

Community Pharmacy Foundation  
Depression Screening in Community Pharmacy: Final Report  
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## **Background Significance**

There is widespread recognition of the need for depression screening in older adults (New Freedom Commission on Mental Health, 2003). While more than six million older adults suffer from mental health conditions, many do not receive the care they need. The prevalence of depression in community dwelling adults aged 55 and over is estimated at 15%. In older persons treated in primary care, depression has been identified in 17 to 37% of patients (Scheinthal et al, 2001; Levkoff et al., 2004). With the projected increase in the number of older persons over the next 30 years, these numbers will only increase.

Despite its substantial prevalence, depression in older adults often remains undetected. A recent article in *Clinical Geriatrics* reports that nearly 75% of cases of major depression among older persons in primary care went undiagnosed by their primary care physician (Grossberg, 1999). Many factors are responsible for the underdetection of depression in older persons, including ageism on the part of the health care provider, that is, the assumption that depression is due to old age alone; the lack of training among health care professionals; the likelihood that older adults may experience multiple co-morbid conditions that complicate a diagnosis of depression; or lack of time in a medical visit to screen for depression (Rynn, DeMartinis, and Rickels, 1999).

In addition to provider related barriers, patient related barriers to detection of depression also exist. Many older persons share the myth that depression is a normal part of aging, and thus do not report symptoms to their providers. The tremendous stigma associated with a diagnosis of depression among the current cohort of older persons who were told “to pull themselves up by their own bootstraps” is likely a reason that many older person fail to seek care for depression, even when they are aware that they are experiencing symptoms. Lack of family support, cost of treatment, lack of transportation, and inability to communicate concerns to their health care providers may also impose barriers to older persons receiving the care they need.

The excess morbidity of untreated depression in older adults is significant. Suicide is one of the more severe consequences. Older adults have the highest risk for suicide of all age groups; the suicide rate for white American men 65 years and older is five times that of the general population. Other outcomes of untreated depression include poor physical function, social withdrawal, and increased morbidity (Crystal et al, 2003) (DasGupta, 1998). This is especially significant, given that depression in older adults is highly responsive to treatment (Grossberg, 1999).

In summary, this intervention was created to respond to the urgent need for new and innovative mechanisms to identify older adults with depression and to help them receive appropriate treatment. We set out to document the feasibility of a community pharmacy based approach to screening, educating and motivating older adults to seek treatment for depression. This work has resulted in the creation of a prototype comprehensive Toolkit for Community Pharmacists, which can be disseminated widely to other community pharmacies wishing to duplicate the intervention program. Included in the toolkit are

training materials necessary for pharmacists to take on this expanded role, including materials on counseling and referral, a brief self-administered depression screen, informational materials for pharmacy clients, and health education materials for older persons such as posters and brochures.

### **Project Goals**

In this intervention we trained community pharmacists to screen for depression in older adults to address the need for increased community awareness and treatment of depression in this population. Specifically, we had three objectives: to teach pharmacists/pharmacist technicians to (a) facilitate a self-administered screen for depression in older adults; (b) provide brief counseling and educational materials on depression, its signs and symptoms, and its treatment options to those who have screened positive for depression; and (c) refer them to a primary care provider or mental health specialist for a diagnostic assessment, and subsequently provide follow-up support to motivate them to seek referral and treatment.

We examined the following questions: 1) Will older adults who learn about the depression screening program outside of the pharmacy come to the pharmacy to participate in depression screening? 2) Will older pharmacy clients consent to being screened for depression? 3) Will older adults who screen positive for depression agree to contact their primary care provider or mental health specialist for a full diagnostic assessment? 4) Will older adults who receive a referral for a full diagnostic assessment follow through with that referral? 5) How many of the older adults screened positive for depression will return to the pharmacy to fill an anti-depressant prescription drug? 6) Will patient traffic in the participating pharmacies be increased?

### **Subject Selection and Methods**

The study sample included older adults over the age of 55 from both local communities involved in the intervention (The Village Pharmacy, Lynnfield, MA and Georgetown Pharmacy, Merriam, KS).

Older adults 55 years and older were recruited to participate in screenings through several techniques: postings in the pharmacy, postings in the local senior centers, advertisements and articles in community papers, educational sessions in local settings such as churches, senior centers, and retirement communities, and inquiries to existing pharmacy clients. Also, during regular pharmacy visits a pharmacy technician and/or a pharmacist would identify clients age 55+ and ask them if they would like to participate in the depression screening program. The program was then explained to the client and if the client agreed to participate, the pharmacist would attempt to obtain informed consent. In order to obtain informed consent, the pharmacists distributed the informed consent forms to potential participants, reviewed the consent form, and answer any client questions. Many participants who agreed to participate in the study changed their mind after encountering the consent form. Many were intimidated by the phrase “we

will contact your physician or primary care provider if you screen positive for depression.”

Once (and if) informed consent was obtained, the pharmacist would hand the PHQ-9 screen to clients. The pharmacist and the pharmacy technician were available during the screening process to answer questions. Upon completion, the technician checked to make sure that the client has filled in all items on the questionnaire. When a client screened positive for depression, the pharmacist immediately met with that client to review the screen and to carry out a brief counseling and education session. If a client did not screen positive for depression, but expressed interest in learning more, the pharmacist would carry out a brief education session.

### **Overall Result**

Patients were screened through the end of December 2006. At the Village Pharmacy, 40 patients were screened for depression. Out of those screened, 10 underwent a counseling/education session with the pharmacist, even though just 1 out of the 40 screened positive for depression. This patient was referred to a new physician, she made an appointment within 10 days, and received treatment and a prescription for antidepressants. At the Georgetown Pharmacy, 23 patients were screened and no patients screened positive for depression.

The consent form was seen as the largest obstacle to getting patients screened for depression. 75% (pharmacist estimation- began counting refusals one month into the project) of patients agreed to be screened but then refused after reading the consent form. The phrase that had the most impact was the indication that the patient’s physician *would* be contacted if the individual screened positive for depression. The finality of that statement prevented many from going ahead with the screening. They stated that the idea that their personal physician *would be contacted* was enough to prevent them from taking the screening, even if they had previously agreed to the screening. For those patients that did sign the consent form, all completed the screening process.

### **Recommendations**

Many recommendations were made by the participating pharmacists in regard to screening methods, consenting, education, and tool kit development.

**Screening Methods.** Pharmacists and pharmacy technicians felt that the screening process could be streamlined to make the procedure easier. Suggestions include including some brief depression information on the consent form so that pharmacy clients could learn some basic facts on depression (symptoms, treatment, etc) while they read through the consent form. It was suggested that including the depression screening in a comprehensive health screen (in addition to blood pressure, etc.) would help decrease the stigma associated with depression and frame it as a potential health issue to be aware of. Also, it was recommended that pharmacists/pharmacy technicians visit community health fairs or senior housing complexes to administer the depression screening,

**Consent form.** The pharmacists felt that the pharmacy clients' concern about having depressive symptoms that potentially required treatment was far outweighed by their concern that they would be forced (by signing the consent form) to share a diagnosis of depression with their physicians. The biggest problem was the immediacy of the reporting (i.e., "if you screen positive for depression, we will contact your physician and/or make an appointment for you"). Pharmacy clients stated that they would like to have the option for more time to think about the diagnosis before having to report it to their doctor. Pharmacists recommended that more responsibility to be left to the patient after receiving a positive screen- that, as opposed to immediately calling and making a referral, the patient would receive some in-pharmacy education, and be sent home with further resources, and a follow up call would be made the next day by the pharmacist to plan for next steps (i.e., making a physician's appointment). These suggestions are reflected in the Pharmacy Toolkit. Individual pharmacies will have to decide upon the consent procedures that they feel are most appropriate

**Education.** Participants had several recommendations for additional topics to be included in the depression education materials given to pharmacy clients. More information was requested on the medications used to treat depression, specifically, the typical side effects of the medication, the cost of the medication, and the insurance coverage available for those medications. Also, more information was requested on the support available for those who screened positive for depression above and beyond the realm of the family doctor. As aforementioned, participants requested that some education be included on the consent form. This should include a 1-page information sheets that states that depression is a real illness, and that great treatments exist, both pharmacological and non-pharmacological, so that the depression screening does not appear to be a ruse to get more prescriptions filled at the pharmacy.

These recommendations were incorporated in the development of the depression screening toolkit for community pharmacy. The toolkit contains the following elements:

- Letter of Introduction. Project Overview.
- "How-to": A step by step introduction to the process
- Forms (on disk, one hard copy)
  - Recruitment Posters
  - Newspaper ads
  - Newspaper article
  - Information sheet (in lieu of consent form)
  - PHQ-9
  - Tally Sheets
  - Bag stuffer brochure
  - PowerPoint for in-pharmacy education
  - PowerPoint for community education
- Continuing education element
  - CD Rom
  - CEU paperwork
  - Certificate

## **Conclusion**

This study was not as successful as we hoped it would be when we set forth. We had hoped to screen 200 pharmacy clients at each site, and in reality the number screened was much less. The number one reason cited by all participants in this study was the fear pharmacy clients had of being reported to their physician as “depressed” without having the time to process the information or to have a say in whether or not the physician was told. This reinforces our understanding of the stigma attached to depression, and allows us to see that pharmacy clients are anxious to let even their personal physician know that they may be depressed. It is our recommendation that community pharmacists continue to educate their clientele on depression, in order to help the public understand the disease and to reduce the stigma surrounding the disease. One method of doing so is to include depression education information in routine pharmacy health education efforts (such as health fairs, brochures, etc). These recommendations are seen in practical form in our Depression Screening Toolkit for community pharmacy.

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