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mind

For better
mental health

LOTTERY FUNDED

Supporting people with depression and anxiety

A guide for practice nurses

This guide has been developed for GP practice nurses following a three year research study called ProCEED (Proactive care and its evaluation for enduring depression), conducted by Dr Marta Buszewicz and a research team at University College London.

The study involved a large number of practice and research nurses working in general practices throughout the UK. It was run in collaboration with the mental health charity Mind and funded by a grant from the Big Lottery fund.

Authors

Dr Mark Haddad RGN RMN
Clinical Research Fellow, Institute of Psychiatry at King's College London and South London & Maudsley NHS Trust

Dr Marta Buszewicz
GP in North London and Senior Lecturer in Primary Care at University College London

Beth Murphy
Information Manager, Mind

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Dr Marta Buszewicz and Beth Murphy

Foreword

The Royal College of Nursing is delighted that nurses working in general practice are able to develop their skills and knowledge of depression by having access to this excellent guide. While the vast majority of practice nurses do not hold mental health nursing qualifications, there is no doubt they are able to make a positive contribution to improving mental health care, when given the learning opportunities to enhance their confidence in this field.

Around 20,000 nurses are currently working in general practice and all of them will at some time be in contact with people whose health is impaired and quality of life reduced as a result of depression. While this guide cannot enable nurses to become experts on diagnosing and managing the care of patients with depression, it will ensure they are better equipped to:

— identify the signs and symptoms of depression

— have the confidence to ask the right questions

— enter into, what many nurses would call, 'difficult conversations' with their patients.

General practice continues to be the core business of health care and the setting where most people who experience depression can be effectively cared for – in terms of both prevention and management.

20,000 practice nurses are a wonderful resource, in terms of the management of long-term conditions and minor illness and this guide could, potentially, help them be as skilled in the management of depression, as they are other chronic and long-term conditions such as diabetes and hypertension.

The RCN is committed to ensuring that all nurses working in primary care have easy access to this excellent guide.

Lynn Young, Primary Care Adviser,
Royal College of Nursing

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Section 1
What does the guide cover?

Is this relevant to me?

Depression can be deeply distressing and without proper care and treatment it can severely damage the lives of those affected and the people close to them.

As a practice nurse you will already be involved in caring for people with chronic physical conditions such as diabetes or asthma and, as you know, people with these conditions are more at risk of also having problems with depression and anxiety. Depression and anxiety are very common – at any given time there are around 2.3 million people in the UK experiencing symptoms of depression.

However, there is limited training to help you to support people with mental health problems, and the result is that people with depression and anxiety do not always routinely get the comprehensive level of care they are entitled to.

2.3 million

Depression and anxiety are very common – at any given time there are around 2.3 million people in the UK experiencing symptoms of depression.

This guide has been designed to support you to work more effectively with people who experience depression and anxiety, and will be particularly useful for you if you answer 'yes' to any of these questions:

— Do you feel uncertain about how to recognise and assess depression and anxiety?

— Do you worry that you don't have the skills needed to talk to people about their feelings?

— Do you think that depression is a life-sentence that people can't recover from?

— Do you worry that if you start to talk about depression people will become suicidal or it will open up a can of worms that you can't help with?

— Are you unsure of the difference between low mood and clinical depression?

— Do you think that mental health problems should be treated by specialists only?

If you have any of these worries you are not alone, and it is natural to be unsure about how you can help. However, you will be seeing patients who experience depression and anxiety already, and if you feel unable to support them or that aspect of their health you are missing out an important part of their care.

How will it help me?

This guide has been designed to help practices nurses working in primary care teams. It focuses on recognising and supporting adult patients who show signs of depression and anxiety.
It will help you to:

Recognise depression and anxiety in patients and understand ways in which these conditions affect people's lives.

Feel more confident talking to and supporting patients with depression and anxiety.

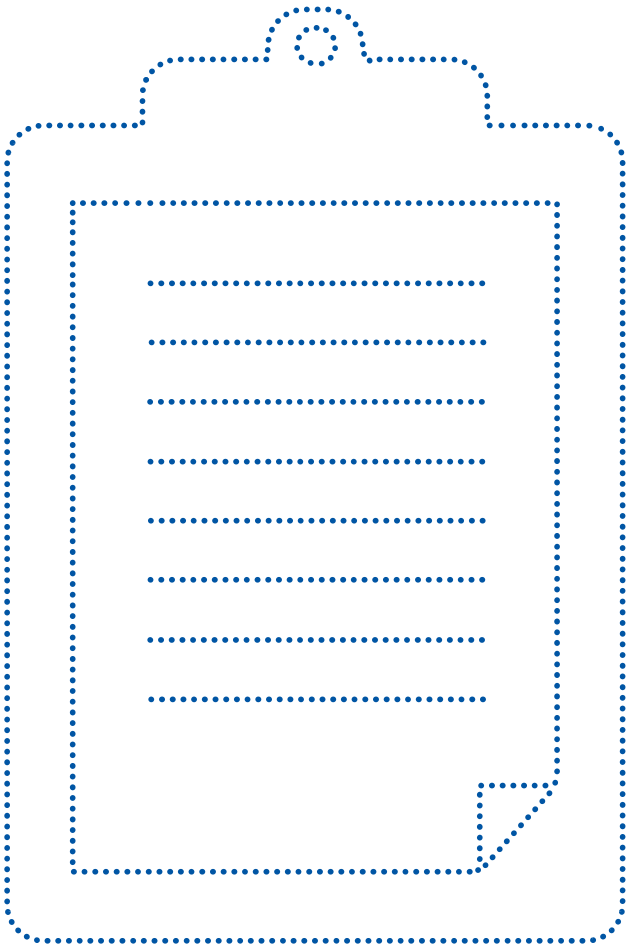
Be aware of the main approaches to managing depression and anxiety and the most commonly used treatments.

Learn more about what different services are available for people with depression and anxiety.

Feel secure about asking someone whether there is any risk of them harming themselves and know how to deal safely and appropriately with their answer.

"It focuses on recognising and supporting adults who show signs of depression and anxiety."

Section 2
Lessons learnt



The ProCEED trial

This guide was developed from a research trial called ProCEED. This was a randomised controlled trial which involved practice nurses from 42 general practices throughout the UK working with patients who had chronic or recurrent depression over a two year period. In many ways the model used was similar to that used in other long-term conditions such as asthma or diabetes.

Practice nurses met with patients every three months to review the management of their depression and whether the treatments prescribed (medication, psychological therapies or lifestyle interventions) had been helpful or needed to be reviewed and changed – if necessary this would involve a GP consultation.

Before taking part in this study the majority of the nurses reported feeling very unconfident about the idea of working with patients who were depressed and felt wary about raising the issue of depression in their clinical practice in case they were unable to deal effectively with the issues raised. They all mentioned a distinct lack of relevant training in working with people with mental health problems in primary care. This was despite the fact that practice nurses are increasingly being expected to broach the topic of depression and anxiety as part of their standard workload, for example screening for depression in diabetes or cardiovascular disease as part of the QOF (Quality and Outcomes Framework).

"Sometimes you ask the question and you think, oh please don't have a problem because if you have – you know. Which is awful to say it, but it's a reality sometimes. You're almost relieved that everything is fine. I don't think that's right, but that's how you sometimes feel."

After taking part in the trial all the nurses interviewed reported an increase in their confidence in asking patients about possible depression and having a sense of what to do if they identified this. It is this response from the nurses, as well as the current lack of relevant training materials for practice nurses in this field, which led to us producing this guide.

"I was always confident to chat to people before but, and maybe I know more of the, you know, sort of things that are available or a little bit more about the medications and things, so maybe happier to lead them through the right pathway."

As well as conducting the main trial we carried out two qualitative studies to get more detailed information from both nurses and patients who had been involved. From the interviews with the nurses we established that all the nurses felt more confident at the end of the trial in identifying people with depression during their day to day work and following up on this where appropriate. However, not all the nurses wanted to develop a special interest in working with people with mental health problems.

This guide covers the range of information about depression and anxiety, its detection and management in primary care which we think will be relevant and of interest to all practice nurses in their routine contact with patients in primary care settings.

We hope that these materials will be of interest and use to you. If you would like to get a further understanding and knowledge about mental health issues, information on a variety of other resources can be found in **Further information** on page 44.

Case study

Working with depression and anxiety as a practice nurse

"Caring for patients with depression is challenging and consequently extremely rewarding."

This guide has been developed from a three year project which provided support and training to practice nurses who had limited experience of working with mental health problems. This is the experience of one of the nurses involved in the project. It explains how she found the process, both the positives and the challenges.

"Caring for patients with depression is challenging and consequently extremely rewarding. I found that I needed to develop new skills to enable me to feel that I could be of benefit to my patients. The most important was listening, really listening to pick up what patients were trying to tell you, this often meant identifying what they weren't saying and finding a way of allowing them to talk comfortably.

"Many patients really valued someone listening to them, often when an appointment was over I realised I had actually done very little, except listen.

"Lateral thinking became useful, as some patients felt that they were unable to see a way out of a certain difficulty and so were receptive to different ideas and another perspective. There is a skill in persuading patients that the situation can improve, but it takes work on their part to bring this about, and for them to recognise the need for their input. This again can take many forms, remembering to take medication, going out for walks, going to see a Relate or Cruse counsellor.

"Patience is a virtue is certainly necessary. It can be very frustrating when a patient does not act on an agreed plan, but again it is then important to find out why this is happening and recognising that this is not failure. However, accepting failure is also relevant; nurses care about helping their patients and it is troubling when you feel you are not succeeding in this. Recognising that depression is a condition with peaks and troughs enables you to cope with these times.

"A tendency I have developed since becoming involved in working with depression is the magpie effect. I collect information in case it is useful to my patients. I am a fountain of knowledge about the courses available through the University of the Third Age (U3A), what is available at the local library, where the nearest Mind branch is, how to contact the local volunteer service and where to go for a yoga class. I have found it important to get feedback on this, so that if something is not useful, or details change I am aware. I recognise that one of my roles is that of a signpost, pointing to where help is available rather than offering it directly."

Feelings I had during the study

Challenged

"Identifying a problem and trying to work out a solution with the patient was challenging. Each patient was an individual with completely differing needs, as opposed to trials in diabetes or hypertension where the pathways are identified and structured. I enjoyed the challenge and mental stimulation."

Fear

"Sitting in front of the computer waiting for a patient who had just joined the study, seriously depressed following a complete breakdown. There was either no eye contact, or a fixed stare, hands continually folding paper, little verbal communication. The sick feeling with the realisation I was now expected to do something."

Rapport

"The nature of the consultations led to a position of trust, with patients feeling able to discuss their fears and anxieties. I felt very privileged that people had the confidence to share this with me. I felt that their family members acknowledged a positive benefit, for example if I had to phone a patient at home I was recognised and given a friendly reception as 'Kate from the surgery' – this meant that I felt as though I knew these people although we had never met."

Friendship

"The study may have finished over a year ago, but if I bump into one of the subjects either at the practice or in the town centre they always say 'hello' and stop for a chat. This is never negative but to let me know how they or their family members are doing, and to ask how I am."

Failure

"The patient who does not accept that there is help available and refuses to recognise that there is even a way forward. All you can do is keep the communication channels open, listen and don't give up."

Continued benefit

"If I am checking notes for any reason and the person is someone I worked with during the study it is such a positive feeling to see that they have not needed to restart their antidepressants or that they have only had a couple of GP consultations in the last year. It reinforces the impression of making a difference."

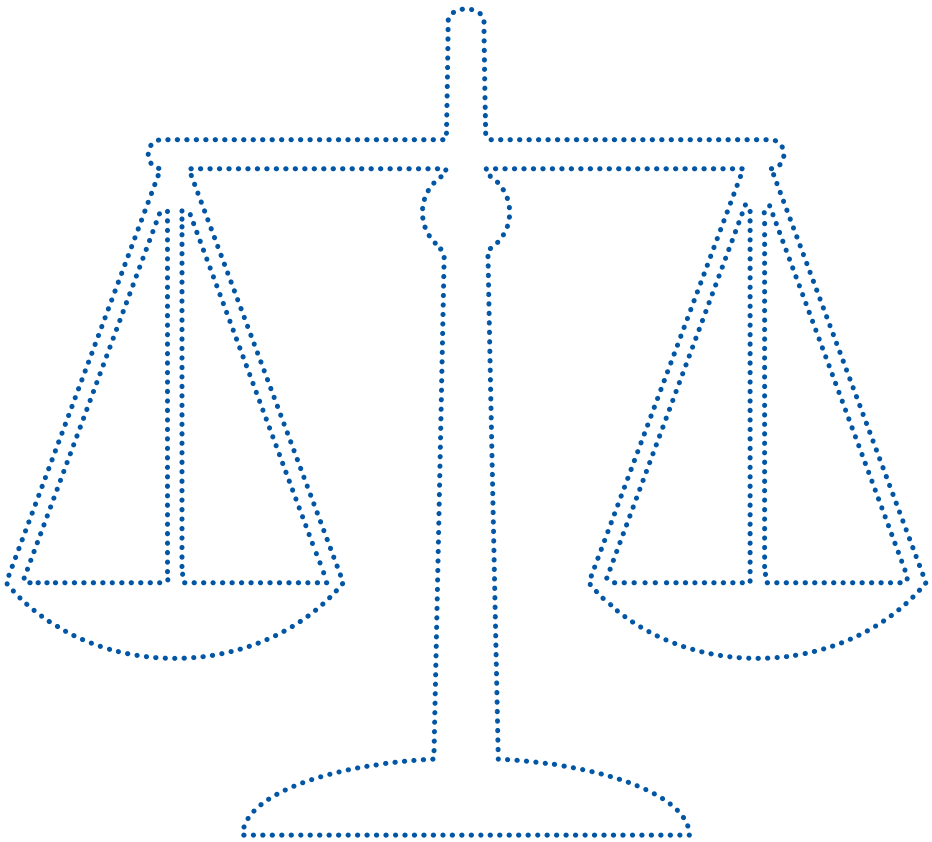
Frustration

"Despite all the advice you offer, the patient is the only one who can act on it. They may choose not to action a plan, even though they have happily agreed that it is what they need to do, often offering this as a solution themselves. Frustration sets in when they attend for a series of appointments without initiating an agreed change. Take a deep breath and try to establish why this is the case and try to look for alternative solutions."

Fulfilment

"The feeling when a patient thanks you saying that they can now see a way forward and a return to their normal life. Just observing the change in appearance, the return of confidence and the ability to smile – this makes it all worthwhile!"

Section 3
Depression and anxiety



What are depression and anxiety?

Depression and anxiety are common mental health problems. This means that they occur relatively frequently in the population. They are thought to affect about 1 in 10 people in the general population at any time, and are the third most common reason for people visiting the GP.

Other common mental health problems include phobias, obsessive compulsive disorder and alcohol and substance misuse problems.

Common mental health problems do not usually involve what are termed as 'psychotic symptoms' when some people lose touch with reality, for example hearing voices or hypomanic episodes. Those symptoms are present in disorders such as schizophrenia and bipolar disorder, which affect approximately 1 in 100 people.

Common mental health problems are mostly managed in primary care – and it is almost inevitable that a number of the patients you care for have these problems alongside the other physical conditions that you help them to manage. Many people with depression are reluctant to consult their GP due to the stigma associated with depression, as well as the perceived lack of appropriate treatments available. They may be apprehensive that their concerns and preferences will not be taken into account and have low expectations of getting any benefits from treatment. Effective treatment helps with both first and later episodes of depression, reducing the time someone is affected by their symptoms and minimising their impact.

What is depression?

In its mildest form, depression can mean just being in low spirits. It doesn't stop people from leading a normal life, but makes everything harder to do and may make things seem less worthwhile. At its most severe, clinical depression can be life-threatening, because it can make people suicidal, simply give up the will to live or have a major and lasting impact on a persons life, work and relationships.

It is important to remember that the experience of depression can vary from person to person, as can the words people use to describe their problems. Many people are uncomfortable using the term 'depression', possibly because they associate this with serious mental illness or a sense of personal failure. It is common for people to deny feeling depressed, but to admit to feeling unhappy, sad or low. Likewise, some people may deny feeling depressed but admit to losing interest in things, or to feeling tired most of the time. It can sometimes be difficult to decide if someone who has some symptoms of depression is 'clinically depressed'.

To classify depression clinically, and distinguish it from other mood problems as well as from normal experiences and life problems, we focus on the symptoms experienced by the person.

1: Core features

Although there are a range of symptoms, the presence of *core features* is essential for diagnosis.

— A lowered mood.

— A lack of interest or pleasure in usual activities.

Either one or both of these must be present for a person to be diagnosed as depressed.

2: Associated features

As well as these two core features, additional symptoms characterise depression. Some of these relate to physical aspects of function (sometimes referred to as *somatic* or *biological* features of depression) and some to emotional/psychological and social aspects.

The features of depression

Physical features

— Disturbed sleeping – waking in the night, or earlier than usual, or sleeping too much.

— Loss of appetite or overeating.

— Tiredness or persistent loss of energy.

— Aches and pains not fully explained by medical problems.

Psychological features

— Feeling sad or unhappy or having a 'low' mood.

— Feeling unable to enjoy things like you used to.

— Loss of confidence and/or loss of self-esteem.

— Feeling particularly guilty or self-blaming.

— Feeling that things won't get better in the future.

— Thoughts of self-harm or suicide.

Social features (features affecting social function)

— Poor concentration or memory.

— Not wanting to see people or do things.

— Irritability or more frequent arguments with people around you.

— Difficulties managing work, family responsibilities or other usual activities.

3: Making a diagnosis of clinical depression and its severity

It is often difficult to decide if someone who has some symptoms of depression is 'clinically depressed'. You can decide whether an individual is experiencing a 'clinical' episode of depression by applying the diagnostic criteria set out in the ICD 10 (the International Classification of Disease) on page 13.

You may also have heard of another classification system – the DSM IV (the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders). This provides a similar list of the features of depression.

We have listed the possible symptoms, and questions to ask on page 13, together with a description of how many symptoms someone would need to have to be diagnosed as having mild, moderate or severe depression.

The length of time that a person experiences the symptoms is another key distinction between depression, and general low mood. For a diagnosis of depression, these features must persist for most days, for much of each day, for a minimum of two weeks.

Questions to ask

- Have you been bothered by feeling down depressed or hopeless?
- Have you lost interest in things?
- Do you get less pleasure from things you used to enjoy?
- If 'yes' to the above – i.e. the two core questions, please prompt further about individual symptoms as in the questions below. (See also the assessment box.)
- Have you noticed any change in your normal sleep patterns?
- Appetite? Weight?
- Have you noticed difficulties in concentrating?
- Have you lost confidence in yourself?
- Are you feeling guilty or blaming yourself for things?
- Have you found yourself to be more physically restless/ or moving more slowly than usual?
- Have you felt that life is not worth living, or that you would be better off dead? (See **Assessing the risk** on page 21.)

Assessment (ICD-10)

Clinical Symptoms

Core Symptoms (at least two)

- Depressed mood, and/or
- Loss of interest.

Additional Symptoms

- Poor concentration.
- Reduced self-esteem and self-confidence.
- Disturbed sleep.
- Change in appetite or weight.
- Feelings of guilt or worthlessness.
- Agitation/slowing.
- Pessimism/hopelessness.
- Suicidal thoughts or acts.

Much of the day, most days for at least two weeks.

Other clinical signs which may be associated with depression

- 'Tired all the time.'
- Irritability.
- Loss of libido.
- Medically unexplained symptoms.
- Depression associated with physical illness.
- Frequent attendance at the surgery.

Mild Depression

At least two core symptoms and at least two additional symptoms.

The person has some difficulty with ordinary activities but does not cease to function.

Dysthymia

Mild depression for more than two years.

Moderate Depression

At least two core symptoms and at least three or four additional symptoms.

The person usually has considerable difficulty continuing with normal work and social activity.

Severe Depression

Two core symptoms and at least four or five additional symptoms, some of which are severe.

The person shows considerable distress and agitation (or retardation) and is unlikely to be able to continue with their normal activities.

An episode of major depression (moderate/severe depression) is disabling by definition and lasts at least two weeks, but often much longer. Increasingly, it is being recognised that some people may have several episodes of major depression in their lifetime – which can be termed recurrent depression. In between these episodes the person may feel well and function completely normally, although sometimes major depression is more enduring.

A further description sometimes used is that of Dysthymia, which means a chronically low mood over a period of time (at least two years but often much longer). Dysthymia features other symptoms which can include sleep disturbance, low energy, low self-esteem, indecisiveness and hopelessness, but the symptoms are generally less severe than in major depression.

Effects on function

In addition to the symptoms and their duration, the impact that the depression has on a person's ability to take part in their life, or their function, is a key part of reaching a diagnosis. Significant limitations on the person's ability to function in work or in their relationships may be associated with being depressed and this in itself will be distressing.

It is at least as important to assess the impact being depressed has on someone's ability to function normally as the severity of their symptoms.

What is anxiety?

As with depression, anxiety is something we all experience from time to time. Most people can relate to feeling tense, uncertain and possibly fearful at the thought of things like sitting an exam, going into hospital, attending an interview or starting a new job. You may worry about feeling uncomfortable, appearing foolish or how successful you will be. In turn, these worries can affect your sleep, appetite and ability to concentrate. If everything goes well, the anxiety will go away.

However, if the anxiety does not go away, and becomes a regular part of a person's life then it might said to be an anxiety disorder. Anxiety disorders are very common in the general population and almost certainly under-recognised in those attending UK primary care.

Diagnoses exist for a number of different types of anxiety disorder, including generalised anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder and post-traumatic stress disorder.

Within primary care, the most common anxiety disorders are:

— generalised anxiety disorder

— panic disorder.

It is common for people to experience both depression and generalised anxiety disorder, and this is associated with a poorer prognosis. As with depression, it is also common for anxiety to be associated or co-morbid with various long-term physical health conditions such as COPD or cardiovascular problems.

Generalised anxiety disorder (GAD) is characterised by persistent excessive worry that the person finds difficult to control. This is accompanied by some of the physical and/or psychological symptoms listed on page 15 which, in order to fit this definition the person should have experienced on more days than not for a period of at least six months.

Physical symptoms of generalised anxiety disorder

— Feeling restless and being 'on edge'.

— Rapid breathing.

— Rising blood pressure and a pounding heart.

— Tense muscles which can cause pain and headaches.

— Sleep disturbance.

— Nausea, sickness or urgent need to use the toilet.

Psychological symptoms of generalised anxiety disorder

— Feeling worried all the time.

— Feeling tired.

— Being unable to concentrate.

— Feeling low or weepy.

Panic disorder involves recurring and unexpected panic attacks. A panic attack is an exaggeration of the body's normal response to fear, stress or excitement. When faced with a situation seen as potentially threatening, the body automatically gears itself up for danger by producing quantities of adrenalin for 'fight or flight'. This happens very quickly, usually in less than 10 minutes, and brings about the symptoms outlined above. In addition people may feel:

— that they're going to die

— frightened of 'going crazy' or losing control

— short of breath

— that they're choking.

These attacks may often lead to avoidance of situations due to fear of developing symptoms and being unable to escape.

Alongside these recurrent unexpected panic attacks, someone with panic disorder also experiences one or more of the following symptoms.

— Persistent worry about having further panic attacks.

— Worry about the implications or consequences of the panic attacks (such as having a heart attack, or losing control).

— Significant change in behaviour related to the panic attacks.

Panic disorder is often accompanied by agoraphobia – which is anxiety about being in places from which escape might be difficult or embarrassing (typical situations include being in a crowd, being outside alone or travelling in a car or public transport). These situations are either avoided or endured with marked distress or worry about having a panic attack. Alternatively, the person affected always needs a companion with them.

Causes and triggers for depression and anxiety

The exact causes of mental health problems are not known, and are likely to vary between different people. Different theories suggest that a family (genetic) history of the disorder, brain chemical imbalances, major life events and social factors (such as bereavement or unemployment) and, in some cases, a history of abuse or other childhood difficulties have a role to play. In some cases there is no apparent cause or trigger for someone's depression.

> "The exact causes of mental health problems are not known, and are likely to vary between different people."

There does appear to be increased risk of depression and anxiety in certain groups:

- **Gender**: depression and all anxiety disorders are around twice as commonly diagnosed in women, but this could be because women are more likely to seek support.
- **Socioeconomic factors**: mental health problems are more commonly diagnosed among people at the lowest socio-economic level.
- **Ethnicity**: South Asian women in England are more likely to experience depression, panic and anxiety disorder than the general population.
- **Medical illness**: there is an increased risk of depression and anxiety disorders linked to chronic physical health problems such as coronary heart disease, diabetes, asthma or chronic obstructive pulmonary disease.
- **Past history of depression and anxiety**: there is a high risk of relapse and recurrence if people have experienced depression and anxiety before.
- **Alcohol misuse**: this is particularly linked with anxiety disorders.
- **Antenatal and postnatal period**: there is an increased risk for depressive symptoms around pregnancy.
- **Psycho-social factors**: people who have experienced or are experiencing difficult life events such as homelessness, poverty, debt or abuse have a higher risk of depression.

Probably the most important factor is a past history of depression and anxiety. It is now recognised that someone who has had one or two episodes of major depression is at high risk of having further such episodes, so it is essential to discuss this with people who you think may be at risk or who have some clinical features. The person's past history also provides important indications of the types of support and treatment that are most likely to be acceptable and effective in the future.

Talking about mental health problems

It can be difficult for people to talk about mental health problems for a variety of reasons, including:

- **Stigma and discrimination**: many people don't want to receive a diagnosis of depression and anxiety because of the stigma that still surrounds mental health problems.
- **Cultural or peer pressure**: people from certain groups or communities can find it difficult to admit to feeling low, or not coping because of the attitudes of their peers.
- **Confidence of professionals**: it is difficult to encourage people to open up if you or they feel you do not have the skills to support them.
- **Nature of depression**: if people are feeling depressed their outlook is generally negative, and it can be difficult to believe that there is anything which can help.

Factors such as these can result in interactions with patients that are unsatisfying and don't fully address the problem. You might find the following tips help you to talk about mental health problems more easily.

Language and tone

It is important to use words and a manner that are appropriate and demonstrate sensitivity to background and spoken language. Try to consider gender and cultural differences. For example, many men prefer more physical and active language rather than more emotional language. Some cultures may use different expressions to explain feelings or mental health problems. Allow yourself to be led by the person and use the phrases and words they are using, and use terms like 'low', 'down' and 'on edge' rather than overtly psychological terms.

Showing empathy and sensitivity by means of your posture, eye contact and gestures are a key part of the non-verbal communication that will assist people in talking about their mental state. Using open questions, offering prompts and repeating or paraphrasing the patient's statements can also be useful.

It is important to set your own experiences aside and focus on the experience and feelings of the patient. Don't jump to conclusions because you think a situation sounds familiar. Give them the space to talk about how they feel.

Stay with painful, distressed feelings. Simply being heard can be of great value in itself, particularly for people whose thoughts, feelings and wishes may have been rushed when talking to their GP, or who haven't opened up about their experiences before.

Don't be afraid of silences. Often when people are trying to make sense of difficult feelings they need time to process their own thoughts. If you fill the silence with a question or comment you can take people away from this and close down the conversation.

Start with physical symptoms

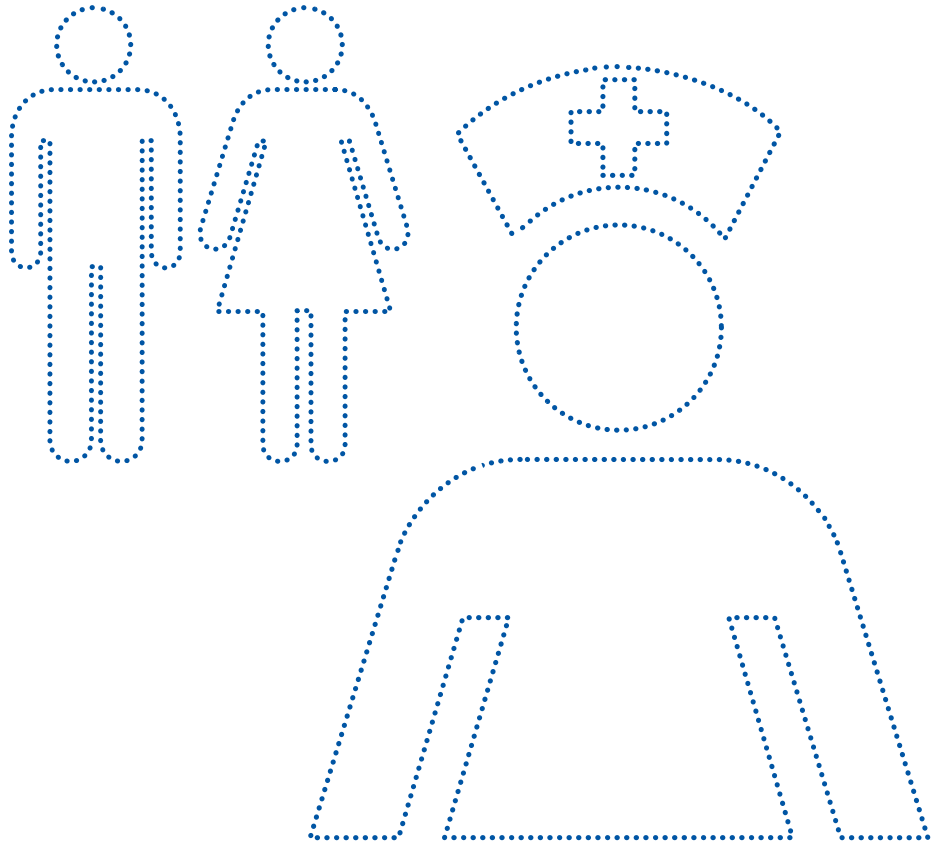
People are often more at ease describing physical symptoms and problems when they first open up about how they are feeling. It may therefore be easier for the patient if you initially consider areas such as sleep, appetite and energy levels.

Your role

Remember that as a nurse there are limits to what you can and can't offer to a patient. People who experience depression or anxiety are likely to have a number of other concerns in their lives which can include financial worries, housing problems or relationship issues. It will not be your role to support them with all these issues, although you may be able to suggest other agencies or organisation which can provide appropriate advice and this can be very helpful.

A person who is very distressed may wish to be able to pass on all of their issues to another person and hope that they can sort them out, so you need to be clear with yourself and with them where your boundaries lie. Finding out from a person about the multiple issues in their lives will allow you to offer them the best options to seek further support (see **Further information** on page 44). It will also help you to gain a fuller understanding of their life circumstances and how they may be impacting on them both physically and mentally.

Section 4
Recognising depression and anxiety



Assessing patients for depression and anxiety

Correctly recognising depression and anxiety is the essential first step to any ongoing assessment, monitoring, support and treatment. An important part of recognising depression or anxiety disorders involves knowing the symptoms that make up these conditions (see **What are depression and anxiety?**).

Rating scales to recognise and monitor depression

Several tools are available to assist identifying depression and anxiety. Two of the most commonly used are described here.

The 'Whooley questions' (named after the researcher who initially tested it) use a 'yes' or 'no' response format to screen for the two core features of depression. A positive response to either or both of these questions identifies a person as having possible depression with further assessment required to identify if this is present. As you'll see the questions are based on the 'core questions' for an ICD-10 diagnosis of depression described on page 13.

It can be used as a self-report where the person completing the responses themselves. Alternatively, the questions can be asked within a clinical consultation or during a telephone conversation.

Whooley questions

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

Asking these two questions as a screen for depression and recording the answer is part of the current requirement for the care of people with Diabetes or Coronary Heart Disease under QOF (the Quality and Outcomes Framework). Practice nurses are quite often tasked to do this, but may be tempted to ask the questions in a way which is unlikely to lead to a positive answer if they feel unconfident about how to provide the relevant further assessment and effective support if the patient answers 'yes' to both questions.

If the person answers 'yes' to both these screening questions another more detailed symptom identification tool called the PHQ-9 is recommended to determine if the person is depressed and to what level. It is brief and simple to complete, and has good detection properties for depression alone and in combination with medical problems. It can be used to grade the severity of someone's depression at baseline (first appointment) and then again at follow-up (after treatment has begun).

It can also be used as a self-report (the person completing the responses themselves) or asked within a clinical consultation. Adding together the score for all the responses at the end gives a simple measure of how severe someone's depression is, the higher the score the more severe. A copy of the PHQ-9 is included as Appendix 1 on page 48.

Further assessment is then required to determine the type and number of symptoms that the person is experiencing, their severity and the effects on their daily life, before discussing the range of possible treatments with them.

Rating scales to recognise and monitor anxiety

We have already explained that anxiety often co-occurs with other mood disorders and with physical health problems. If someone is experiencing symptoms of both depression and anxiety NICE (National Institute for Clinical Excellence) suggest that whichever is the most severe and worrying disorder from the patient's perspective should be assessed and treated first.

Similarly to the 'Whooley questions' for depression, there is a simple two question screening tool for anxiety called the GAD-2.

GAD-2

Over the past two weeks, how often have you been bothered by:

1. Feeling nervous, anxious or on edge?

2. Not being able to stop or control worrying?

There are four response options:

— Not at all (0)

— Several days (1)

— More than half the days (2)

— Nearly every day (3).

> "It is possible that individuals who are coping with anxiety through avoidance behaviour may score quite low on the GAD-2."

People scoring a combined score of three or more are considered to potentially have an anxiety disorder.

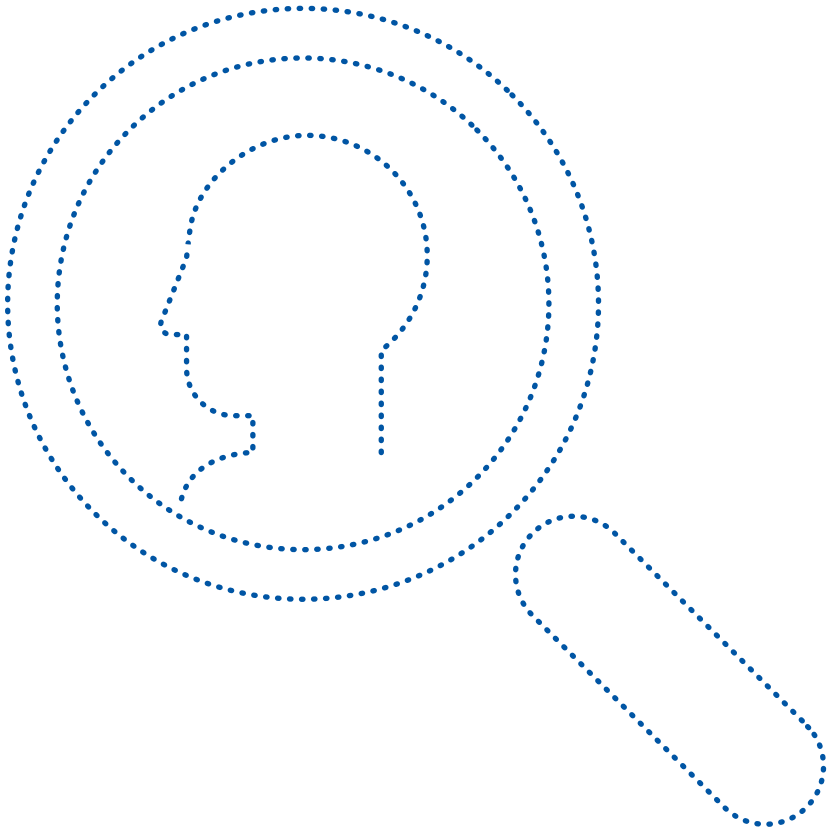
It is possible that individuals who are coping with anxiety through avoidance behaviour may score quite low on the GAD-2. Therefore, if you suspect an anxiety problem but the individual scores less than three, a further question: "Do you find yourself avoiding places/activities and does this cause you problems", should also be asked, and those with a positive response should be assessed further.

Following a positive response to the GAD-2 and/or to the third panic question, a longer questionnaire may be useful in clinical practice to assess the presence and severity of someone's anxiety or to monitor change over time (especially following therapy or when considering treatment).

In this situation, a further five questions which can be combined with the initial questions to make a scale called the GAD-7, may be useful. A score of eight or above indicates an anxiety disorder (the instrument is most sensitive to the detection of generalised anxiety disorder).

A copy of the GAD-7 has been included in appendix 2 on page 49.

Section 5
Assessing the risk



Assessing the risk of suicide and self-harm

Although it is not very likely to happen, you may encounter a patient about whom you become very concerned. This may be because the patient seems very depressed and is not receiving adequate treatment or because they disclose suicidal thoughts or plans.

Many people experiencing depression (probably most people in fact) have transient thoughts of dying or of self-harm or suicide. It doesn't mean they will attempt to act on them.

It is very important to remember that asking about suicidal thoughts or plans does not put the idea into someone's head or increase the risk.

People are often relieved to have the chance to talk about how bad they are feeling or their fears of what they might do. But if people do have these thoughts it is a good idea to ask them the following questions (stop when they say no).

Brief risk assessment

— Have you had thoughts about harming or killing yourself?

— Have you felt like acting on them?

or

— Have you considered actually ending your life?

— Have you made any plans about how you would do this?

— How likely is it that you might act on these plans?

Talking about suicide

It can be frightening or even embarrassing to ask someone about suicidal thoughts or actions. You may also find it distressing to listen to someone who is in despair. However, if you are able to set aside your own feelings and focus on the needs of the person and stay within the remit of your role, then you will be able to work to identify and support someone who may be considering suicide.

Suicide is associated with depression and risk factors such as chronic illness, physical impairment, unrelieved pain, financial stress, loss and grief, social isolation and alcoholism.

People who have self-harmed previously are at more risk of taking their life in the future, as are older men and those who are socially isolated with chronic physical illnesses.

Warning signs for suicide

The following may be associated with a risk of suicide:

— Feeling hopeless or worthless in a persistent way.

— Putting affairs in order, giving things away or making changes to wills.

— Stockpiling medication or any other specific plans to harm themselves.

— Previous suicide or self-harm attempts.

— Goodbyes such as "this is the last time you'll see me" or "I won't need any more appointments."

— Preoccupation with death or a lack of concern about personal safety.

How to respond to what the patient tells you

If this assessment suggests that the patient is at serious risk of suicide or harm then you should give them space and time to talk, as this might be the first time they have spoken about these feelings. If you are concerned that they are at a crisis point then you should explain to them that you need to make sure they see the GP before they leave the practice, and also offer them information about organisations such as the Samaritans.

If a patient has a clear plan as to how they may kill themselves and they (or you) feel there is a chance that they may act soon on their plans, you should speak with a doctor before the patient leaves the surgery and ask them to see the patient before they leave.

However, if the patient has only felt like acting on suicidal thoughts or has made less specific plans which they don't think they will act on at the moment, you should let them know that you will need to discuss this with a doctor as soon as possible and you would like them to see a GP for review in the next day or two. You need to make sure this appointment is made and agreed with the patient before they leave the surgery if they are not assessed by a doctor straightaway.

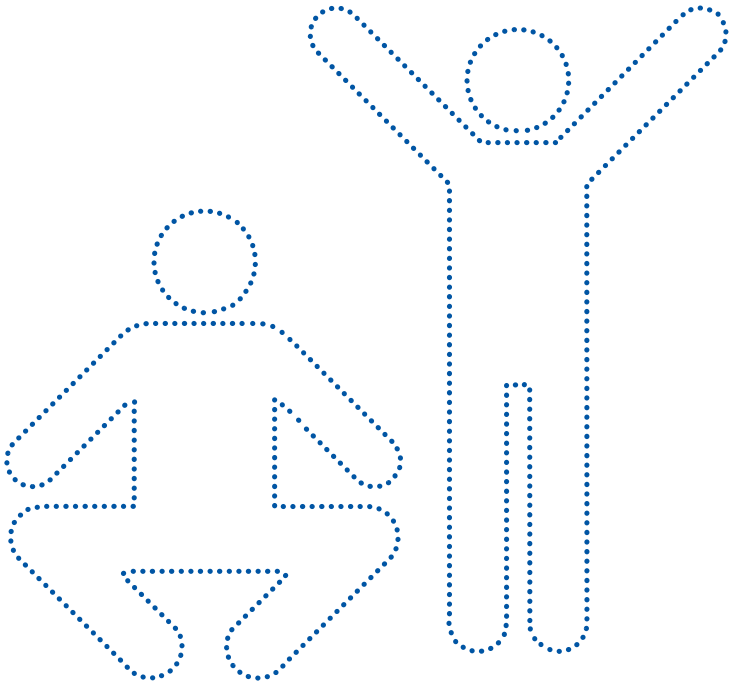
You will need to tell the patient that you are discussing your concerns with one of the doctors in the surgery. People will nearly always agree to this, but if they don't and you are concerned that they are at significant risk of taking their own life you are ethically obliged to inform someone else about this and would be expected to do so even if this breaches confidentiality.

Looking after yourself

If you have worked with someone who is suicidal, perhaps including being with them whilst you wait for a GP to come and assess them, it may have a significant impact on you. For example you may find that it raises emotions in you such as sadness, anger or feelings of helplessness. Remember to take time to give yourself a break in order to calm yourself and find a colleague to talk to for a few minutes if you feel it would be useful in order to help you let go of these feelings.

"If you have worked with someone who is suicidal, perhaps including being with them whilst you wait for a GP to come and assess them, it may have a significant impact on you."

Section 6
Management and treatment



Mild depression and anxiety disorders

One of the most important factors in determining what treatment is most appropriate is the severity of the depression and anxiety. Patient choice, and past history of what may have been helpful or not are also crucial in deciding treatment options.

Active monitoring

For patients presenting with mild features of depression (i.e. relatively few symptoms and little functional impact), getting a clear picture of their symptoms and any life circumstances or stresses which may be associated is the correct thing to do, This also helps them to feel understood and they will be more likely to feel comfortable returning for a further assessment. A follow-up assessment of their symptoms and relevant social situation within two weeks of your first meeting is the appropriate initial response.

This is termed *active monitoring* – and it is important because quite a few of those people who experience relatively mild symptoms of depression and anxiety will find that these resolve without treatment. If you have used a scale like the PHQ-9 or GAD-7 alongside the assessment this can help to determine whether someone's symptoms have improved if you repeat it at their follow-up appointment.

Health education and simple interventions

If at the follow-up review, someone still has clear symptoms of depression and anxiety, but the features are mild, providing health education about the symptoms and their likely cause and the available types of self-management and treatment may be helpful (*termed psycho-education*). The benefits of information, advice and education about depression should not be underestimated. Simple explanations about depression can help people to make sense of their distressing symptoms and give hope about recovery. Organisations like Mind produce lots of information aimed at people who are experiencing mental health problems, see **Further information** on page 44.

Physical activity

Many people with depression experience a loss of energy and constant feelings of tiredness. Taking some form of exercise, for example swimming, walking, running or kickboxing two to three times per week, can help relieve several of the symptoms associated with depression. Where possible, encourage outdoor exercise as that has a greater benefit than indoor exercise. Physical activity is an effective antidepressant, as when we exercise our bodies release 'feel good' chemicals called endorphins. Exercise can also give people more energy and improve their sleep and appetite. Of course you will need to tailor advice about physical activity to the physical health of the person and recognise that a person who is depressed will nearly always lack motivation and energy and so will need to build up their activity level slowly.

Diet

Depression can affect people's appetite, so encourage those affected to eat regular, appropriate amounts. Missing out valuable nutrients can make people feel tired and run down, so it is important to include plenty of fresh fruit and vegetables. Alcohol can act as a depressant so is best avoided, and many recreational drugs which bring about short term improvements in mood have been shown to lower mood over time. Obesity is also closely linked to depression, as it can negatively impact on self-esteem, so support with weight-loss may also be appropriate.

Relaxation techniques

Depression is frequently associated with tension, stress and anxiety. Relaxation is the natural answer to stress. It is good to make time during the day to relax, whether or not an individual feels under stress. There are many ways to relax – yoga, reading, listening to a relaxation tape, going away for a short holiday – encourage the patient to try to find out what works for them and to regularly give themselves time to wind down. Learning and practising relaxation techniques will help them (and you!) to cope better with the effects of stress, particularly if they are used regularly and not just when someone is feeling under particular pressure. Relaxation exercises can also be used to help people to prepare for sleep. A simple example of muscular relaxation exercises which you can copy and give to people are given on the right. Often, these exercises may be adapted to assist people to prepare for sleep.

"Encourage the patient to try to find out what works for them and to regularly give themselves time to wind down."

Some simple relaxation exercises

Sit in a well-supported chair or lie on your back. Concentrate on your breathing for a few minutes. Breathe slowly and calmly, and each time you breathe out say words to yourself such as "peace" or "relax". Then start the muscle exercises, working around the different muscle groups in your body.

Hands – clench one hand tightly for a few seconds as you breathe in. You should feel your forearm muscles tense. Then relax as you breathe out.
Repeat with the other hand.

Arms – bend an elbow and tense all the muscles in the arm for a few seconds as you breathe in. Then relax as you breathe out. Repeat the same with the other arm.

Neck – press your head back as hard as is comfortable and roll it slowly from side to side. Then relax.

Face – try to frown and lower your eyebrows as hard as you can for a few seconds, then relax. Raise your eyebrows (as if you were startled) as hard as you can, then relax. Clench your jaw for a few seconds, then relax.

Chest – take a deep breath and hold it for a few seconds, then relax and go back to normal breathing.

Stomach – tense the stomach muscles as tight as possible, then relax.

Buttocks – squeeze the buttocks together as much as possible, then relax.

Legs – with your legs flat on the floor, bend your feet and toes towards your face as hard as you can, then relax. Then bend them away from your face for a few seconds, then relax.

Sleep

Sleep disturbance is a frequent and distressing feature of depression and anxiety disorders. Often simple things can improve sleep.

Some simple sleep techniques

- Only go to bed when you feel sleepy. Do not try to get more sleep by going to bed early.
- Do not read, watch television or eat in bed, unless you are sure from past experience that these activities help you get to sleep.
- When lying in bed, relax your muscles. Taped or written instructions may help you to do this. You may want to listen to a relaxation tape or soothing music.
- Do not think about getting to sleep or worry about the day's activities. Try instead to think about pleasant events or places.
- If you are unable to get to sleep after a while, get up and do something different in a different room and do not return until you feel sleepy.
- Set your alarm and get up at the same time each morning, regardless of how much you slept during the night.
- Do not drink coffee or tea before you go to bed as they contain caffeine.
- A warm bath before going to bed may help you to unwind.
- Avoid heavy meals and alcoholic drinks late in the evening.
- Make sure your bed is warm and comfortable.
- Try and keep to a fixed routine every night.

Social support

When people are experiencing depression they can often feel very isolated. They may feel that they don't have the energy to socialise, or that their mood is too low to mix with others. The problem is that social isolation can fuel depression and make it even worse. When they're alone, people who are depressed may tend to revert to negative thinking, which only increases feelings of worthlessness, shame and alienation. You may want to make the following suggestions to patients who are affected in this way.

Turn to trusted friends and family members

When depressed, people may retreat from their most important relationships. However, these relationships may be potentially helpful in getting through this tough time. Encourage anyone who is depressed to communicate their needs to people they love and trust, but to be selective in who they confide in. Talking to someone who does not seem sympathetic, or is prone to say tactless things, can make someone who is depressed feel worse.

Join an interest group

Joining or continuing to attend a group that shares an interest such as a choir, music group, adult education class, local neighbourhood group or sports team can help a person experiencing depression to feel more positive and to regain an interest in activities and pleasures. It can also allow a person to have something interesting and positive to focus on at a time when everything can seem to be negative and the person tends to focus only on their feelings of depression.

Join a support group

If it seems appropriate, you can discuss with patients whether they would be interested in finding a group of people who are also working towards getting better from depression. This does not suit everyone, but can be very effective for some. Being with others in the same situation can go a long way in reducing one's sense of isolation, and group members can encourage each other, give and receive advice on how to cope, and share experiences. The Depression Alliance has information about support groups around the country – see **Further information** on page 44.

Problem solving
Often people's problems can play a key role in generating and maintaining the psychological symptoms they present with. Difficulties such as debts, relationship problems or unemployment can provoke low mood – but then a vicious cycle can develop where the person's anxiety or low mood hinder their dealing with these problems, and they become more discouraged and unconfident about taking action.

The problem-solving technique is a way of working through problems, and trying to set goals which are achievable and can reduce the burden of the problem. It has defined stages which can be worked through over a number of sessions, as given below.

— Formulate a problem list – talk about the things that are causing concern and write them down.

— Clarification and definition of problem – choose one from the list and using probing questions find out more about it.

— Setting achievable goals – talk about how the person would like this problem to change, what is a realistic goal for the future.

— Generating solutions – brainstorm as many possible ways of achieving this goal as possible.

— Choosing and implementing preferred solution – look at all the possible solutions and choose the one that seems to be most appropriate. Break it down into stages to make it seem manageable.

Some of the nurses and patients involved in the ProCEED trial found this to be a good way of approaching and working on their problems. It can be applied to any of the psycho-social problems which patients may have and which are not necessarily associated with being anxious or depressed. If you are interested in finding out more there is a useful small book telling you how to do this, *Problem-solving treatment for anxiety and depression: A practical guide*, Oxford University Press, 2005.

"The problem–solving technique is a way of working through problems, and trying to set goals which are achievable and can reduce the burden of the problem."

Moderate and severe depression and anxiety disorders

For moderate and severe depression (and for more severe anxiety disorders), there are two broad approaches to treatment that should be used in addition to helping people address the lifestyle factors as outlined previously: antidepressant medications and formal psychological treatments.

These two approaches appear to be equally effective and there is some evidence that the two together may be more effective than either alone – it may be that taking antidepressants will lift someone's mood sufficiently for them to then be able to make effective use of the psychological therapy offered. Many patients prefer psychological treatments, and dropout rates appear to be lower than for drug treatment.

The patient's past experience, and prior response to treatments, together with their current preferences, and the availability of desired treatments are the key considerations.

You can play a crucial role in helping someone consider and choose the treatment that will be best for them. This section summarises the key points about therapies and medication and there is further useful information available from Mind, see **Further information** on page 44.

"You can play a crucial role in helping someone consider and choose the treatment that will be best for them."

Psychological therapies

There are many different types of psychological therapies, which may be suitable for different people depending on the person's personality and preferences, as well as the nature, severity and duration of their problem.

It is important to gain a sense of the patient's perspective about talking therapies, some helpful areas to explore include:

- Is there a type of treatment that the patient would prefer?
- Would they prefer short or longer term treatment?
- How interested are they in self-exploration?
- Do they see problems as related to life experiences?
- Do they want to address problems 'here and now' or link to their past?
- Are they interested in exploring causes, or alleviating symptoms?
- Are they able to tolerate a degree of emotional distress?
- Are they at risk of turning to alcohol, self-harm or abandoning the treatment if they find it hard to cope?

It can be helpful to think of psychological therapies as ongoing processes – someone might have a 'course' of treatment to deal with a particular crisis or concern, and may come back for further treatment at a later point. One course is not usually going to 'cure' a person's problems, nor is it usually intended to. It can, however, help people to think about their symptoms and their lives, and it can teach them skills or enable them to tackle or manage some of their own problems. It is likely to reduce the risk of further episodes of depression, or to help people to deal with these better if they occur.

We have described a selection of the most commonly used therapies, but this list is not totally comprehensive and you may have heard of others.

Behavioural activation

This therapy aims to identify the effects of behaviour on current symptoms, mood and problem areas. It seeks to reduce symptoms and problematic behaviours through behavioural tasks related to reducing avoidance, activity scheduling, and enhancing positively reinforced behaviours. The intervention usually consists of 12 to 20 sessions over three to four months.

Cognitive-analytic therapy (CAT)

CAT was developed by Dr Anthony Ryle, who had previously worked as a GP. This brief therapy was developed in the context of the UK NHS, with the aim of providing effective and affordable psychological treatment, but is not available in all areas of the UK. The model gives emphasis on collaborative work with the client and focuses on the understanding of the patterns of maladaptive behaviours. The aim of the therapy is to enable the person to recognise these patterns and understand their origins and to learn alternative strategies in order to cope better. It has features of both cognitive behavioural and psychoanalytic therapies.

Cognitive behavioural therapy (CBT)

CBT is a talking treatment which helps people to recognise problems and overcome emotional difficulties. It is based on the premise that emotional difficulties can arise from self-destructive ways of feeling, thinking and behaving. This may mean that people misinterpret situations or symptoms in a negative manner (also termed negative assumptions). This can lower the person's mood and in turn lead to further negative thoughts and a worsening of the situation.

The therapist helps clients to identify connections between their thoughts, how their thoughts affect them and how they may then behave. CBT aims to help people change some of the ways in which they think, feel and behave, in areas of their lives where there are significant difficulties. It aims to help people to develop practical skills which can then help them to lead a more positive and constructive way of life, which should in turn improve their mood. It may not always address the underlying causes behind a problem, but it may be useful in helping people to develop practical skills to help manage their symptoms. Duration of treatment varies depending on the disorder and its severity but for people with depression it should be in the range of 16 to 20 sessions over three or four months; for people with GAD it should usually consist of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting one hour.

Do it yourself CBT

There is a wide range of books and leaflets on self-help for depression (see **Further information** on page 44 for some examples). A further recent development is using interactive CD-Rom programmes on the computer, which can be accessed via the GP or other service-providers. Some of these are very high quality and people may prefer them to seeing a therapist, particularly as a first step. See **Further information** on page 44 for more details. They may become more freely available for self-help use in the near future, as the Government is putting funds into such schemes. However, computerised CBT programmes are not suitable for someone with severe symptoms and it is recommended that people are assessed before using one of these programmes.

Counselling

Counselling involves talking with someone who is trained to listen with empathy and acceptance, allowing people to express their thoughts and feelings without feeling judged or criticised. It is one of the most common types of talking therapy available and is generally well accepted by most people. It has been shown to be an effective treatment for mild to moderate depression. Depending on the setting, it can vary from a short-term (six to 12 sessions) to a more medium-term treatment. As the number of sessions provided on the NHS is usually limited, in this context it is usually indicated for more acute difficulties, or when someone only wants to try a fairly short course of a 'talking treatment'.

Counselling can be used to help with adjustment to life events, such as divorce or retirement, or can create an opportunity to think about ongoing life difficulties with a view to trying to solve them. If time-limited in nature it is likely to be most useful for more acute problems, such as when there is an indication that a person's depression is of fairly recent onset (or has recently worsened) in relation to some external circumstance. Short-term counselling may not be particularly suitable for more severe depression, or addressing problems which may be associated with long-term difficulties going back to childhood. However, it may help people in these positions begin to think about their situation and seek further help if they have found a course of counselling to be helpful.

Group therapy

Group therapy helps people to deal with interpersonal problems and develop self-awareness. There are generally eight to 12 people in the group, who meet together regularly with a therapist, and talk about their concerns.

Interpersonal therapy (IPT)

The person works with the therapist to identify the effects of problematic areas related to interpersonal conflicts, role transitions, grief and loss, and social skills, and their effects on current symptoms, feelings states and problems. They seek to reduce symptoms by learning to cope with or resolve such problems or conflicts. The intervention usually consists of 16 to 20 sessions over three or four months.

Mindfulness-based cognitive therapy

A group-based skills training programme using techniques drawn from meditation and cognitive therapy designed specifically to prevent depressive relapse or recurrence of depression. Its aim is to enable people to learn to become more aware of bodily sensations, and thoughts and feelings associated with depressive relapse. The intervention usually consists of eight weekly two hour sessions and four follow-up sessions in the 12 months after the end of treatment.

Psychodynamic psychotherapy/psychoanalysis

This is what many people might initially think of when they consider psychological therapies. This technique helps people to look at their past experiences and to think about how these may be affecting their current situation and ability to make choices. This method is probably the most useful when someone's problems or depression seem to be caused by difficulties going back to their childhood, their way of looking at things, or the way they relate to others. It can be helpful when problems are long standing. The process requires a high level of interest in self-exploration and an understanding that painful or difficult past experiences may be returned to and talked about. This means that it can be suitable for people who want to 'get to the bottom' of their difficulties and are able to tolerate a certain amount of emotional pain. It is usual for the patient to develop a strong relationship with the therapist and this is one of the ways the therapist works with the patient. As such this process typically takes longer than other kinds of psychological therapies, usually lasting at least six months and often longer.

Relationship counselling and family therapy

This is for couples who want to sort out problems in their relationship. They attend sessions together and the counsellor helps them to express their difficulties, listen to each other, to increase their understanding of each other and find ways of making their relationship work better, or possibly to decide that it is time to separate. If they decide to end the relationship they will hopefully have gained more understanding of why it was not working and what lessons they can learn for the future. Family therapy works in a similar way, with all family members encouraged to attend the sessions.

Accessing talking therapies

The availability of these talking therapies varies enormously and it is worth spending a little time trying to establish what the situation is for you locally. The Improving Access to Psychological Therapies (IAPT) programme supports practices in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people experiencing depression and anxiety disorders.

Many doctors' surgeries have counsellors or psychologists working within the surgery and there are also outside services that people can be referred on to. Despite the implementation of IAPT there are still often long waiting lists, particularly in the NHS, but also sometimes in the voluntary sector. Some organisations will see people fairly quickly for an initial assessment appointment to see if they are suitable for the therapy offered, and then put them on a further (possibly quite a lot longer) waiting list for treatment if accepted.

What is available varies a great deal from place to place and, unfortunately, there is not always something suitable on offer. What services do exist may not be well publicised and it is worth asking about them in as many places as possible.

The cost of private counselling or psychotherapy can vary a great deal. A fee of £50 to £70 per session is quite common but therapy in a group may be cheaper. Sometimes people can pay less if they are on a low income or if they are prepared to see a student.

See **Further information** on page 44 for useful organisations to contact for access to talking therapies.

Antidepressants

Antidepressants are drugs which work by increasing the activity and levels of certain chemicals called neurotransmitters in the brain.

The most common antidepressants work on the neurotransmitters serotonin and noradrenaline. If effective this medication can help to lift a person's mood and can also often be helpful for anxiety symptoms. Sometimes it can improve a person's symptoms, so that they then feel better able to take action to deal with their depression and its effect on their life. This may mean that they are then in a position to make good use of a psychological therapy.

There are several different types of antidepressant, including:

- Selective serotonin reuptake inhibitors (SSRIs)
- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MAOIs)
- Mixed or third generation antidepressants – working on more than one neurotransmitter.

See table on page 37 for further details.

Indications for antidepressants

According to NICE guidelines antidepressants are not recommended for use in mild depression. However, where mild depression does not respond to other treatments or a person presents with mild depression but has a past history of more severe illness, then antidepressants may be considered. Antidepressants may also be appropriate for persistent 'sub-threshold' depression which is termed dysthymia – involving persistent symptoms that only meet a mild depression level, but continue over a couple of years.

Antidepressant treatment should be considered and offered to patients with moderate and severe depression. The trials show a moderate, but by no means universal effectiveness of antidepressants (50 to 60 per cent improvement for antidepressant treatment compared to 30 to 40 per cent for placebo treatment). Use of medication and choice of medication should be tailored to the individual patient; based on patient choice, known side effect profiles, previous response to antidepressants, co-morbidity and cost.

Many patients do not take the antidepressants they have been prescribed or take them intermittently. This may be because of side-effects, worry about becoming addicted, or because they interpret initial improvement as indicating they no longer need them. The role of the nurse in monitoring the use of antidepressants if the patient has decided to try them is therefore very important. There is evidence that people will be more likely to use antidepressants if they are given clear information about how these medications are believed to work and support in taking the medication. Giving an education leaflet is also potentially beneficial – Mind and other organisations produce patient focused information about antidepressants, see **Further information** on page 44**.**

Advice for patients taking antidepressants

— It often takes two to four weeks before such drugs take effect.

— The common side-effects are often experienced initially but fade in seven to ten days.

— Antidepressants need to be taken regularly, even when patients feel better.

— Antidepressants are not addictive but should not be stopped suddenly.

— Patients should consult you or the GP before stopping taking the medication. All antidepressants should be withdrawn slowly. The length of time for withdrawal depends on how long the drugs have been taken for.

— If the patient shows a poor response to antidepressants after four to six weeks, check adherence and consider switching to another type of antidepressant.

— Patients should be maintained on the same therapeutic dose for four to six months after their symptoms have resolved.

— For patients with three or more episodes in the last five years, or a total of five or more episodes ever, maintenance drug treatment for several years or even indefinitely should be considered, if medication is found helpful.

— If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side-effects.

— Monitoring suicide risk is essential. Tricyclics and MAOIS are contra-indicated in people who are a high suicide risk, unless closely supervised by their GP or a psychiatrist. SSRIs are less dangerous in overdose, but there is a small increased risk of suicidal thoughts/behaviours in some people when first starting on SSRIs or with changes in dose.

Common questions and comments about antidepressants'

This section is designed to help you answer questions that patient commonly ask about taking antidepressants:

"I haven't been taking the medication, as I'm not sure about it."

Quite a few people who are prescribed antidepressant medication do not take it. This may be because they are concerned that it may be addictive, or that they will have bad side-effects. Discuss the way that the medication works and the side-effects with the patient and direct them to further sources of information (see **Further information** on page 44) if they feel this way. Suggest that if their depression is quite severe, it is usually a good idea to try taking medication to treat it, and that if one type of antidepressant doesn't suit them, another might.

"I haven't been taking the medication regularly – is this a problem?"

Many people do not take their medication regularly, either because their memory is unreliable (this can be a symptom of the depression) or because they only take their antidepressants on 'bad days', thinking it will help them to feel better at that time, and that they will avoid a risk of getting dependent or addicted to them if they don't take them regularly. Unfortunately, this is not a good idea and can mean that the medication doesn't then work effectively. As most antidepressants work by adjusting the brain chemistry over a period of weeks, they won't work on a daily basis. Also, taking medication on and off can cause withdrawal symptoms, which can usually be reduced or avoided by a careful gradual withdrawal at the end of treatment.

"I don't like the side-effects. Nobody told me I'd feel like this."

Some people stop taking antidepressants because they dislike the side-effects. Tricyclic and SSRI medications may have side-effects which are noticeable in the first few weeks but they tend to pass after this. It also takes a few weeks for the antidepressant effect to begin, so there may be a time at the beginning when people may be experiencing the side-effects but getting little noticeable benefit on mood or other symptoms. If the side-effects don't pass and are not tolerable they should see the doctor again.

Patients should always be fully informed most likely side-effects of a drug, all medications are supplied with a leaflet indicating all the side-effects (see the chart on page 44). There are many possible side-effects listed but most people will not suffer many, if any, of them.

Patients can report any side-effects they experience at www.yellowcard.gov.uk, a national scheme to help monitor the safety of the medication.

"I feel better – can I stop taking my medication?"

Many people tend to stop taking prescribed medication before the recommended time period because they feel better. However, if they do this there is about a 50 per cent chance of the return of the depression and it is usually recommended that people stay on the medication for four to six months after feeling fully better to avoid this risk of a recurrence. In addition, some antidepressants have unpleasant side-effects on withdrawal, which can be reduced by a regime of coming off the medication slowly with support.

"I have a history of many episodes of depression – how long should I stay on antidepressants?"

For some people who have experienced a number of episodes or continuous depression, it may be recommended that they remain taking antidepressant medication indefinitely if it helps to manage their symptoms, or as a preventative measure to stop future recurrences. Some people ask to do this themselves if they have had previous recurrences of their depression when stopping their antidepressants. However, it is always worth at least one trial without medication once the symptoms of depression have subsided, to see what is likely to happen and whether they can remain well off medication.

"I'm taking my medication but I don't feel any better."

Not all people with depression respond to antidepressants. The current guidelines suggest that if someone doesn't seem to be getting any better on an antidepressant within six weeks, the medication should be reviewed and probably changed. Other treatments, such as psychological therapy and appropriate lifestyle interventions should also be reviewed at this point, and it would be appropriate to have an appointment with the GP to discuss this. If three different types of medication have been prescribed and they are not helping a severe depression, the case should be discussed with a mental health specialist.

Treatment Timescale
There is a definite timescale associated with antidepressant medication and it can be very helpful for both you and the patient to know what to expect when.

Up to two weeks	First follow-up appointment to check that the patient is OK, is taking the medication as prescribed and dealing with any side-effects.
Two to four weeks	Between two and four weeks they should be noticing improvements to their symptoms. Side-effects should be lessening.
Around six weeks	Second follow-up appointment to check adherence and effectiveness of treatment. If it is not being effective, a new treatment should be considered.
Up to six months	During this time the depression should have lifted and they should be able to function better than when they were depressed.
After properly well	It is usually advisable to keep taking antidepressant medication for at least four to six months after feeling well again and to discuss how best to come off the medication with the nurse or doctor.

Which antidepressant to suggest
The recommending and prescribing of antidepressants is likely to be carried out by the GP, but it can be helpful to have an idea of how the different types of antidepressants work in order to be better able to discuss them with patients.

SSRIs (serotonin selective reuptake inhibitors)
Prozac (fluoxetine), Seroxat (paroxetine), citalopram, sertraline

These are the most commonly prescribed antidepressants in general practice nowadays and are considered the first line treatment by NICE. Most are taken as one tablet daily and do not need to have the dose titrated (increased over time as needed) which can increase the likelihood of people continuing to take this medication. They generally have less severe side-effects than the other groups, but nausea/indigestion and agitation can be a problem for some people, and can lead to withdrawal problems although these usually wear off with time.

TCAs (Tricyclic antidepressants)
Amitriptyline, lofepramine, clomipramine, dosulepin

These are an older group of drugs, which used to be the most commonly prescribed for depression, but have now been largely supplanted by SSRIs, certainly for first line treatment. They are more complicated to take, in that the patient has to start on a low dose and then titrate upwards to reach what is generally considered a therapeutic level. Their side-effects tend to be more pronounced than with SSRIs – notably anti-cholinergic side-effects such as a dry mouth, constipation and postural hypotension. These side-effects usually decrease over the first couple of weeks of taking the tablets. Nausea can be helped by taking the medication with food.

They can be fatal in overdose and therefore pose a definite risk in suicidal patients. They may however be indicated as a second-line treatment for patients where a first line SSRI has been ineffective. Amitriptyline in particular can be helpful for severe agitated depression and is also sometimes used in lower doses for the management of chronic pain.

MAOIs (Monoamine Oxidase Inhibitors)
Phenelzine, moclobemide, trancylcypromine

These are only ever prescribed as a second or third line medication because MAOIs can affect the way certain foods are digested, causing them to become poisonous. People taking these medications have to avoid matured cheeses, game, protein extracts, alcohol and overripe fruits but this is less of a problem with a newer MAOI, moclobemide, which is sometimes prescribed for people where other antidepressants have proved ineffective.

Others/mixed
Venlafaxine, mirtazapine
(usually second or third line drugs)

These are thought to work on a combination of receptors in the brain, and so can have side-effects commonly associated with either SSRIs or tricyclic antidepressants. They are usually only prescribed as a second or third line treatment, but can sometimes be very effective. Mirtazapine can be quite sedating – which may be a desired effect: it can assist sleep if taken in the evening.

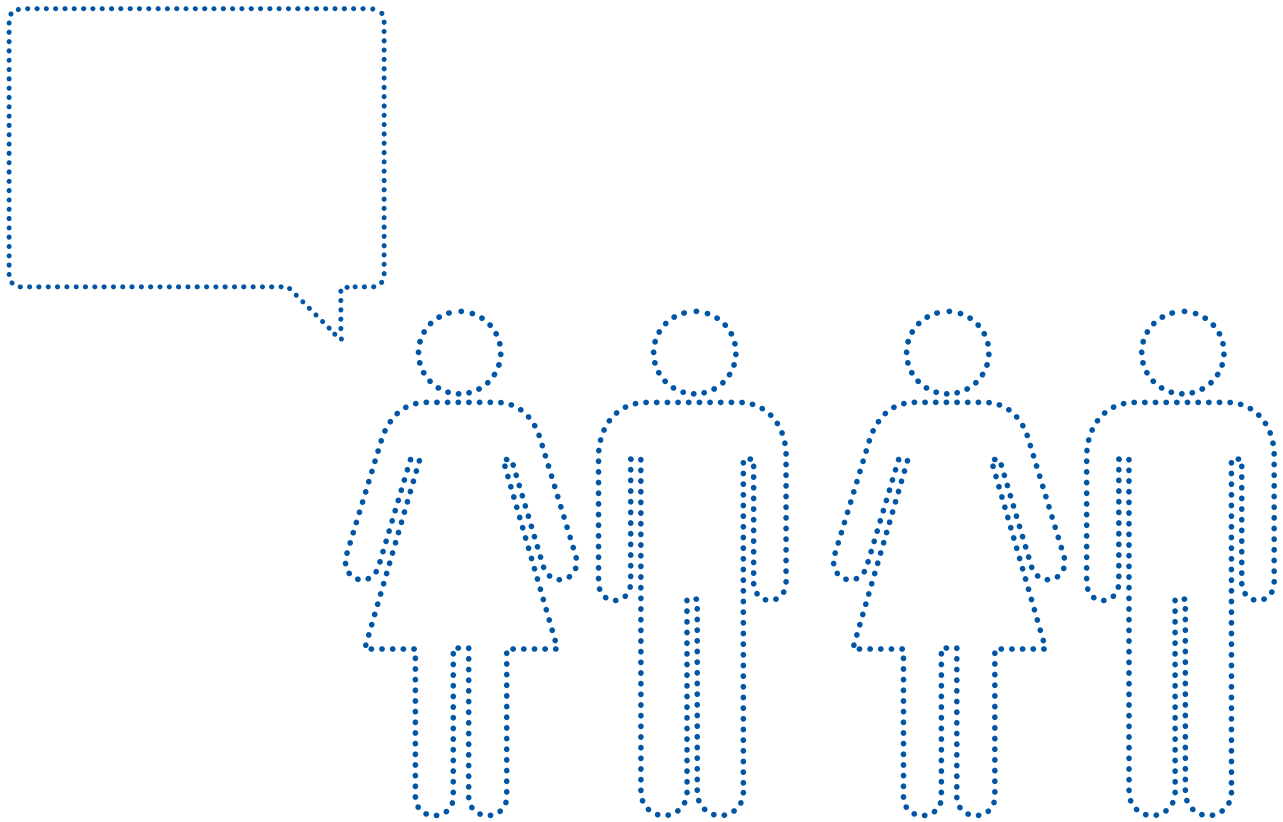
It can be difficult to predict which anti-depressant is likely to be more suitable for a particular patient, although within each group there are some which are usually more likely to be more alerting and some which are more sedating. Patients may however be very individual in their responses, and it is important to take their perspective on the treatment seriously.

If one antidepressant in a particular group has been ineffective this does not necessarily indicate that other drugs in this class will not help – there is considerable individual variation in response, and it is often worth considering more than a single SSRI before trying a move to a different group of antidepressants.

Antidepressants and their possible side-effects

Name and type of medication	Possible side-effects
SSRIs (serotonin selective reuptake inhibitors) *Prozac (fluoxetine), Seroxat, (paroxetine) citalopram, sertraline*	Decreased appetite/indigestion, nausea/vomiting, anxiety/agitation, insomnia or sleepiness, headache, dry mouth, sexual dysfunction, tremor, dizziness. Sexual dysfunction can continue after stopping the drug.
Tricyclics *Amitriptyline, lofepramine, clomipramine, dosulepin*	Drowsiness, blurred vision, constipation, dry mouth, difficulty urinating, eye sensitivity to light, nausea, weight gain, dizziness when standing up, impaired thinking.
MAOIs *Phenelzine, moclobemide, trancylcypromine*	Low blood pressure on standing, dizziness, drowsiness, insomnia, headache, weakness and tiredness, dry mouth. MAOIs can affect the way certain foods are digested, causing them to become poisonous. Avoid matured cheeses, game, protein extracts, alcohol, overripe fruits.
Others *Venlafaxine, mirtazapine (usually second or third line drugs)*	These are thought to work on a combination of receptors in the brain, and so can have side-effects commonly associated with either SSRIs or tricyclic antidepressants.

Section 7
Health care professionals



Working as a team and who to ask for help

Depression and anxiety are common, and using the techniques outlined in this guide can help you to develop the confidence and skills to support patients. However, there will be times where you need support for yourself, or where you feel the patient needs to be referred for more specialist help.

Mental health professionals work in a range of different roles, and it can be difficult to know who the most appropriate person to go to is. This section gives an overview of the key people involved in mental health care.

Advocate
An advocate is someone who represents their own or someone else's interest and speaks on their behalf. There are many forms of advocacy in mental health including advocates for people who have been admitted to hospital under the Mental Health Act, legal advocates and peer advocates.

Approved mental health professional (AMHP)
These are professionals who have had additional training to be able to carry out certain functions of the Mental Health Act, such as assessing people who are unwell and might need to be detained under section. In practice these are often social workers but nurses, occupational therapists, psychologists and other professionals can also perform this role.

Carer
A person who supports someone who has mental health problems is referred to as a carer, although many carers would not use this term to describe themselves. Carers may or may not be related to the person they are caring for. Carers may be adults or children, working or unemployed. They may be providing help and support to their parent, partner, son or daughter, neighbour or friend.

Care coordinator
A care coordinator is a named individual who is designated as the main point of contact and support for a person who has a need for ongoing care from secondary care mental health services. The Government's 'care programme approach' for specialist psychiatric services advises that health and social services should designate a person to keep in close contact with a 'patient' in the community and to monitor their care.

Care manager
A care manager is responsible for assessing a person's social care needs and for arranging delivery of community care services within available resources.

Care managers work within social services departments and organise community care for many different client groups. When arranging services for people with mental health problems, they often work as part of a community mental health team. Their role is to carry out the local authority's duties under the NHS and Community Care Act (1990). This is called 'care management'.

Community mental health nurse (CMHN)
A CMHN, also known as a community psychiatric nurse (CPN), is a registered nurse with specialist training who works in the community. Some are attached to general practice surgeries or community mental health centres, others to mental health units. Most work as part of a community mental health team. The role of a CMHN can be wide and may include:

— Counselling or anxiety management, or exploring different coping strategies with people with acute short-term difficulties.

— Working with people who have had severe mental health problems for many years and require long-term support to enable them to establish a rewarding life in the community.

— Administering psychiatric drugs; for example, as injections.

Clinical psychologist
Clinical psychology involves the assessment and treatment of mental health problems using evidence based psychological therapies. Clinical psychologists are not medical doctors and work in a range of health and social care settings, to help individuals manage and alleviate their mental distress. The Government's IAPT initiative (Increasing Access to Psychological Therapies) has led to a significant increase in the number of clinical psychologists available to deliver psychological therapies to patients in community or primary care settings.

Community mental health team
This is a team of professionals from both health and social care services who work together to provide a coordinated service for people with severe and enduring mental health problems. These patients most often have 'psychotic' disorders such as schizophrenia or bipolar disorder, but people with severe and enduring depression and anxiety may sometimes be under their care. The team will usually include one or two psychiatrists, community mental health nurses, a psychologist, occupational therapist and social worker.

Crisis team
This is a team of mental health professionals who may be contacted if someone is acutely unwell, of a severity which would usually merit a hospital admission, but where it may be appropriate to look after them in the community. This is achieved by the crisis team visiting them at home regularly, daily or more frequently, to review how they are and to support them in taking their medication if needed.

Graduate mental health worker
Graduate mental health workers work in primary care settings, such as general practices or health centres. Their function is to improve the capacity of primary care to manage common mental health problems. The duties of graduate mental health workers vary between health trusts but may include:

— Delivering talking therapies such as cognitive behaviour therapy (CBT).

— Promoting good mental health in the community.

— Providing information and referral to other services, including voluntary sector services.

General practitioner (GP)
A GP is the first point of contact with the NHS for most people. Many mental health problems are dealt with by GPs by themselves or in conjunction with other professionals working within the practice such as a counsellor or graduate mental health worker. If more specialised treatment is needed, the GP can make a referral to secondary mental health services such as a community mental health team or acute mental health crisis service.

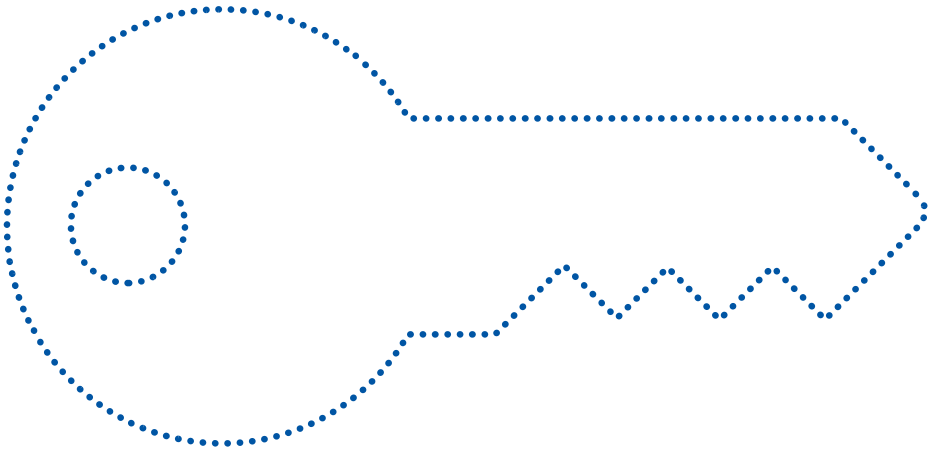
Occupational therapist
Occupational therapists work in mental health units, day hospitals and the community. They may be employed by a health authority, social services department or voluntary organisation. Their role is to help people with mental health problems to build up the confidence and skills needed for personal, social, domestic, leisure and work activities. They focus on the learning of specific skills and techniques, including arts, crafts, drama, dance, writing, group work (such as anxiety management and assertion training), individual counselling and training activities in daily living.

Psychiatrist
Psychiatrists are qualified medical doctors who have specialised and taken further training in 'mental illnesses'. In some areas, psychiatrists have close links with GP surgeries; others work in community mental health centres or multidisciplinary teams.

Social worker
Social workers are involved in mental health in a number of ways and work in a variety of settings. Local authority social services are tending to move away from generalist social workers towards specialist teams, including specific mental health social service teams. However, there are no clear guidelines about the level of social services that people are entitled to expect and there is wide variation between geographical areas in terms of the services provided.

Social workers should be able to offer advice on practical matters such as day care, accommodation and welfare benefits, or can link you with appropriate services. Some may offer counselling.

Section 8
Key messages



Key messages for patients

As a practice nurse you can make a huge difference to the care, treatment and recovery of people with depression and anxiety.

Know about treatment
Make sure people are clear about the treatments they have been given, how they work, what side-effects there might be, and how they will hopefully help. If patients don't know the answers to these points, then encourage them to ask the relevant health professionals and try to become an expert in their own care.

Have realistic expectations
People experiencing depression and anxiety are unwell. They shouldn't expect to be able to achieve all the things they can do in their lives normally. Not being able to do everything as normal isn't a failure.

Getting better
The large majority of people who experience depression will get better, even if they don't believe it at this time. This is a crucial message and one that is often referred to by patients after they have recovered – the importance of those caring for them emphasising that they would get better. Hope aids recovery.

General wellbeing – looking after themselves
People who are feeling depressed and anxious should try to eat healthily and regularly, get regular sleep, and maintain something of a normal routine. They should see their GP if they are physically ill or not able to eat properly.

Decisions
It is not a good idea to make any major life changes when feeling depressed, because negative emotions might unfairly influence decisions. However, making some decisions can help recovery by allowing people to feel in control, and it is very important to involve patients in decisions about their treatment.

Confiding in people
Friends and loved ones are very important, and confiding in them can help people to feel understood and cared for. However, confiding in some people may be problematic if they respond in a critical or unkind way. It is therefore important to identify friends who can be trusted.

Support groups
If people are feeling very socially isolated, consider interest or support groups or activities like volunteering. There may be specific support available for people with mental health problems to volunteer in your local area.

Physical activity
Physical activity has been shown to be an effective antidepressant. If people can take exercise outside in nature it is very likely to boost mood.

Contact with other voluntary and statutory agencies
Voluntary and statutory agencies can provide further support, and can help with bigger issues, such as Relate for relationship difficulties or the Citizens Advice Bureau for financial difficulties.

Feeling worse
If patients start to feel worse, they should get in touch with you or with their doctor, or give permission for a friend to do this. Ignoring symptoms can cause more problems in the future and can slow recovery.

Key messages for you as a practice nurse

A range of social, demographic and health related factors can help inform initial risk prediction for depression and anxiety (such as gender, socio-economic indicators, past history, medical problems).

Where you suspect a problem, use brief screening instruments such as the 'Whooley' screen for depression and the GAD-2 for anxiety.

For individuals who screen positive, follow-up questioning using more detailed instruments such as the PHQ-9 or the GAD-7 may help to grade the severity of the problem and may be useful for monitoring the effects of treatment.

A past history of a common mental disorder is an important predictor of current problems, as is asking the patient what interventions or treatments may have helped in the past.

You can make a big difference as a practice nurse in advising patients about some of the life-style issues which may be impacting on their depression and anxiety, such as diet, exercise and physical health issues. Signposting people to appropriate voluntary sector services, such as the Citizens Advice Bureau for financial or housing queries can be very helpful. See **Further information** for other resources on page 44.

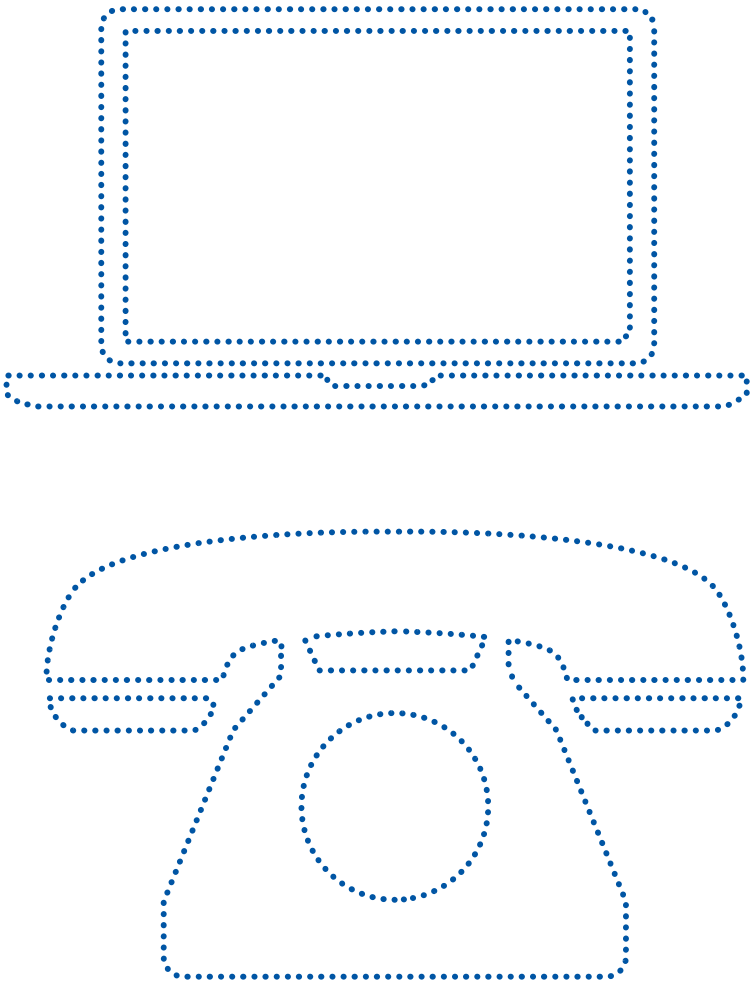
If someone appears moderately or severely depressed the assessment and management of suicide risk is paramount (see page 21).

Management and treatment is based on a shared problem assessment and a care plan that accounts for the patient's preferences. There are a several different treatments for depression and anxiety that seem of equivalent effectiveness. People's past response to treatments is an important guide to what may work again.

If you are interested in developing more skills or working in more detail with patients with depression we recommend you access some of the resources listed in **Further information** on page 44, such as the LMC practice nurse toolkit and RCGP courses which are open to practice nurses to join.

"You can make a big difference as a practice nurse in advising patients about some of the life-style issues which may be impacting on their anxiety or depression, such as diet, exercise and physical health issues."

Section 9
Further information



This list of organisations and resources is provided to help you to begin to find out more about treatments and services and to explore what support is available in your area.

Alcoholics Anonymous
www.alcoholics-anonymous.org.uk
Helpline: 0845 769 7555
AA is a society of people recovering from alcohol abuse.

Anxiety UK
(formerly the National Phobics Society)
www.anxietyuk.org.uk
T: 0844 477 5774
Information, counselling, helpline and online support for those suffering from anxiety disorders.

British Association for Behavioural and Cognitive Psychotherapies (BABCP)
www.babcp.com
T: 0161 705 4304
Can provide details of accredited therapists.

British Association for Counselling and Psychotherapy (BACP)
www.bacp.co.uk
T: 01455 883 316
For details of local practitioners.

British Psychoanalytic Council (BCP)
www.bcp.org.uk
BCP is a linking body of psychoanalytical psychotherapist societies. Website includes guidance on finding the right therapist.

Carers UK
www.carersuk.org
Helpline: 0808 808 7777
Information and advice on all aspects of caring, including for those with mental health problems.

Citizens' Advice
www.citizensadvice.org.uk
The Citizens Advice service helps people resolve their legal, money and other problems by providing free information and advice.

Complementary and Natural Healthcare Council
www.cnhc.org.uk
T: 020 3178 2199
Lists officially registered complementary healthcare practitioners.

Cruse Bereavement Care
www.crusebereavementcare.org.uk
Helpline: 0844 477 9400
Cruse provides information and support to bereaved people.

Depression Alliance
www.depressionalliance.org
T: 0845 123 2320
Information and support groups for people affected by depression.

Depression UK
www.depressionanon.co.uk
E: info@depressionuk.org

Londonwide Local Medical Communities
www.generalpracticenurse.org.uk
General Practice Nurse Toolkit provides a basic unit on mental health – online and face-to-face training available.

Mind
www.mind.org.uk
Mind infoline: 0300 123 3393
E: info@mind.org.uk

- **Information**: Mind has a wide range of patient information materials, covering diagnosis, treatment and wellbeing topics, available online www.mind.org.uk or information can be provided via the Mind infoline.
- **Local organisations**: Mind also has network of over 180 local organisations offering self-help groups, supported housing, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending. (Details available through Mind infoline.)
- **Ecominds**: 130 projects across England and Wales designed to provide a range of outdoor activities for people with mental health problems. Find out more at www.mind.org.uk/ecominds

NHS Livewell
www.nhs.uk/livewell/
Website with tips for healthy living including relaxation techniques, exercise programmes and people talking about their experiences.

NICE (National Institute for Clinical Excellence)
Clinical guidelines on the management of common mental disorders are available from NICE. These are free to access, and full guidelines as well as summary documents are available on the web.

— Common mental health disorders
www.nice.org.uk/guidance/CG123

— Depression with chronic physical health problems
www.nice.org.uk/guidance/CG91

— Depression in adults (update)
www.nice.org.uk/guidance/CG90

— Anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care
http://guidance.nice.org.uk/CG113

No Panic
www.nopanic.org.uk
T: 0808 808 0545
For people experiencing anxiety disorders, such as phobias.

ProCEED
This pack was developed following a three year research study called ProCEED (Proactive care and its evaluation for enduring depression). Further details about the ProCEED trial are available online.

— The final report from the ProCEED trial is available at www.mind.org.uk/proceed

— The protocol paper for the ProCEED trial is available at http://www.biomedcentral.com/content/pdf/1471-244x-10-61.pdf
(Buszewicz M, Griffin M, McMahon E, Beecham J, King M, *'Randomised controlled trial of structured, proactive nurse-led care for chronic depression in primary care: the ProCEED trial'*, BMC Psychiatry 2010, 10:61)

Relate
www.relate.org.uk
Relate offers relationship advice, support and therapy face-to-face, by phone and via their website.

Royal College of GPs
www.rcgp.org.uk
T: 020 3188 7400
Open to Practice nurses to join and offers training both face-to-face and e-learning.

Royal College of Nursing
Royal College Nursing represents nurses and nursing, promotes excellence in practice and shapes health policies. Mental health resources and support are available through:

— RCN Learning Zone which has a number of online mental health resources
http://www.rcn.org.uk/development/learning/learningzone

— RCN Mental Health Forum
http://www.rcn.org.uk/development/communities/rcn_forum_communities/mental_health

— The RCN also publishes a mental health nursing journal 10 times each year.

Royal College of Psychiatrists
www.rcpsych.ac.uk/mentalhealthinfoforall.aspx
The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the United Kingdom. Their website has a wide range of mental health information.

Samaritans
www.samaritans.org.uk
T: 08457 90 90 90
E: jo@samaritans.org
Confidential emotional support 24 hours a day.

Time to Change
www.time-to-change.org.uk
Time to Change is England's biggest ever attempt to end the stigma and discrimination that faces people with mental health problems. It is a campaign to change attitudes, and behaviour too.

TimeBank
www.timebank.org.uk
Timebank gives information about volunteering opportunities.

Weightwatchers
www.weightwatchers.co.uk

Self-help books for depression

'The feeling good handbook' by David D. Burns, Plume publishers, 1999

'Overcoming depression: A step by step approach to gaining control over depression' by Paul Gilbert, Oxford University Press, 2000

'Overcoming depression: A five areas approach' by Dr. Christopher Williams, Oxford University Press, 2001

'Depression: the way out of your prison' by Dorothy Rowe, Brunner-Routledge

Online cognitive behavioural therapy and skills training

Beating the Blues
www.ultrasis.com/products/product.jsp?product_id=1
Beating the Blues is a computerised CBT programme for depression and anxiety which must be purchased for use at your practice, although some PCTs are making it available in more centralized venues such as local libraries. In February 2006 NICE recommended Beating the Blues as a treatment option for all patients seen with mild or moderate depression. The self-help treatment programme involves eight sessions which patients complete.

Down your Drink
www.downyourdrink.org.uk

Fear Fighter
www.fearfighter.com
Fear Fighter is a computerised CBT programme for anxiety and panic disorders, phobias, obsessive compulsive disorder, depression and sleep disorders. Free access can only be prescribed by a GP, who can then give log-in details to the patient.

Mood Gym
www.moodgym.anu.edu.au
Mood Gym is a free interactive self-help programme for people with depression, which is available on the internet. It is based on the principles of CBT and Interpersonal Therapy and is designed to be used by people whose problems are troubling but not incapacitating. The site includes information, games, quizzes and skills training.

Living Life to the Full
www.livinglifetothefull.org
Living Life to the Full is a free on-line life skills course for people feeling distressed, and their carers, which is based on a CBT approach. The computerised programme helps the user to understand why they feel as they do and make changes in thinking, activities, sleep and relationships.

Ultrasis
www.ultrasis.com
Ultrasis produce interactive, computer based CBT programmes.

Appendix 1:

PHQ-9 Assessment for depression

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Over the **last two weeks**, how often have you been bothered by any of the following problems?

1.	**Little interest or pleasure in doing things**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
2.	**Feeling down, depressed or hopeless**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
3.	**Trouble falling or staying asleep, or sleeping too much**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
4	**Feeling tired or having little energy**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
5.	**Poor appetite or overeating**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
6.	**Feeling bad about yourself, or that you are a failure, or have let yourself or your family down**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
7.	**Trouble concentrating on things, such as reading the newspaper or watching television**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
8.	**Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
9.	**Thoughts that you would be better off dead, or of hurting yourself in some way**	0	Not at all
		1	Several days
		2	More than half the days
		3	Nearly every day
	Sum Questions 1-9		Total Score (0-27)

Appendix 2:

GAD-7 assessment for anxiety disorder

The first two questions form the GAD-2

	Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Feeling nervous, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

GAD-7 Anxiety

Column totals: ___ + ___ + ___ + ___

= Total Score _____

Simply reading out these questions or asking a patient to complete the GAD-7 will not provide an effective assessment. It will feel cold and clinical and might damage your relationship with the patient.

You can use the techniques outlined to help assess for depression, such as open-ended questions, and welcoming body language to help the patient feel at ease and talk with you openly.

For more information
about this guide, contact:

Beth Murphy
T: 020 8215 2282
E: b.murphy@mind.org.uk

Mind
15-19 Broadway
London E15 4BQ
T: 020 8519 2122
F: 020 8522 1725
www.mind.org.uk

Design: red-stone.com