

Management of depression in primary care - A cross-sectional study in the North-East of England, UK

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Abstract

Background: Depression is a common and serious disorder that impairs quality of life. Since general practitioners (GP) are considered gatekeepers to secondary care, the choice of interventions offered in primary care can have a significant impact not only on patients' quality of life, but also on health service demands.

Objective: To evaluate the confidence of GPs in diagnosing and managing depression; and, to assess the factors influencing their strategy in treating depression.

Methods: A cross-sectional study was carried out among GPs working in the North-East of England, UK. The survey questionnaire consisted of mostly close-ended questions with some allowing for free-text comments (see Appendix 1). The responses obtained were analysed using Microsoft Excel.

Results: Among the total of 63 respondents, most GPs were comfortable diagnosing depression. Most would consider combining talking therapies with antidepressants (68.3%) at presentation, followed by referral to talking therapies alone (41.2%). In only 14.3% of cases would antidepressant therapy alone be considered. For those patients non-responsive to initial treatment, 25.4% considered offering a different antidepressant or adjunct medication (such as a sedative, anxiolytic, or beta-

blocker), and another 25.4% of GPs considered a combination with another antidepressant. 46.0% of participants were not comfortable prescribing dual antidepressants due to concerns about side effects, lack of experience, paucity of guidelines, and lack of timely access and guidance from the local mental team. Nearly all (98.4%) GP participants would agree to prescribe dual antidepressants on advice of the mental health team with telephone advice being the preferred means of communication in 65.1% of cases.

Conclusion: The results of this study can help to develop closer co-operation between primary and secondary care by not only upskilling GPs through various means (educational events, training posts, etc.), but by also creating better communication channels at the interface between those two services.

Key words: antidepressants, combination therapy, depression, primary care, primary-secondary care interface

Introduction

Mental disorders are a growing public health problem with a considerable burden world-wide (1). Depression causes significant morbidity, increased mortality, reduced functioning, and loss of quality of life with resulting social and economic impact (2). In the UK in 2014, it was estimated that 19.7% of people aged 16 and above had symptoms of anxiety or depression – a 1.5% rise from the year before (3).

Although antidepressants are well-established in the treatment of depression, only 50–60% of patients respond to first-line treatment and experience complete remission of symptoms (4). For non-responders who are compliant with an adequate dose of medication, current guidelines recommend either switching (either within or between classes), augmentation with a non-antidepressant medication, or combination therapy (5). However, evidence on effectiveness of combination antidepressant therapy is limited (4). Psychotherapy can also be considered at any point alongside pharmacological treatment. In addition, in those where there is limited response to treatment, secondary care services can be involved (5,6).

There has been some work done in primary care to understand how GPs approach the treatment of depression (7,8). Several factors may impact on a treatment strategy including clinician factors such as knowledge, skills, and time-pressure; patient factors such as comorbidities, socio-cultural background, and choice; availability and access to talking therapies; prescribing costs, etc. to name just a few.

This study aimed to explore the ease and confidence with which primary care colleagues identify and treat depression, and to look at some of the factors that may have a bearing on the management of this condition. It is hoped that this will help to inform any changes that may be needed in the way local secondary mental health services co-operate with primary care. Assessing the experience of GPs will also help to identify ways of better supporting and empowering them in managing depression within primary care.

Methods

A cross-sectional study was carried out among GPs working in the North-East of England, UK. GPs of more than 4 years' experience were surveyed. They were invited to reflect on their experiences and a questionnaire (see Appendix 1) was used to capture their responses. The opinion and help of a consultant psychiatrist working for the local mental health trust (Tees, Esk and Wear Valley Foundation NHS Trust) was sought in designing both this study and the questionnaire.

Between March 2020 and May 2020, 80 GPs were contacted by email with an outline of what the research entailed. The email also included a link to an online questionnaire on surveysparrow.com – which allowed responses to be captured anonymously. Around 8–10 weeks were allowed for responses and a reminder was sent half-way through for those who had yet to complete the survey.

The survey questionnaire was divided into three parts. The first part consisted of questions to assess the ability of GPs and their confidence in diagnosing depression. The second part looked at the management options for depression and factors influencing prescribing. The third part focused on how comfortable they felt in using combination therapy including dual antidepressants in those patients who do not demonstrate any improvement initially.

The responses were analysed using Microsoft Excel.

Results

A total of 63 (78.8%) GPs responded.

Diagnosis of depression

The confidence levels of GPs in diagnosing depression were generally high with a score ranging from 8 to 10 (mean of 8.6) for the majority (80.9% of respondents). The details are given in Table 1.

Table 1: Confidence of GPs in diagnosing depression

Question	Response	Number	%
How comfortable are you in making a diagnosis of depression?	Score of 5	1	1.6
	Score of 6	0	0
	Score of 7	11	17.5
	Score of 8	22	34.9
	Score of 9	16	25.4
	Score of 10	13	20.6
Do you categorise depression as Mild/Moderate/Severe in routine appointments?	Yes	36	57.1
	No	27	42.9
Are there any circumstances where you might question your diagnosis of depression?	No improvement with antidepressants and/or CBT	31	49.2
	Multiple consultations on the part of the patient despite objective improvement	27	42.9
	Other features making the diagnosis less clear-cut e.g mania, hypomania, anxiety, personality traits etc	52	82.5
	Patient rejecting diagnosis	6	9.5
	Lack of confidence in making the diagnosis	2	3.2
	Other	5	7.9

36 out of 63 GPs (57.1%) would normally categorise depression in terms of severity. The main reason for not able to do so was due to other co-existing features making the diagnosis less obvious. This was followed closely by a lack of improvement to initial treatment.

Management of depression

The details of the various management options are given in Table 2.

Table 2: Management options for depression

Question	Response	Number	%
What is your preferred initial management plan in mild to moderate cases of depression when someone is at low risk?	Refer to IAPT services/talking therapy	26	41.2
	Start on antidepressants	9	14.3
	Both IAPT services/talking therapy and antidepressants are suggested and the patient decides after discussing the options	43	68.3
What influences your management plan?	Level of confidence with the prescription of and overseeing the management with antidepressants	21	33.3
	CBT is more likely to be useful and is not associated with side-effects	17	27.0
	IAPT services/talking therapy are not easily accessible where I work	15	23.8
	Shared-management is something I strive for in my practice	39	61.9
	Time constraints – I chose what I think is more likely to suit the patient's needs	8	12.7
	Other	1	1.6
What are the factors that make you more likely to choose a particular antidepressant?	Safety profile of medication/side-effect	49*	N/A
	Patient co-morbidities	41*	N/A
	Previous use of a specific antidepressant	46*	N/A
	Use of other medications which might interact with an antidepressant	34*	N/A
	Local/national guidelines	36*	N/A
	Other reasons	12*	N/A
	* Average score assigned based on order in which option was ranked against others		
If choosing antidepressants or other medication, what is your preferred first line?	SSRI	63	100

A significant proportion (68.3%) favoured a combination of both antidepressants and talking therapies and would share the options with patients followed by 41.2% who would consider just talking therapies initially. Antidepressants alone would only be used by about 14.3% of GPs. If prescribing, 100% of GPs would prescribe an SSRI as their first-line drug and the reason for this choice is due to its safety profile. Other factors influencing prescribing include – in that order – previous response to treatment, patient comorbidities, the existence of guidelines which clinicians could refer to and drug interactions.

When asked what influences their management plan, 61.9% of GP respondents aimed for a shared management plan which took into account patient preferences, while in 12.7% of cases, time pressure meant that a clinician would decide for the patient. Talking therapies was not seen as being an easily accessible option by 23.8% of GPs.

Combination therapy including dual antidepressant use

In cases where an SSRI did not benefit a patient (assuming compliance and optimal dosing), a further consultation to agree on a better option would be carried out in most instances (88.9%). An equal number (25.4%) stated that they would consider either adding in an alternative antidepressant or offering an alternative medication (such as a different antidepressant or non-antidepressant medication such as beta-blockers, anxiolytics, or sedatives). In those combining treatment, the most favoured medication to be considered as an add-on was Mirtazapine (41.5%) as an antidepressant, and a beta-blocker as a non-antidepressant (41.5%).

The rationale for using combined pharmacotherapy was to help further with symptom management including insomnia and anxiety when the patient was already established on an adequate dose of a first-line antidepressant. The responses are summarised in Table 3.

Table 3: Use of combination therapy including dual antidepressants

Question	Response	Number	%
Do you feel comfortable combining additional antidepressants/other medication?	Yes	34	54.0
	No	29	46.0
If yes, what would be your choice of add-on medication – assuming there is no contraindication? (N=34)	Mirtazapine	22	41.5
	Anxiolytics	3	5.7
	Venlafaxine	4	7.5
	Sedative	2	3.8
	Beta Blocker	22	41.5
If you were choosing to add in a second antidepressant what would be the rationale? (N=33)	Symptom management e.g. insomnia, anxiety	23	35.9
	Patient already on a decent dose of first antidepressant	22	34.4
	CBT not working	8	12.5
	On (and only on) advice of mental health team	8	12.5
	Not applicable – I do not feel comfortable prescribing combination medication	3	4.7
What makes you comfortable using a combination of antidepressants? (N=31)	Experience in dealing with similar patients over many years as a GP	21	28.0
	Previous training in psychiatry	13	17.3
	Attending online lectures/online courses/local mental health updates	10	13.3
	Advice from mental health team colleagues	18	24.0
	Local guidelines	11	14.7
	Not applicable as I am not comfortable using a combination	2	2.7
If you are not comfortable prescribing a second antidepressant, is it because of: (N=29)	Lack of experience in this area of mental health	12**	N/A
	Lack of access to timely advice/guidance from the local mental health team	8**	N/A
	Local guidelines advise not to use combination of antidepressants in primary care	11**	N/A
	Concerns about side-effects, interactions, etc	15**	N/A
	Not applicable as I am not comfortable doing this	6**	N/A
** Average score assigned based on order in which option was ranked against others			

Owing to their previous experience, a fair proportion of GPs (at least 33.3%) surveyed were comfortable with a combination of antidepressant drugs. The most common reasons that would deter from combination therapy with 2

antidepressants are – in that order – concern about side-effects/interactions, lack of experience, paucity of guidelines, and lack of timely access and guidance from the local mental team.

A large proportion of GPs (74.6%) would be open to the idea of initiating a second antidepressant if appropriate education/resources were provided by secondary care. Nearly all (98.4%) GP participants would agree to prescribe dual antidepressants on advice of the mental health team – the medium of telephone (65.1%) seemed to be preferred followed by written advice (33.3%) either in the form of a letter or by email.

Discussion

Our study aimed to evaluate the confidence of GPs in diagnosing and managing depression, and to assess the factors influencing their strategy in treating depression. The use of an online survey which was distributed electronically allowed us to capture the views of a cross-section of practising GPs in a relatively wide geographical area of Teesside in the North-East of England, UK. Our primary care colleagues surveyed tend to rely on similar drug formularies, local guidelines and have access to the same mental health services (overseen by the Tees, Esk and Wear Valley Foundation NHS Trust).

Comparison of findings with existing literature/guidance
Most people with depression are managed in primary care in the UK (9). In our survey, most doctors (80.9%) felt confident in diagnosing depression but the wide heterogenous nature of this condition and associated presentation of patients made it less easy to always to certain about and label the condition.

Antidepressants are generally more effective for moderate or severe depression and less so for mild depression, for which active monitoring, physical activity, psychological therapies and/or social prescribing are preferred (6,7). Many patients with depression are likely to benefit from talking therapies but this is not always available. In the North-East of England, the Improving Access to Psychological Therapies (IAPT) programme has expanded in the last decade or so of its existence and psychological interventions can now benefit more people who can self-refer.¹⁰ In spite of this, talking therapies was not seen as being easily accessible by 23.8% of GPs in the study, although it is unclear whether this is to do with the way services are organised or patient and clinician expectations, which may both be influenced by waiting times. As a consequence, antidepressants are still widely prescribed.

NICE guidance (5) recommends that several factors are considered when prescribing antidepressants – these include age, side-effects, potential interactions, comorbidities, previous response to medication and potential harm from overdose or discontinuation symptoms. An SSRI is generally advised first-line. This was evident in the response of all 63 GPs surveyed who would prescribe

an SSRI in the absence of any obvious contraindication. Only about 50-60% of people who are treated with an adequate dose of an antidepressant for long enough show a demonstrable response (11,12). NICE further recommend that for people who do not respond, a dose increase or a switch (within the same class or to a different one) can be considered, especially if there are any side-effects (5). Vortioxetine is also a possible option for those who have not responded adequately to 2 different antidepressants (13).

Another possible strategy is that of antidepressant augmentation with lithium, an antipsychotic or another antidepressant such as Mirtazapine (14). NICE advise against the combination of antidepressants without first seeking advice from a psychiatrist (5). The use of benzodiazepines for more than 2 weeks alongside an antidepressant is generally not advised due to the risk of dependency, but benzodiazepines can be a useful adjunct in certain cases such as insomnia or increased anxiety either during initiation of or withdrawal from/switch of an antidepressant (5).

In our study both adding in another antidepressant and the switch to a different antidepressant or non-antidepressant medication such as a beta-blocker were equally favoured (41.5% in both instances). Mirtazapine was commonly cited as the second antidepressant of choice if a combination strategy with 2 antidepressants was adopted. There is some evidence on the efficacy of combining two antidepressants (15-18). However, it is interesting to note that a more recent trial in UK primary care failed to show any clinically important benefit of adding Mirtazapine to existing antidepressant treatment (9).

Contrary to NICE guidance which advises against the combination of antidepressants in primary care without liaising with specialist mental health services, it was interesting to note that at least 33.3% of total GPs surveyed felt comfortable initiating this strategy unsupervised based on their previous experience (either within primary care or previous training in psychiatry). With help from secondary care (telephone or written correspondence such as letters or email), almost every single GP surveyed would be happy doing so.

Combination therapy is not without its own risks though (19). There is the risk of serotonergic toxicity depending on combination used as well as less serious side-effects such as weight gain, sedation, dizziness, hypotension to name just a few.

Implications for practice

In order to allow patients – especially those who are more resistant to initial treatment – to be managed appropriately and for GPs to continue to practice within an acceptable regulatory framework, it is important for proper channels to exist at the primary and secondary care interface. In our survey, 15.4% of the GPs did not think that help/advice could be obtained in a timely manner. There was a two-fold preference for telephone advice compared to written advice, and this is something that can be used by health

commissioners in either shaping existing or implementing triage and guidance services at secondary care level. With the changes brought about by the creation of primary care networks (PCNs) and the expansion of its workforce by the creation of additional roles, it will now also be possible to employ mental health practitioners who may act as a liaison between primary care and secondary mental health services (20). Social prescribers are already operating as part of PCNs and there is emerging evidence that social prescribing can help to improve mental well-being and lead to a reduction in depression and anxiety (21).

Empowering GPs by providing access to suitable training and resources will also allow healthcare professionals in primary care to become more confident in independently overseeing the management of depression (e.g. specialist interest in mental health training posts, regular educational events aimed at GPs led by secondary care colleagues, producing new or revamping existing local primary care guidelines on the management of depression, etc.)

Limitations and potential areas for future research

This study relied on GP colleagues reporting what their preferred strategy would be based on their experience. What was not looked at in any detail are factors such as existing specialist interest in mental health problems, length of experience as a practising GP, where the practice is situated and associated patient demographics such as level of deprivation (which can influence severity of depression and availability/choice of treatment), and details regarding the ease of access to mental health services which may vary across the North-East. These factors can all influence the way mental health issues are managed in primary care.

The survey also did not allow respondents to offer any detailed written views on how they think they can best be supported in their role. Other areas that were not looked but which could be explored in future include which second-line antidepressants are used, the length of time spent in consultations (seeing more than a third of GPs wanted a shared management plan), and the experience and role of GPs in prescribing other augmentation strategies such as antipsychotics and lithium (which we suspect will be largely directed by secondary care).

This piece of research has also focussed on patients who newly present with depression. General practice is more complex than this and there is often a large group of patients with treatment-resistant depression – this is another area that could be looked at and the findings compared to existing research (22).

Conclusion

This study adds to the existing literature on what influences the management of depression in primary care. The GPs who participated felt reasonably confident in diagnosing and initiating the management of depression with most normally sharing the decision with patients. NICE guidelines are followed when it comes to initial

prescribing as the safety profile of medication and patient comorbidities – amongst various factors – are kept in mind, but it was surprising to note that a fair proportion of GPs felt comfortable combining two antidepressants without involving the mental health team which is at variance with NICE guidance. The skills mix and experience of practising GPs surveyed may partly explain this. It is clear that despite this, more support – either in the form of educational or training opportunities, or by easier access to advice, especially by phone – would make a difference to the confidence and ability of GPs in managing depression in primary care. The results of this study can help to inform any restructuring of local health services to allow closer co-operation between primary care and secondary mental health services.

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Appendix 1 - Questionnaire

Questions:

Choose the most appropriate answers (you may choose more than one response)

1. How comfortable are you making a diagnosis of depression?

- a. Very
- b. In most instances
- c. Only in some instances
- d. Not at all

Supplementary Q – Do you categorise depression as Mild/Moderate/Severe in routine appointments? Y/N

2. Are there any circumstances where you might question your diagnosis of depression?

- a. No improvement with antidepressants and/or CBT
- b. Multiple consultations on the part of the patient despite objective improvement
- c. Other features making the diagnosis less clear-cut e.g. mania, hypomania, anxiety, personality traits, etc.
- d. Patient rejecting the diagnosis
- e. Lack of confidence in making the diagnosis
- f. Other?

3. What is your preferred initial management plan in mild-moderate cases of depression when someone is at low risk?

- a. Refer to IAPT services/talking therapy
- b. Start on antidepressants
- c. Start other medication e.g. hypnotic
- d. Start Antidepressant and hypnotic/other meds
- e. Both IAPT services/talking therapy and antidepressants are suggested and the patient decides after discussing the options
- f. Refer to secondary care services

4. What influences your management plan?

- a. Level of confidence with the prescription of and overseeing the management with antidepressants
- b. CBT is more likely to be useful and is not associated with side-effects
- c. IAPT services/talking therapy are not easily accessible where I work
- d. Shared-management is something I strive for in my practice
- e. Time constraints – I choose what I think is more likely to suit the patient's needs

5. If choosing antidepressants or other medication, what is your preferred first-line?

- a. SSRI
- b. SNRI
- c. TCA
- d. Sedatives
- e. Anxiolytics
- f. Beta-blocker

6. What are the factors that make you more likely to choose a particular antidepressant?

Please rank your choices from a to f

- a. Safety profile of medication/side-effects
- b. Patient co-morbidities
- c. Previous use of a specific antidepressant
- d. Use of other medications which might interact with an antidepressant
- e. Local/national guidelines
- f. Other reasons

7. If someone does not show any real improvement with a particular medication, what is your preferred next step?

- a. Detailed chat with patient covering expectations, efficacy of medication, dose change, compliance, possible use of counselling (if not already having)
- b. Offer alternative medication e.g. different antidepressant, sedative, anxiolytics, beta-blocker
- c. Add in another antidepressant
- d. Refer to secondary care for the patient to be seen
- e. Seek advice/guidance from secondary services through other channels e.g. telephone discussion, email correspondence, etc.

8. Do you feel comfortable combining additional antidepressants/other medication?

- a. Yes
- b. No

9. If yes, what would be your choice of add-on medication (assuming there is no contraindication)?

- a. Mirtazapine
- b. Anxiolytics
- c. Venlafaxine
- d. Sedative
- e. Beta-blockers

10. If you were choosing to add in a second antidepressant what would be the rationale?

- a. Symptom management e.g. insomnia, anxiety
- b. Patient already on a decent dose of first antidepressant
- c. CBT not helping
- d. On (and only on) advice of mental health team
- e. Not applicable (I do not feel comfortable prescribing combination medication)

11. What makes you comfortable using a combination of antidepressants?

- a. Experience in dealing with similar patients over many years as a GP
- b. Previous training in psychiatry
- c. Attending online lectures/online courses/local mental health updates
- d. Advice from mental health team colleagues
- e. Local guidelines
- f. Not applicable as I am not comfortable using a combination

12. If you are not comfortable prescribing a second antidepressant, is it because of:

- a. Lack of experience in this area of mental health
- b. Lack of access to timely advice/guidance from the local mental health team
- c. Local guidelines advise not to use combination of antidepressants in primary care