How pharmacists can help patients during Depression Awareness Week

Depression Awareness Week begins on 11 April 2011. In this article, Denise Taylor, John Donoghue and Stephen Bleakley call on pharmacists to think about what they might do to help ensure its success.

In 2001, the World Health Organization characterised depression as a “social and economic time-bomb”. This rather melodramatic description gives an accurate portrayal of an illness that has severe consequences not only for the health and social welfare of people who are affected and their families, but also in its economic and social impact on the wider community. The impact of depression is often underestimated by health organisations, yet it is a devastating condition that robs the sufferer of joy and destroys dreams, hopes and aspirations. It can take an almost unbreakable grip on one’s life and impair the capacity for all the things people do such as employment, maintaining relationships, or simply having fun. What makes things still worse is that depression is also one of the most misunderstood conditions. It is associated with huge stigma, and there remains a perception that depression is an illness of the weak-willed and that people should just “snap out of it”. A 2009 poll revealed that 92 per cent of Britons believed that admitting to having or having had a mental illness could damage their career.

Pharmacists could raise awareness for the need of individuals to maintain their own mental health issues. The challenge is for the profession to nurture and look after themselves so that they maintain their own mental health and can cope with the challenges that life sometimes directs their way. This promotion of mental health can also have a positive impact in terms of reducing the stigma associated with poor mental health within a local community.

Possible pharmacist interventions to improve lifestyle include activities associated with current public health promotions since most are also linked with improving cardiovascular health by reducing cardiovascular risk — for example, promoting healthy eating, running smoking cessation services, and providing information on stress management, exercise and safe use of alcohol. It is important to remember that if we have a healthy cardiovascular system we have a healthy cerebrovascular system. Good public health interventions positively support people with depression and also reduce the risk of dementia.

Indenifying people at risk
Pharmacists, especially those working in community and primary care, have the ability to identify people at risk of experiencing a depression and those already on regular antidepressants. But how can we best support these people? It is well known that having a chronic illness, especially diabetes, cardiovascular disease or dementia, increases the risk of people experiencing a clinical depression. According to the National Institute for Health and Clinical Excellence, up to 50 per cent of people with chronic illness experience a clinical depression, and it is an area that pharmacists could be more proactive in, helping to identify those who may be suffering in silence. One of the factors that may stop people seeking help for depression is that once someone has felt low for a month or so, they then accept this new way of feeling as normal. This increases morbidity as the management of the chronic illness is impaired. The medicines used in long-term illness, for example, calcium channel blockers, corticosteroids and benzodiazepines, may also be implicated in the precipitation of depression. This could be a factor to keep in mind when completing any medicine use reviews in people with chronic illness.

Next time you are completing a medicines usage review or handing over a prescription to...
Depression is an illness, like diabetes, asthma or heart disease.

Taking antidepressants is not a sign of weakness, but an important part of treatment for depression.

Onset of effect: all antidepressants take around four to six weeks to have an effect on depression, longer in the elderly. Some signs of improvement may be evident earlier.

Side effects are common, but feelings of anxiety, restlessness or suicidal ideas (on initiation, after dose increase or a change of agent) require prompt medical attention.

Treatment duration: continue for at least six months after all symptoms have resolved. Some cases, especially those with recurrent episodes, or the elderly, may benefit from a longer continuation period.

Antidepressants are not addictive; they do not cause tolerance or cravings, but may cause discontinuation symptoms if stopped abruptly.

Alcohol should be avoided as it can affect ability to drive or operate machinery due to added effects of drowsiness.

Interactions: See www.bnf.org for interactions
• Avoid concurrent use of serotonergics and check for interactions with OTC treatments, eg, St John’s wort, sumatriptan.
• If on monoamine oxidase inhibitors, avoid foods containing tyramine (eg, cheese, pickled herring, broad bean pods, Bovril, Oxo, Marmite).
• If serotonin syndrome is suspected seek urgent medical attention.

Adapted from an article by Rajei-Dehkordi and Taylor (available from the RPS website for mental health — www.rpharms.com/public-health-issues/mental-health.asp)

A positive response to either means a need to signpost for medical review. Signposting material to support groups or for managing stress may also be useful.

Supporting people with depression

People with depression receiving a prescribed antidepressant will need regular proactive information about their medication. Those receiving their first prescription require advice on managing possible adverse effects and the important fact that the medicine may make them feel worse for the first week or two because of this, but to persevere. It is also important that people understand the importance of continuing the medication for at least six months after symptoms resolve, as this reduces rates of relapse.

Key counselling points for people on antidepressants has been outlined in RPS practice guidance on “Pharmaceutical care in depression” (see Panel).

Further information on providing pharmaceutical services for people with depression and practice guidance for those taking antidepressants has been developed as part of the RPS mental health toolkit.

Psychological therapies

Psychological therapies such as cognitive-behavioural therapy are recommended by NICE for mild to moderate depression. People may want information on talking therapies and how these may help them in depression. If you need further information look at the Clinical Knowledge Summaries (www.cks.nhs.uk/patient_information_leaflet/counselling/talking_therapies#), which can then be printed off as a patient leaflet.

Pharmacists can support patient choice

The involvement of patients in treatment decisions is becoming increasingly important. It can support adherence to treatment and lead to the development of self-care. Choice as a key element of NHS policy has been emphasised in the NICE depression guideline, and also been championed by the charity Depression Alliance in its report “Daring to choose”. Choice, of course, depends on information, which is often poor or difficult to access. The NICE depression guideline contains specific recommendations about what information should be provided, including information on the nature, course and treatment of depression and the use and likely side effects of antidepressants. Evidence-based information on all these aspects is available on the Depression Alliance website and we urge pharmacists to point patients toward this resource.

Pharmacists, especially in the community, are well placed to take on many of these roles, which could be defined within the framework of a local enhanced service, and there is evidence that doing this works.1,2 A community pharmacy study demonstrated that antidepressant medicines management, including providing phased patient education and therapeutic outcomes monitoring, provided effective support for patients to continue with antidepressant treatment for longer. Adherence to treatment increased by approximately 60 per cent and was accompanied by clear improvements in patients’ symptoms. The focus of patient care was transferred to a community pharmacy, reducing the burden of care in general practice. The number of hospital referrals was also reduced, which is likely to result in considerable cost savings.

Conclusion

Community pharmacy organisations, pharmacy groups and even individual pharmacists should consider supporting the Depression Awareness week and accessing evidence based resources from the Depression Alliance website for distribution to the people they provide services to. This simple action will help improve awareness of depression locally but also ensure that recipients understand it is an illness that requires help and support from healthcare professionals, family and friends and the local community. Community pharmacists can provide significant input into identification and support of people with depression and with proactive input may improve the quality of life of people with chronic illness. By promoting good mental health, linking in with any local public health campaigns and providing patient friendly advice, leaflets and appropriate signposting, pharmacists could not only improve local public health but also contribute to reducing the stigma of having a depressive illness. The latter may increase individuals’ confidence in seeking help and thereby reduce associated morbidity and mortality.

References