



Consumer perceptions of a project considering the role of community pharmacists in the management of depression

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Abstract

Introduction

International research¹⁵⁻¹⁹ has shown pharmacists can have a significant positive impact on the wellbeing of those suffering depression but despite the prevalence of depression in rural Australia there has been little similar research undertaken in rural Australia. This paper examines consumer perceptions of a project carried out by staff of the University of Sydney and funded through the Pharmacy Guild of Australia considering the role of community pharmacists in the management of depression in rural New South Wales.

Methods

Thirty-two rural pharmacists were recruited to the project and allocated randomly to either the 'control' or 'intervention' group. Intervention pharmacists were trained in depression management and asked to dispense medication with extra advice and support, while control pharmacists gave 'usual care', that is, the care they provided to patients prior to the commencement of the study. Consumer participants who had started taking an antidepressant medication for depression within 3 months of the study's commencement were recruited to the study by the pharmacists. The impact of pharmacist intervention on patient wellbeing was monitored by patient interview carried out by telephone at recruitment, at 1 month and at 2 months after recruitment. The interviews included quantitative assessment of psychological wellbeing, attitudes towards taking antidepressant medication and open ended questions asking for 'other comments' about various aspects of the project.

Results

One hundred and six consumers were recruited by the pharmacists. To be eligible for recruitment the consumer had to be over the age of 18, likely to remain in the area for 3 months, to not have a known history of psychosis and to be able to inform the pharmacist that they were taking their anti-depressant medication to treat depression. Participating consumers had a mean age of 46 years, were not currently employed, and were predominantly female. Responses by the consumers to the 'other comment' questions are identified and grouped under four themes: consumer involvement in the project, pharmacist service, perceptions of telephone interviews and hoped for impacts of the project.

Conclusions

Participant responses reflect a perceived dearth of understanding of their needs from policy makers and, to a lesser extent, from health professionals. They show an appreciation of the value the community pharmacist may play in addressing these needs, suggesting pharmacists with additional training in the identification and management of depression and increased understanding of anti-depressant medications are in the position to enhance the wellbeing of depression sufferers by providing increased information on medication, improved support services and enhanced understanding of depression. Given participants' favourable responses to the contact provided through the telephone interviews it is recommended that further research be undertaken into the value of telephone support for those experiencing depression in rural communities.

Introduction

Depression currently ranks as the fourth highest cause of disease burden in Australia¹, particularly in rural communities², where the impacts of globalisation, increasing government regulation, natural disasters, social and geographical isolation and numerous other factors are combining to increase

pressures on rural residents³⁻⁶. Current accurate figures on levels of depression in rural Australia are impossible to find, with most data dating from the 1997 Survey of Mental Health and Wellbeing of Adults (SMHW) and 2001 National Health Survey (NHS)². The SMHW reports high rates of depression in 45–64 year olds residing in inner regional areas, with males aged 18–24 years residing in inner regional areas 1.79 times more likely to report psychological distress and those residing in outer regional areas 0.51 times more likely to report psychological distress than their counterparts in urban areas². Deaths from suicide of male farmers and farm workers are approximately double that of the Australian population⁷. These problems are compounded by the stigma attached to mental illness in rural communities⁸⁻¹³ and problems with accessing appropriate services^{4,6} which may result in those suffering from depression being reluctant or unable to seek assistance in a timely manner.

Research in a number of international studies suggests that the provision of appropriate information and ongoing support to those suffering from depression will improve recovery from the illness¹⁴⁻¹⁶. Complementing these broader observations is a body of research¹⁷⁻²⁰ suggesting pharmacists who have been trained specifically in skills to best manage depression, and who implement that knowledge in the pharmacy will be more likely to have consumers who are satisfied with their medication and less likely to stop taking the medication. It is also likely that there will be a reduction in the numbers of visits to other primary care providers. They may also act as an intermediary between patient and general practitioner²¹. In summary, specific training combined with their existing skills in screening and monitoring, providing reassurance and countering concerns regarding medication may give pharmacists a valuable role in depression management.

The study discussed here aimed to compare these international findings with the outcomes experienced by rural Australian consumers participating in a pilot project determining the role of the rural community pharmacist in the management of depression. This paper presents the qualitative results of the research from the consumer's perspective only. Clinical outcomes and pharmacist perceptions of the project have been presented elsewhere^{22,23}.

Methodology

Prior to the commencement of the project approval was received from the University of Sydney Human Ethics committee.

A list of New South Wales pharmacies with quality care pharmacy practice accreditation, located in PhARIA categories 3 (accessible group B), 4 (moderately accessible), 5 (remote) and 6 (very remote) was drawn up at the commencement of the project. Pharmacies participating in other University of Sydney projects were excluded from the list, leaving one hundred pharmacists eligible to participate in the project. Following a letter of invitation, forty-two pharmacists initially agreed to take part in the project. Thirty-six pharmacists actually commenced the project, 19 control and 17 intervention; 32 completed the initial survey and 30 the second survey.

The project team arranged recruited pharmacists into clusters made up of four pharmacies in reasonable proximity to each other. This was done to reduce the number of videoconferencing facilities required for training pharmacists and to make training services more interactive by bringing pharmacists together. Clusters were compared by PhARIA rating and those with similar numbers of pharmacies for each PhARIA level were paired, creating two groups. The clusters in each of the two groups thus formed were then randomly allocated as control or intervention.

Intervention pharmacists were required to attend a training session delivered through Telehealth, a videoconferencing facility that links a network of hospitals and health centres for the provision of education and training sessions. Videoconferencing facilities of the Centre for Rural and Remote Mental Health (University of Newcastle, Orange) were utilised for delivery of the intervention pharmacists training, a psychiatrist, psychologist (staff of the Centre) and a local General Practitioner with training and experience in mental health. Intervention pharmacists were also asked to dispense medication with extra advice and support. This extra advice and support involved giving participants information at recruitment (including brochures and access to a video on depression, both provided by SANE Australia) and checking how they were going at subsequent visits to the pharmacy. Control



pharmacists were asked to provide usual care (that is, the care they would normally provide a consumer receiving an anti-depressant medication). This care was documented in the pharmacist's responses to a survey of their current practice carried out subsequent to their allocation to either the control or intervention arm of the study.

The pharmacists were asked to watch for antidepressant prescriptions. When a prescription was received the pharmacist asked the consumer what the medication was for, or what the doctor had told them about the medication. If the consumer used the word 'depression' in their reply and they fitted other selection criteria (viz. over the age of 18, likely to remain in the area for 3 months, not known to have a history of psychosis according to medical records), the patient was asked if they would like to participate in the study.

Consumer participants took part in three phone surveys. The first survey was undertaken as soon as possible after the consumer was recruited (the baseline survey). The second and third surveys took place one month and two months after the initial survey. To meet the requirements set by the Human Ethics Committee a mental health nurse appointed as a project officer carried out all phone calls to consumers.

The first survey asked for demographic data and included a series of open-ended questions related to the current treatment, history of depression, and services received. Consumers were also asked about the services they had received from the pharmacist (including what advice they had been given and what they would like to have received). Psychological wellbeing was assessed using the K10³¹ which measures the level of depressive symptoms in the four weeks prior to the assessment. It comprises a set of 10 questions with 5 possible responses ranging from 'none of the time' to 'all of the time'. The scores range from 10 (no symptoms) to 50 (extreme distress). Attitude towards taking antidepressants was assessed using the Drug Attitude Index (DAI)¹⁶ and adherence to taking the prescribed antidepressant measured by self report.

Open ended questions in the second survey at one month, and the third survey at two months, included questions on any changes, for example, in doses, side effects experienced, any questions asked by the consumer or pharmacist, any information given to them by the pharmacist and what, if any, alternative treatments the consumer had tried. If the consumer had stopped taking the medication the reasons for this were noted. The K10, DAI and level of adherence were also monitored during the second and third surveys.

Patient outcomes of the project are reported elsewhere²¹. In summary, there was no difference between control and intervention groups in the extremely high proportion of patients still taking their medication at two months (95% control, 96% intervention). While there was an improvement in the attitude towards taking antidepressant medication in both groups, the mean DAI score increased significantly in the intervention group but not for the control group. There was a significant improvement in wellbeing in both groups from baseline to two months in both groups. The decrease between baseline and one month was statistically significant for both groups. The K10 score in the intervention group continued to decrease in the second month while that of the control group increased slightly.

Two other papers based on the project's results are currently under review. The first discusses pharmacist perceptions of the project and the other provides a quantitative analysis of service delivery. A third paper, on the value of using teleconferencing as a means of training pharmacists, is in preparation.

During each survey participants were given the opportunity to comment on various aspects of the project. Responses to this opportunity were recorded, then coded inductively (that is, information is induced from the data²⁴) and grouped into overarching themes; these are the themes discussed in this paper.

Findings

Consumer recruitment and characteristics

One hundred and nineteen (119) consumers were recruited over 2 months as control (68) or intervention (51) cases. Complete data was obtained on 106 participants.

No significant differences between the groups were found in any of the demographic characteristics elicited indicating that the two groups were similar in these aspects (Table 1). The average age of participants was 46 years, with the majority (79%), female. Thirty-six per cent had completed post-secondary education and approximately 57% were not currently working in paid employment. The majority (60.5%) had also experienced an episode of depression prior to the episode experienced in the timeframe of this study.

Table 1 Comparison of patient demographic characteristics—control vs intervention

Characteristics	Control % (N=60)	Intervention % (N=48)	P value
Age (Mean)	46 (SD15)	46 (SD 12)	0.951*
Gender (Female)	82	76	0.483#
Education (With higher than school certificate)	37	35	0.726#
Not currently working (Includes pensioners, home duties, unemployed)	50	63	0.668#
PhARIA (Rated >4)	32	24	0.380#
Taking medication for other conditions eg. blood pressure. (Yes)	75	70	0.534#
Previous episode of depression (Yes)	62	59	0.757

* Independent samples t test

Pearson's Chi Square

Consumer perceptions

The vast majority of comments by consumers reflected positive ramifications from their participation in the research, making the discussion that follows overwhelmingly supportive. To address concerns over possible bias in reporting of responses, all negative comments are noted. No distinction is drawn between control and intervention consumers as their comments reflected the similarities in outcomes between the two groups. Their comments are grouped under four themes, involvement in the project, pharmacist service, telephone follow up, and hoped for impacts of the project.

Involvement in the study

The most common responses to the question asking for 'other comments' related to the willingness of participants to take part in the study in order to help fellow sufferers of depression; *"I'm happy to be involved as it will help others"*. This sentiment was reflected in comments of 38 participants. Others (26 respondents) observed how *"good it is to talk to someone"*.

Twenty-three participants identified the feedback from the K10 provided during the telephone interviews as being very valuable:

I got feedback on how I was going—it really helped me to keep going...

whilst others (15 participants) indicated they attached a value to the whole project. The responses below are typical of their comments:

...it was good for me to be part of the project

...I think I got more information out of the process...there should be more of this sort of thing...

..I'm a lot better now—me, family, friends know so much more from being part of the project...



...I think the survey has been good. It's helped me to look at things a lot clearer. This project has also helped me realise how good I'm going. Doing the 'how are you feeling?' has helped too...

Another observed that since participating in the project:

I'm making myself get out more, socialising and talking about depression. This [the project] has been very good. I've been relieved to discover many other people that are or have been on antidepressants...

One respondent observed that from her perspective the positive outcomes of the project:

...shows how important counselling services could be...

Perceptions of pharmacist service

Twenty-three respondents commented on the accessibility of their pharmacist and the positive value of the information provided to them by the pharmacist. They appreciated additional information about their medication, particularly what precisely it was for, what side effects it might produce, how long it would take to work and how long they might need to be on it. These observations are typical:

The pharmacist will always ask how I'm going. And if I answer in the negative the pharmacist asks further questions...

I would have stopped taking the medication if the Pharmacist hadn't shown an interest

I couldn't fault the caring nature and info given by the pharmacist. I would have no hesitation whatsoever in going to pharmacist for advice....

The pharmacist was very thorough with the explanations about the medication....

Thanks for the info...it changed my view of medication and the condition...

The pharmacist is friendly...accessible...

This respondent was so positive about her pharmacist that:

I can't see the need for [this] project as all pharmacists are excellent.

Two consumers remarked the helpfulness of the pharmacist compared to the General Practitioner:

The doctor talked about medication but not in as much detail as the pharmacist. He wasn't as helpful as the pharmacist...

I believe the doctor should explain more about the medication. The GP explained what it was but not as well as the pharmacist...

and 5 participants indicated their pharmacist was "more accessible than their GP".

However, not all comments were as positive. One respondent noted how:

The pharmacist only started checking on how I was going after she had approached me for the project....

And another observed:

The pharmacist is often the first port of call, so they should be trained better...

Nine consumers identified one or more barriers to communicating with the pharmacist. In five cases this was to do with their own reluctance to talk about their medication. This reluctance was most often related to the nature of depression, particularly withdrawal, not wanting to talk. The sentiments expressed in the following comments were not unusual:

I don't let the pharmacist talk. I just want to get the prescription and get out. If I wanted info, I'd ask the GP or pharmacist. The pharmacist is more accessible....

I didn't feel like talking to the pharmacist due to being upset and anxious however a computer printout would have been good to take home with me so I could have read it at home....

Talking about it is a very personal thing...

However, four consumers identified barriers to communicating effectively with their pharmacist, which made them reluctant to ask questions. All were consumers in the control group. One comment reflected a potential breakdown in communication between pharmacist and consumer since the consumer did not receive the information personally but through an intermediary:

I'm never [in the pharmacy]. So I don't ask questions. My husband picks up the prescriptions for me...

One consumer identified the lack of privacy as a barrier:

I don't really like asking pharmacists any questions as it's too open in the shop and I feel like everyone is looking at me and wondering what the problem is... I'd rather talk to my GP...

whilst two others observed:

You don't always get the opportunity to speak to a pharmacist; often you get the assistant for repeat prescriptions. They may ask "have you had this before?" Yes or "are there any problems?" No, then you only get the assistant. In this case you'd only see the pharmacist if there was a problem...

The pharmacist offered me some information but I didn't want to broadcast it. I felt embarrassed that that pharmacist would know what the medication was for....

Others wanted information but didn't want to ask; i.e. they wanted the pharmacist to provide the information without being asked for it:

They should just give it as part of the service....

Please give more written information, especially on side effects...

Perceptions of telephone interviews

Ninety-five per cent of respondents indicated they found the telephone interviews a positive experience. When asked to discuss why this was the case four key sub themes emerged during an analysis of their responses. First, the value of their anonymity could not be underestimated:

You're anonymous. I don't know you, you don't know me...

It's great to talk to someone I don't know...

Another advantage was the consumer's enthusiasm about being able to talk to 'someone':

It's been good to talk to someone else about it and know I'm not alone...

Please ring us up and have a chat anytime...

For some consumers, the calls acted as an indication that 'someone cares':

I'm glad that there's people out there that will do this – ring up and see how people are going...

It's good that people like yourself ring up and see how people are going with their depression...

For some the fear of others close to them knowing about their illness was a major issue. The telephone follow up was particularly important in the case where:



I haven't told anyone I'm depressed, no one but the pharmacist and a close friend. My mother and husband don't know and I don't want them to know...

These comments (and many other similar ones) indicated that consumers in both intervention and control groups benefited from the telephone contact with the mental health nurse when she rang to administer the interviews. Although this nurse was known to them by name she was not part of their community so they felt free to communicate with her.

Hoped for impacts of the project

Sixty-three of the 106 consumers (60%) commented on community oriented issues raised by the project and to its potential to 'get a better deal' for those suffering from depression.

There are several points of interest here, particularly those remarks related to how respondents hope that the 'broader good' of the project will be the reduction in fear and stigma attached to depression and to mental illness more generally (17 respondents). The following comments are telling in this regard and are typical of many responses on this issue:

I find it difficult to talk to someone about it. That you're someone I don't know – that's good. It took me ages to go to the GP about this problem, as I thought if they gave me something it would be on my medical record that I'm mad and that they might take my kids away....

This is great, anything that can be done to de-mystify and de-stigmatise depression. Should get funding from the government to run forums, so people learn more about depression. Also legal issues need changing eg. in divorce, if one person admits to someone they are depressed, because it comes under the "mental illness" tag, the other partner can get the children. When a relationship breaks down everything changes, of course they will be down or depressed. How dare the legal system say they are unfit to care for their own children...

I think it's very, very good that [the project] is actually happening. I'm more than happy to help if it's going to help someone in the future...

I think the project is really good and if somehow some of the findings can be released into the community to help de-stigmatise depression all the better...

These comments are reflective of a desire by some respondents for more research, including that undertaken by universities:

Hopefully any outcome will be available to medical staff, especially in the country...especially with results that help in the future. There's not enough support from the government so if the universities can help out with this, that's great...

I think it's a really good survey and there should be more of them....All credit to the person who thought of it and put it together. Often the GP doesn't have time to do the education...

One such 'further research project' should be specifically related to the mental health needs of men:

Hopefully there are some more blokes in the project. The pharmacist told me that blokes are pretty hopeless at taking this type of medication. They'll only take it for a month or two and then stop. I think you should be given a bigger government grant for this study...

Another collection of remarks relate to the project's implications for rural regions in particular (made by 23 respondents). For example:

it's great for the country regions. Zoloft seems to be the 'be all and end all' and every second person seems to be on it. There's no one to go to for counselling in the bush. It's a big problem...

rural and remote areas don't have very much in the way of support services. Pharmacists are more accessible. Sometimes it takes 2 weeks or more to get into the GP...

I think you're doing a really worthwhile thing. I am seeing things more clearly now. Our government has no idea of the needs in this area and the support systems are so poorly organised...

The project should get more government funding into rural areas. They don't understand [what's happening]...

Medication isn't the only answer – we also need good counselling services [out here] – not the bad ones I've experienced...

Underlying the comments was a plea for all assisting consumers and carers to provide their consumers with more information on all matters related to depression.

Two respondents indicated they were going to set up support groups in their local community. When contacted at the end of the project, they had done exactly that.

Discussion and conclusions

It is apparent from the above that consumer perceptions were generally extremely positive overall, especially given the short timeframe of the study.

Participants in this study identified a number of key requirements that needed to be met during the diagnosis and treatment for depression, the one of greatest import being the reduction in stigma attached to depression in rural communities. This, and the fear of being labelled as 'depressed' and 'crazy' had discouraged many from actively seeking support early on in their illness, compounding other problems related to distance from, and access to, appropriate assistance.

Once diagnosed and treatment is commenced, their needs of many consumers do not stop. They would like to know more about their medication, what precisely it is for, what side effects it might produce, and how long it will take to work. It is apparent that consumers generally appreciate the pharmacist's willingness and ability to talk about these issues, although there were exceptions to this. Consumers identified a number of services they valued highly, particularly in provision of information on medication and importantly, the significance of staying on the medication "long enough" to give it time to work. The pharmacist's ready access, 'their 'friendliness' and 'approachability', the longer term relationship the rural pharmacist has with their customers were considered important advantages. This means that they may often be in the position to refer customers, including those who would not normally seek medical care, to appropriate mental health care providers, particularly General Practitioners. Further, the more the pharmacist is willing to be involved in education, the more likely the stigma surrounding depression will be reduced in rural communities.

An unexpected outcome of the research was the value 95% of respondents attached to the regular phone-calls made to them the research's project officer (the mental health nurse). This process was perceived as 'follow-up' by a number of patients and suggests that where the consumer is approached with due respect and tact, discussing the nature and treatment of depression can be helpful to the depressed person in terms of psychological wellbeing and in adherence to prescribed medication. In fact, it is our belief, supported by the comments of participants in this study that consumers will be more likely to feel positive that someone cares enough about them to talk with them than for them to feel traumatised by questioning, so long as the questions have been formulated appropriately and delivered sensitively^{15,16,19,25}. This component of the project lends much support to the literature²⁶⁻²⁹ suggesting telephone follow-up of consumers from the pharmacist, an appropriately trained mental health practitioner employed by the pharmacy, or from staff of a government department or not for profit agency, in the few weeks after being prescribed their medication will increase the compliance rate and provide other positive outcomes for consumers.

Evidence provided by consumers participating in this study suggests strongly that the role of the pharmacist in providing information on medication and follow-up on the efficacy of that medication throughout the treatment process cannot be underestimated in achieving positive consumer outcomes. To achieve this, the consumer must initially be provided with knowledge and understanding of the



possible side effects of their medication, complemented with follow-up support when repeat prescriptions are filled. This is important in terms of addressing possible negative side effects and reducing low levels of adherence arising from perceived dissatisfaction with medication – key roles of the community pharmacist.

If the comments of this study's participants are any indication there is little doubt that appropriately trained pharmacists have an integral role to play, alongside other allied health and medical professionals, in the provision of a patient centred approach to the treatment and management of depression in rural communities. In this context it is recommended that pharmacists be provided with on-going opportunities to increase their skills in working with consumers experiencing mental illness. It is also recommended that further research be undertaken into the value of telephone support for those experiencing depression in rural communities, particularly those on antidepressant medication for the first time.

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Presenter

Judith Crockett is a rural sociologist and farmer who lectures in sociology of health at Charles Sturt University, where she is Course Co-ordinator of the Bachelor of Rural Studies. First diagnosed as suffering depression 18 years ago, her research interests now focus on improving health and wellbeing in rural communities.

