple supply distribution programs and overdose prevention sites
  - Insite: supervised consumption, drug testing, overdose treatment, wound care
  - Onsite: 12-bed medically supported detox, 18-bed transitional housing
  - Community Managed Alcohol Program
  - Community Transitional Care Team: residential setting with 24/7 medical care including IV antibiotics to facilitate earlier discharge from hospital
  - Health, dental and Opioid Agonist Therapy services, including iOAT
  - Supportive housing
What it could ultimately look like

- Manitoba Centre of Excellence for Addiction Medicine
  - low barrier drop-in space, with access to
    - supervised consumption (all routes) + drug checking
    - harm reduction supplies and education
    - primary care services
      - e.g. wound care, vaccinations, STBBI testing & treatment
    - social work & housing supports
    - peer support navigators
  - co-located with
    - Expanded urban RAAM clinic, addressing high Wpg volumes
      - Centre of the hub & spoke model
        - Supports rapid assessment as a bridge between harm reduction & treatment
    - Centralized Manitoba OAT service
    - iOAT and SROM clinic
    - Managed alcohol program
  - transitional housing with nursing supports

Criteria for success:
- identify partner agencies
- meaningfully engage with people who use (PWU) drugs and peer networks
- integrate educational, research & policy initiatives
- foster communication & partnership between sectors
- develop care & referral pathways
- focus on building capacity within the whole system
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Approaching Mental Health in Pharmacy Practice

Dr. Christine Leong
B.Sc. (Gen), B.Sc. (Pharm), Pharm.D., Assistant Professor, College of Pharmacy, Rady Faculty of Health Sciences
APPROACHING MENTAL HEALTH IN PHARMACY PRACTICE

Presenter: Dr. Christine Leong, BSc, BScPharm, PharmD
College of Pharmacy, University of Manitoba
Presented to: College of Pharmacists of Manitoba
November 23, 2021
CONFLICT OF INTEREST / DISCLOSURES

• Presenter Name: Christine Leong

• I have no conflicts of interest to disclose

• Member of the Adults Inquest Review Committee (AIRC), Chief Medical Examiner Office of Manitoba

• Speaking fees for current program
  • I have received a speaker’s fee from the College of Pharmacists of Manitoba for this learning activity
LEARNING OBJECTIVES

• By the end of this presentation, participants should be able to:
  1. Recognize the signs and symptoms of someone experiencing a mental health crisis
  2. Describe the pharmacist’s role in helping patients experiencing a mental health crisis
  3. Explore strategies for communicating with patients experiencing a mental health crisis
  4. Identify resources for patients in need of mental health support
CASE 1: DREW, 49M

• History of PTSD, alcohol use disorder, depression, hypertension, GERD, withdrawal seizures, insomnia, and polysubstance use

• He has a hematoma on his forehead from a fall earlier today (blackout)

• He appears uninterested in engaging in conversation (one-word responses, flat affect), lost quite a bit of weight, eyes are bloodshot, tired
### CASE 1: DREW, 49M (DOB: OCT 10, 1970)

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<th>Days Supply</th>
<th>Quantity</th>
<th>Prescriber</th>
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<td>56</td>
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What are your thoughts or concerns about this patient? What is your approach?
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How confident do you feel about addressing the potential concerns you have for this patient?

A. Very confident
B. Somewhat confident
C. Somewhat not confident
D. Not confident
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CASE 1: DREW, 49M (DOB: OCT 10, 1970)

What are your thoughts or concerns about this patient?

- Multiple sedating medications
- PTSD with diazepam as outpatient
- Naltrexone not refilled/alcohol use
- Hematoma on forehead
- Withdrawn/weight loss

What is your approach?
### CASE 1: DREW, 49M (DOB: OCT 10, 1970)

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- Substance use and overdose risk
- Trauma-informed care
- Suicide ideation
- Multiple sedating medications
- PTSD with diazepam as outpatient
- Naltrexone not refilled/alcohol use
- Hematoma on forehead
- Withdrew/weight loss

What are your thoughts or concerns about this patient?

What is your approach?
MENTAL HEALTH SPECTRUM

- Cope with stress
- Work productively
- Contribute to community
- Feel capable despite life’s challenges

- Affects a person’s thinking, emotional state, behaviour
- Negative effects on health and social function

- Find new meaning of living a satisfying, hopeful, contributing life as one grows beyond the effects of mental illness

For everyone/those at risk

Aim to prevent problems from becoming more serious

Medication
Psychological Support groups Rehabilitation Family/friends Professional (family physician, psychiatrist) Counsellor
<table>
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<th>Percentage</th>
<th>Description</th>
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<tr>
<td>2 in 5</td>
<td>People who experienced anxiety or depression reported not seeking medical treatment for it¹</td>
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<tr>
<td>95%</td>
<td>Of people with SUD did not seek treatment because they perceived they did not need it²</td>
</tr>
<tr>
<td>17.5%</td>
<td>Of people with SUD who perceived they needed SUD treatment did not receive treatment because they were concerned about their neighbors/community having a negative opinion about them²</td>
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What role is stigma playing in treatment for people with mental illness and SUD?

CAMH Mental Illness and Addiction: Facts and Statistics; Han et al. Center for Behavioral Health Statistics and Quality, 2020
Alcohol related cancers, diabetes, ischemic heart disease diagnoses peaked one year prior to AUD recognition.

Problematic drinking more likely to be detected when individuals seek care for a serious medical condition.

Need for better recognition and early treatment of problematic alcohol use in primary care.

1.3% with AUD take AUD pharmacotherapy in Manitoba between 1996 and 2015. 58% naltrexone, 36.3% acamprosate, 5.7% disulfiram.
MEASURING STIGMA

**Attitude**
- **Stigmatized Person**
  - “I am not normal”
  - “People at work will not treat me the same if they know I have a SUD”
- **Person Stigmatizing**
  - “People with SUDs are dangerous”
  - “People with SUDs don’t have enough self-control”

**Affect**
- **Shame**
- **Embarrassment**
- **Fear**
- **Anger**

**Behaviour**
- **Avoiding getting help**
- **Increased substance use**
- **Avoid providing treatment to people experiencing SUDs**
- **Avoid employing people experiencing SUDs**
STIGMATIZING LANGUAGE

- **Questioning credibility** (implies disbelief)
  
  “He claims that the NRT isn’t working for him”

- **Disapproval** (convey patient is unreasonable)
  
  “Informed patient there is no evidence for this, but patient has strong beliefs”

- **Stereotyping** (quoting incorrect grammar)
  
  “Reports that the bandage got “a li’l wet’”

- **Difficult patient** (info with little clinical importance to convey annoyed)
  
  “She perseverated on the fact that ”a lot of stuff is going on at home” but that ”you wouldn’t understand”

- **Unilateral decisions** (emphasize physician authority)
  
  “She was told to discontinue…”

**SMALL ACTIONS HAVE A LARGE IMPACT**

- **Non-Stigmatizing Person-Centered Language**
  "person experiencing a substance use disorder"

- **Training/Resources**
  National Alliance on Mental Illness – Stigma Free; SAMHSA The Power of Perceptions and Understanding 4-part webcast series; CAMH Understanding Stigma Course

CASE 1: DREW, 49M

- Admits to using substances because his medications that his doctor prescribed for anxiety “don’t work”

- Drug of choice is alcohol, started drinking at 14 years old
- Daily drinker 15 beers

- Snorts cocaine <1x/month at most

- Sought treatment at HSC Psychiatry and AFM three months ago for low mood and alcohol use
CASE 1: DREW, 49M

- Two years ago, experienced a frightening home invasion with minor injuries. Since then has been ++hypervigilant boarded up window, does not leave apartment, ++checking behaviors, restless sleep waking up to smallest sounds.

- Found brother post hanging at 17 years of age. Feels guilt, self-blame.

- Recurring nightmares about brother and about home invasion.
CASE 1: DREW, 49M

- Two years ago, experienced a frightening home invasion with minor injuries. Since then has been ++hypervigilant.
  - boarded up window, does not leave apartment, ++checking behaviors, restless sleep waking up to smallest sounds
- Found brother post hanging at 17 years of age. Feels guilt, self-blame.
- Recurring nightmares about brother and home invasion.

Elements of trauma:
- Repeated living of memories of the traumatic experience
- Avoidance of reminders of trauma
- Pattern of increased arousal
- Negative cognitions and mood
WHY IS IT IMPORTANT TO BE TRAUMA-INFORMED?

Trauma

- Substance use
- Difficulty enjoying time with family/friends
- Avoiding specific places, people, situations (e.g., driving)
- Shoplifting
- Self-harm
- High-risk sexual behaviors
- Suicidal impulses
- Gambling
- Isolation
- Justice system involvement

Behavioral

- Frequent conflict in relationships
- Lack of trust
- Difficulty establishing and maintaining close relationships
- Experiences of revictimization
- Difficulty setting boundaries

Inter-personal

- Unexplained chronic pain or numbness
- Stress related conditions (chronic fatigue)
- Headaches
- Sleep problems
- Breathing problems
- Digestive problems

Physical

- Depression
- Anxiety
- Anger management
- Compulsive and obsessive behaviors
- Dissociation
- Difficulties concentration
- Fearfulness
- Emotionally numb/flat
- Memory problems
- Suicidal thoughts

Emotional or Cognitive

- Loss of meaning/faith
- Loss of connection to self, family, culture, community, nature, higher power
- Feelings of shame, guilt
- Self-blame
- Self-hate
- Feel completely different from others
- No sense of connection
- Feel like a "bad" person

Spiritual

From The Trauma Informed Practice Guide, 2013
<table>
<thead>
<tr>
<th>FROM (Deficit Perspective)</th>
<th>TO (Trauma Informed &amp; Strengths Based)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is wrong?</td>
<td>What has happened?</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Adaptations</td>
</tr>
<tr>
<td>Disorder</td>
<td>Response</td>
</tr>
<tr>
<td>Attention Seeking</td>
<td>The individual is trying to connect in the best way they know how</td>
</tr>
<tr>
<td>Borderline</td>
<td>The individual is doing the best they can given their early experiences</td>
</tr>
<tr>
<td>Controlling</td>
<td>The individual seems to be trying to assert their power</td>
</tr>
<tr>
<td>Manipulative</td>
<td>The individual has difficulty asking directly for what they want</td>
</tr>
<tr>
<td>Malingering</td>
<td>Seeking help in a way that feels safer</td>
</tr>
</tbody>
</table>

Adapted from Royal College of Nursing, 2008 in Trauma Informed Practice Guide, May 2013
HOW CAN PHARMACISTS CAN MAKE A DIFFERENCE

• Learn about trauma and trauma-informed care
• Approach things with curiosity
• Willingness to be empathetic, to listen and learn from those affected by trauma
• Treat those affected by trauma as equal
• Explain why we are asking sensitive questions
• Be flexible
• Be comfortable with unknown

This is the information. This is the common experiences that people experience. You may experience X, Y, and Z. These reactions are normal and not everyone will experience it. Treatment is just one form of therapy.
CASE 1: DREW, 49M

- Over last few months having worsening mood, frequent unprompted crying episodes.
- Fleeting suicide ideation but no history of suicidal attempts (psychiatry note)
- No energy, no concentration, anhedonia, poor appetite, and lost 100 lbs due to not leaving apartment to grocery shop.
- Feeling sad about his birthday coming up. Says, “I sometimes don’t see what the point of anything is anymore”
CASE 1: DREW, 49M

- Lives alone in apartment
- Worked as a mechanic 4 years ago but stopped working following a physical injury from being hit by a car while riding a bike; currently on EIA
- Separated from ex-wife 20 years ago; no contact with daughter (28 years old) but some with son (25 years old), poor social supports
- Current stressors: getting evicted, financial issues
<table>
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<tr>
<th>Patient concern type</th>
<th>Warning sign</th>
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| **Statements/questions** | • How much of this medicine would it take to kill someone?  
• What combination of medicines could I use to kill myself?  
• If I overdose on this medicine and don’t die, what damage will it cause?  
• I can’t take living like this anymore  
• The side effects of this medication are worse than death  
• I just wish I could go to sleep and neve wake up  
• I am going to kill myself |
| **Behaviors, non-verbal** | • Someone who is typically cheerful, is now looking down and depressed  
• Decline in hygiene (change in frequency of showers, make-up, dress)  
• Anxiety, agitation, lack of sleep, or sleeping too much  
• Dramatic mood changes |
Asking if the patient is considering suicide:

- “I am concerned about some of the information that you told me. I need to ask if you have thought about suicide or harming yourself or others? I care about you and I want to know that you are ok.”

- “With the information that you told me, I am wondering if you are thinking about suicide?”

- "When you say that you don’t see the point in anything anymore, have you had thoughts about suicide?

If the answer is no:

- “Thank you for sharing with me. It sounds like you are overwhelmed with everything going on. Can I call someone for you or connect you with a counselor who can provide support?”

- “Thank you for talking to me. It sounds like you have been having a rough year. Can I offer you some resources and a crisis hotline number in case you need to call someone?”

- Practice responding ahead of time
- Try to remain calm and listen
- Be direct
- Name their emotion and allow them to talk
- Show you care
Asking if the patient is considering suicide:

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- “With the information that you told me, I am wondering if you are thinking about suicide?”

- ”When you say that you don’t see the point in anything anymore, have you had thoughts about suicide?

If the answer is yes:

- “I don’t want anything bad to happen to you, would it be all right if I called the suicide lifeline for you?”

- “Is there someone I can call to make sure you stay safe?”

Practice responding ahead of time

Try to remain calm and listen

Be direct

Name their emotion and allow them to talk

Show you care
## NATIONAL RESOURCES

<table>
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<tr>
<th>Service</th>
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<tr>
<td><strong>211</strong></td>
<td>Through partnerships with United Way, each province and territory has access to 211, a database of social support resources.</td>
</tr>
<tr>
<td><strong>CRISIS SERVICES CANADA</strong></td>
<td>Connect with trained crisis responders. Hours and availability: crisisservicescanada.ca/</td>
</tr>
<tr>
<td>1.833.456.4566/text 45645</td>
<td></td>
</tr>
<tr>
<td><strong>KIDS HELP PHONE</strong></td>
<td>24/7 access to a counsellor for persons aged 5 to 20. Available in French and English.</td>
</tr>
<tr>
<td>1.800.668.6868</td>
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<tr>
<td>Text 686868</td>
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<td>Kidshelpphone.ca</td>
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<td><strong>HOPE FOR WELLNESS</strong></td>
<td>Counseling and crisis intervention for Indigenous peoples. Available 24/7 in English, French, Cree, Ojibway, and Inuktitut.</td>
</tr>
<tr>
<td>1.855.242.3310</td>
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<tr>
<td>Hopeforwellness.ca</td>
<td></td>
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<tr>
<td><strong>WELLCAN</strong></td>
<td>Wellbeing resources for Canadians during the COVID-19 pandemic, including mental health, financial and social support info.</td>
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<td>Wellcan.ca/download the app</td>
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## LOCAL RESOURCES

| **Crisis Response Centre (CRC)**  
| Located at 817 Bannatyne Avenue | Drop in 24/7 for adults experiencing a mental health crisis. If you refer a patient to visit the CRC, please call the Mobile Crisis Line (204-940-1781) to let staff know your concerns. Patients under the Mental Health Act (Form 4) must go to an emergency department. |
| **Mobile Crisis Service**  
| Call 204-940-1781 | A 24/7 phone service assisting individuals experiencing a mental health or psychosocial crisis. If appropriate, Mobile Crisis can meet with individuals in crisis at a location within Winnipeg that is comfortable for them. |
| **Klinic Crisis Line**  
| Call 204-786-8686 | A 24/7 phone service assisting individuals experiencing a mental health crisis, difficulty coping or need help sorting out a problem. |
| **Rapid Access to Addictions Medicine Clinic (RAAM)**  
| CRC 817 Bannatyne Ave or River Point Centre 146 Magnus Ave | A drop in clinic for individuals seeking help with high risk substance use and addictions. Not for individuals needing urgent medical attention. |
| **Rapid Access to Consultative Expertise (RACE)**  
| Call 204-940-2573 M-F 9a-4p | For quick access to psychiatric consultant for questions that may not require an in-person assessment of the patient (e.g., med adjustment, choice/timing of investigations, suitability of referrals). |
The Patient Self-Help Guide for Mental Health in Winnipeg

I am interested in self-help resources.

Online Modules & Courses

- eCoach (FBS)
  Interactive module.
  Website: ecoach.cmha.ca

- OBT Coach (FBS)
  For treatment of anxiety.
  Website: mobile.oastb.ca/obt/obtcoach

- Here to Help (FBS)
  Self-guided module on wellness tools.
  Website: www.hanewholo.bc.ca/wellness-modules

Mindset (FBS)

- Skills building for coping with anxiety.
  Website: www.careyourbrain.ca/resources/mindset-ap

Mood Gym (FBS)

- Structured module.
  Website: moodgym.ca

PTSD Crash Canada (FBS)

- Information on PTSD & tools for screening and tracking symptoms.
  Website: www.vancouver.psyc.mcgill.ca/ptsdcrash

Self-Guided Workbooks

Some books include:

- The Mindfulness and Acceptance Workbook for Anxiety - J. Forsyth & C. Elliott
- Mind Over Mood – D. Greenberger & C. Padesky
- Feeling Good: The New Mood Therapy – D. Burns
- Overcoming Depression and Mood: A Mindful Approach - C. Williams
- Calming the Emotional Storm – S. van Dijk
- DBT Made Simple – S. van Dijk
- Self-Compassion: The Proven Power of Being Kind to Yourself - J. Linehan

MTSDS Labelling Apps

- BoostApp - www.boostapp.ca
- Cam In The Storm - www.caminthestormapp.com
- MindBodd - www.mindbodd.com
- Simple Habit - www.simplehabit.com
- Stop Breathe & Think - www.stopbreathethink.com

Psyber.org - reviews mental health apps based on credibility, user experience, & transparency.

Aboriginal Healing Foundation www.ahf.ca
Alberta Family Wellness Initiative – Brain story certification course
https://www.albertafamilywellness.org/
Canadian Mental Health Association www.mbwpg.cmha.ca
Klinic Community Health www.klinic.mb.ca
Trauma Informed www.trauma-informed.ca
Trauma Recovery www.trauma-recovery.ca
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**What are your thoughts or concerns about this patient?**

**What is your approach?**
CASE 1: DREW, 49M

- MHFA
  - Assess safety/severity, Listen, Give
  - Reassurance, Encourage help/support

- Re-assess the efficacy and safety of medications to determine need for continued use (renal/liver function monitoring, obesity/sleep)

- Help create a gradual taper schedule with frequent follow-up to reduce the risk of combination sedating medications

- Limit dispensing quantities (weekly or daily)
FINAL THOUGHTS

- Create a safe space in your practice, use person-first language
- Approach encounters with curiosity
- Explain the purpose of questions
- Allow space to identify needs
- Convey acceptance in body language and tone
- Accumulation of small things for patients to feel seen and heard
- Support patients to open up and seek support to begin healing when ready
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| **Physical Self-Care**          | - Eat regularly (e.g. breakfast, lunch and dinner)  
- Eat healthy  
- Exercise  
- Get regular medical care for prevention  
- Get medical care when needed  
- Take time off when needed  
- Get massages  
- Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun  
- Take time to be sexual—with yourself, with a partner  
- Get enough sleep  
- Wear clothes you like  
- Take vacations  
- Take day trips or mini-vacations  
- Make time away from telephones  
- Other: |
| **Psychological Self-Care**     | - Make time for self-reflection  
- Have your own personal psychotherapy  
- Write in a journal  
- Read literature that is unrelated to work  
- Do something at which you are not expert or in charge  
- Decrease stress in your life  
- Let others know different aspects of you  
- Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings  
- Engage your intelligence in a new area, e.g. go to an art museum, sports event, auction, theater performance  
- Practice receiving from others  
- Be curious  
- Say “no” to extra responsibilities sometimes  
- Other: |
| **Emotional Self-Care**         | - Spend time with others whose company you enjoy  
- Stay in contact with important people in your life  
- Give yourself affirmations, praise yourself  
- Love yourself  
- Re-read favorite books, re-view favorite movies  
- Identify comforting activities, objects, people, relationships, places and seek them out  
- Allow yourself to cry  
- Find things that make you laugh  
- Express your outrage in social action, letters and donations, marches, protests  
- Play with children  
- Other: |
| **Spiritual Self-Care**         | - Make time for reflection  
- Spend time with nature  
- Find a spiritual connection or community  
- Be open to inspiration  
- Cherish your optimism and hope  
- Be aware of nonmaterial aspects of life  
- Try at times not to be in charge or the expert  
- Be open to not knowing  
- Identify what in meaningful to you and notice its place in your life  
- Meditate  
- Pray  
- Sing  
- Spend time with children  
- Have experiences of awe  
- Contribute to causes in which you believe  
- Read inspirational literature (talks, music, etc.)  
- Other: |
| **Workplace or Professional Self-Care** | - Take a break during the workday (e.g. lunch)  
- Take time to chat with co-workers  
- Make quiet time to complete tasks  
- Identify projects or tasks that are exciting and rewarding  
- Set limits with your clients and colleagues  
- Balance your caseload so that no one day or part of a day is “too much”  
- Arrange your work space so it is comfortable and comforting  
- Get regular supervision or consultation  
- Negotiate for your needs (benefits, pay raise)  
- Have a peer support group  
- Develop a non-trauma area of professional interest  
- Other: |
| **Balance**                     | - Strive for balance within your work-life and workday  
- Strive for balance among work, family, relationships, play and rest  |

---

**Notes:**
- The worksheet provides a comprehensive list of self-care practices across different dimensions including physical, psychological, emotional, spiritual, workplace or professional, and balance.
- Each category includes specific activities that individuals can engage in to promote their respective aspects of self-care.
- The source for the worksheet is a workbook on vicarious traumatization.
MENTAL HEALTH FIRST AID (MHFA)

MHFA Actions - ALGEES

A - Approach the person, assess and assist with any crisis
L - Listen and communicate nonjudgmentally
G - Give reassurance and information
E - Encourage the person to reach out to appropriate professional help
E - Encourage other supports
S - Self-care for the first aider
MHFA FOR MANITOBA PHARMACISTS RESEARCH

- Recruiting practicing community pharmacists to participate in a pilot project to train pharmacists in Mental Health First Aid

- Time commitment entails:
  - MHFA Training (~8 hours online or in-person)
  - Debrief Session (~1 hour)
  - Pre- and post-training surveys
  - Patient encounter forms for 3 months

- Honorarium $100 for your participation

- Funded by the Canadian Foundation for Pharmacy

- Contact: Christine.leong@umanitoba.ca

Eligible for Self-Study Continuing Education credit
THANK YOU!
Dr. Marina Reinecke

MBChB, CCFP(AM), ISAM, Medical Consultant, Prescribing Practices Program, College of Physicians and Surgeons of Manitoba
Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice