Pharmacist self-reported antidepressant medication counseling

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Abstract

Objectives: To identify the extent of pharmacists' self-reported antidepressant counseling (SRAC) and to identify factors that may affect pharmacists' decisions to provide antidepressant counseling.

Design: Cross-sectional study.

Setting: Alabama community pharmacies in 2011.

Participants: Full-time pharmacists from 600 community pharmacies.

Intervention: Self-administered survey; three mail contacts with alternate electronic surveys were used.

Main outcome measures: Pharmacists' SRAC behavior and its relationship with pharmacists' illness perceptions of depression, self-efficacy, and organizational and environmental influences.

Results: 600 surveys were sent; 22 were undeliverable, 1 was partially completed (<80% questions answered), and 118 were completed (20.6% overall response rate). Pharmacists reported low rates of involvement in antidepressant counseling; 61% reported assessing patient knowledge and understanding of depression, and 36% discussed options for managing adverse effects with no more than a few patients. More than one-quarter (28.6%) never asked patients whether they had barriers to taking antidepressants. Pharmacists' perceptions regarding consequences, control/cure, and the episodic nature of depression, as well as their self-efficacy, had significant relationships ($P < 0.05$) with pharmacists' involvement in antidepressant counseling.

Conclusion: Low rates of pharmacists' involvement in antidepressant counseling were reported. Pharmacists must become more involved in counseling patients about their antidepressant medications and overcoming barriers preventing greater involvement.

Keywords: Depression, antidepressants, counseling, medication therapy management, self-efficacy, pharmacotherapy.

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Antidepressants are an effective and accessible treatment for alleviating depression symptoms.[1] Clinical guidelines recommend taking antidepressants for at least 3 to 4 weeks before deciding whether the medication is effective[2] and to continue taking antidepressants for a minimum of 8 months after symptom remission to prevent relapse.[3] Antidepressant nonadherence rates are substantial, with 21% to 33% of patients discontinuing treatment within the first 30 days and up to 44% discontinuing treatment within 90 days of beginning treatment.[4–6] Because treating depression is very costly,[6,7] antidepressant nonadherence exacerbates this already substantial cost burden on the U.S. health care system.[6]

Both patient and provider factors affect patient adherence. Patients prematurely discontinue antidepressants for a variety of reasons, including cost, adverse effects, and ineffectiveness.[8] Patients' beliefs about their depression and its treatment can have an impact on adherence as well.[9,10] Common reasons reported by patients for prematurely discontinuing antidepressants include the perception that their depression symptoms were eradicated, disbelief in the medication efficacy, and belief that additional treatment is unnecessary.[5] Hence, to increase the likelihood of patient adherence to antidepressant regimens, patients must have an understanding of their depression and the purpose of taking their antidepressants as prescribed.[11] This is especially important among newly prescribed antidepressants (defined as the first 90 days of medication therapy).

Provider factors also affect patient adherence to antidepressants, including their knowledge of depression, willingness to treat patient depression, and willingness to monitor the medication's effectiveness.[12] Moreover, depression treatment limitations in primary care[13] include limited access to physicians,[14] insufficient and/or inadequate information provided to patients about depression and antidepressants,[8,15] suboptimal antidepressant dosing, and lack of follow-up and monitoring of treatment efficacy.[16,17] Estimates indicated that less than 20% of patients receive proper follow-up and monitoring of treatment efficacy by the treating primary care physician.[16]

Pharmacists are in an excellent position to address these systematic factors associated with antidepressant nonadherence due to their knowledge of medication therapy, generally positive relationships with patients, and frequent contacts with patients.[18–20] Pharmacists can provide patients with accurate information about depression and antidepressants,[21] monitor medication adherence,[19,22] assess antidepressant medication efficacy,[15,23] and monitor for adverse effects.[24] Further, pharmacists can collaborate with patients' primary care providers,[20] particularly when critical medication changes are indicated. The aforementioned description of these components of pharmacist care for depression is referred to as antidepressant counseling hereafter. Despite pharmacists' potential contributions to enhancing antidepressant adherence, little is known regarding the extent to which pharmacists are providing antidepressant counseling and key factors affecting pharmacists' decisions to provide antidepressant counseling in the community setting.

Objectives

The primary objectives of this study were to identify the extent of pharmacist self-reported involvement in antidepressant counseling and to identify factors that affected pharmacists' decisions to provide antidepressant counseling.

At a Glance

Synopsis: A survey of Alabama community pharmacies was conducted to describe the extent of pharmacist involvement in self-reported antidepressant counseling (SRAC) and the relationship of pharmacists' SRAC behavior with their illness perceptions of depression, self-efficacy, and organizational and environmental influences. Low rates of involvement in antidepressant counseling were reported: 61% reported assessing patient knowledge and understanding of depression, and 36% discussed options for managing adverse effects with no more than a few patients. More than one-quarter (28.6%) never asked patients whether they had barriers to taking antidepressants. By obtaining a better understanding of the impact of depression on patients' lives, pharmacists can become more comfortable in providing antidepressant counseling to patients.

Analysis: *The current results can be used by pharmacy managers and practitioners to assist in developing effective strategies to minimize and/or eliminate barriers affecting pharmacist involvement in antidepressant counseling. These findings are consistent with aspects of the theory of planned behavior, which suggests that individual motivational factors are determinants of the likelihood of engaging in a particular behavior, and with aspects of the common sense model, which suggests that an individual's representation of an illness will be the primary determinant of his/her actions and will assist in (common sense) health decisions. Self-efficacy and antidepressant-related continuing education hours had the greatest magnitude coefficients in the model, suggesting that confidence and knowledge of depression are major determinants in pharmacists' decisions to provide antidepressant counseling.*