

Quality use of antidepressants self-audit

Why a self-audit on the provision of antidepressants?

The management of depression is complex. Over 50% of patients stop taking antidepressants before the recommended treatment duration.¹ Pharmacists can play an important role in reducing this discontinuation rate and optimising outcomes for patients with depression by providing information and advice about antidepressant drugs.^{1,2}

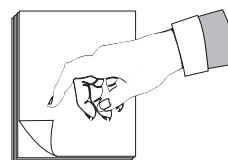
Participation in this self-audit provides pharmacists with an opportunity to:

- identify counselling points for patients using antidepressants
- reinforce key messages about depression management to patients
- demonstrate provision of quality care.

Please tear off each section and forms carefully.

Registration form, signed confidentiality agreement and self-audit forms to be received at NPS by

Wednesday, 30 November 2005.



“A good way to reinforce the counselling points and assess how I was performing.”
“Offers a very good method of structuring counselling.”
“It only takes a few minutes to complete and provides immediate feedback about best practice in this area.”

How to participate

1. Select patients

Select 10 patients (older than 18 years) using antidepressants for treatment of depression. Select patients prospectively as they present their prescriptions.

Patient privacy

Patients must be informed that health information from their medication records may be used for the purposes of quality assurance activities. Please:

- display the enclosed poster *Quality assurance activities in this pharmacy and your privacy* in your pharmacy
- ask patients/customers to read the poster.

2. Collect data and review

- **Complete** one self-audit form as soon as possible **after** your interaction with each of your 10 patients/customers.
- **Check** this *Guide* and Tables 1 and 2 for supporting information on data collection and review.

Note: Professional Practice Standards stipulate that counselling on medicines is carried out by a pharmacist. Self-audit forms should be completed by a pharmacist or a pre-registration pharmacist under the direct supervision of a pharmacist.^{1,3}

3. Return the self-audit forms

Return the 10 self-audit forms and *Registration form/confidentiality agreement* to:

NPS Pharmacy Self-audit

Locked Bag 4888

STRAWBERRY HILLS NSW 2012

To be received at NPS not later than:

Wednesday, 30 November 2005

Please note: Unfortunately, late submissions cannot be accepted.

4. Professional development

This self-audit is recognised by the Pharmaceutical Society of Australia (PSA) Continuing Professional Development (CPD) and Practice Improvement (PI) Program. Registered pharmacists who are PSA members are eligible for 8 CPD & PI credit points (or State equivalent) according to PSA Guidelines. Recognition No. R1-7/05.

- This self-audit is recognised for 1 QCPP point.
- All 10 self-audit forms must be returned by **Wednesday, 30 November 2005** if you wish to obtain CPD & PI (PSA) credit points or QCPP/CQI points. If you are unable to complete all 10 forms, you may still participate but will not receive points.



5. Receiving your results

When the results have been analysed (approximately three months after completion of the audit), you will receive:

- your original self-audit forms
- your own results
- the aggregate results of all participants
- expert commentary on the aggregate results
- review and reflection points
- certificate of completion
- CPD & PI credit points, or QCPP/CQI points (if applicable).

6. Confidentiality

Individual results of your audit are kept confidential. The aggregate results (which do not identify any individual patient or pharmacist) will be provided to all participants and may be used in NPS reports. Please note that any potentially identifying data will be removed from NPS records after completion of analysis and reporting.

For more information about the treatment of depression see:

- *NPS News 35* and *NPS News 42* (available at www.nps.org.au)
- *PPR 27* and *PPR 32* (available at www.nps.org.au)
- *Australian Medicines Handbook 2005*
- *Therapeutic Guidelines: Psychotropic, Version 5, 2003.*

Data collection and review

Use this information to complete the forms.

Section A: Presentation of the prescription

Establish who the prescription is for.

Section B: Dispensing antidepressant drugs

Use of antidepressant drugs is one aspect of the management of depression. Pharmacists have an important role in encouraging adherence to treatment with antidepressant drugs.

Antidepressants are approximately equal in efficacy, although individual patient response may vary markedly.⁴ Factors influencing the choice of antidepressant will include⁵:

- prior response to medication
- risks of drug interaction (See Table 1)
- adverse-effect profile of the antidepressant (See Table 2)
- safety in overdose
- simplicity of administration.

Combining antidepressants with different receptor profiles has not been shown to be more effective than treatment with a single drug. The balance of evidence suggests there is a very significant risk of toxic and fatal interactions, especially those that lead to cardiac arrhythmias, or serotonin syndrome.⁶ In addition, the risk of dying from an overdose is increased.⁵

On the data collection form, record:

- the drug prescribed
- whether the drug was dispensed for the first time at your pharmacy, was a repeat prescription, or if this was not determined

- if the dose was in the usual TOTAL dose range and, if not, the reason (if known)

Note: This question refers to TOTAL daily dose (e.g. venlafaxine 37.5 mg twice daily equals a total daily dose of 75 mg).

- period of use of the antidepressant
Note: A delay in onset of antidepressant response of at least 1–2 weeks occurs with all antidepressants and the full benefit may not occur for up to 6 weeks.⁴ Continued drug therapy for 6–12 months is recommended for all episodes of major depression.⁵
- if the patient has been on a different antidepressant recently and, if so, the reasons for the change and whether tapering and washout periods were required.

When stopping antidepressants, gradual tapering of the dose should be considered to reduce the risk of withdrawal symptoms (See Table 2).⁵

When changing antidepressants, an appropriate interval ('washout period') should be observed between medications to avoid interactions (See Antidepressant changeover category in Table 2).⁵

Note: See Appendix 1 of the *Therapeutic Guidelines: Psychotropic, Version 5, 2003*⁵ for an extensive overview of the risks and benefits to be considered when using antidepressants in pregnancy and breastfeeding.

Section C: Other medicines

Was the patient using any drugs or complementary medicines that may interact with current antidepressant therapy?

Patients may be taking other medicines to manage other health problems. It is important for pharmacists to provide counselling and to ensure that patients understand the potential for any interactions with their antidepressants.

Table 1 outlines potential drugs/drug classes and some complementary medicines that may interact with antidepressants. It also highlights that serotonin syndrome can occur with high doses of a single serotonergic agent as well as after adding a second serotonergic drug. Symptoms include mental changes (confusion, agitation), hyperreflexia and clonus, tremor, shivering, sweating, fever and diarrhoea.⁴

Section D: Providing counselling

Patient counselling is the dissemination or exchange of medicine information (including skills required to safely and effectively administer the medicine) by the pharmacist to the patient and/or their carer.³ The information is provided to achieve safe and appropriate use of medicines and adherence to the prescribed treatment regimen to optimise therapeutic outcomes.¹

The Professional Practice Standards state that:

- pharmacists have a legal and professional obligation to ensure patients have the information they need to enable them to make informed decisions about their medicines
- it is envisaged that counselling is offered to all patients each time a product is dispensed.³

Professional judgment and the expressed needs of the patient or carer will influence the scope of the counselling and how it is conducted.³

- Remind patients of what to expect from antidepressants and of the need for ongoing monitoring of their response to them as part of their overall depression management.
- Mention common adverse effects and that most should only persist for 1–2 weeks (use Table 2).
- Check for potential interactions (use Table 1).
- Use consumer medicine information (CMI) to counsel the patient to discuss with their GP any concerns about adverse effects, mood changes or thoughts about suicide.

Section E: Providing written material

CMI can be used to supplement verbal counselling.³

CMIs may be offered to the patient each time a product is dispensed.³ Whether this is appropriate is a matter for professional judgment.

CMI should be provided:

- when a medicine is first provided to the patient
- on provision of a medicine for which:
 - the dosage form has been changed (e.g. from an injection to a tablet)

- a significant change to the CMI has been notified by a sponsor (e.g. additional warnings about suicidal thoughts on SSRIs, late 2004)
- with each supply of medicine for which there are valid reasons for regular reinforcement of information
- at the request of the patient
- at regular intervals for medicines used for long-term therapy (e.g. every 6 months).³

Section F: Total counselling time

Pharmacists should ensure that counselling provided to the patient or carer is done in a manner that is sensitive to privacy and confidentiality to ensure the opportunity for discussion is optimal.³

Please provide an estimate of the total time spent counselling. Pharmacists report that the key points about how to take a medicine can usually be addressed in 2–3 minutes.

Section G: Self-assessment

Assess your interaction with this patient and any changes you could make to improve the quality of your advice and interactions.

Returning your forms

Look over all the forms.

Attach the completed *Registration form* and signed *Confidentiality agreement* to the **10** completed self-audit forms and return to NPS by **Wednesday, 30 November 2005**.



This is correct – using a cross mark
Use a **black biro** to mark a **cross (X)** in the box beside your response.



This is wrong – using a tick mark
Please **do not use pencil** to mark any of the boxes!
If you make a mistake, use white correction fluid.

Further information

Contact Gwen Higgins
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To order more copies of this pack
Email: info@nps.org.au
Phone: (02) 8217 8700
Fax: (02) 9211 7578

References

1. Parker G. Depression and the pharmacist. *Aust Pharm* 2002;21:922–6.
2. Garfield S, Smith F, Francis S. From black clouds to lighter grey: how pharmacists can help in depression. *Pharmaceut J* 2004;272:576–7.
3. Pharmaceutical Society of Australia. *Australian Pharmaceutical Formulary and Handbook*, 19th Edition. Canberra: The Pharmaceutical Society of Australia, 2004.
4. Australian Medicines Handbook 2005. Adelaide: Australian Medicines Handbook Pty Ltd, 2005.
5. Writing Group for Therapeutic Guidelines: Psychotropic. *Therapeutic Guidelines: Psychotropic*. Version 5, 2003. Melbourne: Therapeutic Guidelines Limited, 2003.
6. Tiller J. The new antidepressants — clinical applications. *Aust Prescr* 1999;22:108–11.

The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.



National Prescribing Service Limited

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NPS is an independent, Australian organisation for Quality Use of Medicines, funded by the Australian Government Department of Health and Ageing.

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Table 1: Selected antidepressant drug interactions

Table 2: Antidepressant therapy: adverse and withdrawal effects, monitoring, and changeover categories

Table 1: Selected antidepressant drug interactions¹⁻⁴

Interactions selected are only those generally known to occur in humans and likely to be of clinical importance.

Serotonin syndrome can occur:

- with high doses of a single serotonergic agent
- when a second serotonergic drug is added
- with the addition of drugs that inhibit cytochrome isoforms CYP2D6 and CYP3A4
- when changing antidepressants with an inadequate washout period between drugs.

Symptoms include mental state changes (confusion, agitation), hyperreflexia and clonus, tremor, shivering, sweating, fever, and diarrhoea.

Drugs and compounds that contribute to serotonin syndrome

Antidepressants	Opioids	Stimulants	5HT ₁ agonists	Others
TCAs, MAOIs, SSRIs, mirtazapine, moclobemide, venlafaxine, St John's wort	tramadol, pethidine, dextromethorphan	phentermine, diethylpropion, hallucinogenic amphetamines, sibutramine	sumatriptan, naratriptan, zolmitriptan	Illicit drugs (e.g. 'ecstasy', LSD), selegiline, tryptophan, buspirone, lithium, ginseng*

* *Panax ginseng*³

Note: This table is not an exhaustive list. Interactions are shown only for more commonly used drugs.

Antidepressant drug/Drug class	Interacting drug and/or potential clinical effect	Minimising risk
TCAs, MAOIs, SSRIs, mirtazapine, moclobemide, venlafaxine, St John's wort	See above list of drugs that increase the risk of serotonin syndrome	Avoid combinations or monitor clinical course carefully
MAOIs, SSRIs, TCAs, mianserin, mirtazapine, reboxetine, venlafaxine	May lower seizure threshold or cause seizures	Use low doses and titrate slowly
TCAs, mianserin, mirtazapine	Additive sedative effects with other agents causing sedation	Avoid combinations or monitor clinical course carefully
TCAs	Additive anticholinergic effects with other anticholinergic agents	Avoid combinations or monitor clinical course carefully
TCAs, venlafaxine	May lower blood pressure or cause dizziness and falls. Increased risk when used with other drugs causing hypotension	Avoid combinations or monitor clinical course carefully
Paroxetine, fluoxetine, sertraline, some TCAs, venlafaxine, moclobemide	Increased serum concentration of CYP2D6 substrates, e.g. carvedilol, codeine, flecainide, haloperidol, metoprolol, metoclopramide, propranolol	Avoid combinations or monitor clinical course carefully
Fluvoxamine, norfluoxetine (metabolite of fluoxetine)	Increased serum concentration of CYP3A4 substrates, e.g. alprazolam, midazolam, triazolam, amiodarone, bromocriptine, carbamazepine, erythromycin, methadone, statins, warfarin, zopiclone, zolpidem Milk thistle (silymarin) may increase antidepressant efficacy	Avoid combinations or monitor clinical course carefully
TCAs	Prolonged QT interval with anti-arrhythmic drugs, droperidol or antipsychotics	Avoid combinations or use with caution
SSRIs	Warfarin increases the risk of bleeding in people aged 80 years or more, those taking drugs known to increase risk of gastro-intestinal bleeding (aspirin or NSAIDs) or those with a history of gastro-intestinal bleeding	Avoid combinations or monitor clinical course carefully
MAOIs	Ginseng — Asian, American and Siberian may affect monoamine oxidase levels	Avoid combination
Antidepressants	<i>Ginkgo biloba</i> may reverse antidepressant-induced sexual dysfunction	Use together with caution
St John's wort	Cyclosporin, tacrolimus, digoxin, simvastatin, theophylline: reduced blood levels Oral contraceptives: may cause breakthrough bleeding or unwanted pregnancy	Avoid combination, monitor levels and observe signs of lack of efficacy Suggest alternative contraceptive method

1. Australian Medicines Handbook 2005. Adelaide: Australian Medicines Handbook Pty Ltd, 2005.

2. Therapeutic Guidelines: Psychotropic. Version 5, 2003. Melbourne: Therapeutic Guidelines Ltd, 2003.

3. Boyer EW, Shannon M. The serotonin syndrome. *N Engl J Med* 2005;352:1112–20.

4. Pharmaceutical Society of Australia. Australian Pharmaceutical Formulary and Handbook, 19th Edition. Canberra: The Pharmaceutical Society of Australia, 2004.

Table 2: Antidepressant therapy: adverse and withdrawal effects, monitoring, and changeover categories^{1,2}

Drug	Usual total daily dose range*	Antidepressant changeover category (see below)	Common adverse effects	Monitoring and withdrawal effects
Selective serotonin reuptake inhibitors (SSRIs)				
citalopram <i>Celapram, Cipramil, Talam, Talohexal</i>	20–40 mg	II	Nausea, agitation, insomnia, drowsiness, tremor, dry mouth, diarrhoea, dizziness, headache, sweating, asthenia, anxiety, weight gain or loss, sexual dysfunction, rhinitis, myalgia, rash	Withdrawal effects: Dizziness, nausea, paraesthesia, anxiety, agitation, tremor, sweating, confusion, electric shock-like sensations Most common with paroxetine and least likely with fluoxetine
escitalopram <i>Lexapro</i>	10–20 mg	II		
fluoxetine <i>Auscap, Fluohexal, Lovan, Prozac, Zactin</i>	20–40 mg	I		
fluvoxamine <i>Faverin, Luvox, Movox</i>	100–200 mg	II		
paroxetine <i>Aropax, Oxetine, Paxtine</i>	20–40 mg	II		
sertraline <i>Zoloft, Xydep</i>	50–100 mg	II		
Tricyclic antidepressants (TCAs)				
amitriptyline <i>Endep, Tryptanol</i>	75–150 mg	II	Sedation, dry mouth, blurred vision, constipation, weight gain, orthostatic hypotension, urinary hesitancy or retention, reduced gastrointestinal motility, anticholinergic delirium, impotence, loss of libido, other sexual adverse effects, tremor, dizziness, sweating, agitation, insomnia	Monitoring: Blood pressure: before and after starting treatment and after each dose change ECG to detect heart block or existing prolonged QT interval in adults < 60 years for TCA doses > 200 mg daily and in patients ≥ 60 years at TCA doses > 100 mg daily Withdrawal effects: Cholinergic rebound: hypersalivation, runny nose, abdominal cramping, diarrhoea, sleep disturbance Most common with amitriptyline, doxepin, trimipramine
clomipramine <i>Anafranil, Placil</i>	75–150 mg	II		
dothiepin <i>Dothep, Prothiaden</i>	75–150 mg	II		
doxepin <i>Deptran, Sinequan</i>	75–150 mg	II		
imipramine <i>Tofranil, Melipramine</i>	75–150 mg	II		
nortriptyline <i>Allegron</i>	75–150 mg	II		
trimipramine <i>Surmontil</i>	75–150 mg	II		
Other antidepressants				
mianserin <i>Lumin, Tolvon</i>	60–90 mg	II	Sedation, dry mouth, dizziness, vertigo	Monitoring: Full blood examination at baseline, then every 4 weeks during the first 3 months Stop drug if signs of agranulocytosis
mirtazapine <i>Avanza, Axit, Mirtazon, Remeron</i>	30–45 mg	II	Increased appetite, weight gain, sedation, asthenia, peripheral oedema	Whenever practical, withdraw over at least 1–2 weeks to minimise risk of withdrawal symptoms
moclobemide <i>Arima, Aurorix, Clobemix, Maosig, Mohexal</i>	300–600 mg	III	Nausea, dry mouth, constipation, diarrhoea, anxiety, restlessness, insomnia, dizziness, headache	
Monoamine oxidase inhibitors (MAOIs)				
phenelzine <i>Nardil</i>	45–90 mg	I	Orthostatic hypotension, sleep disturbances, headache, drowsiness, fatigue, weakness, agitation, tremors, twitching, myoclonus, hyperreflexia, constipation, dry mouth, weight gain, impotence, loss of libido, elevated serum transaminase levels	
tranylcypromine <i>Parnate</i>	20–40 mg	I		
reboxetine <i>Edronax</i>	8–10 mg	III	Urinary retention, dry mouth, sweating, paraesthesia, constipation, increase in diastolic blood pressure, increase in heart rate, impotence, insomnia, headache	Monitoring: Blood pressure and heart rate at baseline, then weekly until stable, then as clinically indicated
venlafaxine <i>Efexor, Efexor XR</i>	75–150 mg	III	Nausea, vomiting, anorexia, headache, sweating, rash, anxiety, dizziness, fatigue, syncope, hypertension (dose-related), orthostatic hypotension, tremor	Monitoring: Blood pressure: more frequently when starting, then periodically, especially with doses > 200 mg daily Withdrawal effects: May cause a syndrome similar to that seen with SSRIs

* Maximum doses may be higher for some antidepressants

Antidepressant changeover category

Note: Consider hospitalisation during washout/changeover if severely depressed.

Drug	Recommendation	
	Withdrawal period when switching	Drug-free interval
Category I changeover (drugs with longest half-life or persistent effects)		
fluoxetine	Fluoxetine: Gradual withdrawal to avoid withdrawal symptoms is generally unnecessary; interactions continue because of long half-life and long-acting metabolites	Wait for at least 2 weeks before starting next antidepressant If starting a MAOI, increase interval to 5 weeks after stopping fluoxetine
phenelzine tranylcypromine	Phenelzine and tranylcypromine: Withdraw gradually to minimise withdrawal effects. Maintain drug and diet restrictions for 2–3 weeks after stopping	
Category II changeover (intermediate half-life)		
TCAs, SSRIs (except fluoxetine), mianserin, mirtazapine	Withdraw gradually to prevent withdrawal symptoms (particularly if higher dose or long-term use — usually reduce dose by 25% per day). Of the SSRIs, withdrawal symptoms most likely with paroxetine	Wait for 2–4 days before starting next antidepressant
Category III changeover (shortest half-life)		
moclobemide reboxetine venlafaxine	Moclobemide: Withdrawal symptoms not reported Venlafaxine: Withdraw gradually to prevent withdrawal symptoms (discontinuation syndrome is similar to that for SSRIs)	Wait for 1–2 days before starting next antidepressant

1. Australian Medicines Handbook 2005. Adelaide: Australian Medicines Handbook Pty Ltd, 2005.

2. Therapeutic Guidelines: Psychotropic. Version 5, 2003. Melbourne: Therapeutic Guidelines Ltd, 2003.

Quality use of antidepressants: self-audit form

Completing the form

- The pharmacist or pre-registration pharmacist may complete the form. The pharmacist conducting the self-audit should oversee the completion of all forms.
- Complete the form as soon as possible after serving each customer who presents a prescription for a person aged 18 years or over that contains drugs specifically for the treatment of depression. (Reminder: some antidepressants are used for other indications, e.g. tricyclic antidepressants for pain management.)

- Use a black biro to make a cross (X) in the appropriate box beside your response.

- If you make a mistake, use white correction fluid.



NPS office use only

Section A: Presentation of the prescription

1. Who presented the prescription?

- The patient Carer/support person
 Other (please specify) _____

Section B: Dispensing antidepressant drugs

2. Was the dispensing of the antidepressant drug(s):

- for the first time at this pharmacy?
 ▶ Consider counselling on key points.
 Was counselling provided on this occasion? Yes No
- as a repeat prescription at this pharmacy?
 ▶ Consider reinforcing 1–2 points from previous counselling.
 Was counselling provided on this occasion? Yes No
- not determined
 Was counselling provided? Yes No
 ▶ Consider checking medication records to prioritise patients for counselling.

3. What drug(s) was dispensed:

Selective serotonin re-uptake inhibitors (SSRIs)	Usual TOTAL daily dose range
<input type="checkbox"/> citalopram <i>Celapram, Cipramil, Talam, Talohexal</i>	20–40 mg
<input type="checkbox"/> escitalopram <i>Lexapro</i>	10–20 mg
<input type="checkbox"/> fluoxetine <i>Auscap, Fluohexal, Lovan, Prozac, Zactin</i>	20–40 mg
<input type="checkbox"/> fluvoxamine <i>Faverin, Luvox, Movox</i>	100–200 mg
<input type="checkbox"/> paroxetine <i>Aropax, Oxetine, Paxtine</i>	20–40 mg
<input type="checkbox"/> sertraline <i>Zoloft, Xydep</i>	50–100 mg
Tricyclic antidepressants (TCAs)	
<input type="checkbox"/> amitriptyline <i>Endep, Tryptanol</i>	75–150 mg
<input type="checkbox"/> clomipramine <i>Anafranil, Placil</i>	75–150 mg
<input type="checkbox"/> dothiepin <i>Dothep, Prothiaden</i>	75–150 mg
<input type="checkbox"/> doxepin <i>Deptran, Sinequan</i>	75–150 mg
<input type="checkbox"/> imipramine <i>Tofranil, Melipramine</i>	75–150 mg
<input type="checkbox"/> nortriptyline <i>Allegron</i>	75–150 mg
<input type="checkbox"/> trimipramine <i>Surmontil</i>	75–150 mg

Other antidepressants	Usual TOTAL daily dose range
<input type="checkbox"/> mianserin <i>Lumin, Tolvon</i>	60–90 mg
<input type="checkbox"/> mirtazapine <i>Avanza, Axit, Mirtazon, Remeron</i>	30–45 mg
<input type="checkbox"/> moclobemide <i>Arima, Aurorix, Clobemix, Maosig, Mohexal</i>	300–600 mg
<input type="checkbox"/> phenelzine <i>Nardil</i>	45–90 mg
<input type="checkbox"/> reboxetine <i>Edronax</i>	8–10 mg
<input type="checkbox"/> tranylcypromine <i>Parnate</i>	20–40 mg
<input type="checkbox"/> venlafaxine <i>Efexor, Efexor XR</i>	75–150 mg

4. Was the dose within the usual TOTAL daily dose range?

- Yes
 No ▶ Dose higher Dose lower

5. Was action taken because the dose was outside usual TOTAL daily dose range?

- Yes (Go to Q5a)
 No (Go to Q5b)

5a. Action taken:

- prescriber contacted and dose changed
 prescriber contacted and considering dose change
 other (please specify) _____

5b. No action taken:

- prescriber contacted previously
 other (please specify) _____

6. Period of use of this antidepressant:

- first-time use 1–2 months
 3–6 months > 6 months
 not determined

7. Is the patient changing from another antidepressant?

- No (Go to Q11) Yes (Go to Q8)

8. Reason for change:

- adverse event (see Table 2 for a detailed list)
 failure of therapy not determined

9. Was the dose tapered before cessation?

- No Tapering not required
 Yes Not determined



10. Was a 'washout period' allowed when switching between antidepressants?

- No Washout not required
 Yes Not determined

Section C: Other medicines

11. Is the patient currently using other medicine(s) that may interact with the antidepressant (see Table 1 for list)?

- Yes (Go to Q12)
 No (Go to Q13) Not determined (Go to Q13)

12. Is the potentially interacting other medicine:

- a serotonergic agent (see Table 1)
 St John's wort
 opioid, e.g. tramadol, pethidine
 5HT₁ agonist, e.g. sumatriptan
 other (please specify) _____
 other (please specify) _____

13. Is the patient:

- presenting for first-time use of an antidepressant?
 using a different antidepressant than in the previous prescription dispensed?
 taking a dose outside the usual TOTAL daily dose range?
 taking any medicines or complementary medicines that may interact with the antidepressant (see Table 1)?

If you checked any of these boxes, the patient is a high priority for counselling on all aspects of their medicines.

Section D: Providing counselling

14. What counselling was provided at this presentation (by the pharmacist or pre-registration pharmacist)?

See *Guide to self-audit*, page 3, and Table 1 for more information.

- Purpose of antidepressant drug
▶ Depression is common. Most people recover but treatment speeds recovery. Antidepressants are one aspect of depression management.
- How to take antidepressant drug
▶ Include details on dose, timing to optimise compliance (e.g. some antidepressants are taken in the early morning to minimise insomnia/sleep disturbances) and the importance of not stopping antidepressants abruptly.
- Time to effect
▶ Up to 6 weeks of treatment may be required before benefits are experienced.
- Likely duration of treatment
▶ A course for at least 6 months after symptoms improve is usual.
- Response to therapy
▶ Stress the importance of taking antidepressant every day and remind the patient not to stop when feeling better. Ask regularly about progress.
- Possible adverse effects
▶ Many adverse effects of antidepressants (e.g. nausea with SSRIs or sedation with TCAs) resolve within the first 1–2 weeks of treatment.
- Potential interactions with other medicines or complementary medicines
▶ Remind patients to check with their doctor or pharmacist before using other drugs, to avoid potential drug interactions.

- Role of non-drug interventions
▶ Talking things through with family, friends or a counsellor and cognitive behavioural therapies are often useful adjuncts to drug therapy (see *NPS News* 42).
- Referral to GP
▶ Refer patient to their GP if troublesome side effects develop or if mood worsens or there are thoughts of suicide.
- Referral to other resources
▶ Refer patient to websites (e.g. *HealthInsite* www.healthinsite.gov.au) for more information/resources.

Section E: Providing written material

15. What written material was supplied to support verbal counselling?

- Consumer medicine information (CMI) leaflet on antidepressant drug(s)
▶ Note that the addition of information regarding suicidal thoughts was added to many CMI leaflets in late 2004.
- NPS patient leaflet (available November 2005)
- CMI for other medicines
- Pharmacy self-care card
- Other (please specify) _____
- None

Section F: Total counselling time

16. Approximate time taken for counselling :

- < 2 minutes 2–5 minutes
 6–10 minutes > 10 minutes

Section G: Self-assessment

On a scale of 1–5, where 1 = Very poor, 2 = Poor, 3 = Good, 4 = Very good, 5 = Excellent

17. How would you rate:

a) your ability to gather information from this patient?

- 1 2 3 4 5

b) your ability to explain the benefits and risks of antidepressant therapy?

- 1 2 3 4 5

c) your ability to answer any questions from the patient?

- 1 2 3 4 5

d) the overall quality of your interaction with this patient ?

- 1 2 3 4 5

18. Which staff member(s) were involved with this customer?

(more than one response may apply)

- Pharmacist Pre-registration pharmacist

19. How could you improve future counselling interactions?

(more than one response may apply)

- Make appointment to allow more time for discussion
 Conduct counselling in private
 Provide more written information
 Provide more reassurance regarding duration of therapy and adverse effects
 Improve own knowledge of management of depression
 Other (please specify) _____