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Depression & Anxiety Lunch & Learn

SURREY HEARTLANDS
Health and Care Partnership

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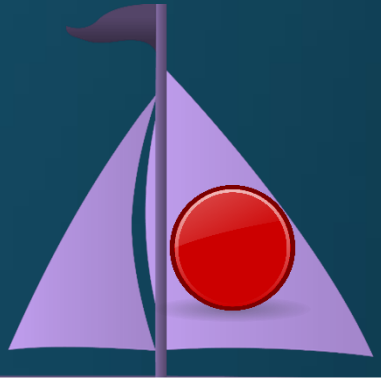
Housekeeping

Training is Recorded



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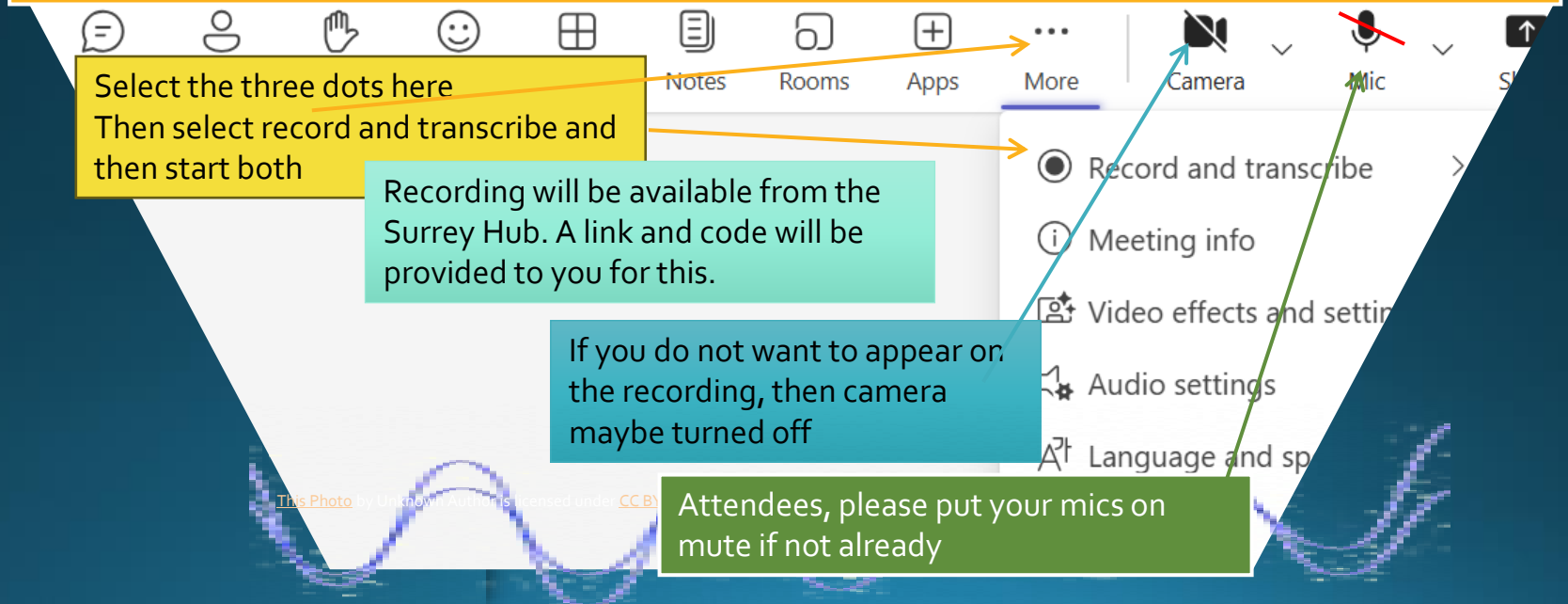

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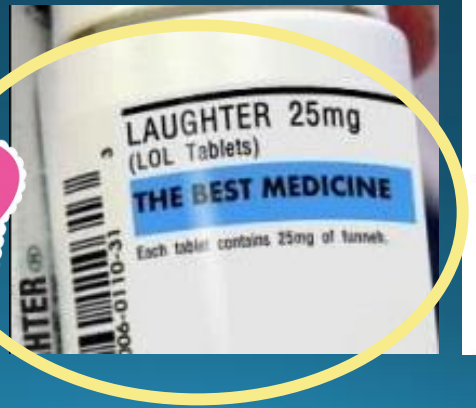
Then select record and transcribe and then start both

Recording will be available from the Surrey Hub. A link and code will be provided to you for this.

If you do not want to appear on the recording, then camera maybe turned off

Attendees, please put your mics on mute if not already

Please have your lunch and self provided fancy cakes and teas etc..



Mics: Off

How To Ask Questions

- Add you question to the chat or feel free to ask at the end

- We will provide you a summary of Q and A at the end of the six sessions and this will be emailed to all participants via the Surrey Hub.

Surrey Training Hub

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DEPRESSION & ANXIETY LUNCH AND LEARN

SURREY HEARTLANDS Health and Care Partnership

3 x 1-hour sessions designed for primary care prescribers
Delivered by specialists from SABP and Surrey Heartlands

Session Dates & Topics

Thursday 13th February | 1-2 PM
Part 1 - Identifying and Documenting
Part 2 - Pharmacological treatments

Thursday 6th March | 1-2 PM
Part 3: How clinicians can support patients in deciding if medicine is appropriate and which one?
Part 4: Monitoring of Pharmacological Treatments

Thursday 13th March | 1-2 PM
Part 5: Swapping or Stopping
Part 6: Resources and Referrals

Who Should Attend?

Primary care prescribers and healthcare professionals interested in improving care pathways and outcomes for patients with depression and anxiety.

NHS England

If you missed Part 1 and 2 on 13th February 2025

Please click here to view the recording and here to access the slides which are on the Surrey Training Hub website (www.surreytraininghub.co.uk)

(The video is protected, contact Surrey Training Hub to obtain the password.)

Part 1: Identifying and documenting

- How to differentiate between depression and anxiety including use of screening tools (PHQ2, PHQ9, HADS and GAD)
- State the prevalence and symptoms of Depression & Anxiety
- State why optimising antidepressants is a national priority (overview of NICE guidance)
- How to correctly document consultations utilising SNOMED codes and meeting QOF requirements

Part 2 : Pharmacological treatments

- Overview of medicines used in pharmacological management of depression and anxiety (in line with severity of condition)
- Consider risk assessments and safety netting (including suicidality, harms and safeguarding)
- State when to refer to secondary care services

If you missed Part 3 and 4 on 6th March 2025

Please click here to view the recording and here to access the slides which are on the Surrey Training Hub website (www.surreytraininghub.co.uk)

(The video is protected, contact Surrey Training Hub to obtain the password.)

- **Part 3: How clinicians can support patients in deciding if medicine is appropriate and which one?**

- Outline the importance of Shared Decision Making and tools available to support this process
- How to discuss treatment options for depression and anxiety with patients (in line with treatment pathway recommendations)

- **Part 4: Monitoring of pharmacological treatments**

- State the monitoring requirements for medication review in depression and anxiety
- Ensure those who need review are recalled as part of annual health check

Part 5: Swapping or Stopping Antidepressants

Learning Outcomes

Switching anti-depressant treatments, discontinuation and deprescribing (why, when and how)

Identify those at high risk of discontinuation

How to differentiate between withdrawal and relapse

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Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults

NICE guideline [NG215]

For a better life

Before starting medicines associated with dependence or withdrawal symptoms

This is a summary of recommendations 1.3.1 to 1.3.5 in the NICE guideline on medicines associated with dependence or withdrawal symptoms. It is intended to support prescribers before starting treatment with an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant. It is not an exhaustive list but should supplement standard prescribing practice. The guideline includes more detailed information for prescribers on supporting people (section 1.1) and making decisions (section 1.2) using a collaborative and person-centred approach.

Give verbal and written information about the medicine

Before starting an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant, discuss:

- All other suitable management options, including non-pharmacological approaches, and ensure that they have been offered
- Potential side effects and if they are likely to be temporary or permanent and improve or worsen over time
- Any implications if pregnant or planning pregnancy
- Possible difficulties with stopping the medicine and how to manage this
- That missing doses may lead to symptoms of withdrawal
- How to store their medicine safely
- Options if the medicine does not work

For an opioid, benzodiazepine, gabapentinoid or Z-drug, also discuss:

- That dependence is common with these medicines but not a reason to avoid them
- The potential for developing problems associated with dependence and risk factors (such as mental health problems, history of drug misuse, taking an opioid with a benzodiazepine)
- Symptoms that suggest the development of problems associated with dependence and the importance of telling people close to them about the symptoms

For an antidepressant or gabapentinoid, also discuss:

- That any benefits may occur slowly and side effects might be experienced first, but many side effects ease over time

Discuss and agree a medicines management plan

Include in the medicines management plan:

- What the medicine has been prescribed for
- Intended outcomes of treatment and how these might be assessed
- Starting dose and intervals between dose adjustments or titrations
- Who to contact if problems occur
- How long the medicine will take to work and how long they might be taking it for
- Duration of each prescription that will be issued
- Risks of taking more than the prescribed dose
- Symptoms of an overdose and what they should do if this happens
- Plans for reviewing the medicine, including when, where and by whom their next review will be done

NICE National Institute for Health and Care Excellence

Reviewing medicines associated with dependence or withdrawal symptoms

This is a summary of recommendations 1.4.5 and 1.4.6 in the NICE guideline on medicines associated with dependence or withdrawal symptoms. It is intended to support healthcare professionals carrying out medicines reviews for people taking an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant. It is not an exhaustive list but should supplement standard practice for reviews, including the advice on reviewing medicines in the NICE guidelines on medicines optimisation and medicines adherence. The guideline includes more detailed information on reviewing medicines (section 1.4) and making decisions about withdrawing medicines (section 1.5) using a collaborative and person-centred approach.

Regularly review the person's medicines and update their management plan

At each medicines review for people taking an opioid, benzodiazepine, gabapentinoid, Z-drug or antidepressant, discuss:

- The benefits and risks of continuing the current dose, adjusting the dose or stopping the medicine
- The benefits or harms the person is experiencing from continuing the medicine
- Any signs that the person is developing problems associated with dependence such as:
  - running out of a medicine early
  - making frequent requests for dose increases
  - reporting that a medicine that was working well previously is no longer working
- The person's preferences for continuing the current dose, adjusting the dose or stopping the medicine
- Who to contact if they have problems or concerns

Agree and update the management plan with the person and give them a copy

Add your notes here

Public Health England

Protecting and improving the nation's health

Dependence and withdrawal associated with some prescribed medicines

An evidence review

For a better life

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A sea of troubles – prescription drug dependency

Patients who become dependent on prescription drugs often lack the support and information they need. Following years of work by the BMA and campaigners, they are being promised new services and clinical guidelines. Peter Blackburn reports

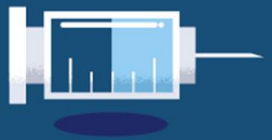
Drug misuse related deaths – have been increasing

- Number related to prescription medicines is not known (likely to be a small proportion)

Public Health England

Healthmatters Drug misuse deaths by subst

All drug poisoning deaths registered in England and Wales in 2015
3,674 (3,416 of which were in England)



Opiates (including heroin, methadone)
1,989

Benzodiazepines
366

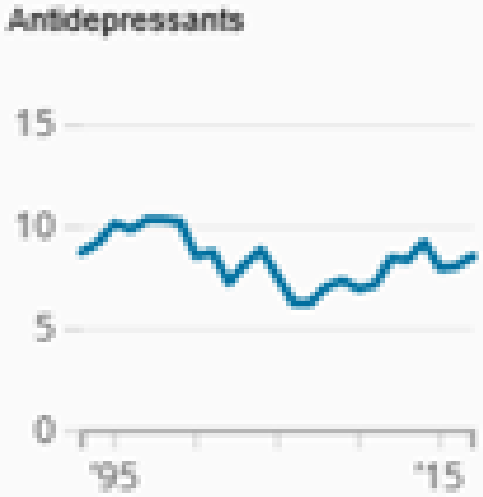
Amphetamines
157

Anti-depressants (in combination)
447

Cocaine
320

1/3
of drug misuse deaths involve alcohol

Figure 6: Age-standardised mortality rates for selected substances, deaths registered between 1993 to 2017



Ten deaths per year per million pop associated with Antidepressantts

Margaret Feeney: Prevention of Future Deaths Report - Courts and Tribunals Judiciary

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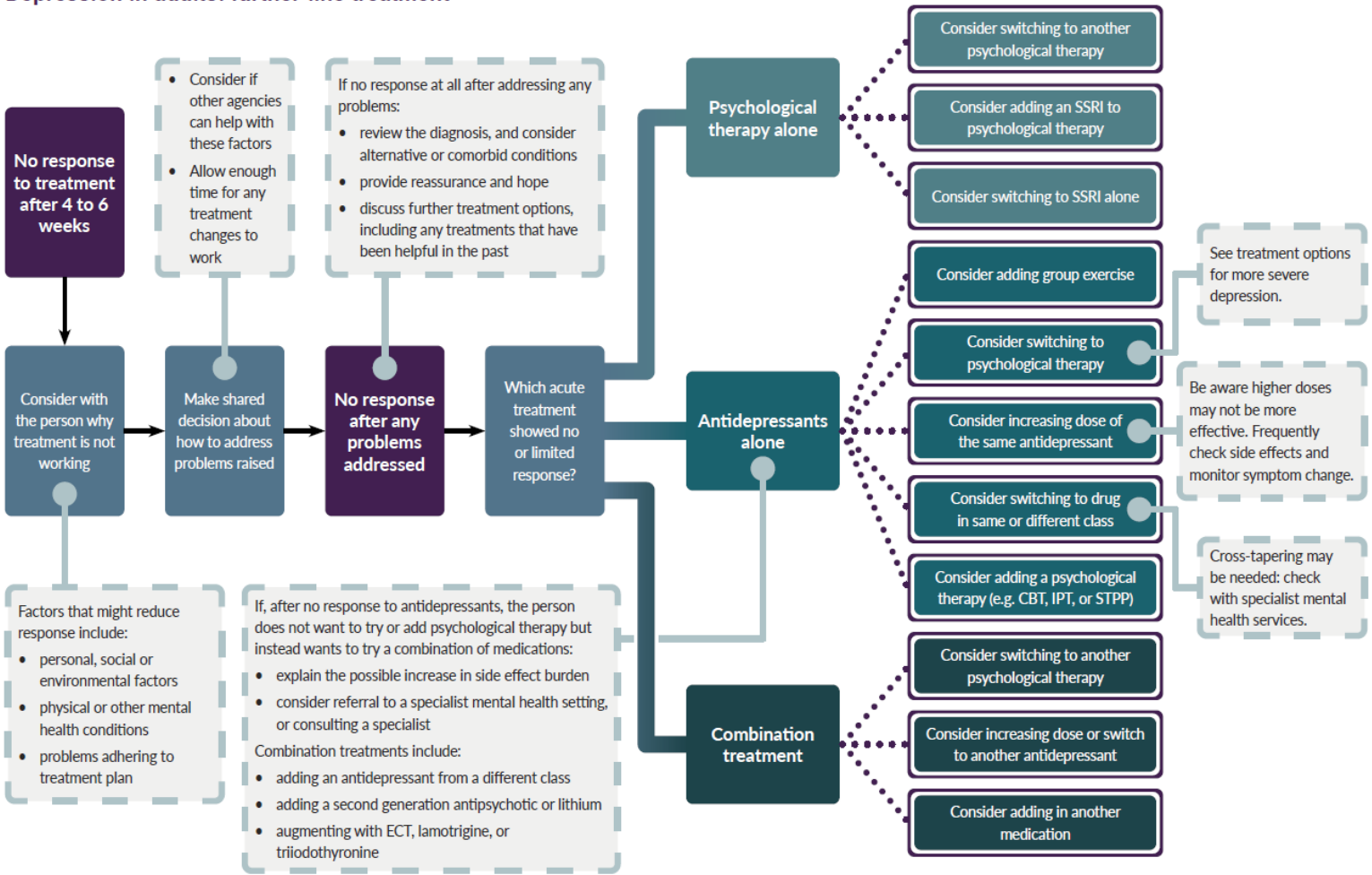
- Margaret died due to taking excess prescribed medication which she had become dependent on and addicted to.
- She had access to excess medication because of medical prescribing decisions and arrangements leading up to a bank holiday period.
- Margaret had a long history of being prescribed benzodiazepines and codeine, the latter medication for pain for diagnosed conditions. Unfortunately Margaret had become dependent on those medications and was recognised to overuse them. As a consequence, she was given seven-day prescriptions.

Depression in adults: further-line treatment



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Switching Antidepressants

Need to consider:

diagnosis

non-medication options

reason for switch

tolerability

adverse effects

risk of serotonin syndrome

properties of antidepressant(s)

Examples:

Fluoxetine to other SSRIs or SNRIs – stop fluoxetine and wait 4 to 7 days

Other SSRIs to other SSRIs – direct switch possible

Other SSRIs to SNRIs – direct switch possible

MAOIs must have 2-week washout – check guidance

Useful Resources:

Switching – SPS - Specialist Pharmacy Service

Maudsley Prescribing Guidelines

Psychotropic Drug Directory

Advice & Guidance service (if patient specific guidance needed)

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When to stop antidepressants..?

Antidepressant use may be considered inappropriate when:

the antidepressant is not working	the depression or anxiety has resolved	the harms of the antidepressant outweigh the benefits	the patient wants to stop taking the antidepressant	the patient has experienced previous difficulties with withdrawing

Inappropriate use may lead to patient harm from problematic polypharmacy, adverse-effects, or both

SPS: Deprescribing of antidepressants for depression and anxiety

Highest potential risk	Medium potential risk	Low potential risk	Lowest potential risk
Desvenlafaxine	Amitriptyline	Dosulepin	Agomelatine
Duloxetine	Bupropion	Mianserin	Lofepramine
Isocarboxazid	Citalopram	Trimipramine	
Mirtazapine	Clomipramine	Vortioxetine	
Moclobemide	Desipramine		
Paroxetine	Doxepin		
Phenelzine	Escitalopram		
Tranylcypromine	Fluoxetine		
Venlafaxine	Fluvoxamine		
	Imipramine		
	Nortriptyline		
	Reboxetine		
	Sertraline		
	Trazodone		

For a b

RCPsych - Stopping antidepressants

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Symptoms of antidepressant discontinuation / withdrawal

- anxiety which comes and goes, sometimes in intense 'surges'
- difficulty in getting to sleep and vivid or frightening dreams
- low mood, feeling unable to be interested in or enjoy things
- a sense of being physically unwell
- rapidly changing moods
- anger, sleeplessness, tiredness, loss of co-ordination and headache
- the feeling of an electric shock in your arms, legs, or head. These are sometimes called ‘zaps’ and turning your head to the side can make them worse.
- a feeling that things are not real (‘derealisation’), or a feeling that you have ‘cotton wool in your head’
- difficulty in concentrating
- suicidal thoughts
- queasiness
- dizziness (this is usually mild, but can be so bad that you can’t stand up without help)
- a feeling of inner restlessness and inability to stay still (akathisia)

Discontinuation

- Considering non-specific effects, as evidenced in placebo groups, the incidence of antidepressant discontinuation symptoms is approximately 15%, affecting one in six to seven patients who discontinue their medication.

For a better life

https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(24)00133-0/fulltext

Incidence of antidepressant discontinuation symptoms: a systematic review and meta-analysis

Jonathan Henssler*, Yannick Schmidt, Urszula Schmidt, Guido Schwarzer, Tom Bschor, Christopher Baethge*

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See Comment page 485

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Summary

Background Antidepressant discontinuation symptoms are becoming an increasingly important part of clinical practice, but the incidence of antidepressant discontinuation symptoms has not been quantified. An estimate of antidepressant discontinuation symptoms incidence could inform patients and clinicians in the discontinuation of treatment, and provide useful information to researchers in antidepressant treatments. We aimed to assess the incidence of antidepressant discontinuation symptoms in patients discontinuing both antidepressants and placebo in the published literature.

Methods We systematically searched Medline, EMBASE, and CENTRAL from database inception until Oct 13, 2022 for randomised controlled trials (RCTs), other controlled trials, and observational studies assessing the incidence of antidepressant discontinuation symptoms. To be included, studies must have investigated cessation or tapering of an established antidepressant drug (excluding antipsychotics, lithium, or thyroxine) or placebo in participants with any mental, behavioural, or neurodevelopmental disorder. We excluded studies in neonates, and those using antidepressants for physical conditions such as pain syndromes due to organic disease. After study selection, summary data extraction, and risk of bias evaluation, data were pooled in random-effects meta-analyses. The main outcome was the incidence of antidepressant discontinuation symptoms after discontinuation of antidepressants or placebo. We also analysed the incidence of severe discontinuation symptoms. Sensitivity and meta-regression analyses tested a selection of methodological variables.

Findings From 6095 articles screened, 79 studies (44 RCTs and 35 observational studies) covering 21 002 patients were selected (72% female, 28% male, mean age 45 years [range 19·6–64·5]). Data on ethnicity were not consistently reported. 16 532 patients discontinued from an antidepressant, and 4470 patients discontinued from placebo. Incidence of at least one antidepressant discontinuation symptom was 0·31 (95% CI 0·27–0·35) in 62 study groups after discontinuation of antidepressants, and 0·17 (0·14–0·21) in 22 study groups after discontinuation of placebo. Between antidepressant and placebo groups of included RCTs, the summary difference in incidence was 0·08 [0·04–0·12]. The incidence of severe antidepressant discontinuation symptoms after discontinuation of an antidepressant was 0·028 (0·014–0·057) compared with 0·006 (0·002–0·013) after discontinuation of placebo. Desvenlafaxine, venlafaxine, imipramine, and escitalopram were associated with higher frequencies of discontinuation symptoms, and imipramine, paroxetine, and either desvenlafaxine or venlafaxine were associated with a higher severity of symptoms. Heterogeneity of results was substantial.

Interpretation Considering non-specific effects, as evidenced in placebo groups, the incidence of antidepressant discontinuation symptoms is approximately 15%, affecting one in six to seven patients who discontinue their medication. Subgroup analyses and heterogeneity figures point to factors not accounted for by diagnosis, medication, or trial-related characteristics, and might indicate subjective factors on the part of investigators, patients, or both. Residual or re-emerging psychopathology needs to be considered when interpreting the results, but our findings can inform clinicians and patients about the probable extent of antidepressant discontinuation symptoms without causing undue alarm.

Funding None.

Introduction

The occurrence of adverse symptoms following the discontinuation of antidepressants is increasingly becoming a topic of research in psychiatry, and is also gaining attention in clinical practice, with patients, and in the general media.[1] The emergence of adverse symptoms was described as early as 1959,[2] but remained largely neglected until the late 1990s. Until very recently, guidelines have been criticised for referring to the duration of typical antidepressant discontinuation symptoms as 1–2 weeks, ignoring evidence of longer courses.[3,4] Experiences occurring after antidepressant discontinuation have been called withdrawal symptoms, phenomena, or events, or antidepressant discontinuation symptoms, syndromes, or symptomatology. In this Article, we refer to antidepressant discontinuation symptoms. Antidepressant

High risk of discontinuation

Between a third and half of people who take an antidepressant will experience such symptoms to some extent. We cannot yet predict who will get these symptoms.

The risk seems to be greater if taken a high dose for a long time

It can also depend on the type of antidepressant

If you stop taking an antidepressant suddenly or if you reduce the dose quickly

Examples of tapering – for majority of patients

Examples of tapering – proportional tapering

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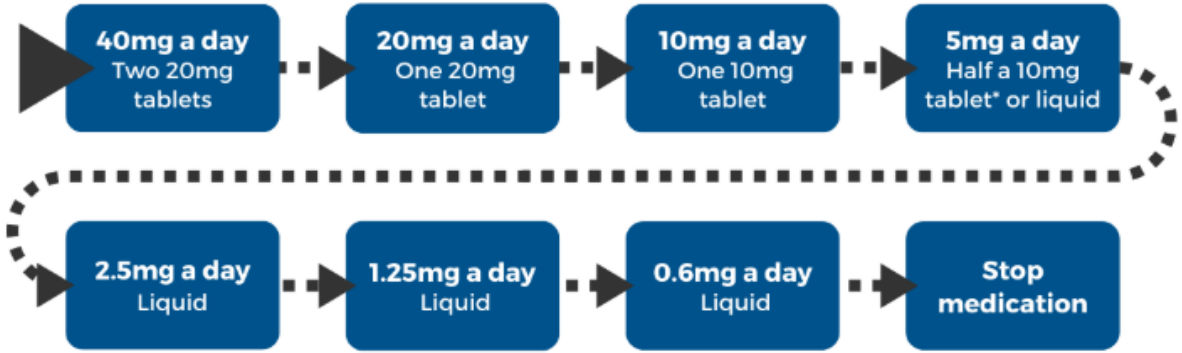
Example 1

In this example, you would reduce your current dose by approximately 50% every 2-4 weeks.

Some people may need to reduce more slowly still, which you can see in Example 2.



*Not all tablets are suitable to be halved. Check with your pharmacist or prescriber before doing this.

RCPsych Stopping antidepressants

Examples of tapering

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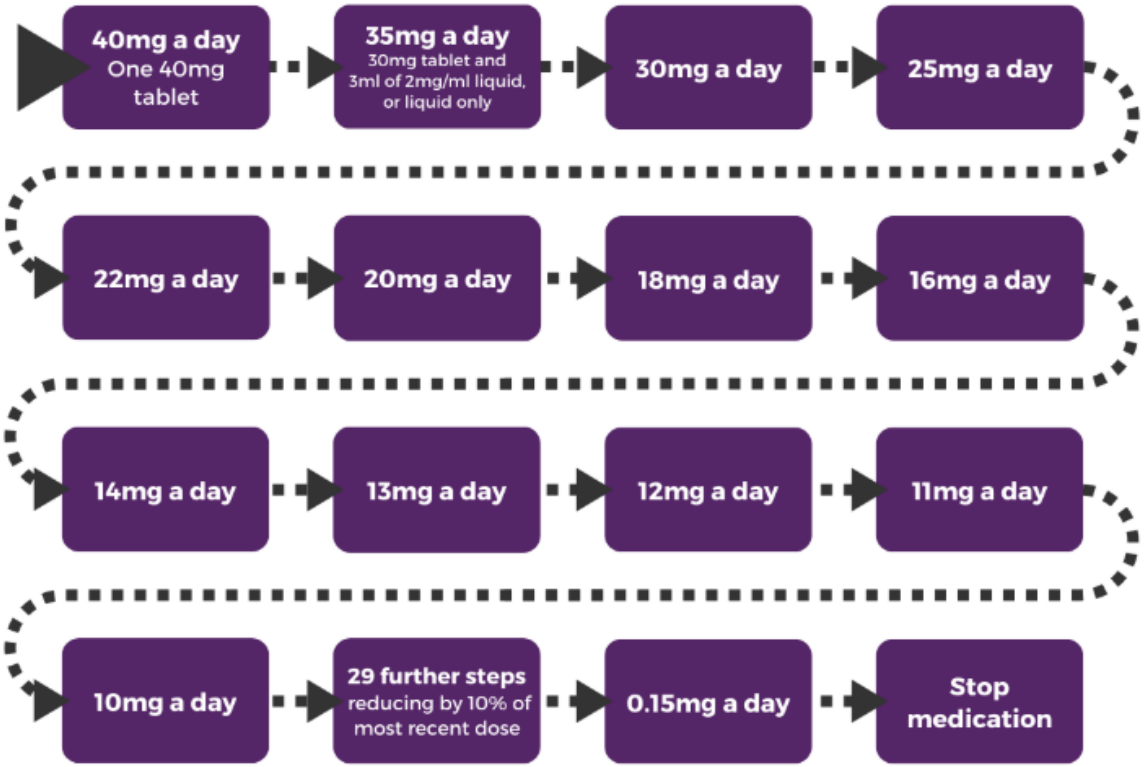

RCPsych Stopping antidepressants

Case Discussion

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27 year old male

- Depression and Anxiety

Venlafaxine started in final year of university; symptoms resolved with treatment

Wanting to stop but experiencing significant discontinuation / withdrawal

Current Medication

- Venlafaxine XL 75mg tablets at night

Worked example – hyperbolic tapering

Switch Venlafaxine 75mg XL OD to Venlafaxine 37.5mg (in 5ml) liquid BD

Enable a slower reduction by 10% of the last dose, every 2-4 weeks

Taper example:

- Reduce total dose by 10% then review at 2 to 4 weeks e.g. 33.75mg (4.5ml) BD
- Then reduce by 10% of the previous dose e.g. 30mg (4ml) BD - review at 2 to 4 weeks
- Continue as 3.6ml BD, 3.2ml BD, 2.9ml BD, 2.6ml BD, 2.3ml BD, 2ml BD, 1.8ml BD, 1.6ml BD, 1.4ml BD, 1.3ml BD, 1.2ml BD, 1.1ml BD, 1ml BD, and so on…

Withdrawal vs Relapse

TABLE 2 **Distinguishing features between antidepressant withdrawal symptoms and relapse of an underlying condition**

	Withdrawal symptoms	Relapse
Time of onset	Often within hours or days of reducing or stopping antidepressant (but can be delayed for fluoxetine and in some cases of withdrawal)	Usually weeks or months after stopping an antidepressant (may not be a characteristic of some patients' conditions)
Duration	Can range from days to months or years	Variable
Response to reinstatement	Improvement can be within hours or days (especially if reinstatement occurs soon after symptom onset)	Usually delayed by weeks
Attending physical symptoms	Characteristic accompanying symptoms, e.g. dizziness, nausea, headache, sweating, muscle ache and brain 'zaps', may be pathognomonic	Not commonly associated – core symptoms are psychological and cognitive; neurovegetative symptoms can be a feature; individual patients' episodes may have typical characteristics
Pattern of symptoms	Wave pattern – onset, worsening, peak, improvement and resolution often over days or a few weeks for small dose reductions	Usually more constant over time

Withdrawal vs Relapse

- When a patient reports low mood, anxiety or insomnia following dose reduction or stopping an antidepressant the clinician should:
  - in addition to considering the possibility of relapse, hold a high index of suspicion for antidepressant withdrawal symptoms, as these are common
  - inquire about the symptoms of the original condition: are they different from the symptoms that are currently reported?
  - inquire about the presence of symptoms indicative of withdrawal syndrome such as electric shock (‘zap’) sensations in the head, dizziness, nausea, headache (and other symptoms).
  - inquire about the timing of these symptoms – did they arise a few days after stopping an antidepressant (or weeks after stopping fluoxetine)?

Withdrawal vs Relapse

- inquire about the pattern of these symptoms – have they continued to worsen in the days and weeks after stopping or reducing the antidepressant?
- inquire about past experience of stopping antidepressants – have similar symptoms occurred?
- if the patient has trialled an increase in dose, did this lead to a lessening of these symptoms? How long did this improvement take?
- guided by Table (slide 30), make a diagnosis of antidepressant withdrawal syndrome if it is concluded that a withdrawal syndrome is likely
- following guidance from the RCPsych (Burn Reference Burn, Horowitz and Roycroft2020), suggest increasing the dose back to the last dose at which the patient was stable, allow a period of stabilisation and then suggest reduction in a more gradual manner than previously tried

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Part 6: Resources and referral

Learning Outcomes

Services and resources available to support primary care (for patients and healthcare professionals)

An overview of SABP services i.e. Advice & Guidance, GPimhs and CMHRS

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Group Discussion

Please share via the chat function:

What services and resources do you find helpful for either patients or healthcare professionals?

Useful Websites

- SPS: Deprescribing of antidepressants for depression and anxiety
- RCPsych: Stopping antidepressants
- The Maudsley Deprescribing Guidelines
- A 50-minute video presentation by Dr Mark Horowitz

- Welcome to benzo.org.uk: Main Page
- Deprescribing Guidelines and Algorithms: Deprescribing.org

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Advice and Guidance

- Initially a 1 yr pilot led by Pharmacy, made permanent a year ago
- Advanced Specialist Pharmacist
- Consultant Psychiatrist input
- Covers working age and older age adults
- **Non-Urgent service** with 10 working days response time
- Conversion to referral to SPA

Service specification	Advice and Guidance	GPimhs/ MHICs
Interface	Digital via eRS	Digital/ MDT/ face-2-face/ phone
Contact	Advice given by Professional to Professional	Consultation with patient, with MDT support (Mental Health Practitioner, Community Connectors, Pharmacy, Psychiatry, Charitable organisations/ Social Care)
Expertise	Pharmacy Led with Psychiatry support	Psychology Led with MDT support
Route of access	National platform eRS	Request for service form submitted via EMIS
Turnaround time	5 working days	Based on urgency
Level of Medication review	Brief guidance issued – no assessment with the individual	Level 2 and 3 reviews, with phone or face-2-face consultation with individual.
Access criteria	Specific well defined clinical question	Individual will require a broader assessment

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What Advice and Guidance 'can do'

Provide access to Advanced Specialist Mental Health Pharmacist and Consultant Psychiatrist for brief advice

Provide answers to medical or medication related questions relating to mental health issues

Help in supporting GPs and other Primary Care Healthcare Professionals/ Prescribers to manage people needing help within the GP Practice setting

Escalate to a referral where appropriate

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Advice & Guidance - 'do nots'

A&G will not assess the patient directly – if a patient assessment is necessary, then refer to SPA

SABP services have been asked to respectfully ask GP surgeries to redirect their enquiries to the A&G service for working age adults which can be accessed via eRS – this can save valuable time

Please do not send the same referral to different services – there is a risk of being given different advice / falling through net

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Remember!

Do come back if you need more advice

Please do check there is a question in the conversation box!

Please give us feedback as we love to hear how we can improve our service

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A&G vignette

53-year-old lady, significant trauma in her life

she is struggling and feeling really quite low, shows signs of depression and in her low periods will just sleep most of the time and want to retreat and hide

never feels suicidal or self-harms

in 2023 she had a normal QT which is now prolonged possibly due to her antidepressants which have been increased - ECG attached (QTc of 472 ms)

She is on both Escitalopram 20mg and Buspirone 10mg BD

more specialist advice and support requested as changing or decreasing these medications could significantly destabilise her

Accessing mental health support in Primary Care

Identify mental health and wellbeing need

Patient needs support to access help but is safe to stay in primary care
Referral to GPimhs

Patient can access help without support or with Social Prescriber

GPimhs team:

- **Community Connector** – focussed on social issues and behaviour change, supporting to access resources.
- **Mental Health Practitioner** – Focussed on complexity/risk and link with mental health services
- **Psychologist** – to support team decisions and offers some limited brief interventions
- **Psychiatrist** – to support team and advise GP prescribing
- **Pharmacy** – to advise psychiatry and GPs.
- **Administrator** – organise referral flow and bookings.

GPIMHS
GP Integrated Mental Health Service

- **Psychosocial assessment, formulation, action planning, risk assessment**
- **Brief interventions** (e.g. managing emotions skills, activity scheduling, problem solving)
- **Up to 4 initial sessions** booked consecutively, then option to self-book directly subsequently, indefinitely
- **Low to moderate risk** - needs to be able to wait between appointments
- **GP liaison** – supporting GPs with their patients

GPimhs can support engagement with community services

Community support services, including:

- Adult Social Care & Safeguarding
- Recovery College
- CAB, Benefits tenancy support, housing
- Carers support services
- Mary Frances Trust and RF employment support
- ESDAS domestic violence support
- Substances services (i-access, Catalyst, AA)
- IAPTS talking therapy and groups
- Children's centres and services

Interventions for managing intense emotions

GPimhs can refer to these programs – for patients with PD traits:

- **Managing Emotions Pathway (MEP)- 3** workshops
- **Carer Workshop** – to explain EUPD traits and support carers
- **Service User Network (SUN) –** support groups available daily
- **PICT –** staff/team consultations for complex dynamics

- *Patients can book again directly with GPimhs*
- *Changes way people seek support*

GPimhs referral to SPA enhanced by close relationship

Secondary care provides periods of support for higher risk and complex interventions

Transforming Community Mental Health Care: Surrey and Borders Partnership NHS Foundation Trust

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Find out more about your local GPimhs teams

Find out more about the AEDimhs

Find out more about the MEP

Find out more about SUN

Find out more about Lived Experience Practitioners

Find out more about HOMEFirst

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Mental health crisis helpline (all ages)

- 24-hour support is available to all in Surrey and North-East Hampshire experiencing a mental health crisis
- Call **0800 915 4644** for free if you or someone you care for is in a crisis
- If you are at immediate risk of harm, call **999**
- Get help in a mental health crisis: Surrey and Borders Partnership NHS Foundation Trust

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Q&A session

Surrey and Borders Partnership
NHS Foundation Trust

Feedback

Please complete the evaluation form for this session
13th March 2025
Thank you ☺

Scan the QR or use link to join

https://forms.office.com/e/nB3FSPP5Jb

Surrey Training Hub

NHS Surrey and Borders Partnership NHS Foundation Trust

DEPRESSION & ANXIETY LUNCH AND LEARN

SURREY HEARTLANDS Health and Care Partnership

3 x 1-hour sessions designed for primary care prescribers
Delivered by specialists from SABP and Surrey Heartlands

Session Dates & Topics

Thursday 13th February | 1-2 PM
Part 1 - Identifying and Documenting
Part 2 - Pharmacological treatments

Thursday 6th March | 1-2 PM
Part 3: How clinicians can support patients in deciding if medicine is appropriate and which one?
Part 4: Monitoring of Pharmacological Treatments

Thursday 13th March | 1-2 PM
Part 5: Swapping or Stopping
Part 6: Resources and Referrals

Who Should Attend?

Primary care prescribers and healthcare professionals interested in improving care pathways and outcomes for patients with depression and anxiety.

NHS England

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Thank you

For a better life