Mental Health Theme

The following questions can be used as discussion points for peer groups or self-reflection of practice. The questions relate to topics within a mental health theme; it is recommended that the linked article is read before considering the questions.

Clozapine: safe prescribing

See: www.bpac.org.nz/2017/clozapine.aspx

Clozapine is often effective for patients with treatment-resistant schizophrenia; proactive and co-ordinated management, however, is required. In particular, patients should not necessarily be relied on to report symptoms of adverse effects. The primary care team can improve safety through monitoring and management of constipation, neutropenia, metabolic effects and cardiac toxicity, and being aware of medicines which may interact with clozapine or exacerbate its adverse effects.

Constipation is an under-recognised and under-reported consequence of clozapine treatment. The need for increased awareness of clozapine-related constipation has been highlighted recently with reports of avoidable fatalities.

1. Do you prescribe clozapine or provide care for a patient taking clozapine? If so, do you feel confident in managing the monitoring requirements and wide range of adverse effects associated with its use?
2. Constipation due to clozapine can be severe and have fatal consequences. After reading this article would you now feel more confident in preventing and if required, managing constipation in a patient taking clozapine?
3. In your experience, do you feel that there is good communication and co-ordination between mental health teams and primary care regarding the care of patients with mental health problems? Can you think of any particular strategies that could be put in place to assist?

I dream of sleep: managing insomnia in adults

Part 1: Diagnosis and non-pharmacological treatment

See: www.bpac.org.nz/2017/insomnia-1.aspx

Adults with insomnia have difficulty initiating or maintaining sleep, with adverse effects on their daytime functioning. A sleep diary can help with diagnosis and tracking improvements. A non-pharmacological approach is initially preferred; primarily cognitive behavioural therapy for insomnia (CBTi), which includes sleep hygiene and bedtime restriction. Evidence shows that CBTi can be effective and provide greater long-term benefits than pharmacological measures.

1. How realistic is it to suggest that general practitioners address lifestyle factors and use CBTi techniques as first-line measures in patients with insomnia? In your experience does this work in practice or do patients expect a "quick fix"?
2. Sleep hygiene has been shown to improve sleep in approximately 30% of patients. Discussing the many lifestyle steps that patients can take to improve sleep can be difficult to manage in a time limited consultation. What strategies have you found to be helpful to accomplish this? Do you find patient information sheets on sleep hygiene a useful tool?* One key factor that can impact on sleeping habits is our reliance on modern technology such as cellphones, laptops and tablet devices. What strategies have you found useful when advising patients about limiting screen time if it is contributing to insomnia?
3. Bedtime (or sleep) restriction can be a valuable technique for improving sleep. Have you used this technique with patients? If so, what were the results? If this technique is new to you, do you think you would be more likely to use sleep restriction after reading the article?*

* Printable PDF handouts for sleep hygiene and sleep restriction are available at: www.bpac.org.nz/2017/docs/insomnia-patient.pdf

I dream of sleep: managing insomnia in adults

Part 2: Pharmacological approaches for improving sleep

See: www.bpac.org.nz/2017/insomnia-2.aspx

Pharmacological approaches to managing insomnia are a second-line option for adults who do not improve sufficiently with cognitive and behavioural measures alone. For some patients with severe symptoms, medicines to help sleep can

be used for a short time initially, while non-pharmacological measures are optimised. The assessment and management of insomnia in general practice can be difficult, especially in relation to managing patient expectations about pharmacological treatments.

1. Do you find patients expect to be routinely prescribed sleeping tablets? If so, what strategies have you found effective in your practice to counteract this expectation?
2. An "exit strategy" is recommended at the time of prescription of a hypnotic medicine – a discussion about the intended length of treatment and a plan for withdrawal. Is this something that you routinely do?
3. Do you have many patients who continue on benzodiazepines (and similar medicines) long term? Does your practice have a policy for reviewing the use of pharmacological treatments for sleep?
4. Do you attempt to withdraw benzodiazepines in patients who have been taking them long term? What have you found to be the best methods for this?

The role of medicines in the management of depression in primary care

See: www.bpac.org.nz/2017/depression.aspx

Non-pharmacological interventions are the mainstay of treatment for patients with depression. Antidepressants should not be routinely prescribed for patients with mild depression as they will often respond to psychological interventions alone, especially in the early stages of illness. A selective serotonin reuptake inhibitor (SSRI) is usually the first-line pharmacological treatment for patients with moderate to severe depression who have not responded sufficiently to non-pharmacological interventions, e.g. citalopram, escitalopram, sertraline or fluoxetine.

There are no guidelines for selecting a particular SSRI as there is little clinical trial data separating the SSRIs in terms of efficacy and the results of meta-analyses have been contentious. The adverse effect profile, potential for medicine interactions, ease of withdrawal and prescriber experience can be used to guide discussions regarding medicine choice. Other medicines may be considered in some cases, e.g. mirtazapine, bupropion, venlafaxine or tricyclic antidepressants.

Patients should be followed–up in the first weeks after initiating an antidepressant to assess treatment response and any adverse effects. If there has been no response to a therapeutic dose of an antidepressant after at least three weeks consider switching to another medicine. Consider withdrawing antidepressants from patients who are coping well one year after recovery from a single episode of depression or at least three years after recovery from multiple episodes.

1. Non-pharmacological interventions are the mainstay of treatment for patients with depression. Online patient resources have become relied upon as access to counselling and other support services are often limited. Which online resources have you found to be most helpful for patients and why?
2. The literature regarding antidepressant use is increasingly questioning the effectiveness of medicines for mild to moderate depression and the role of the placebo effect. Has this recent information changed your prescribing of antidepressants?
3. At this stage, data from randomised controlled trials does not clearly determine which SSRI should be prescribed over another. Do you have one SSRI that you use more than another? If so, for what reasons?
4. In your experience, have you found that patients with severe depression respond well to a tricyclic antidepressant? Or do you no longer prescribe these medicines for patients with depression?
5. In what clinical circumstances would you consider prescribing a non-SSRI antidepressant such as mirtazapine, bupropion or venlafaxine?