White paper on expanding the role of the community pharmacist in managing depression

APhA Foundation Coordinating Council Discusses Collaborative Role of the Community Pharmacist in Managing Depression

Abstract

Objective: The purpose of this initiative was to establish a Coordinating Council To Discuss the Collaborative Role of the Community Pharmacist in Managing Depression. The Council convened September 15–16, 2008, in Washington, DC. The APhA Foundation, in conjunction with leading national experts and caregivers in mental health and depression, assessed the level of care and services currently provided by community pharmacists to patients with depression and developed this document discussing how their collaborative role might be expanded and made more effective in helping patients and caregivers manage the burden of depression.

Data source: A literature review was undertaken and a premeeting survey developed. The survey was conducted to elicit Council members' perceptions of the top needs and challenges facing patients with depression and to gain insights as to what roles pharmacists are, could be, and should be playing in helping patients with depression.

Summary: Depression affects 9.5% of the U. S. population, or more than 19 million people, each year. Depression is a major, albeit treatable illness. The presence of other chronic diseases is a major risk factor for depression in adults. More than 70% of people diagnosed with depression are employed, and depression results in 400 million lost workdays each year. Left untreated, depression costs more than $43.7 billion in absenteeism from work, lost productivity, and direct treatment costs.[1] The Council's findings confirmed that community pharmacists are playing important collaborative roles in managing patients with depression but can, and should, expand these roles.

Conclusion: Depression is real and is best managed through provider collaboration. Community pharmacists are accessible, trusted, and respected resources. Increased involvement by community pharmacists in the care of patients with depression could improve clinical outcomes and enhance quality of life. Innovative approaches for expanding community pharmacist involvement in identification of patients with depression and in their care should be developed to maximize the impact pharmacists can make in the lives of those who suffer from the disease.

Key words: depression, pharmacy services, family caregiver, collaborative practice, APhA Foundation

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Funding: The Coordinating Council To Discuss the Collaborative Role of the Community Pharmacist in Managing Depression was made possible through grant support provided by Wyeth Pharmaceuticals.

Introduction

The American Pharmacists Association (APhA) Foundation invited a group of national experts and caregivers in mental health and depression to serve on the Coordinating Council To Discuss the Collaborative Role of the Community Pharmacist in Managing Depression. The Council convened September 15–16, 2008, in Washington, DC, to assess the level of care and services currently provided by community pharmacists to patients with depression. The meeting was supported by a grant from Wyeth Pharmaceuticals. This white

paper is intended to serve as an initial "blueprint" for how the pharmacist's collaborative role might be expanded and made more effective in helping patients and caregivers manage the burden of depression.

Scope of the problem

Depression is real. It is not a passing mood. It is not a personal weakness. It is a major but treatable and often chronic illness.

This year, more than 19 million American adults (9.5% of the population) will suffer from depression. About 5% to 10% of women and 2% to 5% of men will experience at least one major depressive episode during their adult life. That equates to 31.6 million adults.[2] Nearly twice as many women (12%) as men (7%) are affected by a major depression each year. While some people experience only a single episode of major depression, it is estimated that between 50% and 85% of patients will experience a recurrence.[3] The lifetime risk of having another depressive episode is 17%.[4]

Depression affects people of all races, incomes, and ages.[5] Individuals with depressive disorders suffer limitations in physical and social functioning that are as severe as or more severe than those caused by conditions such as hypertension, coronary artery disease, lung problems, and back pain.[6] Depression also affects families. Mood changes can have negative impact on family members, causing conflict, displacing responsibilities, and creating stress.

Depression is a risk factor for heart disease, high cholesterol, high blood pressure, chronically elevated levels of stress hormones, stroke, and low levels of day-to-day functioning.[7] Similarly, the presence of other chronic diseases (e.g., diabetes, heart conditions, asthma) is a major risk factor for depression in adults. In a recent analysis, depression symptoms were identified in 72.1% of 217 primary care patients aged 18 years and older with type 2 diabetes.[8] Failure to treat both physical and mental health conditions causes poorer outcomes and higher costs[9] (Table 1).

The workplace is especially vulnerable. No job category or professional level is immune. More than 70% of people diagnosed with depression are employed, and depression results in 400 million lost workdays each year.[10] Employees who are depressed are twice as likely to miss work for health reasons compared with their colleagues and will miss 9.9 days of work on average each year.[11] Moreover, the chance of less-than-optimal job performance is seven times higher in depressed workers.

Table 1: Annual medical expenditures for adults with a specific chronic condition, with and without a mental health condition

	Cost without mental health condition	Cost with mental health condition
All adults*	$1,913	$3,545
Heart condition	4,467	6,919
High blood pressure	3,481	5,492
Asthma	2,908	4,028
Diabetes	4,172	5,559

*Refers to all adults with and without chronic conditions. Source: Peterson SM, Phillips Jr. RL, Bazemore AW, et al. Why there must be room for mental health in the medical home. Am Fam Physician. 2008; 77 (6):757.

Depression is treatable, with one-half to two-thirds or more of those treated showing improvement, yet fewer than half of those suffering from depression seek medical treatment.[12] When depression is left untreated or partially treated, patients have an increased risk for future episodes.

Untreated depression is costly. Left untreated, depression is as costly as heart disease or diabetes to the U.S. economy, costing more than $51.5 billion in absenteeism from work and lost productivity and $26.1 billion in direct treatment costs. People who are depressed use significantly more health care services than those who are not. Depressed employees use, on average, more than $4,000 per year in medical services compared with less than $1,000 per year used by employees without depression.[14] Depression is the third most common reason for seeking help from workplace assistance programs. Only family crises and stress push more people to seek help.[15]

In essence, there is no health without mental health.

Identifying people at risk for depression

In a comprehensive study on the extent of depression in the United States, Kessler and colleagues reported, "More than half the people surveyed with depression had severe depression, and only 10% were considered mild. Yet just one in five received adequate treatment." Kessler found fewer than half of those surveyed were receiving minimal treatment.[16]

While depression is the most common mental disorder in the primary care setting, many people with clinical depression fail to seek treatment. Only one-third of those with a mental health disorder seek care.[17] According to the National Institute of Mental Health (NIMH,) people who do seek treatment typically do so after a decade or more of delays, during which time they are likely to develop additional problems. Reasons for delays in treatment can include the continuing stigma of mental illness, a conviction that they can overcome the illness on their own, and limited access to mental health information and care, among others.[18]

While there is no blood test for depression, a diagnosis can be made from scientifically valid criteria by trained mental health and medical professionals. A diagnosis of depression can be made when five or more of the following symptoms

have been present during the same 2-week period and represent a change from previous functioning and at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:

- A depressed mood nearly every day
- Loss of interest in pleasurable activities nearly every day
- Significant appetite or weight change (e.g, a change of more than 5% of body weight in a month not due to dieting)
- Sleep disturbance nearly every day
- Psychomotor agitation or retardation
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- Loss of concentration nearly every day
- Recurrent suicidal thoughts or ideation[19]

Screening people at risk for depression can help overcome barriers to adequate identification and treatment. While a positive result to a screening tool is not an adequate substitute for a diagnosis, screening can be extremely helpful in making a diagnosis and monitoring. Referring patients to providers for evaluation, diagnosis, and treatment is also critical. Key differences exist among a major depressive episode, chronic depression, dysthymia, and bipolar disorder. Correct diagnosis is important in developing an effective treatment plan.

A variety of screening tools can be used to screen and evaluate depression symptoms at the point of care. While these instruments range in length and complexity, two simple tools are the most widely used and best validated in the primary care setting. These are the nine-item Patient Health Questionnaire (PHQ-9) (www.treatmenthelps.org/treatmenthelps/PHQ9.pdf, www.phqscreeners.com, www.phqscreeners.com/terms.aspx) and the two-item version, the PHQ-2 (www.cqaimh.org/pdf/tool_phq2.pdf). Both are accessible to the public (Table 2).
A single-item screening question (Have you felt depressed or sad much of the time in the last year?) can also be used, but it is less sensitive than the PHQ-2 and has not been evaluated in the primary care setting. In addition to screening, these tools are used to monitor response to therapy in patients receiving treatment for depression.[20]

Table 2: PHQ-2 Questionnaire for major depressive disorder

During the past month—
Have you often been bothered by feeling down, depressed, or hopeless?
Have you often been bothered by little interest or pleasure in doing things?

Note: An affirmative answer to either question is a positive test result; a negative answer to both questions is a negative test result.

www.phqscreeners.com
www.phqscreeners.com/terms.aspx

The PHQ-9 is being used by pharmacists in Project IMPACT: Depression. The project seeks to address the need for depression management issues through the use of a community pharmacy–based health care service delivery model; this is an extension of the 10-year-old Asheville Project. In this project, once enrolled, patients agree to meet with a pharmacist on a regular basis. At the initial visit, the pharmacist conducts a medication and condition assessment using the PHQ-9 validated depression scoring instrument. If medications are being taken properly but no improvement in depression is occurring, pharmacists provide therapy treatment recommendations to the patient's prescribing physician. They can also refer patients to the employer's Employee Assistance Program for further assessment and referral to counseling programs, psychiatrists, and other services. Adherence assessment, goal setting, and depression improvement are measured at each visit, with results provided back to the prescriber and patient's other caregivers. The goal is to get patients into a routine and "on track" with their therapy. The final data analysis on the project will look at overall clinical and economics outcomes.

Needs of individuals with depression and their family caregivers

In order to focus the agenda and prioritize discussion topics during the Coordinating Council meeting, a survey was developed and administered to the Council members before the meeting.

Council members were asked to identify the major needs of patients with depression and their caregivers. The most significant areas of need include the following:

- General information about depression and its treatment
- Access to appropriate, quality care
- Medication management and support
- Social support and resources
- Coordination of care
- Increased pharmacist involvement

General information needs for patients and their caregivers about depression include its diagnosis, risk factors, symptoms, treatment options, and life style changes that improve prognosis. Providing patient and caregiver education about monitoring for warning signs of relapse is essentail. Helping to reduce stigma and its consequences, including affirmation that depression is a disease, not a personality defect, is also important.

Patients suffering from depression need access to appropriate quality care, including insurance coverage. The importance of treatment quality once patients access services was empha-

sized. Evaluating comorbidities is necessary because these conditions often coexist. Access to appropriate medication, psychological counseling, providers, and regularly scheduled follow-up care is critical.

Medication management and support needs include information on specific medications, their indications, side effects, and realistic expectations of what medications can do in depression treatment. Effective medication management needs include the following:

- Screening for drug interactions
- Monitoring efficacy, toxicity, and side effects
- Managing treatment–emergent side effects
- Selecting appropriate medications
- Medication history
- Support and education for patient self-management, including monitoring for efficacy and toxicities
- Implementing adherence strategies (education to improve medication use, behavioral approaches, adherence tools, drug administration challenges)
- Education about the time course of response to antidepressant treatment
- Education about self-medication
- Managing treatment costs
- Treating to remission

The importance of providing medication therapy management (MTM) services was identified. MTM is a distinct service or group of services that optimize therapeutic outcomes for individual patients. These programs encompass a broad range of professional activities and responsibilities within the licensed pharmacist's, or other qualified health care provider's, scope of practice. These services include but are not limited to the following, according to the individual needs of the patient:

- Performing or obtaining necessary assessments of the patient's health status
- Formulating a medication treatment plan
- Selecting, initiating, modifying, or administering medication therapy
- Monitoring and evaluating the patient's response to therapy, including safety and effectiveness
- Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Documenting the care delivered and communicating essential information to the patient's other primary care providers
- Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications
- Providing information, support services, and resources designed to enhance patient adherence with his/her therapeutic regimens
- Coordinating and integrating MTM services within the broader health care management services being provided to the patient

Beyond medication therapy, identification of support systems and community resources for patients and their caregivers is an important need. Social support systems can serve to decrease the social isolation often involved in depression. Talking with others in social support groups can provide patients with a sense that they are not alone. Reassurances from support groups, family caregivers, and a patient's health care providers that the patient will get better are important. Psychotherapy is also an effective treatment for clinical depression and is often combined with other treatments. Psychotherapy can help the patient develop appropriate and workable coping strategies.

Because of the varying complexity of depression, other mental health conditions, and the existence of comorbidities, coordination of care among a patient's health care providers is a critical need. Patients may be seeing numerous providers, including primary care physicians, psychiatrists, therapists, social workers, case managers, pharmacists, and others, as well as specialists for the treatment of accompanying physical complaints and diseases (e.g., asthma, diabetes, cardiovascular disease). Continuing communication among providers was identified as a role pharmacists could help fill, perhaps as part of formal MTM programs. (See Collaboration in Community Health: Case Studies.)

Last, a need exists for increased pharmacist involvement in activities such as identifying individuals at risk for depression, screening patients with co-morbidities and other risk factors, providing MTM services and participating in collaborative practice arrangements (including serving as case managers), providing information on accessing patient assistance programs, serving as a source for information on depression and social support resources, and participating in local/regional/national mental health organizations, advisory boards, and other support resources.

Current and emerging collaborative roles for pharmacists

Council members were asked through the premeeting survey about their experiences working with pharmacists in the care of patients with depression as well as what potential roles they felt pharmacists could play. The majority of Council members had experience working with pharmacists. They cited having a pharmacist serve as a physician extender for certain chronic conditions, including depression, with prescribing privileges and separate service billing. One member described working with a trained psychiatric pharmacist specialist who served as a medication management resource (education, monitoring). Another member described a mental health MTM practice with adherence strategies such as special packaging,

coordinating refills with physicians and other health care practitioners, providing a refill reminder phone call service to patients, and an injection clinic. Others said pharmacists had served as patient advocates, helping them find the most appropriate Medicare Part D prescription plan, referring them to assistance programs, and providing other medication support services.

Council members agreed, however, that these experiences are not the norm for most providers and their patients with depression. They also agreed that, while the current role of the community pharmacist may be minimal, there is a great opportunity for enhancement.

When asked to rank some potential roles for pharmacist involvement in the care of patients with depression, Council members felt the following would have the most impact (shown in order):

1. Improving medication adherence and compliance to medication regimens
2. Providing general medication regimen review
2. Providing patient medication counseling and education
2. Screening patients at risk for depression, including those with comorbidities
3. Serving as a source for referral of patients to other health care practitioners and local support resources
4. Administering medications/injections under collaborative practice agreements
4. Including pharmacists in support groups and education programs
4. Delivering community education programs
5. Providing information on patient assistance programs

Council members identified additional MTM roles such as patient education and lifestyle modification counseling, implementing medication adherence strategies, monitoring medication efficacy and teaching patients how to self-monitor their condition and providing tools to do so. Pharmacists were also seen as part of an interdisciplinary care team and potentially serving as care coordinators/case managers for patients with depression, encouraging patients to talk with their physicians, and providing feedback to the patient's physician and other health care providers.

Council members strongly agreed that depression is best managed through provider collaboration and that there is a need to expand the community pharmacist's role in managing patients with depression.

Pharmacist impact in mental health

Published studies bear out the positive impact of pharmacists in collaborating to treat patients with mental health conditions. In a systematic review of the literature from 1972 to 2003, Finley, Crismon, and Rush found cumulative results reported in 16 investigations to be "overwhelmingly positive" about the impact of pharmacists in mental health.[21] Most of the studies featured the role of clinical pharmacists as treatment consultants or educators, and consistently demonstrated significant improvements in the safe and efficacious use of psychotropic drugs. Several studies focused on the role of the pharmacist as a case manager. In one study, a clinical pharmacist with prescriptive authority provided case management services for outpatients over a 3-year period. Results were compared with patients treated by other clinic providers. Authors reported superior patient satisfaction and clinical outcomes for patients seen by the pharmacist at a cost of 60% less than for the control group.[22] Three other studies focused on the pharmacist serving as a case manager for patients suffering from depression receiving primary care. Medication adherence increased substantially in all three studies, and patient satisfaction favored pharmacist intervention.[23, 24, 25]

Hare and Kraenow explored a model for conducting depression screening in community pharmacies.[26] Using the 10-item Harvard Department of Psychiatry/National Depression Screening Day Scale (HANDS), six pharmacists in four supermarket pharmacies in Kansas City, MO, screened 18 participants. Fourteen were found unlikely to have symptoms of major depressive disorder (MDD), while three had symptoms consistent with MDD, and one person had symptoms strongly consistent with MDD. Patients followed the pharmacists' recommendations for referral in all cases. Authors concluded that with training, community pharmacists are capable of performing screenings and referring patients for treatment. In another study on depression screening in a university campus pharmacy, Knox et al. found that depression screening was feasible, participants reported feeling comfortable discussing depression with the pharmacist, and the information on depression that the pharmacist provided was useful.[27] Brook et al. have also found coaching by community pharmacists to be an effective and acceptable way to improve the attitude of patients with depression.[28]

Looking at providing patients with information on antidepressant medications, Sleath et al. found that patients were significantly more adherent to their medication regimen when they received information from more sources, including the pharmacist, primary care physician, mental health specialist, friends and family members, and the Internet.[29] Rickles et al. found telephone follow-up monthly for 3 months by pharmacists to patients with new antidepressant medication prescriptions resulted in improved patient feedback to pharmacists that could help pharmacists identify and address patient misconceptions, concerns, and progress with antidepressant therapy.[30]

Numerous strategies for pharmacists to enhance medication adherence in patients receiving antidepressant therapy have been documented by Bucci et al.[31] The authors outline various reasons for nonadherence and provide detailed strategies and counseling tips for pharmacists based on documented successes.

Enhancing the pharmacist's role in depression care: Challenges

In a more recent survey of pharmacist attitudes, current practices, and barriers related to the pharmacist's role in depression care in Belgium, Scheerder et al. posit that expanding the role of nonclinical community professionals would improve depression care.[32] They suggest that pharmacists could play the following roles in depression care:

- Screening patients at risk for depression and referring for treatment
- Providing information to patients about depression and medications
- Monitoring patients for medication effectiveness, adherence, and side effects
- Collaborating and communicating with the patient's primary care physician and other health care providers
- Providing information to support adherence

The study's authors note that pharmacists are already successfully involved in pharmaceutical care for patients with chronic conditions such as asthma, diabetes, and hypertension, yet this success has not been widely translated to patients with depression. Their survey was designed to explore pharmacists' attitudes, current practices, and perceived barriers concerning depression care so that they can be addressed.

Pharmacists' attitudes toward their potential role in depression care were very positive across the nine roles surveyed—upward of 85%. The main perceived barrier to providing depression care was a lack of education on mental health issues. Other frequently reported barriers included lack of time with individual patients, lack of information about patients and their treatment, lack of privacy in the pharmacy, and difficulties communicating with patients with depression. Concerning care collaboration, pharmacists' desired partners included general practitioners and the patient's relatives.

The study authors conclude that for pharmacists to take enhanced roles in depression care, training programs will be required to provide the knowledge and skills needed to perform these roles. Further, increasing collaboration with general practitioners can help pharmacists gain the information and patient insight needed to perform these roles.

Like Scheerder et al., Council members identified barriers and the strategies to address them. With regard to pharmacy education and competency, Council members noted that many pharmacists might be unfamiliar with the mental health system, lack knowledge of depression and its treatment, and feel uncomfortable counseling patients with depression. Increasing the comfort level of pharmacists in treating this patient population was among the strongest recommendations of the Council, although members recognize that not all community pharmacists may learn to be comfortable in this role.

Workplace and pharmacy infrastructure issues that create challenges to pharmacists providing depression care included lack of time in a traditional dispensing environment because of work volume and other priorities, inadequate pharmacy layout and space, fragmented and uncoordinated electronic records, the silo model of health care, and lack of marketing of new services, if offered. These challenges are similar to those identified for other chronic care management and MTM services.

Financial support for implementing a new care model can also be a challenge. There are limited grant opportunities to implement new services, no payment for coordination of care, and a lack of incentives and reimbursement for providing care. Council members believe that employers must pay for screening and pay pharmacists for services. They noted that the APhA Foundation has conducted and documented successful collaborative care models in chronic conditions and provides incentive grants to practitioners for implementing new care models. Pharmacist participation in practice-based research networks can also help with future documentation of collaborative care models. The Council encouraged continued research into collaborative care models and pharmacist involvement in providing care to patients with depression.

Council members are anticipating the forthcoming publication of the Foundation's Project ImPACT: Depression demonstration project and believe it will help drive more pharmacists to implement depression care collaborative practices.

Collaboration in community health: Case studies

"This specialty lends itself to collaborative practice [between patients, their health care providers, and their pharmacist] because the patient's needs are so complex and there is no way single health care providers can do it by themselves."

— Julie Fike, PharmD

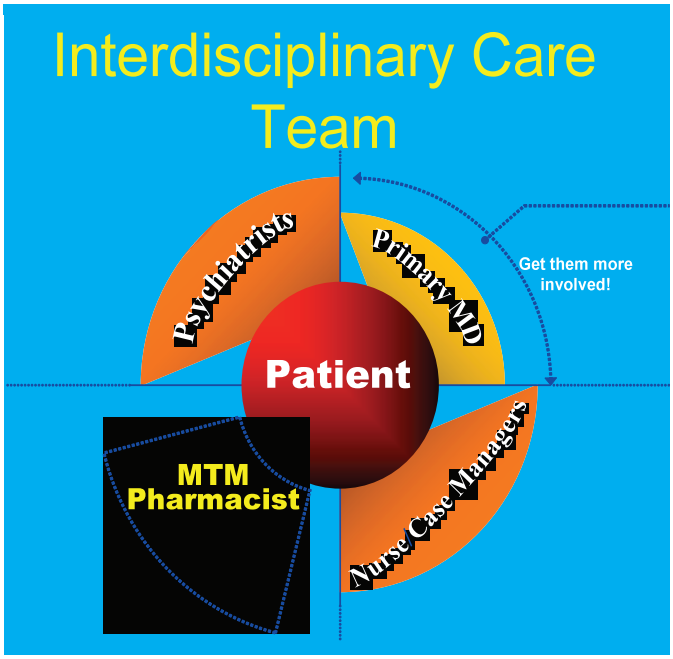

Figure 1: The Genoa interdisciplinary care team

Julie Fike, PharmD, has a mental health MTM practice that is a shining example of how pharmacists can collaborate with other health providers in an interdisciplinary team to improve outcomes for patients with mental health conditions.

Fike practices at the Family Life Center (FLC) operated in partnership with Genoa Healthcare in Anoka, MN (Figure 1). Genoa Healthcare was founded in 2002, and the privately owned company provides a full array of traditional and non-traditional in-house pharmacy services for community mental health centers throughout the United States. The company began by offering monitoring services for patients who were taking clozapine and grew to a specialty mental health pharmacy with nearly 60 locations.

Medication dispensing services are provided separately from MTM services and often include sending medications directly to the patient's home. Patient referrals to the MTM program come from a variety of avenues: the clinic's psychiatrists, therapists, physicians, nurses, and case managers or through RISE, a community organization providing support for patient employment and housing. The FLC staff often assist in setting up patient appointments for the MTM service. Fike has full access to the patient's paper-based charts and laboratory values if they have been done. If they have not been done, she can recommend that labs be conducted. She provides a comprehensive medication review, documents her recommendations in the patient chart, and provides patients with a personal medication record and a copy of her MTM recommendations. Those recommendations are faxed to the patient's primary care physician and to the patient's psychiatrist if they are not at the FLC. Follow-up visits are scheduled based on each individual patient, varying from monthly to every 3 months.

Within the FLC clinic, Fike operates under two formal collaborative practice agreements. The first agreement's scope covers influenza, pneumoccocal, and other immunizations, while the second agreement covers injectable psychiatric medications that she administers during MTM visits. She also coordinates patient medication order refills with physicians, nurses, and case managers, often including special compliance packaging from the Genoa Healthcare's dispensing pharmacy. A collaborative practice agreement to cover refill authorizations is pending. The practice model is depicted in Figure 2.

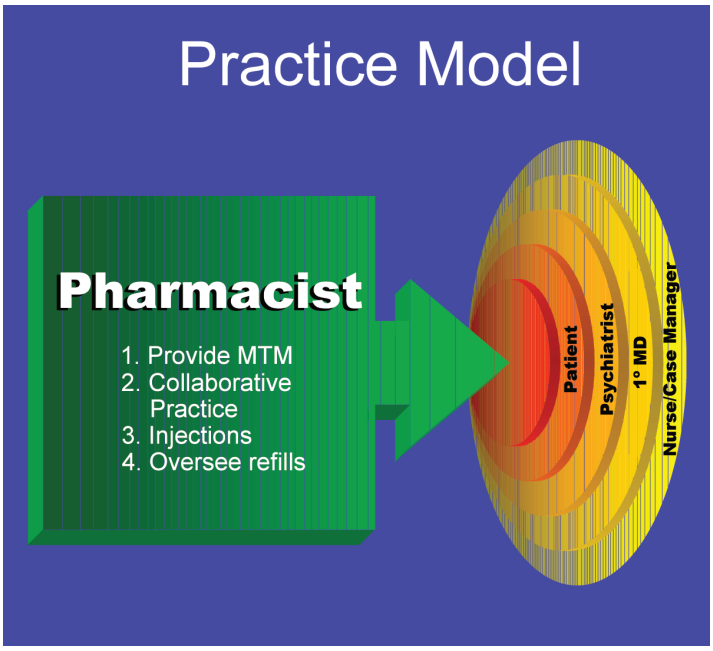

Figure 2: The Genoa Healthcare practice model

While Fike engaged in a comprehensive diabetes MTM service before establishing her current practice with Genoa, she said that her new practice "never results in turf battles. Other providers are thankful for [my] help." She noted that 99% of her recommendations to FLC physicians are accepted, and among non-clinic providers, that rate is still an impressive 90%.

Fike noted that coordination of care is the key with patients. Pharmacists can interact with case managers, provide a close connection with psychiatrists, have the ability to follow up to ensure refills are received and any problems are addressed, provide specialty packaging for complex medicine regimens, get required labs drawn, and help get patients to a primary physician if they do not have one. "Pharmacists have the opportunity to make a huge impact on medication adherence and management in mental health patients. Patients may have poor insight because of their disease state and MTM is crucial to help patients understand the importance of their medications," she noted.

Case examples

Case examples provide insight into how helpful the practice model can be for patients.

JH is a 44-year-old white male patient with a diagnosis of bipolar illness and schizophrenia. He has smoked for 25 years, drinks 2 to 6 alcoholic beverages each week, and drinks fewer than 2 cups of caffeinated beverages a day. His activity level is 2.5 to 5 hours a week. JH has not had a primary care physician for more than 5 years. JH was referred to Fike as a result of a phlebotomist home visit to conduct labs. When Fike saw JH, he said he hadn't taken his medication for 10 days because he was out of refills and he felt he was overmedicated. His medication profile follows:

- Lorazepam 0.5 mg every 4 to 6 hours prn
- Trileptal 300 mg every night at bedtime
- Paroxetine 60 mg a day
- Risperdal 2.5 mg every night at bedtime

A review of his fasting labs showed a glucose of 88 mg/dL, TG of 122 mg/dL, HDL of 40 mg/dL, and LDL of 151 mg/dL. Fike's MTM plan for JH included decreasing the Risperdal to 2 mg at bedtime and discontinuing the lorazepam to help with JH's low activity level and feeling of being overmedicated. Chantix was started and smoking cessation counseling provided. A daily aspirin was started for cardiovascular health and a multivitamin for general nutrition. At the 6 week follow-up appointment, JH's adherence had improved to 90% and he no longer complained of feeling overmedicated. His Chantix use continued, he was smoking less, and all lab values were normal.

BJ, a 32 year-old white female is another MTM patient of Fike's who has ADHD, depression, hypertension, sleep disorder, and acne. She does not use alcohol, caffeine, or tobacco. She's very sedentary, with less than an hour of exercise each week. BJ is somewhat agoraphobic and only leaves her home for her part-time job. When she saw Fike, her chief complaint was getting to the local pharmacy to pick up her medications. She was referred by an FLC therapist for the visit.

In conducting a medication review, Fike found BJ's medication to include the following:

- Tetracycline 250 mg every morning
- Adderall XR 60 mg every morning
- Wellbutrin XL 450 mg every morning
- Seroquel 100 mg every morning and 200 mg at bedtime
- Effexor XR 450 mg every morning
- Atenolol 25 mg daily
- Ambien 10 mg at bedtime

Fike's assessment was that BJ had difficulty getting to the pharmacy to pick up medications and this led to low adherence. Her ADHD was also not controlled by the current medication regimen. BJ admits to a diet rich in sugar and does not take a multivitamin. She complains of sweating; this may be due to hyperinsulinemia after eating sugar. The plan that was implemented included transferring the patient's prescriptions to the Genoa Healthcare pharmacy where special adherence packaging and home medication delivery were implemented. Vyvanse was started and Adderall XR discontinued to achieve more stable daily drug levels; lifestyle modifications included a healthier diet and exercise, along with a daily multivitamin.

At a 4-week follow-up, BJ's adherence had improved. Administration of the ADHD scale also showed improvement with Vyvanse. BJ's blood pressure was 142/95, and a dose increase of atenolol was considered. BJ's sweating was ruled out being caused by sugar intake by blood glucose monitoring. Effexor XR was decreased to 375 mg to help with the sweating. Another 4 to 6-week follow-up was scheduled.

A key driver: Employer/payer issues

The Council identified employer and payer issues as a key driver for an enhanced community pharmacist's role in managing patients with depression. The APhA Foundation hosted the 2008 Employer Summit To Address Depression as a Component of Chronic Disease February 20–22, 2008, with support through a grant from Wyeth. The program presented employers, pharmacists, and other key stakeholders with an opportunity to discuss the impact of depression and chronic disease, while providing a forum to share ideas and discuss strategies that can be adopted to address depression in the workplace. Summit proceedings and presentations are available at http://healthmaprx.com/related_links.

Breakout sessions at the meeting focused on improving access to services, addressing workplace destigmatization, and engaging community stakeholders. Specific recommendations related to access included conducting health screenings for employees, conducting lunch-and-learn sessions, coordinating with an easy-to-access provider that employees can see confidentially for help, implementing waived co-payments for people who enter a program, and ensuring that employees are aware of resources available. Training management on what depression is and how it affects the workplace was recommended, as was continually evaluating programs and staying current on what community providers have to offer.

Regarding workplace destigmatization, Summit participants recommended that employers develop a communication strategy, find a champion among peers who can speak to his/her depression and the importance of seeking care, and educate employees and management on depression. Successful work-

place programs have used a third party to make employees more comfortable seeking care or have used a longstanding depression care manager whom employees trust.

To engage community stakeholders, recommendations included financial support to develop education programs for pharmacists, physicians, and other stakeholders; involvement from Employee Assistance Programs in developing referral and training programs; adequate staffing for coordination among stakeholders; and better awareness of programs already in the community that are underused.

The Council's discussion built on the Summit's foundation. Council members said employers need to focus on offering "value-based benefit design." Such benefit programs would contain the four cornerstones of value-driven health care, defined by former U.S. Department of Health & Human Services Secretary Michael Leavitt: use of health information technology; measurement and publishing of quality information; measurement and publishing of price information; and creation of positive incentives for high-quality, efficient health care. The National Business Coalition on Health has created the *Partnership for Value Driven Health Care Purchaser Guide* to assist employers (see Resources) to make value-driven health care a priority in purchasing health care services for employees.

Given the significant prevalence and impact of depression in the workplace, such tools can help employers understand the return on investment (ROI) of offering depression programs and the resultant productivity gains. This is especially important because the cost of depression is borne disproportionately by businesses. Employers pay two-thirds of the cost of depressive disorders annually, according to Katherine A. Durso, PhD.[33]

The Mid-America Coalition on Health Care has had a program since 2000 called the Community Initiative on Depression. Numerous successful case reports from employers have come out of this program, as well as several tools employers can use to implement programs (see Resources). Other successful case studies from employers of all sizes can be found at the Partnership for Workplace Mental Health website at www.workplacementalhealth.org/search.aspx. The Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and its employer partners. The partnership delivers educational materials and provides a forum to explore mental health issues and share innovative solutions and promotes the business case for quality mental health care, including early recognition, access to care, and effective treatment.

One important tool bears mention. The "depression calculator" helps individual companies understand how much time and money they are losing from depression and what they can recover if employees receive treatment. The tool is available at: www.depressioncalculator.com/Welcome.asp. The productivity impact model takes into account the costs of comorbidities as well.

Best practices for employers for depression have been studied and documented by the University of Michigan Depression Center.[34] The Center is multidisciplinary and dedicated to research, education, and treatment of depressive and bipolar illnesses. The best practices include the following:

- Ensuring that employees have appropriate access to outpatient care and a broad continuum of services, settings, and providers
- Providing information to employees to help them understand the health care system and the benefits available to them for the treatment of depression
- Providing information to employees on symptoms of depression and the importance of seeking care
- Having employee screening or early detection mechanisms for depression
- Having guidelines for job accommodations, including time to participate in therapy and other mental health programs, for those with depression
- Having supervisor training to help them identify, manage, and assist employees with depression
- Having a return-to-work plan for employees who have been absent because of depression
- Ensuring privacy and confidentiality for those seeking treatment

The Council emphasized the importantance of having return-to-work policies in place as well. *Preventing Needless Work Disability by Helping People Stay Employed* contains detailed guidance and is available from the American College of Occupational and Environmental Medicine at www.acoem.org/guidelines.aspx?id=566. Other important employer resources can be found at the Partnership for Workplace Mental Health website at www.workplacementalhealth.org/employer_resources/index.aspx.

While having a comprehensive, value-based benefit design for depression is ideal, employers can take three "most important and practical" steps for tackling depression in the workplace, according to Alberto Colombi, MD, Corporate Medical Director at PPG Industries.[35] These steps offer employee education programs to destigmatize depression, give employees easy access to depression resources and care, and ensure that primary care providers are paid to screen for depression.

Strategies and recommendations

Community pharmacists are in an ideal position to make a difference in the recognition and management of people with depression. Pharmacists have frequent contact with patients with depression as well as those at risk for depression due to comorbidities. They have expertise in MTM and are easily accessible. They can support and collaborate with primary care physicians in identifying patients at risk for depression and in treating those who have been diagnosed with the condition. Promising roles are being played by practitioners and pharmacy education has evolved to include training pharmacists to provide MTM services.

Specific strategies to enhance the community pharmacist's role in managing patients with depression recommended by the Council include the following:

Education and training

Schools, colleges, professional organizations, and professional journals should develop and provide access to timely and relevant education and training opportunities. The importance of destigmatizing depression and its treatment cannot be overemphasized. In particular, the Council recommends creating a certificate training program on the pharmacist's role in recognizing and managing patients with depression. Such a program should have an interdisciplinary focus. It should provide education on screening tools (using PQH-9 at point of care), MTM and adherence strategies, patient monitoring tools and strategies (how to recognize cognitive function changes, depression signs and symptoms, patient questions, patient monitoring using a variety of methods, including computer and telephone). The program should also provide information to develop skills to communicate and provide feedback to physicians. Information on resources about depression and support services for patients and their family caregivers should also be provided.

When developing curricula, pharmacy schools should provide specific education to student pharmacists on mental health conditions, their prevalence and treatment, how to recognize and manage depression and comorbidities, and how to develop internship/clerkship opportunities. They should support students to attend conferences where depression is the focus.

Pharmacists' role in collaborating with physicians to identify patients at risk

The Council strongly recommends that pharmacists identify patients who have risk factors that may lead to depression, such as comorbidities or medications that may cause depression. The Council also recommends that pharmacists implement the PHQ-9 and/or PHQ-2 at the point of care. Results from screenings could trigger specific actions by the pharmacist, including patient referral. Minnesota is currently developing pharmacy-specific protocols in this area. Pharmacists should be encouraged to administer the PQH-9 to any patient with chronic disease, as prevention tool. Council member J. Paul Martin stated, "Often seven different interventions in seven different ways are needed to find the *right* one in this patient population." Primary care practitioners may not have adequate time to screen patients and these time pressures may contribute to poor diagnosis. Lack of payment for screening is also a challenge. Pharmacists can collaborate with practitioners by identifying patients at risk for depression, conducting screenings, and referring patients to their physician for treatment.

Pharmacists' role in providing patient education

The depression disease process can prevent patients from seeking help for their condition. Building trusting relationships with patients helps pharmacists provide patients with information about depression and its treatment. Council members noted that education and awareness among patients should be built using the following basic messaging: what the medication is for, how to take it, and what to expect from the medication. Pharmacists should emphasize the value of early treatment and the fact that medications do not work unless they are taken. Pharmacists should provide patients and caregivers with a depression symptom checklist and rating scale to help them track changes and risks of relapse. These tools can empower the patient when pharmacists provide interpretation of test results and report cards (e.g., Do results show things are better than last month?). Numerous resources for pharmacists are included in the Resources section of this report.

Provider collaboration and communication

The Council noted that often in an insured patient population, a standard team care approach to mental health is missing in uninsured populations. They believe depression is best managed through provider collaboration. Council members feel strongly that the pharmacist can play a role in creating a team care approach by communicating with various providers and serving in case management/care coordination roles. They recommend that work be undertaken to define a coordination of care process and team member roles, including employee assistance programs. Further, education programs featuring strategies for physician–pharmacist relationship building should be developed featuring those methods that work best in the community of care.

Quality of care and outcomes

The impact and cost savings of the collaborative approach to depression care should be demonstrated and documented, including how it helps physician practices. Further, the Council recommends that pharmacy quality measures related to depression care be developed. The Council urged PQA (a pharmacy quality alliance) to work with the National Committee for Quality Assurance (NCQA) to develop appropriate, coordinated quality measures for depression screening and treatment generally and for broad pharmacy performance measures. The Council believes that seeking NCQA recognition of the pharmacist as a team member would be an important step in enhancing depression care. Council members suggested that depression care programs be built off other successful, pharmacist-provided chronic disease management programs such as asthma, diabetes, and hypertension, especially because depression is a common co-morbidity.

Current quality measures tend to be process rather than outcomes based, in part because there is no "magic bullet" for depression. Quality standards examine whether patients receive 12 weeks of filled antidepressant medication prescriptions after diagnosis in an acute phase of depression and 6 months of filled prescriptions for ongoing care. They also measure follow-up appointments after diagnosis. The following specific quality measures related to depression listed on the Agency for Healthcare Research and Quality (AHRQ) website (www.qualitymeasures.ahrq.gov/browse/browsemode.aspx?node=7417&type=1) may be positively affected by pharmacist screening with PHQ-9 and MTM services:

> Antidepressant medication management (effective acute treatment phase): Percentage of members who were diagnosed with a new episode of major depression and treated with antidepressant medication, who remained on an antidepressant drug during the entire 84-day (12-week) acute treatment phase.

National Committee for Quality Assurance 2007 Jul. NQMC:002783

> Antidepressant medication management (effective continuation phase treatment): Percentage of members who were diagnosed with a new episode of major depression and treated with antidepressant medication, who remained on an antidepressant drug for at least 180 days.

National Committee for Quality Assurance 2007 Jul. NQMC:002784

> Depression: Percent of clinically significant depression patients who attain a 5-point or greater reduction in Patient Health Questionnaire (PHQ) score within 6 months after their New Episode PHQ.

HRSA Health Disparities Collaboratives: Depression Collaborative 2005 Jan. NQMC:001621

> Depression: Percent of clinically significant depression patients who have had a documented follow-up 1 to 3 weeks after their last New Episode Patient Health Questionnaire (PHQ).

HRSA Health Disparities Collaboratives: Depression Collaborative 2005 Jan. NQMC:001625

> Depression: Percent of clinically significant depression patients who, within 1 month of last New Episode Patient Health Questionnaire (PHQ), are on an antidepressant and/or in psychotherapy.

HRSA Health Disparities Collaboratives: Depression Collaborative 2005 Jan. NQMC:001632

> Major depression in adults in primary care: Percentage of patients with diabetes with documentation of screening for depression.

Institute for Clinical Systems Improvement 2008 May. NQMC:004014

Increase awareness of the pharmacist's role and involvement in public and private groups

Educating patients, physicians, and public and private organizations about the pharmacist's role in providing MTM services and depression care in particular was an important need identified by the Council. Identifying and involving key pharmacy stakeholders in local, state, and national mental health organizations and associations may be an important step in building awareness of the pharmacist's role. Encouraging pharmacist involvement in the *Depression Is Real* campaign (See Resources) should be encouraged.

Call to action

Depression affects people, employers, and society in significant and costlyways. While depression is real and manageable, it remains underidentified and undertreated. The APhA Foundation Coordinating Council has identified numerous opportunities for community pharmacists to undertake enhanced roles in managing patients with depression and believes the disease is best managed by collaboration among patients and their health care providers.

In order for these enhanced roles to be realized, the Coordinating Council calls for the following actions:

1. Create and implement a national stigma reduction program among all stakeholders, possibly using the *Depression Is Real* Campaign.

2. Create and implement interdisciplinary depression care education and certificate programs for pharmacists and other providers.
3. Encourage pharmacists to implement depression screening programs and depression MTM services, in conjunction with programs for managing other chronic diseases.
4. Create programs to increase awareness of the pharmacist's role among stakeholders.
5. Encourage employers/payers to institute a value-based benefit design that includes best practices for depression.
6. Encourage NCQA to recognize pharmacists as part of the care team for patients with depression and other mental health conditions.
7. Encourage PQA to work with NCQA to further develop pharmacy quality measures for depression treatment.
8. Work with other professional and community stakeholder organizations

The Coordinating Council's discussions are intended to stimulate the development and implementation of pharmacist-based service offerings for individuals suffering from depression. The Council's strategies and recommendations support the belief that there is no health without mental health.

Resources

The *Depression Is Real* Coalition

The *Depression Is Real* Coalition is a group of physician, patient, and constituency groups that has created an educational campaign about depression. These groups are concerned about confusing messages in popular culture suggesting that depression is "just the blues" or worse, a "made-up disease." The goal of the Coalition is to help people living with depression, their families, friends, and the public to understand these essential facts about depression. Numerous patient and health care provider resources are available at the Coalition's website: *www.depressionisreal.org/index.html.*

Mental Health America (formerly the National Mental Health Association)
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
703-684-7722
www.mentalhealthamerica.net

The Mental Health America website provides educational material and resources, including information on local mental health organizations, and community crisis and support groups; it also covers advocacy efforts.

National Institute of Mental Health
Public Information and Communications Branch
6001 Executive Boulevard, Rm. 8184, MSC 9663
Bethesda, MD 20892
866-227 NIMH (6464)
www.nimh.nih.gov

The NIMH website offers access to research, educational material, and information on outreach programs. NIMH is the largest scientific organization in the world dedicated to research focused on the understanding, treatment, and prevention of mental disorders and the promotion of mental health.

Partnership for Workplace Mental Health
American Psychiatric Foundation
1000 Wilson Boulevard
Suite 1825, Arlington, VA 22209-3901
703-907-8673
www.workplacementalhealth.org

The partnership advances effective employer approaches to mental health by combining the knowledge and experience of the American Psychiatric Association (APA) and its employer partners. The partnership offers a range of materials, including educational brochures for employees and a free newsletter that highlights employers' efforts to improve mental health care. The website also features links to related organizations, including APA, and tools such as the depression calculator.

The Mid-America Coalition on Healthcare
1 West Armour Boulevard
Suite 204
Kansas City, MO 64111
816-753-0654
www.machc.org

The National Business Coalition on Health
www.nbch.org/resources/toolkits.cfm

The coalition provides depression resources for consumers, human resources managers, and medical and mental health professionals. Tools for managers include a self-assessment that can be used to evaluate a company's depression management policies and a ready-to-use presentation on depression. NBCH has several toolkits for employers available.

Productivity Impact Model
http://www.depressioncalculator.com

The APA, the Pharmaceutical Research and Manufacturers of America, the Institute for Health and Productivity Management, and the Mid-America Coalition on Healthcare developed the Productivity Impact Model, which is also called the depression calculator. The tool enables employers to view the effect that improved treatment of depression could have on its bottom line. The program examines an employer's population by age, location, and industry type, and estimates how many employees in each age group are likely to be affected and the associated impact on the bottom line. It then projects savings based on reduced absenteeism, increased productivity, and a reduction in direct medical costs.

National Network of Depression Centers
4250 Plymouth Road
Ann Arbor, MI 48109
734-232-0175
http://nndc.org/

NNDC comprises 14 university-based departments of psychiatry and associated multidisciplinary academicians. Formed in 2007, NNDC is taking steps to build and/or integrate the clinical expertise, organizational structure, partners, information technology, and funding to form depression centers by building the model of the University of Michigan Comprehensive Depression Center.

Resources

University of Michigan Depression Center
Rachel Upjohn Building
4250 Plymouth Road
Ann Arbor, MI 48109
800-475-MICH (6424)
www.depressioncenter.org

College of Psychiatric & Neurologic Pharmacists (CPNP)
8055 O Street, Suite S113
Lincoln, NE 68510
402-476-1677
www.cpnp.org

Formed in 1998, the mission of The College of Psychiatric & Neurologic Pharmacists is to promote excellence in pharmacy practice, education, and research to optimize treatment outcomes of individuals affected by psychiatric and neurologic disorders.

Appendix 1

Members of the APhA Foundation Coordinating Council on Expanding the Collaborative Role of the Community Pharmacist in Managing Depression

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* At the time of this meeting Miall serverd as a consultant to the APhA Foundation

** At the time of this meeting Bryner served as the Senior Marketing Manager, Retail Pharmacy Segment, Healthcare Systems Marketing, Wyeth Pharmaceuticals, Collegeville, PA

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