

Guidelines
for the Management of
Depression
and
Anxiety Disorders
in Primary Care



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INTRODUCTION TO GUIDELINES

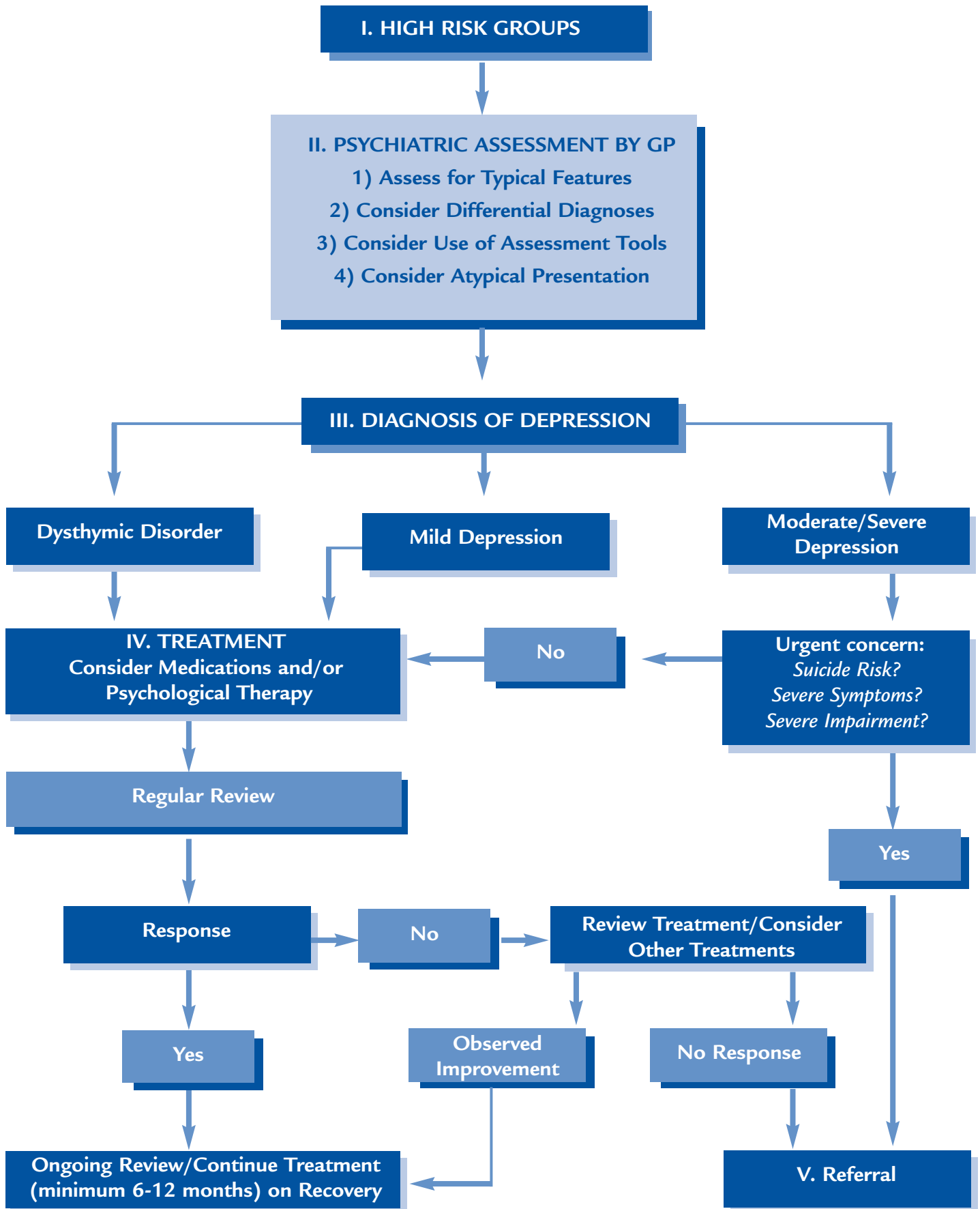
A recent GP survey of Mental Health in Primary Care, conducted in the South Western Health Area Health Board, indicated that depression and anxiety disorders are the two most prevalent mental health conditions in the adult patient population.¹ The majority of these disorders can be treated effectively in primary care. These guidelines provide recommendations based on current evidence for best practice in the management of depression and anxiety disorders. The guidelines include screening, assessment, diagnosis, and management involving primary care. The guidelines are likely to be of interest to general practitioners, pharmacists, psychiatric nurses, psychiatrists, clinical psychologists, users of services, and all other professions caring for people with depression and anxiety disorders.

I would like to thank the Mental Health in Primary Care Steering Committee for their contribution to the development of these guidelines. A special thanks to the Clinical Guidelines Sub-committee consisting of Dr. Denis O' Driscoll, Chief Pharmacist; Dr. Pat Gibbons, Consultant Psychiatrist; Dr. Andree Rochfort, General Practitioner; Dr. Alan O'Donohoe, General Practitioner; and Ms. Deirdre Dunne, Clinical Psychologist for giving generously of their time and expertise.

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Mental Health in Primary Care
The Irish College of General Practitioners

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MANAGEMENT OF DEPRESSION IN PRIMARY CARE



MANAGEMENT OF DEPRESSION

Most people will experience subjective depressed mood at some point in their lives. Depression can be associated with disappointment, grief and many physical illnesses. Depression becomes abnormal when it is severe or persistent and is associated with objective changes in mood or function.

I. HIGH RISK GROUPS

High risk groups include:

- 1) Previous history of depression or family history of depression
- 2) Co-existing physical illnesses, especially if chronic, painful or neurological in nature (note that the elderly are at particular risk of mood disorders)
- 3) Co-existing alcohol or other drug misuse
- 4) Social stressors, especially negative life events involving loss (bereavement, separation, unemployment, difficulties within close interpersonal relationships and lack of social support)
- 5) Postpartum especially in those with past history of psychiatric disorder such as depression and those with mood disorder during pregnancy. Poor social support and operative intervention at birth may also increase risk.

NOTE: Depression may present with recurrent somatic symptoms without an organic symptoms basis.

II. PSYCHIATRIC ASSESSMENT BY GP

- 1) The relative severity of the depression is the most important aspect to assess.
Look for typical features such as:
 - Low / sad mood
 - Loss of interest and pleasure
 - Fatigue / loss of energy
 - Poor concentration
 - Disturbed sleep
 - Change in appetite or weight
 - Agitation / slowing of movement or speech
 - Pessimism / hopelessness about the future
 - Suicidal thoughts or acts
- 2) Consider differential diagnoses and relevant co-morbid conditions such as:
 - Physical illness e.g. anaemia and hypothyroidism
 - Drug side effects (see Appendix 1)
 - Other psychiatric disorders such as manic depression, alcohol dependence and adjustment disorder

Sometimes psychiatric assessment may necessitate discussing the patient's condition with a relative or friend of the patient, i.e. a collateral history, but only with their consent.

3) GPs might consider these two screening questions in assessing depression:

Question (1): In the past month, have you often been bothered by feeling down, depressed and hopeless?

Question (2): In the past month, have you often been bothered by little interest or pleasure in doing things?

One study showed that using the two screening questions is helpful in identifying depression in individuals answering *yes* to both questions.²

GPs might also consider the use of an assessment tool. Some of the most widely used instruments for measuring depression are the Beck Depression Inventory (BDI-II), the Hamilton Depression Rating Scale, the Prime-MD, and the Edinburgh Postnatal Depression Scale.

4) Consider atypical presentation. Keep in mind that the primary presenting complaint may not be of subjective low mood. Depression may instead present with recurrent somatic symptoms with no organic basis or other atypical symptoms e.g. hypersomnia and weight gain.

III. DIAGNOSIS OF DEPRESSION

Five or more of the following symptoms lasting at least two weeks are regarded as fulfilling the criteria for a major depressive episode. Less than five lasting at least two weeks constitutes a minor depressive episode. A milder but more chronic version of the above is called dysthymic disorder.

- 1) Low / depressed mood for most of the day, nearly every day
- 2) Loss of interest/pleasure in all, or almost all, activities for most of the day, nearly every day
- 3) Decreased or increased appetite. Significant weight loss when not dieting; or weight gain
- 4) Insomnia or hypersomnia nearly every day
- 5) Psychomotor (thoughts and actions) retardation or agitation nearly every day
- 6) Feelings of loss of energy nearly every day
- 7) Feelings of worthlessness or excessive/inappropriate guilt nearly every day
- 8) Diminished ability to think or concentrate nearly every day
- 9) Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

NOTE: The above are based on DSM IV criteria.³

IV. TREATMENT

PHARMACOLOGICAL TREATMENT

In moderate to severe depression, antidepressant medication may be deemed necessary while considering psychological interventions. Mild depression may be treated with appropriate psychological therapy alone.

General Considerations about Antidepressants

- Discuss the patient's fears of addiction and inform about risk of discontinuation symptoms (particularly associated with some of the SSRI and SNRI) and potential side effects at the time that treatment is initiated (see Appendix 2).
- Inform the patients about the delay in onset of effect, the time course of treatment and the need to take medication as prescribed. Written information appropriate to the patient's needs should be made available.
- Monitor the patient on a regular basis with regard to side effects and efficacy.
- For patients with a depressive episode, continue antidepressants for at least 6 months following remission. Continuation of antidepressants beyond this will depend on the number of previous episodes, presence of residual symptoms, and concurrent psychosocial difficulties.

Choice of Antidepressants

- For routine care consider an SSRI, because they are as effective as Tricyclic antidepressants and their use is less likely to be discontinued due to side effects.
- Consider generic form of SSRI.
- If increased agitation develops on an SSRI early in treatment provide appropriate information and, if the patient prefers, either change to a different antidepressant or consider a brief period of concomitant treatment with a Benzodiazepine followed by a clinical review within 2 weeks. Clinicians should be aware of the Clinical Guidelines on Benzodiazepines as issued by the Department of Health and Children.⁴
- Medication should only be prescribed with reference to the clinical indications as licensed.⁵

Suicide Risk and Antidepressants

- Caution should be exercised in the prescribing of antidepressants for the treatment of the patient with suicidal ideation in the absence of a depressive disorder.
- If high risk of suicide, consider appropriate quantity of antidepressants prescribed for example by having medications dispensed daily or weekly. Provision of additional support might be needed in the administration of medication such as involving a family member.
- Consider toxicity in overdose; note that SSRIs, Lofepamine, Mirtazapine and Reboxetine, Duloxetine are safer in overdose than other Tricyclics or SNRI.
- Monitor for signs of akathisia and increased anxiety, which can lead to increased dysphoria and occasionally suicidal ideation in the early stages of treatment with an SSRI.

Poor Response

- When a patient fails to respond to the first antidepressant prescribed, check that the drug has been taken regularly and in the prescribed dose for at least four weeks.
- If response to a standard dose of an antidepressant is inadequate, and there are no significant side effects, an increase in dose within BNF dosage limits should be considered.
- If an antidepressant has not been effective and, after consideration of a range of other treatment options, the decision is to offer a further course of antidepressants then switch to another single antidepressant.
- Choice of second antidepressant should take into account patients' symptom profile - choices for a second antidepressant include a different SSRI or Mirtazapine (note propensity to cause sedation and weight gain) but consideration may also be given to other alternatives including Moclobemide, Reboxetine, Tricyclics and SNRI.
- Be aware of the need to have a wash out period for certain antidepressants (see Appendix 3).
- Be aware of the need for gradual and modest incremental increases of dose and of interactions between antidepressants.
- Start on a low dose and, if there is a clear clinical response, maintain on that dose with careful monitoring. Gradually increase dose if there is lack of efficacy and no major side effects.
- Tricyclics should be used with caution due to their side effect profile e.g. cardiotoxicity and potential for misuse.

Augmentation

Treatments such as combined antidepressants, Lithium augmentation of antidepressants, and Phenelzine should not be routinely initiated in primary care. If augmentation is deemed necessary referral to specialist should be considered.

Special Patient Characteristics

Gender

- Note that female patients have a poorer toleration of Imipramine.

Age

- In older adults care should be taken to establish the appropriate drug and dose, and careful monitoring for side effects should be undertaken. In those who have made a partial response, treatment should be continued for a further 6 weeks.
- Consider the increased risk of drug interactions when prescribing an antidepressant to older adults (see Appendix 4).
- Consider the increased risk of side effects associated with Tricyclic antidepressants in older adults.

Patients with Dementia

- Depression in the context of dementia should be treated in the same way as depression in other older adults

Patients with Cardiovascular Disease

- Sertraline is the treatment of choice when initiating treatment in a patient with ischaemic heart disease.
- Consider the increased risks associated with tricyclic antidepressants in patients with cardiovascular disease.
- When considering prescribing a Tricyclic antidepressant for a depressed patient at significant risk of cardiovascular disease, consideration should be given to carrying out ECG(s).

NOTE: The above are based on N.I.C.E. and Maudsley guidelines.^{6,7}

PSYCHOLOGICAL THERAPY

Development of Services and Referral Routes

The provision of psychotherapeutic services at primary care level has typically occurred on an ad hoc basis. Many of these services have been accessed on a private level, either through counsellors/ psychotherapists employed by individual GP practices or through referral to independent private practitioners. The terms counselling and psychotherapy are often used interchangeably as there is overlap between the two. However counselling is more often aimed at addressing specific problems whereas psychotherapy typically aims to address more deep-seated questions and problems.

Primary care access to HSE psychological services has been limited for many years. However, although the Primary Care Strategy does not provide for the inclusion of psychotherapists/ counsellors within either the primary care team or wider primary care network, there is a commitment to the development of psychological services as part of the wider primary care network.⁸ Counselling psychologists rather than clinical psychologists will most likely provide these psychological services.

The Department of Health in the Republic of Ireland does not require statutory registration of psychologists/ psychotherapists/ counsellors, although this will change for psychologists from January 2005. As such, currently there is considerable variation in the training and qualifications of psychological therapists.

There are a number of professional bodies that accredit and hold registers for private psychologists/ psychotherapists and counsellors (see the Irish Council for Psychotherapy 2003 book 'A guide to Psychotherapy in Ireland'). It is recommended that referrals only be made to private practitioners who are accredited by (1) the Psychological Society of Ireland, (2) Irish Association of Humanistic and Integrative Psychotherapy, (3) The Irish Association of Counselling and Psychotherapy and/ or (4) the Family Network of Ireland.

General Guidelines for Referrals

Patients presenting with mild to moderate mental health/ psychological problems should be referred to primary therapy services. These might include:

- Private counsellors offering a range of interventions such as CBT, brief intervention therapies as well as longer term psychodynamic or integrative psychotherapy
- HSE counselling services
- Voluntary organisations offering self help or mutual support (see Appendix 5)

Listings of these services can be found by accessing:

- Golden pages or equivalent phone directory
- HSE Directory
- Psychological Society of Ireland
- Irish Association of Humanistic and Integrative Psychotherapy (IAHIP)
- Irish Association of Counselling and Psychotherapy (IACP)
- Irish Medical Directory

Referral to secondary or tertiary care services is appropriate in cases where the patient presents with moderate to severe difficulties. In all cases, the patient should be educated about the therapeutic process and consent should be obtained before a formal referral is made.

Referral criteria at primary care level should not be exclusively focused on the severity of the disorder. With the emphasis being on "well being" rather than maladjustment/ psychopathology, referrals to primary care therapy services should be made for clients who exhibit a reasonable degree of psychological mindedness; that is clients who are motivated to change, have some insight into their psychological/ emotional experience, are able and willing to verbalise and reflect on their difficulties. Although many clients referred to mental health services are seeking help and are aware of their difficulties, psychological services at secondary care level also work with people who are less willing or able to engage in relationships with others. Where doubt exists about the appropriateness of referral to services at either level of care, consultation prior to referral is recommended.

Given the wide range of therapies/ therapists available, a referral for assessment as to a patient's suitability for a particular orientation is advised (see Appendix 6).

SUICIDE RISK

There are many issues and factors involved when a person makes a decision to end their life, and only a few of these factors can be influenced by medical and pharmacological interventions. Reductions in suicide are not easy to influence, though it is thought that an important contribution could be made to reduce suicide rates by improving the treatment of depression⁹ (see Appendices 7 – 9).

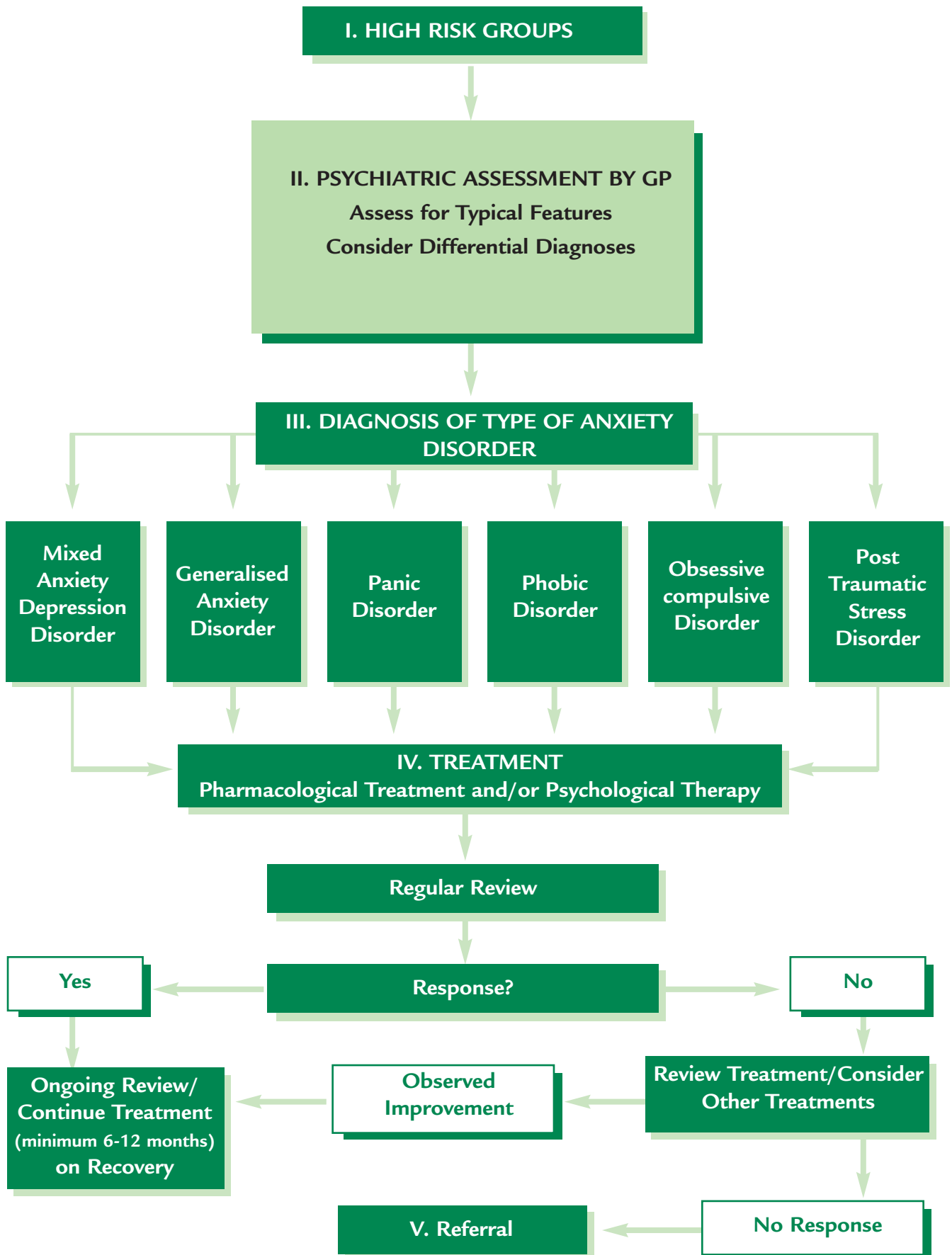
The death of a patient by suicide can have an emotional impact on doctors and on practice staff. Ideally, distressing incidents should be discussed within the practice, and everyone should be alert to providing personal support to work colleagues who have been affected. In some instances, it may be necessary or advisable to seek help outside the practice. The Irish College of General Practitioners Health in Practice Programme (HiPP) has a directory of GPs, counsellors and occupational physicians who are available to provide confidential personal and occupational healthcare to GPs and their families or staff. This directory is available from the ICGP website at info@icgp.ie or on request from the ICGP.

VI. INDICATIONS FOR REFERRAL TO SPECIALIST

The following should be considered in making a decision for referral to a psychiatrist:

- Risk such as:
 - Suicide or serious self-harm
 - Harm to others due to psychiatric illness e.g. paranoid illness, delusional jealousy, and hopelessness in post-natal depression
 - Neglect or accidental injury due to psychiatric disability e.g. severe depression, psychosis
- The illness is severe (subjective level of distress).
- The illness is likely to be long-term and potentially disabling e.g. psychotic illness, bipolar illness.
- Failure of illness to respond to standard treatment (at adequate dosage, for adequate time-period).
- The diagnosis is unclear and needs more comprehensive evaluation.
- The therapeutic relationship has broken down due to psychiatric illness, with non-compliance with assessment/treatment.

MANAGEMENT OF ANXIETY DISORDERS IN PRIMARY CARE



MANAGEMENT OF ANXIETY DISORDERS

This guideline provides recommendations based on current evidence for best practice in the management of anxiety disorders. The guideline includes screening, assessment, diagnosis, and management involving primary care. The guideline is likely to be of interest to general practitioners, pharmacists, psychiatric nurses, psychiatrists, clinical psychologists, users of services, and all other professions caring for people with anxiety disorders.

I. HIGH RISK GROUPS

Anxiety – groups at higher risk of developing anxiety disorders:

- 1) Family history of anxiety disorder
- 2) Life events (e.g. bereavement, separation and unemployment)
- 3) Female gender for most types of anxiety disorders
- 4) Alcohol and drug misuse

II. PSYCHIATRIC ASSESSMENT BY GP

Anxiety is an unpleasant emotional state. It is characterized by the feeling of fear and frequently distressing physical / somatic symptoms.

Anxiety is considered to be pathological when it continues after the stressor has gone or the anxiety is out of proportion to the severity of the stressor. It can also occur in the absence of any provoking agent and this is also considered to be pathological.

III. DIAGNOSIS OF TYPE OF ANXIETY DISORDER

(1) Mixed Anxiety Depression Disorder

This diagnosis is made when symptoms of both anxiety and depression are simultaneously present to a mild or moderate degree. Individuals with this mixture of comparatively mild symptoms are frequently seen in primary care, but many more cases exist among the population at large which may never come to medical or psychiatric attention.

(2) Generalised Anxiety Disorder

As the name suggests, this is an anxiety state not confined to a particular situation, but tends to be 'free-floating'. Physical symptoms are usually prominent and, together with psychological distress, tend to cause significant impairment.

(3) Panic Disorder

This is characterised by unpredictable attacks of anxiety with pronounced physical / autonomic symptoms not related to any particular situation. Commonly described fears are that of 'going mad', dying etc.

(4) Phobic Disorders

Phobias are defined as persistent, irrational fear of and the wish to avoid an object, activity or situation. They can take the form of:

a) Agoraphobia (with or without panic):

- Anxiety in situations where escape is difficult or help unavailable.
- Fear of specific situations: alone at home, crowds, public transport, lifts etc.
- Active avoidance of feared situation.
- Resultant limitation of functioning.

b) Social Phobia:

- Extreme and persistent fear of social situations.
- Fear of embarrassment or humiliation.
- Anxious anticipation of above.
- Avoidance of situations and fear recognized as unreasonable.

c) Specific Phobias:

- Extreme and persistent fear of specific object.
- Precipitated by appearance or anticipation of specific object.

(5) Obsessive Compulsive Disorders

Obsessions are characterized by intrusive, unwanted and often unpleasant thoughts or fears.

Compulsions are repetitive and seemingly purposeful forms of behaviour, performed in a stereotypical way.

Both obsessions and compulsions are recognized as senseless by the individual and are accompanied by an urge to resist.

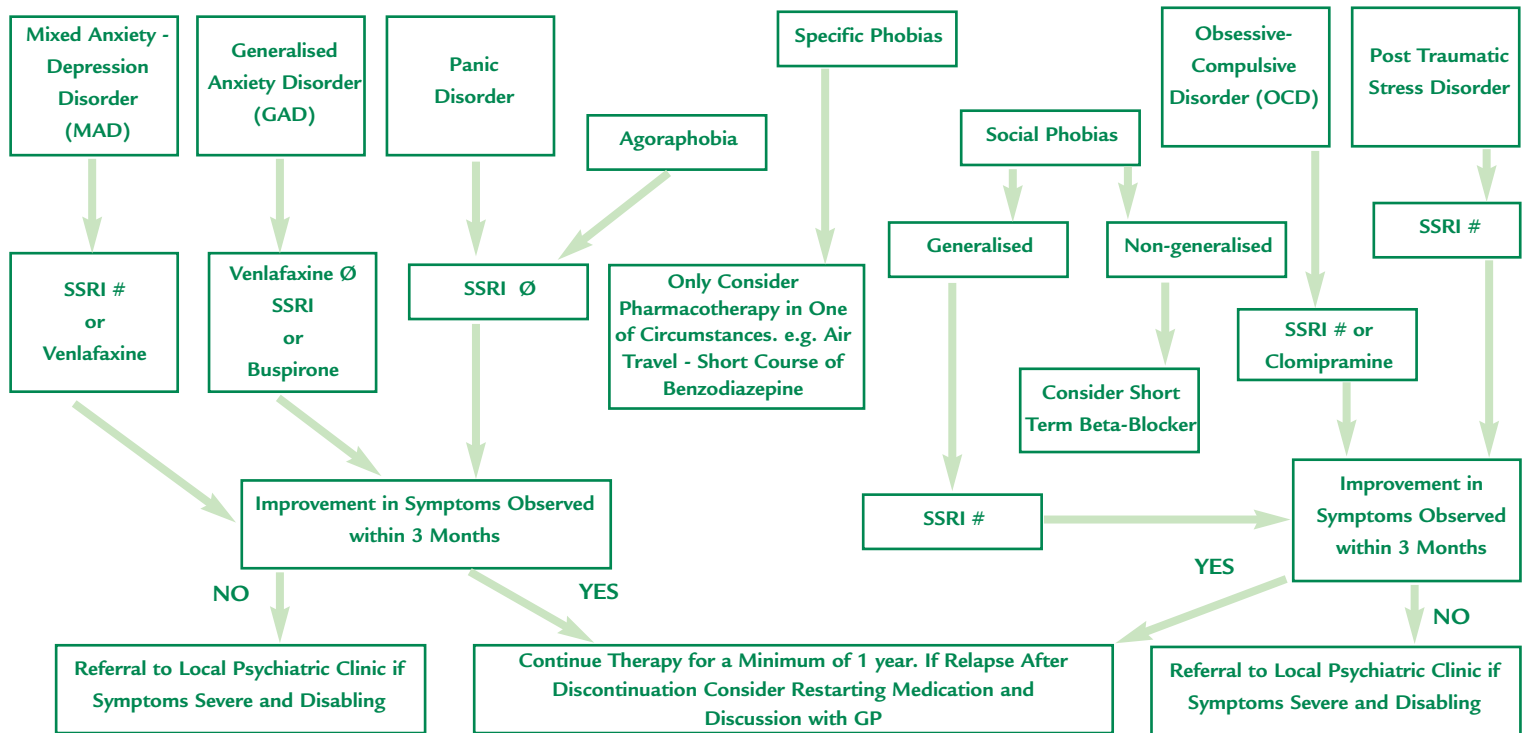
(6) Post Traumatic Stress Disorder

In this disorder, anxiety and other symptoms follow an accident, assault or other incident perceived to be highly threatening by the individual. It is possible that some vulnerable personalities may suffer even though the stressor may not be apparently great.

(See Appendix 10)

IV. TREATMENT

PHARMACOLOGICAL TREATMENT



Short-term adjunctive therapy with a Benzodiazepine should be considered in patients with severe anxiety (e.g. a 2 week maximum course of Diazepam)

Ø When treating generalised anxiety disorder, panic disorder, agoraphobia and post traumatic stress disorder therapy it is recommended that therapy be started at a $\frac{1}{4}$ or $\frac{1}{2}$ Of the normal recommended dose for depression. This minimises the risk of exacerbating anxiety ("activation syndrome")

Start at normal dose for depression

Once in remission the dose should be reduced slowly to avoid discontinuation syndrome (e.g. 25% every 2 months for shorter acting SSRIs, e.g. Paroxetine).

For further information consult BNF or National Medicines Information Centre on 01 453 7941.

This chart is adapted from Croydon Protocols.¹⁰

PSYCHOLOGICAL TREATMENT

Please see guidelines for depression pages 7 to 8.

V. INDICATIONS FOR REFERRAL TO SPECIALIST

Please refer to depression guidelines page 9.

APPENDIX 1

Drugs That May Cause Depression ^{5, 11}

Cardiovascular Drugs

- Beta Blockers
- Calcium Channel Blockers
- Digoxin
- Methyldopa
- Statins

Hormones

- Corticosteroids
- Oestrogen's
- Progestogens

Drugs Acting on CNS

- Alcohol
- CNS Stimulant Withdrawal e.g. Cocaine, Amphetamines
- Amantadine
- Benzodiazepine
- Carbamezepine
- Levodopa
- Phenothiazines

Antibacterials

- Sulphonamides
- Ciprofloxacin

Miscellaneous Drugs

- Disulfiram
- Interferon
- Isotretinoin
- Mefloquine
- Metoclopramide
- NSAIDs
- Alpha Blockers

APPENDIX 2

Table: Comparison of the Side Effect Profile of Antidepressants ¹²

DRUG	USUAL THERAPEUTIC DOSE	RELATIVE SIDE EFFECTS AT USUAL DOSES			
		Anticholinergic	Cardiac	Nausea	Sedation
Tricyclics	150mg	+++	+++	++	+++
Amitriptylline	150mg	++	++	0	+++
Dothiepin	140mg	++	+	+	+
Lofepramine					
RIMA	300mg	+	0	+	0
Moclobemide	(150mg twice daily)				
SSRI					
Citalopram	20mg	0	0	++	0
Fluoxetine	20mg	+	+	++	0
Paroxetine	20-30mg	0	0	++	0
Sertaline	100mg	0	0	++	0
SNRI					
Venlafaxine	75-150mg	0	++	++	+
Duloxetine	60-120mg	0	+	++	+
NaSSA					
Mirtazapine	30mg	0	0	0	++

Key: 0, little or minimal effect, +, mild effect, ++, moderate effect, +++, marked effect

APPENDIX 3

Summary of Precautions Needed When Switching Antidepressants¹¹

CHANGE TO FROM	SSRI	Trazodone	Venlafaxine	Moclobemide	MAOI	Reboxetine	TCAD	Mirtazapine	Duloxetine
SSRI	Lower starting dose may be required	Lower starting dose	Lower starting dose	Wash out period*	Wash out period*	Lower starting dose	Wash out period/ lower starting dose		No Wash out at moderate dose [^]
Trazodone	Lower starting dose	Lower starting dose	Lower starting dose	Wash out period 1 week	Wash out period 1 week	Lower starting dose	Lower starting dose		No Data
Venlafaxine	Lower starting dose	Lower starting dose		Wash out period 1 week	Wash out period 1 week		Lower starting dose		No Wash out at moderate dose [^]
Moclobemide	Wait 24 hours	Wait 24 hours	Wait 24 hours			Wait 24 hours	Wait 24 hours	Wait 24 hours	Wash out period 2 weeks
MAOI	Wash out period 2 weeks	Wash out period 2 weeks	Wash out period 2 weeks	Continue diet for 2 weeks		Wash out period 2 weeks	Wash out period 2 weeks	Wash out period 2 weeks	Wash out period 2 weeks
Reboxetine				Wash out period 1 week	Wash out period 1 week				No Data
TCAD				Wash out period 1 week	Wash out period 1 week				No Data
Mirtazapine				Wash out period 2 weeks	Wash out period 2 weeks				No Data
Duloxetine	No Wash out at moderate dose [^]	No Data	No Wash out at moderate dose [^]	Wash out period 2 weeks	Wash out period 2 weeks	No Data	No Data	No Data	

Key: Washout required, risk of interaction Care required
 No specific precaution

*Washout period depends on SSRI half-life and varies between one and five weeks (Citalopram one week, Paroxetine/Sertraline two weeks, Fluoxetine five weeks)

[^] Washout is not considered for moderate dosing Venlafaxine ≤150mg, Fluvoxamine ≤150mg, Citalopram ≤40mg, Paroxetine ≤40mg, no data for Fluoxetine

Chart adapted with permission from Oxleas NHS Trust Pharmacy Department.

APPENDIX 4

Table: Summary of Some of the Possible Antidepressant and Drugs Used in Anxiety Interactions^{5,12,13}

DRUG	MECHANISM OF ACTION AND EFFECT	DRUGS IMPLICATED
TCAD	Pharmacodynamic interaction: increased sedation P450 enzyme system: Increase TCAD levels Reduce TCAD levels Increased antimuscarinic and sedative effects	Alcohol, Benzodiazepine, Opioid Analgesics Cimetidine, Haloperidol Barbiturates, Carbamazepine Antihistamines
RIMA	Some of the food associated problems of MAOIs	
SSRI	P450 enzyme system: Increase implicated drug level (Particularly seen with Fluoxetine to a lesser extent with Sertaline and Citalopram) Enhance effects of Warfarin Increased risk of CNS effects Hypertension and CNS excitation Risk of CNS toxicity Increased risk of bleeding	Clozapine, Carbamazepine Phenytoin, Metoprolol and Clarithromycin Warfarin Lithium, Sibutramine Dopaminergics e.g. Selegiline with Paroxetine, Sertiline or Fluoxetine Tramadol NSAIDs
SNRI	Enhance effects of Warfarin Increase Serotonin levels and MAOI inhibit SNRI metabolism P450 enzyme system Risk of CNS toxicity	MAOI- Serotonin syndrome, to avoid a washout period is required TCAD and SSRI, increased antichloenergetic effects and Serotonin syndrome, washout period is required Sibutramine
NaSSA	Pharmacodynamic effect: increased sedation Enhance effects of Warfarin P450 enzyme system: Reduce levels of Mirtazepine Increase levels of Mirtazepine Risk of CNS toxicity	Alcohol, benzodiazepines MAOI coprescribing should be avoided Warfarin Anticonvulsants e.g. Carbamazepine Ketoconazole Sibutramine
NARI	P450 enzyme system: Increase NARI levels Increase implicated drug levels Pharmacodynamic interaction: increased sedation	Azole antifungals e.g. Ketoconazole, Macolide anitbacterials and Fluvoxamine Antiarrhythmics, antipsychotics, and TCADs Alcohol, Benzodiazepine MAOI coprescribing should be avoided
Buspirone (Anxiety)	Pharmacodynamic interaction: increased sedation P450 enzyme system: Increase Buspirone levels Reduce Buspirone levels Serotonin syndrome Increased risk of adverse effects	Alcohol, Benzodiazepines, upload analgesics Erythromycin and Azole antifungals Rifampicin Citalopram Fluoxetine, Fluvoxamine
Beta-Blockers	Antagonise hypotensive effects Increased risk of myocardial depression and Bradycardia P450 enzyme system: Increase Beta Blocker levels Reduce Beta Blocker levels Increased risk of Bradycardia and AV block	NSAIDs. MAOI Anti-arrhythmics Fluvoxamine, Chlorpromazine, Cimetidine, Propafenone Rifampicin, Barbiturates

NOTE: Beta-blockers are contraindicated in individuals who have asthma.

APPENDIX 5

Mental Health Voluntary Organisations

ALZHEIMER SOCIETY OF IRELAND – Alzheimer’s disease or a related dementia.

Alzheimer House, 43 Northumberland Avenue, Dun Laoighre, Co. Dublin

Phone: 01 2846616, Fax: 01 2846030, Helpline: 1800 341 431

Email: info@alzheimer.ie, Website: www.alzheimer.ie

AWARE – Support group to help persons with elation or depression, and their families.

72 Lower Leeson St. Dublin 2

Phone: 01 6617211, Helpline: 1890 303302 (Local), Email: aware@iol.ie, Web: www.aware.ie

BODYWHYS – Voluntary support organisation for people with eating disorders, their families and friends. Support groups throughout the country a helpline and an education and awareness programme.

The Eating Disorders Association of Ireland, PO Box 105, Blackrock, Co. Dublin

Phone: 01 2834963, Helpline: 1890 200 444, Email: info@bodywhys.ie, Website: www.bodywhys.ie

GROW – Helps the individual to grow towards personal maturity by use of their own personal resources through mutual help groups.

167A Capel St, Dublin 1

Phone: 01 8734029, Email: easternregion@grow.ie, Infoline: 1890 474 474, Web: www.grow.ie

HEADWAY – National Association for acquired brain injury.

Unit 1-3 Manor Street Business Park, Dublin 7

Phone: 01 8102066, Web: www.headway.ie

MENTAL HEALTH IRELAND – Promotion of positive mental health and support people with mental health difficulties and their families.

Mensana House, 6 Adelaide St, Dunlaoighre, Co. Dublin

Phone: 01 2841166, Fax: 01 2841736, Email: info@mentalhealthireland.ie, Web: www.mentalhealthireland.ie

OUT AND ABOUT – A self help organisation for sufferers and their families of agoraphobia and panic attacks.

140 St. Lawrence's Road, Clontarf, Dublin 3

Phone: 01 8338252 / 8338253, Fax: 01 8334243, Email: oandamartinance@eircom.net

RECOVERY INC – Offers a self- help method of will training.

PO Box 2210, Dublin 13

Phone: 01 6260775, Email: recovirl@indigo.ie, Website: http://indigo.ie/~recoveryirl/

SAMARITANS – A support group that is available 24 hours a day to befriend those passing through personal crisis and in imminent danger of taking their own life.

112 Malborough Street, Dublin 1

Phone: 1850 60 90 90, Email: jo@samaritans.org, Email: admin.dublin@samaritans.ie

SCHIZOPHRENIA IRELAND – Advocates for those effected by schizophrenia and related illnesses and promoting and providing best quality services.

38 Blessington St, Dublin 7

Phone: 01 8601620, Fax: 01 860 1602, Email: info@sirl.ie, Web: www.sril.ie

IRISH ADVOCACY NETWORK – It is a user run, use led organisation which exists to promote and facilitate peer advocacy on Island wide basis. Their aim is to support people in speaking up for themselves achieving empowerment by taking control of their own lives.

National Office, Old Rooskey House, Monaghan

Phone: 047 38918, Fax: 047 38682, Website: www.irishadvocacynetwork.com

APPENDIX 6

Treatment of Mental Health Problems by Psychological Therapy

Mild to Moderate Mental Health Problems	General Guidelines
Depression (obvious life event triggers/ minimal biological markers)	CBT/ Psychotherapy
Relationship difficulties	Counselling/ Psychotherapy
Anxiety Disorders e.g. Mild to Moderate Social Phobia Panic Disorder/ Agoraphobia Obsessive Compulsive Disorder Generalised Anxiety Disorder	CBT
Bereavement	Counselling/ Psychotherapy
Response to Physical Illness	Counselling/ Psychotherapy
Life Cycle Developmental Issues	Counselling/ Psychotherapy
Adjustment problems	Counselling/ Psychotherapy
Response to Trauma	CBT/ Psychotherapy
Sexual Difficulties	Sex Therapy/ Psychotherapy/ Counselling
Moderate to Severe Mental Health Problems	
Depressive Disorders	CAT, Individual Psychotherapy, CBT
Personality/ Behaviour Disorders	DBT, CAT, Psychotherapy
Obsessive Compulsive Disorder	CBT
Post Traumatic Stress Disorder	CBT
Eating Disorders Bulimia Nervosa Anorexia Nervosa	CBT/ Psychotherapy CAT/ Psychotherapy
Deliberate Self Harm	Psychotherapy/ CAT
Severe Anxiety Disorders As above in “Mild to Moderate Problems”	Psychotherapy / CBT/ CAT
Hypochondriasis	Psychotherapy
Substance Abuse	Addiction Counselling/ Therapy

NOTE: These guidelines are not intended to be prescriptive and assessment to address each patient's individual needs is strongly advised.

APPENDIX 7

Risk Factors for Suicide

VARIABLES	HIGHER RISK	LOWER RISK
Age	Younger men (15-40) and older men (>60)	Middle age (40-60)
Sex	Male	Female
Relationship Status	Divorced, widowed, separated	Stable relationship
Social Circumstances	Living alone, socially isolated, financial difficulty	Good social network
Physical Health	Chronic, painful, debilitating or terminal illness	Good health
Mental Health	Mental illness: depression, psychosis, substance misuse, personality disorder (e.g. impulsivity). Increased risk following recent discharge from hospital	Good mental health
Mental State	Hopelessness, worthlessness, guilt	None
Substance Misuse	Alcohol or drug misuse or dependence	No substance misuse
Previous Episodes	Premeditated, carried out in isolation (little risk of discovery), violent method, aim was suicide and regrets survival, carried out 'final acts', believed act would be irreversible and lethal, no action of gain help afterwards	No previous episodes
Family History	Actual or attempted suicide by a close relative/friend	No history of suicide or attempts
Loss	e.g. bereavements, relationship break-up, anniversaries	No loss events
Learning Disability	Mild/borderline disability	Severe

APPENDIX 8

Assessment of Risk of Suicide - Prompt Questions:

NOTE: Asking direct questions about suicide is important in assessing suicide risk, and does not increase the risk of subsequent suicidal behaviour. Collateral history can be very useful in assessing suicide risk. The following are sample questions only, and can be adapted freely depending on the circumstances and educational level of the patient.

SUICIDAL IDEATION:

- Do you ever feel that life is not worth living?
- Have you considered taking your own life? How often have you had those feelings? Are there particular situations where these feelings trouble you most?
- Have you made any plans to take your own life? Can you describe these plans to me? Will you put these plans into action? When? How?
- Do you see any alternative to suicide? If no current intent, what event might provoke you to carry out the plan?
- What has stopped you from acting on the plan up to now?
(i.e. protective factors)

IF THERE HAS BEEN AN EPISODE OF DELIBERATE SELF HARM -DSH:

- Have you made any attempt to take your own life? Can you describe the circumstances? (Look for evidence of previous planning vs impulsive DSH e.g. keeping a rope/hose in the car, buying tablets in advance? Any precipitating event? Was alcohol/drug intoxication a factor in the attempt? Any evidence of 'final acts' such as writing a will, sorting financial affairs, writing a suicide note)
- Did you take any steps to get help after the event? (e.g. phoning an ambulance after an OD?) Why did you do that? (i.e. may provide evidence of ambivalence about deathwish)
- What did you think the likely outcome of the attempt would be? (e.g. did you think the amount of tablets you took was likely to kill you?)
- What was your motivation for the attempt? (despair, anger, 'cry for help'?)
- Do you regret the attempt, or regret that you survived it?
- What impact do you think your death would have had on people you care about? (Assess evidence of feeling a burden to others e.g. 'they'd be better off without me')
- Are you a religious person? How do your religious beliefs affect how you feel about suicide? (Religious beliefs may protect against completed suicide)

HOPELESSNESS:

- How do you see your future?
- Do you think things can get better for you? How might that happen?
- Do you have any hope that help from the psychiatric service (medication, support, psychotherapy etc.) can help you?

WORTHLESSNESS AND GUILT:

- What is your opinion of yourself (or how do you see yourself) as a person? Do you have a good opinion of yourself?
- What opinion do other people (family, friends, work colleagues, neighbours) have of you?
- Do you feel guilty about things? What do you feel guilty about?
- Do you feel responsible for any recent events you've heard about in the news or in the papers? What events? In what way were you responsible? (Delusions of guilt)

CONTROL OVER-RIDE SYMPTOMS:

- Do you feel that any other person or agent (such as the devil?) has influence or control over you? How is that control put into effect (or exercised)?
- Does the person/agent directly control your body (or part of your body)?
- Do you have the feeling that a person/agent puts thoughts that are not your own into your mind? What thoughts?
- Do you have the experience of hearing a voice or voices telling you what to do, or giving you commands? Whose voice? What commands?
- Do you feel any pressure or need to obey these commands?
- What has prevented you from obeying these commands up to now?

APPENDIX 9

Brief Risk Factors Record

1. HISTORICAL FACTORS	COMMENTS
Serious psychiatric illness	
Previous deliberate self-harm (lethality, context)	
Family history of suicide	
Aggression to others	
Other forensic history	
Harm from others	
Self neglect or poor self care, non-compliance	
2. CONTEXTUAL FACTORS	
Recent acute stresses or losses	
Serious/chronic physical illness/disability, post-natal	
Social: age, sex, single, support, living conditions	
3. DISPOSITIONAL FACTORS	
Impulsivity	
Anger/hostility/aggression	
4. CLINICAL FACTORS	
Depressed mood, worthlessness, hopelessness	
Recent self-harm, suicidal ideation or plans	
Substance misuse	
Psychotic symptoms e.g. 'control over-ride'	
Recent acts of aggression or ideas of harming others	

Evidence of risk Y / N:
Assessed by:

Action taken:
Date:

APPENDIX 10

Diagnostic Criteria for Anxiety Disorders (Based on DSM-IV 4th Edition)

Generalised Anxiety Disorder

- Excessive anxiety and worry (apprehensive expectation)
- The person finds it difficult to control the worry
- The anxiety and worry are associated with three or more of the following symptoms:
 - Restlessness or feeling keyed up or on edge
 - Being easily fatigued
 - Difficulty concentrating or mind going blank
 - Irritability
 - Muscle Tension
 - Sleep Disturbance
- The focus of the anxiety and worry is not confined to features of an Axis 1
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, and other important areas of functioning
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive development disorder

Panic Disorder

- A discrete period of intense fear or discomfort, in which four (or more) of the followings symptoms developed abruptly and reached a peak within 10 minutes:
 - Palpitation, pounding heart, or accelerated heart rate
 - Sweating
 - Trembling or shaking
 - Sensations of shortness of breath or smothering
 - Feeling of choking
 - Chest pain or discomfort
 - Nausea or abdominal distress
 - Feeling dizzy, unsteady, light-headed or faint
 - Derealization (feelings of unreality) or depersonalization (being detached from oneself)
 - Fear of losing control or going crazy
 - Fear of dying
 - Paresthesias (numbness or tingling sensations)
 - Chills or hot flushes

Phobic Disorders

- Marked and persistent fear that is excessive or unreasonable
- Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response
- The person recognizes that the fear is excessive or unreasonable
- The phobic situation is avoided or else endured with intense anxiety or distress
- The avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person's normal routine

- In individuals under age 18 years, the duration is at least 6 months
- The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder

Obsessive Compulsive Disorders

Obsessions as defined by:

- Recurrent, persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress
- The thoughts, impulses, or images are not simply excessive worries about real-life problems
- The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
- The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind

Compulsions as defined by:

- Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
- The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation
- At some point during the course of the disorder, the person has recognized that obsessions or compulsions are excessive or unreasonable
- The obsessions or compulsions cause marked distress
If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition

Post Traumatic Stress Disorder

- The person experienced, witnessed, or was confronted with events that involved actual or threatened death or serious injury
- The person's response involved intense fear, helplessness or horror
- The traumatic event is persistently re-experienced
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness
- Persistent symptoms of increased arousal as indicated by the following:
 - Difficulty falling or staying asleep
 - Irritability or outbursts of anger
 - Difficulty concentrating
 - Hypervigilance
 - Exaggerated startle response
 - The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

REFERENCES

- (1) Coptly M. Mental Health in Primary Care Report. Dublin 2003.
- (2) Arroll B, Khin N, Kerse N. Screening for depression in primary care with two verbally asked questions: cross sectional study. *BMJ* 2003; 327: 1144-146.
- (3) American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association; 1994.
- (4) Department of Health and Children. Benzodiazepines: Good Practice Guidelines for Clinicians. Dublin: The Stationary Office; 2002.
- (5) British National Formulary, 47. London: British Medical Association and The Royal Pharmaceutical Society of Great Britain; 2004.
- (6) National Institute of Clinical Excellence. Depression: the management of depression in primary and secondary care. London: HMSO; 2003.
- (7) Taylor D, Paton C, Kerwin R. 2003 Prescribing Guidelines. 7th ed. London: The South London and Maudsley NHS Trust; 2003.
- (8) Department of Health and Children. Primary Care – A New Direction: Quality and Fairness – A Health System for You. Dublin: The Stationary Office; 2001.
- (9) Rutz W, Walinder J, Eberhard G, Homberg G et al. An educational programme on depressive disorders for general practitioners in Gotland: background and evaluation. *Acta Psychiatry Scand* 1989;79:19-26.
- (10) Bruce M. Primary Care Protocols for Common Mental Illnesses. Croydon: Croydon Health Authority NHS; 2001.
- (11) Fraser K, Martin M, Hunter R, Hudson S. Mood Disorders: Drug Treatment of Depression. *The Pharmaceutical Journal* 2001;266: 433-441.
- (12) Carter K. Management of Clinical Depression. *Hospital Pharmacist* 2002; 9:223-28.
- (13) Stockley I. Stockley's Drug Interactions. 6th ed. London: Pharmaceutical Press; 2002.

ABBREVIATIONS

SSRI	Serotonin Selective Reuptake Inhibitor
DoHC	Department of Health & Children
BNF	British National Formulary
ECG	Electro Cardiograph
RIMA	Reversible Inhibitor of Mono Amine Oxidase
TCAD	Tricyclic Antidepressant
SNRI	Serotonin Noradrenaline Reuptake Inhibitor
NaSSA	Noradrenergic & Selective Serotonergic Antidepressants
CNS	Central Nervous System
NSAIDS	Non Steroidal Anti Inflammatory Drugs
MAOI	Mono Amine Oxidase Inhibitors
NARI	Selective Noradrenergic Reuptake Inhibitor
CBT	Cognitive Behavioural Therapy
CAT	Cognitive Analytic Therapy
DBT	Dialectical Behaviour Therapy

NOTES

