Pharmacy students' experiences in provision of community pharmacy mental health services

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ABSTRACT

Background: Little information is available describing the pharmacy student's experience working in community practice with people with lived experience of mental illness. Students' perspectives as observers, learners, technical staff and future pharmacists are important.

Objective: To gain a better understanding of the pharmacy student experience in community pharmacy-based service provision to people with lived experience of mental illness.

Methods: We conducted a qualitative study using interpretive description and application of the Theoretical Domains Framework. Focus groups were held with third- and fourth-year undergraduate pharmacy students from one Canadian university.

Results: Two student focus groups were held in the fall of 2012 with 11 students (7 third year and 4 fourth year), 6 women and 5 men, mean age 24.5 (range, 21 to 30) years, averaging 3.2 years (range, 2 weeks to 7 years) of cumulative, mostly part-time, community pharmacy experience. Three broad themes emerged from the pharmacy student experience: (1) business tension; (2) roles, responsibilities and relationships; and (3) stigma. Students discussed their own roles, responsibilities and relationships in a pluralistic identity experience (i.e., pharmacy student, technician, future pharmacist). Application of the Theoretical Domains Framework demonstrated numerous influences on behaviour.

Conclusions: From the students' description of community pharmacy-based care of people with lived experience of mental illness, significant issues exist with current practices and behaviours. Advancing the role of pharmacists and pharmacy students to meet the needs of people with mental illness will require strategies to address multifactorial influences on behaviour. *Can Pharm J (Ott)* 2014;147:55-65.

People with lived experience of mental illness experience inequalities in access to health care and in health outcomes. In our program of research, we are examining the roles that pharmacy team members play in community-based mental health care.

Les personnes qui ont une expérience concrète de maladie mentale connaissent des inégalités quant à l'accès aux soins de santé et aux résultats de soins. Dans notre programme de recherche, nous examinons les rôles que jouent les membres de l'équipe de pharmacie dans les soins de santé mentale communautaires.

Introduction

People with lived experience of mental illness should receive needed supports, interventions and assistance as close to their place of residence as possible.¹ Much of this care can be effectively and efficiently delivered in community settings through primary health care providers able to address patient and family needs using

multiprofessional collaborative teams.¹⁻³ Recently, primary health care competencies have been developed in Canada for pharmacists.⁴ Although no national mental health care competencies exist for pharmacists in Canada, Australia has developed such a framework.⁵ Pharmacists have the potential to play a more significant role in the care of people with lived experience of

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KNOWLEDGE INTO PRACTICE

- Pharmacy students are required to reconcile multiple expectations related to their responsibilities and roles in community pharmacy settings.
- Pharmacist behaviours affect student self-efficacy and influence student professional development in the care of people with lived experience of mental illness.
- Strategies to overcome product-focused approaches and reactive engagement communication styles are required to advance the pharmacy team role in the care of people with lived experience of mental illness.

mental illness in their communities. However, to date, pharmacists are not usually included in collaborative care teams that are increasingly being recognized for their provision of better community-based mental health care.^{3,6-8}

Given this situation, a focus of our program of research is to explore enhanced integration of community pharmacists and other pharmacy team members, including pharmacy students and technicians, in mental health service provision within community-based primary health care. We include technicians and pharmacy students, because people with lived experience of mental illness will interact with all pharmacy team members. The inclusion of students is also imperative, given that the community pharmacy setting serves as a place for structured and unstructured learning experiences in which students gain health-related knowledge and skills but are also socialized in the profession. To integrate pharmacy team members in mental health service provision, we require a better understanding of the multiple factors that influence the inclusion of pharmacy team members. The research in this area to date has not yet provided adequate understanding of this complex phenomenon and primarily focuses on examining stigma. Thus far, consumer experiences with community pharmacy services,^{9,10} pharmacists' experiences in serving people with lived experience of mental illness¹¹⁻²³ and students' experiences primarily outside of the Canadian context²⁴⁻²⁹ have been explored.

In this paper, we report findings of the experiences of pharmacy students in a Canadian context as they were introduced to the pharmacy-based care of people with lived experience of mental illness. We explore their experience

through qualitative methods of interpretive description and apply the Theoretical Domains Framework to examine influences on behaviour.

Methods

In our research, we draw from several frameworks and conceptual models that describe factors affecting successful implementation of complex interventions in practice and make parallels to enhanced pharmacy team member integration.³⁰⁻³³ A natural extension of our work is also to consider the body of knowledge regarding theory-driven approaches to changing behaviours, as enhanced integration of pharmacy team members in mental health service provision in community-based primary health care will ultimately require changes in behaviour of pharmacy team members, other health care providers and people with lived experience of mental illness. To date, research endeavours exploring physicians' behaviours outnumber those of other disciplines,³⁴ but advances are being made in attempts to delineate specific constructs (e.g., self-efficacy, habit) from various theories that predict clinician behaviours.^{35,36} In our work, we use the Theoretical Domains Framework,³⁷ which was developed to make theories for implementation more accessible and includes constructs from 33 behaviour change theories.³⁶

We conducted a qualitative study using interpretive description.^{38,39} This inductive approach draws upon the disciplinary knowledge and insight of health care professionals. According to Thorne and colleagues, "the foundation of interpretive description is the smaller scale qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding."⁴⁰ Interpretive description is inspired by, and borrows from, various qualitative traditions (e.g., grounded theory, ethnography, phenomenology, naturalistic inquiry) and is suitable for this study, as it allows for production of knowledge and contextual understanding so that the information can be applied directly to practice.⁴⁰ The phenomenon of interest in this study was pharmacy students' experiences with how mental health care is provided in the context of community pharmacies. Third- and fourth-year pharmacy students from a

Canadian undergraduate pharmacy program were recruited through purposeful sampling. Focus groups were the preferred mechanism of collecting data, given the nature of the research question. The study was advertised through e-mail, word of mouth and posters.

A semistructured interview guide (available upon request) was developed by the research team and included 6 main questions and related probes. All dialogue with participants was recorded and transcribed verbatim and has been edited for flow and space constraints. Field notes, including observations and impressions, were recorded by the principal investigator (AM) and the research associate (DR). AM and DG met biweekly following independent constant comparative analyses⁴¹ over a period of 4 months to discuss and finalize thematic description of the data, visually depict the data and apply the Theoretical Domains Framework (Table 1).³⁷ The framework was applied by AM and DG independently to representative quotes within themes to categorize influences on the behaviours^{36,37,42} of pharmacy team members when interacting with people with lived experience of mental illness and to consider potential behaviour change techniques.⁴²⁻⁴⁵ ATLAS.ti 6.2 was used for data management and assigning codes.

All participants provided informed consent and approved the use of anonymized quotes. Ethics approval was obtained from the research ethics board of Capital District Health Authority (CDHA), Halifax, Nova Scotia. There is a reciprocal ethics approval agreement between the research ethics boards of CDHA and Dalhousie University. Participant names were changed to protect identities.

Results

Two student focus groups were held in October and November 2012 with 11 students (7 third year and 4 fourth year): 6 women and 5 men, mean age 24.5 (range, 21 to 30) years, averaging 3.2 years (range, 2 weeks to 7 years) of cumulative, mostly part-time, community pharmacy retail work experience. All students but 1 reported currently working as an employee in a community pharmacy during the school term. Students estimated the monthly proportion of prescription volume for psychotropic medications in their practice setting to be 10% to 50% of all prescriptions in their practice settings.

TABLE 1 Theoretical Domains Framework³⁷

1. Knowledge
2. Skills
3. Social/professional role and identity
4. Beliefs about capabilities
5. Optimism
6. Beliefs and consequences
7. Reinforcement
8. Intentions
9. Goals
10. Memory, attention and decision processes
11. Environmental context and resources
12. Social influences
13. Emotion
14. Behavioural regulation

Five of the 11 participants reported providing methadone as part of their role in the community pharmacy setting.

The students' experience was characterized as "identity pluralism." Student participants discussed the enactment of multiple roles at their pharmacies, including "technician," "pharmacy student" and "future pharmacist." Each of these roles had a self- or externally imposed suite of knowledge, attitudes, behaviours, skills, level of responsibility and decision-making authority. When discussing their experiences in practice, student participants made distinctions as to whether they were functioning in the role of "techs" (i.e., paid employees) versus pharmacy students "on rotation" and engaging in activities during structured learning experiences. Student participants discussed their own knowledge and behaviours but also spent significant time discussing what they observed other pharmacy team members, primarily pharmacists, doing in practice. Within these descriptions, patterns emerged regarding how pharmacy team members interacted with people with lived experience of mental illness, with their support people (e.g., family members) and with other health professionals (Figure 1). Pharmacy team members engaged in care *proactively* when they

FIGURE 1 Pharmacy students' experiences in caring for people with lived experience of mental illness

initiated purposeful dialogue with patients or other health care professionals or *reactively* in response to a request or a problem or issue that required their attention, such as a potential error in a prescription written by a physician. When pharmacy team members reactively engaged, student participants described little or no action resulting from the interaction. At most, the pharmacy team member might have passed the responsibility for action to another health care provider, for example, by instructing people to make an appointment and talk with their physician.

Themes

Three broad themes emerged from the pharmacy student experience in the care of people with lived experience of mental illness: (1) business tension; (2) roles, responsibilities and relationships; and (3) stigma (Figure 1; Appendix 1, available online at cph.sagepub.com/supplemental). Business tension primarily arose from student participants' descriptions regarding finances and other resources (e.g., time, space, human resources, information) that affected how pharmacy team members engaged with people with lived experience of mental illness and the services that

were provided. Students often voiced frustration (Appendix 1) regarding how business objectives and work flow were prioritized over patient-centredness. Student participants discussed their own roles, responsibilities and relationships in their pluralistic identity experience as well as the roles, responsibilities and relationships of other pharmacy team members. Student participants also described the responsibilities and roles that patients, support people and other health care providers assumed in the care process. The issue of stigma arose at various times, including when the number and types of educational resources (e.g., pharmacy-based educational pamphlets and sessions) made available for people living with other chronic health conditions (e.g., diabetes, osteoporosis and cardiovascular diseases) compared with mental illness were discussed. Negative attitudes of the public and some pharmacy team members regarding patients with mental illness and especially addictions were identified by the students.

Theoretical Domains Framework

Application of the Theoretical Domains Framework (TDF) within the themes is shown in Appendix 1 with representative quotes. In the

business tension theme, issues with reinforcement (TDF 7) and environmental context and resources (TDF 11) were prevalent. Students discussed with discomfort the basis of incentives and punishments in community pharmacies, such as prescription volume and other product-focused activities as a driver to support renovations for private counselling areas.

Roger: You [only] have so much room for the pharmacy. If you build another counselling room, well, maybe that's going to take off a whole shelf and that's going to drop your store's profit.

Alvin: That's right. . . . That's the conversation that they're having. It's not, "What will work best for getting the most information from the patient?" It's like, "We need to sell these chips."

Roger: Or head office says, "This store . . . you know what, you guys don't do enough scripts. You're not getting any renovation funding." And this busy store, "Yeah, we'll give you some money. You guys are doing good."

Some student participants who discussed using the private counselling area for patient-centred activities were discouraged from this due to time demands or interrupting dispensary flow. These redirections in their behaviours appeared to occur more frequently when they were working as paid employees or "techs." They were regarded as a resource (TDF 11) and had their behaviours redirected away from people with lived experience of mental illness, either through direct requests or indirectly, to keep up with the pace of the dispensary despite the existence of a learning opportunity or enhancing patient-centred care.

Gail: I was talking to a patient this summer . . . and I actually had a staff member come over and knock on the table by the semi-private counselling room and tell me that I had to "stop" because it didn't fit in work flow. . . . I never saw that patient again so I don't know if that patient felt like, "You don't have time for me."

Mary's comments below demonstrate this phenomenon, while she also makes clear distinctions regarding being "on rotation" and working, which we described as identity pluralism. In addition to reinforcements, her

MISE EN PRATIQUE DES CONNAISSANCES

- Les étudiants en pharmacie doivent concilier des attentes multiples concernant leurs responsabilités et leurs rôles dans les pharmacies communautaires.
- Les comportements du pharmacien influencent l'efficacité personnelle et le perfectionnement professionnel des étudiants dans les soins offerts aux personnes qui ont une expérience concrète de maladie mentale.
- Il faut adopter des stratégies permettant de dépasser les approches axées sur les produits et les styles de communication par la mobilisation réactive pour faire progresser le rôle de l'équipe de pharmacie dans les soins offerts aux personnes ayant une expérience concrète de maladie mentale.

comments include elements of TDF 2, discussing the practice and skills of her "counsel"; TDF 12, relating to the social norm within the profession for time spent on counselling (i.e., 8 to 10 minutes) and providing patient education, the power of her supervisor and variations in standards created whether on rotation or as a paid employee; and TDF 13, the emotions and stress related to the "time crunch" and being watched.

Mary: That's one thing I find that's hard . . . during my counsel the other day, I was there for probably 8 or 10 minutes. And at the same time in the back of your mind, you're like, "Okay, I have a million other things to do." . . . My boss is kind of watching me. And you want to have a great interaction, but there's always that time crunch. So that's the difference between working and rotations.

Within the *roles, responsibilities and relationships* theme, there was broad application of the Theoretical Domains Framework, including knowledge (TDF 1), skills (TDF 2), social/professional role and identity (TDF 3), beliefs about capabilities (TDF 4), optimism (TDF 5), beliefs and consequences (TDF 6), reinforcement (TDF 7), environmental context and resources (TDF 11), social influences (TDF 12) and emotion (TDF 13).

Students described many situations in which they were unclear about their social/professional role and identity (TDF 3). Mary discussed issues pertaining to engaging in dialogue with patients and the practice of

having refill prescription bags “stapled shut.” This practice effectively limits conversation and promotes a reactive engagement style, and it reinforces her notion of public expectations with prescription refills.

Mary: Because once you open up that conversation, they often have quite a few more questions. . . . And the problem is that we don't always ask if they need help. . . . We don't even know what's inside the refill bags. They're stapled shut and nothing on the outside. . . . And then if you wanted to open up the bag, they'd be like, “Why are you opening up my bag?”

Ian also described situations in which there was uncertainty as to roles, responsibilities and boundaries of pharmacy team members in circumstances that extended beyond dispensary-related duties.

Ian: One day I think I spent 30 or 40 minutes on the phone with her [a patient]. . . . She just wanted to talk. She had no family support and everything was spiraling. . . . We got to a point where it was very alarming. We were all concerned that she would potentially commit suicide or commit harm to herself.

Student participants also discussed collaboration. Much of the discussion was of the limited collaborative efforts between physicians and pharmacists and the reactive rather than proactive basis of collaboration. The discussion of collaboration with other health care professionals was essentially nonexistent. As one student mentioned, the pharmacist calls the doctor when something is “wrong,” or as Melanie describes below, collaboration is avoided and this responsibility is shifted to the patient. TDF 3 and 12 were applied reflecting the pharmacist role and identity and the norms assumed within relationships.

Melanie: We had an instance where someone just got their . . . I think it was Prozac. They got it bumped up. But they were controlled. And she was like, “I was not having any problems,” and now she's having all these side effects. . . . The pharmacist was kind of like, “I don't know why they bumped it up. Why don't you

talk to your. . . .” Like, they weren't really willing to call them [the doctor] and say, “I think you made a mistake” or “I don't know why you did that.”

Phil discussed similar interactions demonstrating the professional roles and boundaries of pharmacists restricted to less clinically oriented functions and a reactive engagement approach.

Phil: “Oh, did you mean to not write for their diuretic or did you mean not to write for their this or that?” The physician would say, “Oh, yeah,” or “Oh, no,” and that would be it. That would be the entire discussion. Sometimes I did see us kind of shoot ourselves in the foot as far as being more clinicians than, you know, dispensers, in the sense that we didn't actively pursue a clinical role. We pursued more of a technical [role].

When students discussed beneficial experiences in collaborating with physicians, including in proactive ways, they expressed optimism (TDF 5) about the care delivered.

Roger: With the collaboration. . . . I mean, we hear it all the time from our teachers here, usually when a pharmacist calls the doctor, it's because something is wrong. And it's almost always a negative interaction with the doctor. So a couple of times this summer, I called a doctor up to, I guess, try to learn more about the patient or update the doctor how the patient was doing. And they really liked that. You could see going forward, that would be huge.

When supervising pharmacists proficiently and competently engaged in patient care activities with people with lived experience of mental illness, students' notions of their roles (TDF 3) and capabilities (TDF 4) as professionals were reinforced (TDF 7).

Alvin: And the people that are receptive, I find that the overwhelming response is positive, like almost overly positive. So it kind of tells me that the expectations are too low. You know, the public's perception of what students can actually offer. Or maybe just pharmacists in general. So when we're extending to follow

up or to look up something and call them back, they're amazed. You know, like, "You guys can do this?"

Theoretical domains including, but not limited to, 1 (knowledge), 3 (social/professional role and identity) and 12 (social influences) were applied to situations involving *stigma* that students observed. Relevant constructs within these included group conformity, social pressure, power, group identity, professional role and professional confidence. As an example, stigmatizing activities were carried out by pharmacy team members, as described by one student who subsequently modeled these activities with conformity to the group's views and perceptions (TDF 12).

Mary: I definitely see a stigma with the methadone patients in the pharmacies from different team members, mostly based on their personal beliefs regarding it. . . . It's a tetchy subject for some people. Interviewer: Do they treat people differently or what is it about? Mary: It's just . . . they don't treat people differently when they come in. They're polite and kind. It's afterwards, they'll make a comment that's sort of just not. . . . Roger: It's almost gossiping. Mary: It is. And it's unfortunate. . . . Roger: And I'll admit, I've probably been part of that too.

Further, stigma was apparent regarding the type and quantity of resources dedicated to physical health concerns (e.g., cardiovascular disease, osteoporosis), which far exceeded those of mental health conditions. TDF 3, 5, 7, 11 and 12 were applied in the following:

Kelly: Not once have I seen a clinic with regards to, like, depression or whatever. It's always blood pressure or cholesterol. . . . I've never thought of it before but that's . . . all the booklets they have. Like if I were to go through all of their booklets at these clinics, it's all . . . I've never seen them [educational materials for mental disorders].

Discussion

The experiences of the pharmacy students in mental health care service provision in our study reflect ongoing challenges in community pharmacy practice in which product-focused

approaches can be dominant. Business tension, roles, responsibilities and relationships, and stigma were the main themes identified from our data. Previous research in this area has focused largely on knowledge, attitudes and behaviours of pharmacy students and measuring stigma or attempting to improve student knowledge and attitudes through consumer-led educational sessions in pharmacy education and clinical experiences.^{24,25,29,46-49} Using interpretive description has provided depth and breadth of the pluralistic identity experience of students.

Our results contribute to the body of knowledge regarding pharmacy team members' behavioural influences in practice. Our study's overall findings support recent calls to define pharmacy culture and the factors that inhibit the profession from orienting to patient-focused care.^{50,51} To our knowledge, this is the first exploration that applies the Theoretical Domains Framework to help understand the practical experiences of students in a nonphysician health care field. Application of the Theoretical Domains Framework can enable identification of potential strategies for future targeted behaviour change techniques.⁴³⁻⁴⁵ The approach used in our study follows that of others in establishing "steps for developing a theory-informed implementation intervention,"⁴² in which step 1 (identification of who needs to do what differently) and step 2 (use of a theoretical framework to identify barriers and facilitators to change) were completed in this analysis. From here, efforts can be placed on examining the application of behaviour change interventions that target these influential factors.^{43,45} As an example of this, a current research project in Nova Scotia called "More Than Meds"⁵² involving pharmacists and people with lived experience of mental illness on teams is targeting multiple behavioural domains including knowledge (TDF 1), skills (TDF 2), social/professional role and identity (TDF 3), belief about capabilities (TDF 4), reinforcement (TDF 7), environmental context and resources (TDF 11) and social influences (TDF 12).⁵² Behaviour change techniques applied in this project include training, education, modeling, incentivisation, enablement and persuasion.⁴⁵

Student participants experienced a pluralistic identity while engaging in formal activities (i.e., based on objectives of structured rotations) and informal and hidden curricular experiences (i.e., unstructured activities and influences

such as organizational culture and place).⁵³⁻

⁵⁵ They vacillated in their identity and roles (i.e., pharmacy student, technician, future pharmacist), often attempting to reconcile differences among them. It appeared that this was done without mentorship by supervisors. For example, while “on rotation” in a structured learning experience, students were afforded more time for engaging with people with lived experience of mental illness and were not questioned on how their activities would fit into workflow compared with when they were “working” as “techs.” These redirections in the student participants’ behaviours contrasted with ideals about patient-centred care that were taught in school. Current undergraduate pharmacy curricula espouse patient-centred, collaborative care approaches; however, most of the interactions between people with lived experience of mental illness and students and their supervising pharmacists appeared to be product-focused. Although some people may prefer product-focused pharmacy encounters,⁵⁶ it appears that this was the typical approach with people with lived experience of mental illness. Limited interactions were also standard with collaboration with other health care providers. Student participants discussed a desire for enhanced collaboration with physicians (and other health care providers) and people with lived experience of mental illness, but overall, physician interactions and expectations by patients of pharmacists were perceived to be low, findings similar to others.⁵⁷⁻⁵⁹ Relationships with physicians and patient expectations are important factors previously identified in facilitating practice change in pharmacy settings.⁶⁰

Student participants discussed various motivators of their own and their pharmacist supervisors’ behaviours. Business tensions primarily negatively influenced aspects of care, and within the Theoretical Domains Framework, reinforcement (TDF 7) and environment context and resources (TDF 11) were frequently applied. These issues with business tension are particularly important in the context of practices that support product-focused approaches to patient care and are tied to financial reimbursements. Several student participants described situations in which pharmacy team members spent significant effort and time on patient care activities unrelated to a product. Other researchers have found that business and professional interests

can come into conflict and present a barrier to service delivery.⁶¹⁻⁶³ Factors such as manpower/staffing, communication and teamwork and pharmacy layout have been previously identified as important factors within the pharmacy environment that can facilitate or hinder practice change, which would include implementation and delivery of services.^{60,64} It has also been reported in previous survey research that depending on a pharmacy manager’s role within the pharmacy and the kind of pharmacy in which he or she works (e.g., corporate, franchise, independent), the manager’s autonomy, decision-making ability and amount of control with decisions, including those regarding workflow and service delivery, in the work environment can be variable.⁶²

In the broader theme of roles, responsibilities and relationships, we frequently applied knowledge (TDF 1), skills (TDF 2), social/professional role and identity (TDF 3) and beliefs about capabilities (TDF 4). This last finding is important, given that beliefs about capabilities and self-efficacy have been previously found to be critical factors in predicting behaviours of pharmacists⁶⁵ and other health professionals in providing services.³⁵ This is an especially important implication from our work, as pharmacist supervisors’ redirections of student behaviours to fit within norms of the profession could be negatively shaping students’ beliefs about their capabilities and self-efficacy and reinforcing social norms that may not encompass patient-centred care.

Another dimension of mental health care delivery includes consideration of stigma. This concept has been explored in the student experience by others regarding how attitudes affect their interactions.^{24,25,48,49,66} It has been shown that student attitudes toward patients with schizophrenia are more stigmatizing than attitudes toward those with severe depression and that many students perceive that patients with schizophrenia are “a danger to others,” “unpredictable” and “difficult to talk to.”²⁴ Although one Canadian study⁹ showed that the stigma that people with lived experience of mental illness experienced from pharmacists was similar to experiences with other health providers, the results of the current study demonstrate that within the profession and community pharmacy environment, there could exist an underlying stigmatizing culture (TDF 11, 12) regarding social norms within the workplace.

Limitations

This study was conducted with undergraduate pharmacy students from one Canadian university. While it can be assumed that some, if not most, students worked in pharmacies in Atlantic Canada, we did not determine the exact locations of their cumulative experiences. We also did not explicitly ask them to describe specific characteristics (e.g., independent pharmacy, etc.) of their work environment. Therefore, we are not certain whether our findings would be transferable across Canadian pharmacy practice settings.

As a method, interpretive description generates knowledge for applied health disciplines within the context of their distinctive social mandates.³⁸ Our analysis was conducted primarily by 2 pharmacists with discipline-specific knowledge regarding the roles and professional scope for pharmacists. We cannot claim that this is the only possible interpretation of our data.

Conclusion

Pharmacy students assume many roles as a part of the pharmacy team while observing and engaging in the care of patients with lived

experience of mental illness. Students face a reconciliation process between learning from formal curriculum and experiences and learning from informal and hidden curricular activities. Their experiences demonstrate a complex mix of influences on their behaviours, as well as the behaviours of their supervising pharmacists, as demonstrated by application of the Theoretical Domains Framework. Future endeavours aimed at shaping the practical educational and work-related experiences of pharmacy students in the care of people with lived experience of mental illness need to consider the roles and responsibilities of students and a theoretical approach to modifying the behaviours of students and their supervising pharmacists.

The results of our study identify and echo challenges for advancing pharmacists' roles in the direct and collaborative care not only of people with lived experience of mental illness but of community pharmacy patients in general. Moving forward will require pharmacy systems issues (e.g., workflow, services provision, resources); pharmacist knowledge, attitude and behaviour; and public and health care professionals' expectations to be duly considered and addressed. ■

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