



module 232

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Welcome to the two hundred and thirty second module in the *Pharmacy Magazine* Continuing Professional Development Programme, which looks at managing depression in primary care.

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for this module

GOAL:

To provide an update on managing depression in primary care.

OBJECTIVES:

After completing this module you should be able to:

- Describe the causes, signs and symptoms of depression
- Discuss the pharmacological and non-pharmacological treatments used to manage the disease
- Give patients appropriate lifestyle advice.



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Managing depression in primary care

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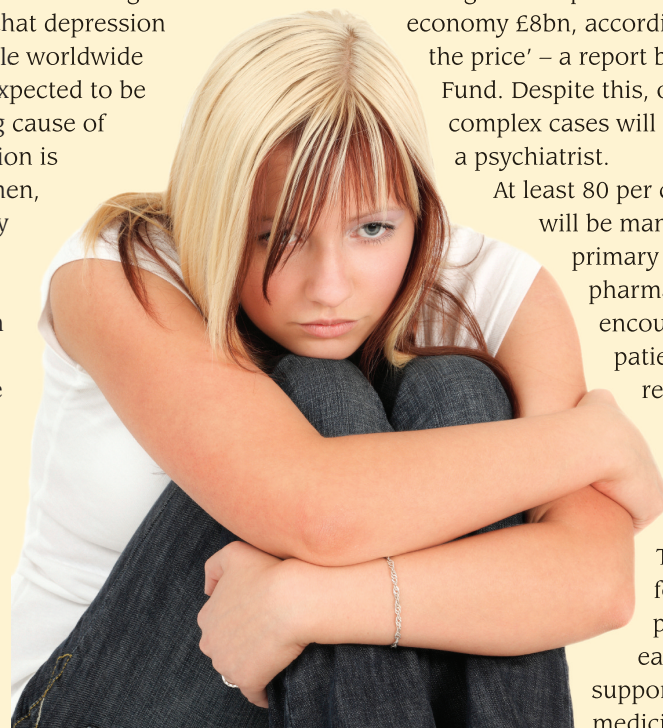
Introduction

Depression is widespread throughout all sectors of society and affects all ages and cultures. The World Health Organization recently reported that depression afflicts 350m people worldwide and by 2020 it is expected to be the second leading cause of disability. Depression is commoner in women, with approximately 20–25 per cent of women and 7 to 12 per cent of men being affected. Approximately one in four people will experience a mental health disorder in their lifetime, with depression the commonest.

The burden of depression in society is

enormous, with the damage extending to the carers and family of those affected. In total, sickness, lost productivity and early retirement resulting from depression costs the UK economy £8bn, according to 'Paying the price' – a report by The King's Fund. Despite this, only severe or complex cases will be referred to a psychiatrist.

At least 80 per cent of cases will be managed in primary care, so pharmacy teams encounter these patients on a regular basis and can have a significant impact on their care. The potential for community pharmacy to aid early detection, support adherence to medicines and long-



term management is a massively underutilised resource – yet some studies have shown that pharmacists are reluctant to engage in discussions with patients suffering from mental health disorders.

When qualified pharmacists and pharmacy students were asked about discussing medication-related issues with this group of patients, they reported that, while they felt they understood the therapeutics, they felt ill-equipped to deal with the possibilities of emotional or difficult discussions.

A recent report by the Royal College of Psychiatrists draws attention to the differences in how mental and physical health conditions are treated by society in general and healthcare professions in particular.

The document, 'Whole person care: From rhetoric to reality. Achieving parity between mental and physical health', highlights the need to approach the treatment of these disorders with the same urgency, empathy and funding as physical disorders.

The report draws particular attention to the requirement that all healthcare professionals receive adequate training in these disorders, to enable them to better support patients.

Role of pharmacy

In 2013 the Royal College of Psychiatrists published 'No health with mental health' to draw attention to the strong link between patients with long-term conditions, such as diabetes, COPD and coronary heart disease, and the risk of developing mental health conditions. It is estimated that a quarter of patients with a chronic condition will develop a mental health disorder as a result of the stress of their illness presenting as depression or anxiety.

Studies have shown that once chronic illness develops, it can cause a reduction in quality of life, reduced ability to exercise, financial insecurity, increased worry, family strain and the emergence of maladaptive health behaviours (such as increased alcohol consumption). Each of these factors, separately or in combination, can increase the risk of depression.

Developing a mental illness is, in itself, a distressing situation for patients and their families, but it has more complex negative outcomes on the physical condition. Patients



Consultations should address any worries a patient may have with their medicines



Reflection exercise 1

Using your PMR system, how many patients do you currently dispense a SSRI, venlafaxine or mirtazapine for? How many of these patients have you invited to have a MUR?

who develop a mental health condition may be affected in the following ways:

- Recovery from the condition is impeded
- Pain can be difficult to control
- Confidence to participate in rehabilitation programmes is reduced
- In extreme cases, the patient can come to believe that they are a burden on their family or the hospital and would be better off dead.

Physical illness in the elderly, for example, is a major risk factor for suicide. Unfortunately many cases of depression go unrecognised. Some patients may exhibit symptoms of depression that are difficult to distinguish from their physical condition – for example, extreme fatigue is common in both COPD and depression. Also, when a patient is diagnosed with a chronic physical condition, there is a danger that his/her mental health may be overlooked.

The RCP report calls for increased awareness of the relationship between physical and mental health among all healthcare practitioners, a raised awareness of the need to identify potentially undiagnosed depression, and highlights a need to increase training in this area.

Currently antidepressants are not included in either targeted MURs or the NMS – an omission that has been criticised by mental health pharmacy services. Depression can be classified as a chronic disease and, as with any other chronic disease, offering support only when a patient actively seeks help is not an efficient or patient-centred approach.

Developing a service for depression in community pharmacy has been shown to work in a recent project run by NHS Bristol, which saw a community pharmacy-based service commissioned as part of its increased use of healthy living pharmacies.

Another pilot study of six community pharmacies in NW England in 2003 used a phased model of care to support treatment¹. Patients were offered support and ongoing active monitoring of medication efficacy and

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side-effects. They were encouraged to continue treatment. An evaluation of the project showed a significant increase in adherence to anti-depressant treatment at three and six months.

Additionally GP and hospital visits were significantly reduced, representing clear cost savings to the NHS. The study was a 'proof of concept' design and was not funded further, but it was able to demonstrate that community pharmacists can reduce the burden of care and support positive treatment outcomes.

What can cause depression?

There is no one single cause of depression but it is thought that psychological, genetic and biological factors play a part. The genetic link to depression has been extensively researched, with studies showing first degree relatives with depression are a risk factor for a depressive disorder. Psychosocial factors also have a big influence, with stressful life events, such as childhood abuse, bereavement, unemployment and the breakdown of relationships, increasing the risk of the condition.

There are many possible triggers for a depressive disorder including:

- Seasonal changes (known as seasonal affective disorder)
- The death of a loved one
- Loneliness
- Loss of job/unemployment
- A chronic physical illness/chronic pain.

Depression can also be associated with the side-effects of some medicines used to treat arthritis, heart disease, high blood pressure or cancer. These side-effects may have a slow, insidious onset. Consumption of alcohol has been linked to depression – both as a possible cause and as a symptom. Alcohol is itself a depressant, especially when taken in combination with certain drugs.

Drugs of abuse, such as cocaine, have also been linked with depression, while the mental health issues that can occur with so-called 'legal highs' are only just starting to be understood. Their long-term effects are not fully known but could, potentially, have a chronic impact on brain physiology.

As discussed earlier, patients suffering from chronic, debilitating illnesses (e.g. Parkinson's disease and stroke) often seem to develop

symptoms of depression. Medical conditions such as thyroid disease can also cause the disease, which is why a physical examination should be conducted before a diagnosis of depression is made.

Depression can also be influenced by nutritional factors, such as low levels of vitamin B12, or by iron-deficiency anaemia, which can result from poor diet or from heavy menstruation.

Spotting the signs and symptoms

It is widely accepted that most individuals will experience low mood and feel tired from time to time. The problem for primary care professionals is telling the difference between a patient with major depression from someone who is just temporarily low, and whether the depression signifies some previously unrecognised physical or mental health problem.

All healthcare professionals, including pharmacists, can help by having a high index of suspicion and by using a simple questioning technique to identify people with major depression.

The NICE clinical guideline on depression (nice.org.uk/Guidance/CG90) suggests the following two-question approach to help detect serious problems:

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

People answering 'yes' to one or both of these questions should be more carefully screened for depressive signs and symptoms. This is usually undertaken by a GP. Screening, using a brief

questionnaire, can be a quick and effective way of detecting depression that may otherwise have been missed. It should be directed towards cases of suspicion or high prevalence groups.

Screening tools may be useful where the patient is depressed but is reluctant to accept the diagnosis. They may also be used in situations where the chance of depression is very high but the doctor is uncertain. These include:

- Parkinson's disease, where the problem is common but often missed
- Dementia, where the two problems can often resemble each other
- New mothers (as many as 11 per cent may show positive results)
- People with alcohol and drug problems
- Victims of abuse
- People with physical disease (e.g. cancer, cardiovascular disease or diabetes)
- People in chronic pain
- People with stressful home environments
- The elderly and those in social isolation.

Signs and symptoms of depression present in individual ways depending on the person. Some people may experience physical symptoms in addition to the psychological symptoms of persistent low mood and anhedonia (lack of enjoyment).

Table 1 shows the commonly presenting biological, psychological and social symptoms of depression. During a period of depression, people typically report symptoms in all three domains.

The NICE guideline recognises four levels of severity of depression:

- Sub-threshold
- Mild

Table 1: Symptoms of depression		
Biological	Psychological	Social
Sleep disruption: • Early morning waking and difficulty getting back to sleep • Sometimes through upsetting dreams • Exhaustion on waking • Improved energy as the day goes on • Appetite changes	• Difficulty concentrating during the day • Memory impairment • Anxious worrying and intrusive, upsetting thoughts • Becoming emotional or upset for no particular reason • Shortness of temper or irritability • Increased negative thinking • Guilt/self-blame • Suicidal thoughts or acts	• Doing less of what a person used to enjoy • Loss of self-confidence • Withdrawal from social contact



'It is estimated that a quarter of patients with a chronic condition will develop a mental health disorder as a result of the stress of their illness'



Table 2: Assessing the severity of depression

Depression severity	Symptoms
Sub-threshold depressive symptoms: Fewer than five symptoms of depression	Persistent sadness or low mood* Loss of interest or pleasure* Fatigue or low energy* Disturbed sleep Poor concentration or indecisiveness Low self-confidence Poor or increased appetite Suicidal thoughts or acts Agitation or slowing of movements Guilt or self-blame
Mild depression: Few, if any, symptoms in excess of the five required to make the diagnosis, and symptoms result in only minor functional impairment	
Moderate depression: Symptoms or functional impairment are between 'mild' and 'severe'	
Severe depression: Most symptoms and they markedly interfere with functioning. Can occur with or without psychotic symptoms	
	* = key symptom

- Moderate
- Severe.

Severity is assessed partly on the number of symptoms and partly on the degree to which they interfere with a person's normal functioning (see Table 2).

Summary of the NICE guideline

Depression is managed using pharmacological and non-pharmacological therapies.

Pharmacological treatment

Effective treatment for depression should return the person to their premorbid state. They need to be completely free from depressive symptoms ("feeling better" is not good enough) because residual symptoms are predictors of relapse, suicide and functional impairment. Effective treatment must be provided early to reduce mortality and the risk of developing resistant depression.

Which antidepressant?

When dispensing antidepressants you may have wondered why a patient is prescribed one particular drug over another. A landmark meta-analysis published in *The Lancet* in 2013 compared the relative efficacy of the most widely used antidepressants. The study reported that efficacy is broadly similar between all antidepressants. What is truly different and often dictates choice is tolerability. There are specific differences in tolerability even among SSRIs due to pharmacokinetic and pharmacodynamic interactions.

Reflection exercise 2

How good is your signposting information for people with depression? Check whether it includes local patient self-help groups, exercise activities, relevant websites and local community mental health teams. Establish how to refer and when it is appropriate to contact team members.

Patients will often be able to tolerate mild side-effects (see Table 3) but some severe side-effects will require an urgent referral. Hyponatraemia is a rare but potentially serious complication of antidepressant treatment.

Antidepressants can induce an excessive secretion of antidiuretic hormone (ADH) from the pituitary gland, which causes the kidneys to retain water. As a result, the body has more water for the same amount of salts, leading to an effective drop in concentration of ions, such as sodium, resulting in hyponatraemia (sometimes called dilutional hyponatraemia), which can cause headache, nausea, vomiting

and confusion. The risk of this occurring is highest in the first 30 days and elderly patients are more at risk, so any patient complaining of these symptoms shortly after treatment should be referred immediately.

St John's Wort

Patients will often self-treat with herbal remedies in the false belief that they are safer than prescribed medicines. It is therefore always worth asking about herbal medications during a MUR.

Constituents of St John's Wort have activity on serotonin receptors in the brain and can produce side-effects similar to prescribed antidepressants, including conversion to mania in susceptible individuals.

When patients ask if St John's Wort is appropriate for them, it should be remembered that depression can have an organic cause and this should be ruled out by a prescriber.

St John's Wort does have evidence in mild depression; however the best evidence for treating mild depression comes from using psychological therapies (such as CBT).

NICE guidelines currently state that healthcare professionals should not advocate the use of St John's Wort due to its numerous drug interactions and concerns over the quality assurance of the available products.

Table 3: Side-effects and management strategies for antidepressants

Side-effect	SSRIs & venlafaxine	Tricyclics (nortriptyline, amitriptyline, imipramine)	Bupropion	Mirtazapine	Management strategy
Sedation	1	4	1	3	Administer at bedtime Try caffeine
Anticholinergic symptoms: Dry mouth/eyes Constipation Urinary retention Tachycardia	1	4	1	2	Increase hydration Sugarless gum/candy Dietary fibre Artificial tears Referral in resistant cases?
GI distress Nausea	4	1	3	2	Often improves in 1-2 weeks Take with meals Consider antacids or H ₂ blockers
Restlessness, jitters, tremors	3	2	4	1	REFERRAL: Patient must be advised to return to the GP, who may wish to adjust the dose, choice of treatment or add a beta-blocker or benzodiazepine
Headache	3	1	3	1	Give paracetamol but if recurrent and non-responsive refer to the GP
Insomnia	3	1	3	1	Take in the morning but advise referral if persistent and problematic
Sexual dysfunction	4	1	1	1	REFERRAL: Make no promises. May be part of depression or medical disorder
Seizures	1	1	3	2	REFERRAL: Ask patient to see their GP as soon as possible
Weight gain	2	2	2	4	Exercise and diet REFERRAL: GP may consider changing if problematic
Agranulocytosis	1	1	1	2	Monitor for signs of infection or flu-like symptoms

KEY: 1 – very unlikely 2 – uncommon 3 – mild 4 – moderate
 Adapted from 'The MacArthur Depression and Primary Care 3CM Three Component Model'; Managing Depression in Primary Care
 Source: NHS Bristol

Reflection exercise 3

How do you and your team deal with customer requests for St John's Wort? Discuss with your staff how they respond.

Is the antidepressant working?

Clinicians are advised to review response and tolerability to antidepressants over three to four weeks. If a partial response is seen, the recommendation is to consider increasing the dose and continuing treatment for a further two to four weeks. If no improvement is seen, the recommendation is to consider switching to another antidepressant.

Antidepressants should be continued for at least six months after remission of symptoms, or for two years or more in those at risk of relapse. Those under 30 years of age or at risk of suicide should be reviewed one week after starting an antidepressant to monitor for severe anxiety and any increase in suicidal thoughts.

Adverse effects and toxicity of antidepressants

Fluoxetine, fluvoxamine and paroxetine are more likely to cause drug interactions than other SSRIs due to their effects on the metabolic cytochrome P450 isoenzyme system. Paroxetine is associated with a higher incidence of discontinuation symptoms resulting from its short half-life and unusual non-linear kinetics, but all SSRIs are associated with an increased risk of bleeding as platelets require uptake of serotonin to activate. Gastroprotection may therefore be required in elderly patients or in those concurrently prescribed NSAIDs or medication that can increase the risk of bleeding (e.g. clopidogrel).

Non-pharmacological treatments

NICE recommends psychological interventions at every stage of treatment so it is important community pharmacists are aware of what is involved (see Table 4).

The non-pharmacological options include psychosocial support, counselling or psychotherapy, including cognitive behavioural therapy (CBT). In general, psychological treatments alone seem most effective in milder forms of depression, but in combination with an antidepressant they have a synergistic effect at

the more severe end of the spectrum. The decision about the type of treatment offered depends on patient preference, the severity of the symptoms, the therapies available locally and if the patient has engaged successfully in psychological therapies before.

There is still a dearth of adequate access to psychological therapies in the UK despite it being a NICE recommended therapy. The NHS has commissioned a service called IAPT (which stands for Improving Access to Psychological Therapies). IAPT operates in all localities and can help patients access psychosocial interventions faster, although the wait is still often too long for most patients. Some patients may not wish to consider CBT despite the fact it has a proven evidence base and can help not only treat depression, but improve resilience. There are a variety of resources you can signpost your patients to that offer step-by-step CBT courses.

How can you support a 'choice and recover' agenda?

Community pharmacists and their teams may be the first health practitioners that many people with depression – whether it is diagnosed or undiagnosed – will consult, so it is important that the pharmacy team:

- Is clear on how to proceed if depression is suspected
- Have key resources available in the pharmacy
- Know where to signpost patients and carers.

Identifying undiagnosed mental health problems

Many patients will present in community pharmacy with physical symptoms that may be an indicator of depression. Discussing repeat purchases of analgesics, OTC sleep aids or St John's Wort can be one way to raise the issue of depression with patients, although this should always be carried out sensitively and preferably in a private discussion.

Members of the pharmacy team, particularly counter assistant staff, can be educated to bring to the pharmacist's attention anyone who might benefit from a confidential discussion. Technicians and those involved in the dispensing process can be on the look-out for any patient receiving an antidepressant for the first time, in order to prompt a discussion about initiating these medicines and what to expect.

Table 4: NICE advice regarding psychological interventions

Persistent sub-threshold depressive symptoms or mild to moderate depression

Consider offering one or more of the following interventions, guided by the person's preference:

- Individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
 - Computerised cognitive behavioural therapy (CCBT)
 - A structured group physical activity programme.
- Do not use antidepressants routinely to treat persistent sub-threshold depressive symptoms or mild depression because the risk/benefit ratio is poor, but consider them for people with:
- A past history of moderate or severe depression **or**
 - Initial presentation of sub-threshold depressive symptoms that have been present for a long period (typically at least two years) **or**
 - Sub-threshold depressive symptoms or mild depression that persist(s) after other interventions.

Treatment for moderate or severe depression

For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or internet-delivered psychotherapy).

Continuation and relapse prevention

Support and encourage a person who has benefited from taking an antidepressant to continue medication for at least six months after remission of an episode of depression. Discuss with the person that:

- This greatly reduces the risk of relapse
- Antidepressants are not associated with addiction.

Psychological interventions for relapse prevention

People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue their antidepressant treatment) or who have residual symptoms, should be offered one of the following psychological interventions:

- Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment
- Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.

Supporting patients with a diagnosis

When supporting patients with a diagnosis of depression, it is useful to print off leaflets from the choiceandmedication.org website to help them better understand potential side-effects of treatment and, more importantly, how to manage them. Another useful website is whatyoushouldknow.depression-alliance.co.uk.



Giving patients control over their treatment and being involved in decisions regarding their medicines can help to foster a concordant relationship.

Counselling sessions

The following points (see Table 5) may help you structure a MUR or counselling session for patients taking antidepressants.

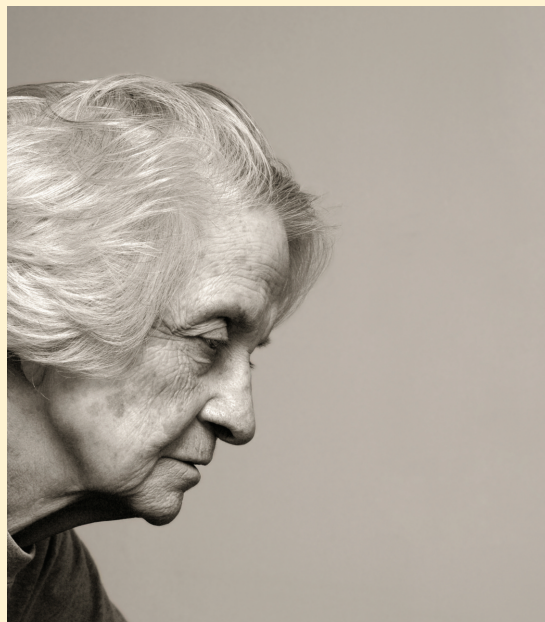
What are you using the medication for?

Although antidepressants are licensed for affective disorders, there are several off-licence uses. It is therefore important to ensure that patients understand what the medication is being used for and what its side-effects are – particularly when being prescribed a new drug.

Do you have any worries about the medication?

A patient-centred approach involves asking the patient what he/she wants to know, as these concerns are often very different to the issues healthcare professionals would choose to raise with them. A good consultation with a patient involves addressing any worries regarding their medicines and trying to identify barriers that could prevent adherence to their regimen.

To strengthen your consultation skills and adopt a more patient-centred approach, take a look at the Consultation Skills for Pharmacy website (consultationskillsforpharmacy.com).



Loneliness can be a trigger for depression



Reflection exercise 4

Invite one or two patients taking antidepressants to have a MUR using the checklist in Table 5. Ask the patients how useful they found it and which information was most helpful to them.

Are you experiencing any side-effects?

Antidepressants are often linked to an initial increase in anxiety, which can be extremely distressing and shares a common pathology with dysphoria. Increased restlessness, arousal and anxiety could be a sign of hypomania, which would need urgent medical assessment. Some reports have linked these initial effects with an increased suicide risk, so patients should be referred back to their GP as a matter of urgency.

The majority of side-effects will diminish with time but an acknowledgement of the patient's concerns is essential. Patients will often be too embarrassed to volunteer details of side-effects, such as loss of libido, so sensitive questioning may be required.

A reduction in libido is often reported in depression but this can improve with adherence to treatment. However if sexual dysfunction occurs as a result of antidepressant therapy, this is unlikely to diminish with time and must be referred back to the GP.

Journey to recovery

Patients should be aware of the delay in onset of antidepressant efficacy. Recent studies have shown that beneficial effects can occur within the first week but true separation from placebo effect can take between two and four weeks, so a reasonable trial of medication is needed before a switch is considered.

Some patients will be diagnosed with treatment-resistant depression when the actual reason for the treatment failure is non-adherence.

To achieve a paradigm shift in the care of patients with depression, pharmacists need to provide proactive follow-up e.g. the NMS can be used to support adherence and identify possible causes for premature discontinuation.

Patients may want to know how long they need to take the medication for – many may want to stop the moment they feel better. NICE suggests treatment should continue for six months following remission, while the British Association of Pharmacology (BAP) guidelines suggest nine months.

Patients may continue for longer if there are specific risk factors or it is not their first depressive episode. Between 50-85 per cent of people who have had one episode will relapse when medication is ceased but prophylactic use of antidepressants can reduce this. The patient will need to discuss their situation with the prescriber and the course length of medication may exceed that recommended in the guidelines.

Do you have any questions?

Questions that are frequently asked by patients can be found at choiceandmedication.org/cms/?lang=en.

Many patients will want to know about drinking alcohol and driving. Alcohol should be discouraged as it is strongly correlated with attempted and successful suicide attempts and can also potentiate the sedative effects of some medications used in depression. As a rule, SSRIs are not sedative and should not affect reaction times, but some patients do find they are drowsy and therefore should not drive.

A counselling point you may wish to include is that, while the new changes to drug testing and driving do not yet apply to antidepressants, patients should take responsibility for their ability to safely drive or operate machinery.



Table 5: MUR/NMS checklist

- Does the patient know why they are taking an antidepressant?
- Do they have any specific concerns or worries?
- Does the patient with a newly prescribed antidepressant know what to expect in terms of initial side-effects and when these should abate?
- Do they understand there will be a delay in the onset of the antidepressant action?
- Are they experiencing any side-effects? (this applies to new therapy and long-term treatment)
- Do they know what to do if they miss a dose and how this might affect them?
- Are they aware that stopping their medication is a joint decision with the GP and should be done by slow withdrawal?
- Provide lifestyle advice
- Provide information regarding psychological therapies and/or support groups

Is the antidepressant working?

When reviewing whether an antidepressant is effective, you should bear in mind that the goal of treatment is complete remission. Residual symptoms are strongly correlated with deliberate self-harm and suicide. It is easy to check if a patient's new inhaler, for example, helps their asthma-related breathing difficulties – but there is no physical test that can be applied to assess the efficacy of an antidepressant.

Recovery will mean different things to different people and is completely subjective, so taking a person-centred approach is essential. Some patients may struggle to leave the house or get dressed properly and the medication may enable them to take pride in their appearance once again. Alternatively, a patient may find their medication enables them to become involved in their hobbies and social life.

It can be useful to ask patients to reflect on their symptoms before they started treatment to the present time and assess if it is meeting their needs.

Stopping

The majority of antidepressants can cause discontinuation effects when stopped abruptly. For example, as a result of their short half-lives, venlafaxine and paroxetine can produce symptoms from as little as one missed dose. It is important to correctly counsel the patient on this, encouraging them that the decision to stop is theirs but should be done in a planned way with support from a GP. For most patients discontinuation effects are mild and will pass without medical intervention, but some may experience severe or prolonged symptoms that must be referred immediately.

Discontinuation symptoms can include:

- Dizziness, light headedness, vertigo, ataxia
- Nausea, vomiting, diarrhoea
- Lethargy, headache, tremor, sweating, anorexia

- Paraesthesia, numbness, 'electric shock'-like sensations
 - Irritability, anxiety, agitation, low mood.
- Patients may wrongly associate these discontinuation symptoms as a withdrawal and think they are 'addicted' to antidepressants. Remind patients that antidepressant use does not result in craving, tolerance or primacy (the three key features of addiction to drugs of dependence).

Living with depression

In mental illness, recovery does not always refer to the process of complete recovery in the way that people may get over a physical health problem. For many, the concept of recovery is about staying in control of their life despite experiencing a mental illness. Most people with depression will get better with the right treatment and support. For some it takes months; for others years. Periods of stress or change can be difficult, resulting in an exacerbation of symptoms. Recovery is about being able to manage depression in the long-term and make lifestyle choices that aid recovery.

Lifestyle advice

Patients with depression can also benefit from the following healthy living advice:

Eating

- Have a healthy diet and be a healthy weight – suggest they look at foodandmood.org

Drinking

- Try to drink seven to eight glasses of water or caffeine-free drinks a day
- Avoid excess caffeine intake
- Limit alcohol intake. Alcohol interacts with medication and is a depressant. It is best to avoid alcohol completely when first starting treatment, then only drink in moderation after this, if at all. Do not miss doses of medication in order to have an alcoholic drink.

Lifestyle advice checklist

- Good adherence to therapies is essential
- Self-care including exercise where possible is useful
- Reduction in alcohol
- Smoking cessation
- Engaging in hobbies and social interaction

Smoking cessation

- Encourage attendance at a local smoking cessation service or pharmacy scheme.

Activities

- People with depression can lose interest/enjoyment in activities and hobbies they usually enjoy. Encourage patients to re-start such activities if they have stopped them and reassure them that their motivation, interest and enjoyment will return as their depressive illness improves
- Exercise has an instant positive effect, reduces stress, encourages healthy sleeping and is a good way of meeting people. Structured exercise has been found to be more effective than unstructured exercise in depression. Some surgeries participate in the 'Exercise on prescription' scheme
- Relaxation – locate and signpost local classes for relaxation and stress control
- Hobbies, arts and crafts, adult learning – find out what is available from local community and adult education centres.

REFERENCE

1. Donoghue J, Farrar K, Slee A, Rowe P. Medicines management in depression may increase the length of antidepressant therapy in primary care. Abstract. *International Journal of Pharmacy Practice* 2003; 11 (Suppl): R23

Additional resources

- therecoveryletters.com
- choiceandmedication.org/cms/?lang=en
- consultationskillsforpharmacy.com
- getselfhelp.co.uk
- moodgym.anu.edu.au/welcome



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MANAGING DEPRESSION IN PRIMARY CARE

assessment questions

- Which statement is correct concerning depression in the general population?
 - Experienced by more than twice as many women as men
 - Experienced by a similar number of men and women
 - Approximately one in 10 people with depression are referred for specialist treatment
 - Approximately one in four people are referred for specialist treatment
- Which is considered a key symptom of depression?
 - Disturbed sleep
 - Loss of interest or pleasure
 - Low self-confidence
 - Guilt or self-blame
- Which level of depression is defined as having fewer than five symptoms?
 - Sub-threshold
 - Mild depression
 - Moderate depression
 - Severe depression
- Which of the following is a NICE recommendation for sub-threshold or mild depression?
 - Antidepressants and psychological therapies are first-line treatments
 - Psychological therapies should be tried before antidepressants
 - A combination of antidepressant and psychological treatment
 - Antidepressants are no longer used routinely
- Which statement is TRUE regarding antidepressant overdose?
 - Tricyclic antidepressants are associated with greater risk than SSRIs
 - Lofepramine is the tricyclic antidepressant associated with the greatest risk
 - Venlafaxine is associated with a lower risk than SSRIs
 - Lofepramine is associated with a greater risk than venlafaxine
- After symptom remission NICE recommends that antidepressants be continued for:
 - One month
 - Three months
 - Six months
 - Nine months
- Which side-effect is rated as moderate for bupropion?
 - Headache
 - Seizures
 - Restlessness, jitters and tremors
 - Weight gain
- What lifestyle advice is recommended for people with depression?
 - All types of exercise are effective in depression
 - Weight bearing exercise is more effective than non-weight bearing exercise
 - Structured exercise is more effective than unstructured exercise
 - A self-help exercise programme is effective

Use this form to record your learning and action points from this module on **managing depression in primary care** and include it in your CPD portfolio and record online at www.uptodate.org.uk. Any training, learning or development activities that you undertake for CPD can also be recorded as evidence as part of your RPS Faculty practice-based portfolio when preparing for Faculty membership. Start your Faculty journey today by accessing the portfolio and tools at www.rpharms.com/development/faculty.asp

Activity completed. (Describe what you did to increase your learning. Be specific)
(ACT)

Date: _____ Time taken to complete activity: _____

What did I learn that was new in terms of developing my skills, knowledge and behaviours?
Have my learning objectives been met?*

(EVALUATE)

How have I put this into practice? (Give an example of how you applied your learning).
Why did it benefit my practice? (How did your learning affect outcomes?)

(EVALUATE)

Do I need to learn anything else in this area? (List your learning action points.
How do you intend to meet these action points?)

(REFLECT & PLAN)

* If as a result of completing your evaluation you have identified another new learning objective, start a new cycle. This will enable you to start at Reflect and then go on to Plan, Act and Evaluate. This form can be photocopied to avoid having to cut this page out of the module. You can also complete the module at www.pharmacymagazine.co.uk and record on your personal learning log

ENTER YOUR ANSWERS HERE Please mark your answers on the sheet below by placing a cross in the box next to the correct answer. Only mark one box for each question. Once you have completed the answer sheet in ink, return it to the address below together with your payment of £3.75. Clear photocopies are acceptable. **You may need to consult other information sources to answer the questions.**

- | | | | | | | | | | | | | | | | |
|----|-----------------------------|----|-----------------------------|----|-----------------------------|----|-----------------------------|----|-----------------------------|----|-----------------------------|----|-----------------------------|----|-----------------------------|
| 1. | a. <input type="checkbox"/> | 2. | a. <input type="checkbox"/> | 3. | a. <input type="checkbox"/> | 4. | a. <input type="checkbox"/> | 5. | a. <input type="checkbox"/> | 6. | a. <input type="checkbox"/> | 7. | a. <input type="checkbox"/> | 8. | a. <input type="checkbox"/> |
| | b. <input type="checkbox"/> | | b. <input type="checkbox"/> | | b. <input type="checkbox"/> | | b. <input type="checkbox"/> | | b. <input type="checkbox"/> | | b. <input type="checkbox"/> | | b. <input type="checkbox"/> | | b. <input type="checkbox"/> |
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| | d. <input type="checkbox"/> | | d. <input type="checkbox"/> | | d. <input type="checkbox"/> | | d. <input type="checkbox"/> | | d. <input type="checkbox"/> | | d. <input type="checkbox"/> | | d. <input type="checkbox"/> | | d. <input type="checkbox"/> |

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Business/home address _____

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I confirm the form submitted is my own work (signature) _____

Please charge my card the sum of £3.75 Name on card _____ Visa Mastercard Switch/Maestro

Card No. _____ Start date _____ Expiry date _____

Date _____ Switch/Maestro Issue Number _____

Processing of answers
Completed answer sheets should be sent to Precision Marketing Group, Precision House, Bury Road, Beyton, Bury St Edmunds IP30 9PP (tel: 01284 718912; fax: 01284 718920; email: cpd@precisionmarketinggroup.co.uk), together with credit/debit card/cheque details to cover administration costs. This assessment will be marked and you will be notified of your result and sent a copy of the correct answers. The assessors' decision is final and **no correspondence** will be entered into.