



NMS for Antidepressants
Safe, Compassionate, Effective Consultation

MEHMOONA USMAN
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 ABPI CERTIFIED




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Learning Outcomes

By the end of this session, participants will be able to:

- Explain** the role of the New Medicine Service in supporting patients starting antidepressants, referencing **NICE N6222** and NHS England service specifications.
- Identify** key red flags (psychiatric and physical) requiring urgent escalation in the first weeks of antidepressant therapy.
- Apply** a structured consultation framework to explore patient concerns, optimise adherence, and manage side effects.
- Assess** suicide risk confidently using direct, evidence-based questioning.
- Recognise** important drug interactions and patient-specific cautions, particularly in older adults and high-risk groups.
- Document** NMS consultations to meet clinical governance and NHSBSA audit requirements.




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Why Antidepressants in the NMS?

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Why NMS Matters in Antidepressants

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|--|--|
| High prevalence | In 2023/24, approximately 8.6 million adults in England were prescribed at least one antidepressant, the most commonly issued class of psychotropic medicines in primary care. |
| Critical early phase | Discontinuation rates are highest in the first 2-4 weeks due to early side effects, perceived lack of benefit, and stigma. This period carries the greatest risk for non-adherence, symptom relapse, and suicidal ideation. |
| Impact of proactive pharmacist follow-up | Structured contact within the first fortnight has been shown to increase adherence, reduce relapse rates, and lower unplanned GP and urgent care attendances. |
| NMS as an intervention | Provides a clinically robust, patient-centred framework for education, early detection of red flags, and safe, cost-effective prescribing. Supports patient engagement, shared decision-making, and improved long-term outcomes. |




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Common Antidepressants & Key Facts

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Quick Map (by class)

- SSRIs:** fluoxetine, sertraline, citalopram, escitalopram, paroxetine.
- SNRIs:** venlafaxine, duloxetine.
- Others:** mirtazapine, trazodone.
- TCA's (limited in primary care):** amitriptyline, lofepramine, nortriptyline (caution).



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SSRIs: What to Know

- First-line** for depression/anxiety disorders.
- Early **GI upset, headache, sleep change**, often settle in 1-2 weeks.
- Sexual dysfunction** common; discuss early to maintain adherence.
- Bleeding risk** ↑ with NSAIDs/anticoagulants.
- Hyponatraemia** risk (older adults, diuretics).
- Escitalopram/citalopram**: QT concerns at higher doses.

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SNRIs: Venlafaxine, Duloxetine

- Useful for depression + **GAD, neuropathic pain** (duloxetine).
- BP/HR** can rise (venlafaxine); monitor if history of hypertension.
- Nausea, sweats, agitation** early on; taper carefully to avoid withdrawal.
- Drug interactions** via CYP pathways—check if polypharmacy.

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Others: Mirtazapine, Trazodone, TCAs

- Mirtazapine**: sedating at low dose; **appetite/weight gain**, helpful if insomnia/poor appetite.
- Trazodone**: sedating; sometimes for sleep at low dose; **postural hypotension**.
- TCAs**: anticholinergic burden; **overdose toxicity** generally not first-line in primary care.

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Onset & Side-Effect Timeline

- 2-4 WEEKS** FOR EARLY IMPROVEMENT; **6-8 WEEKS** FOR FULLER EFFECT.
- SIDE-EFFECTS** TEND TO IMPROVE BEFORE MOOD BENEFITS ARE CLEAR.
- DO NOT STOP SUDDENLY**—DISCUSS CHANGES FIRST.

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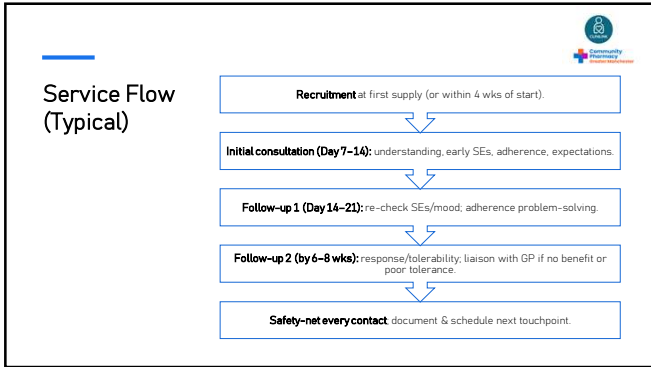
Discontinuation (FINISH)

- More likely with **short t½** (paroxetine, venlafaxine).
- FINISH**: Flu-like, Insomnia, Nausea, Imbalance, Sensory "zaps", Hyperarousal.
- Plan**: gradual taper; escalate severe cases.

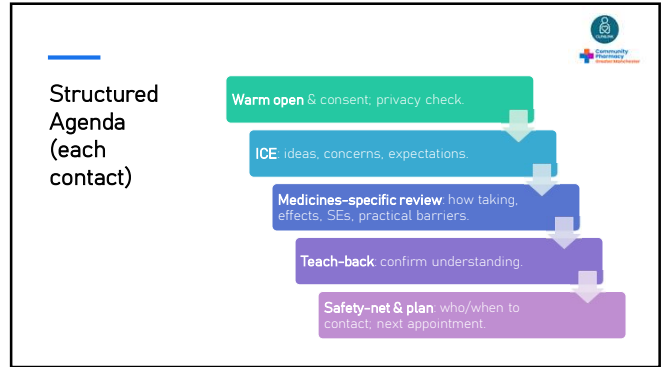
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Conducting the NMS for Antidepressants

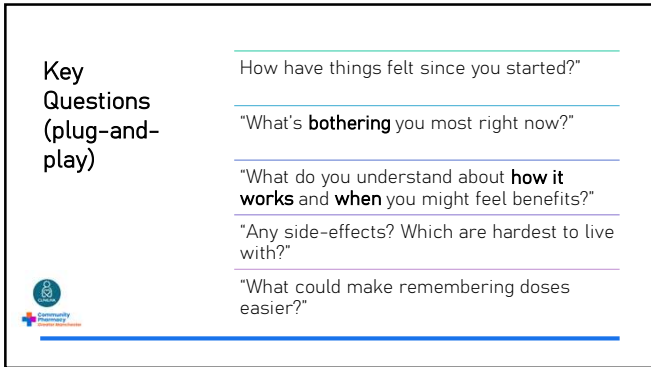
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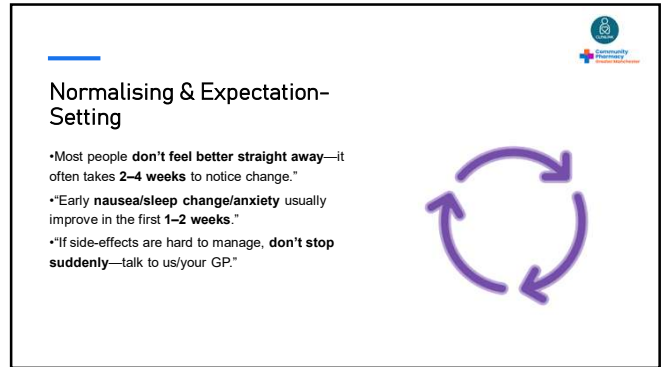
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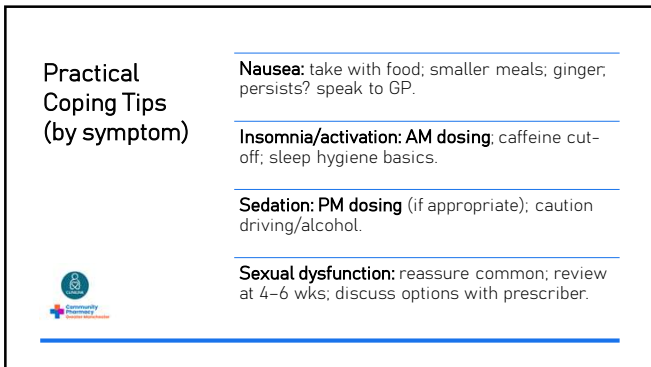
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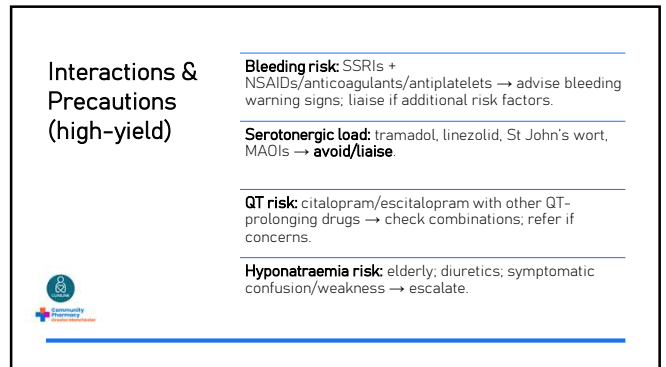
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Communication Skills in Mental Health

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Therapeutic Communication

| Common Statement | Why it's a Pitfall | Better Alternative |
|---|--|---|
| Don't worry, you'll be fine. | Can feel dismissive, like brushing off the patient's experience. | I can hear this feels overwhelming right now — lots of people find it hard at the start. Let's talk through it together. |
| Why haven't you been taking your tablets? | Puts the patient on the defensive. | Many people find it tricky to remember every day — how has it been for you? If you ever stop suddenly, your body can feel like it's in shock — you might feel dizzy, flu-like, or have strange sensations. That's why it's important to taper slowly. |
| This drug may cause discontinuation syndrome. | Uses jargon that patients may not understand. | Recovering from depression takes time and support, and the medicine is part of that process. |
| Just think positive and it'll get better. | Suggests depression is just a mindset issue, deepening stigma. | |

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Therapeutic Communication

| Common Statement | Why it's a Pitfall | Better Alternative |
|--|---|---|
| Oh, everyone gets side effects, it's normal. | Makes the patient feel unheard. | It sounds uncomfortable — and you're right, nausea is common at the start. The good news is, it usually settles in a week or so. Here's what you can try in the meantime. |
| You just need to stick with it. | Sounds dismissive and doesn't acknowledge difficulty of side effects. | The first few weeks can feel tough — many people notice improvement after 4-6 weeks. Let's talk about what to expect and how to manage any early effects. |
| These medicines aren't addictive. | May come across as brushing off a genuine fear. | I understand why you might worry about dependence — antidepressants don't cause cravings, but if stopped suddenly your body can react. That's why we taper carefully. |
| You should feel better soon. | Creates unrealistic expectations; improvement can take time. | Everyone responds differently — some people feel changes in a couple of weeks, others take longer. We'll keep checking in on your progress. |

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Managing Distress

| | |
|-------|--|
| Pace | Slow pace; offer water/seated area/private room. |
| Use | Use short, concrete steps; write the plan. |
| Offer | Offer choices to restore control (next check-in time, written leaflets). |
| Know | Know your boundaries; escalate when needed. |

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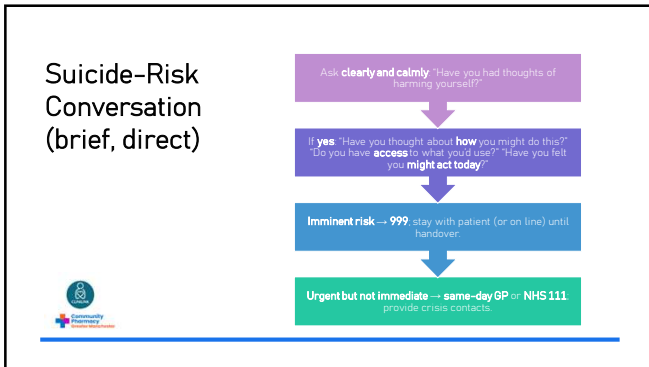
Red Flags & Referral Pathways

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Clinical Red Flags (Act Now)

- Suicidal ideation with intent/plan**, recent self-harm, or imminent risk → 999.
- Severe agitation/akathisia** (can't stay still), **serotonin syndrome** signs (clonus, hyperreflexia, fever, confusion).
- Mania/hypomania** (reduced sleep, grandiosity, risk-taking).
- Severe allergic reaction**, **GI bleed**, **marked hyponatraemia** symptoms.
- Pregnancy/breastfeeding** concerns needing prescriber review.

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Pathways & Signposting (England)

- GP (same day/soon); **NHS 111** for urgent advice.
- Local mental health crisis team (add your ICS number).
- NHS Talking Therapies (self-referral; formerly IAPT); [NHS England](#)
- Samaritans **116 123** (24/7) and **Shout 85258** (text); [Samaritans](#)
- Andy's Man Club: <https://andysmanclub.co.uk/groups/>

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Record-Keeping & Follow-Up

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Confidentiality & Stigma

- 1 Use **non-stigmatising** language; record **facts + patient words**.
- 2 Record **risk assessment**, advice given, **safety-net** and **who informed**.
- 3 Respect privacy: offer **consultation room** for all MH conversations.

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SOAP Template

| S (Subjective) | O (Objective) | A (Assessment) | P (Plan) |
|--|--|--|---|
| • "Feels wired since day 3; nausea AM; no self-harm thoughts." | • Anxious affect; no tremor; BP not taken. | • Early SEs likely; adherence good; no immediate risk | • AM dosing; nausea coping; follow-up in 7 days; safety-net provided. |

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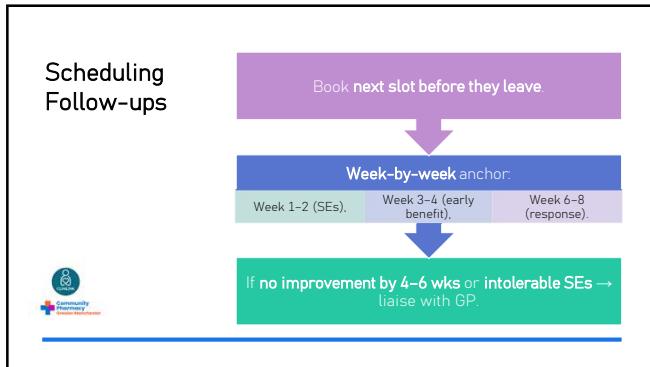
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SBAR to GP

| S | B | A | R |
|---|--|--|--|
| • Sertraline day-10; severe agitation + new restlessness. | • Started 50 mg; no prior SSRI; caffeine high; no substance use. | • Concern akathisia vs anxiety; sleep <3 h; no suicidality disclosed. | • Same-day GP review For assessment/management; pt aware of 111/999 if worse. |

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Case Study 1: Early Adverse Effects (Activity)

- **Scenario:**
 - 32-year-old, fluoxetine 20 mg OD, Day 7
 - Reports nausea, loose stools, reduced appetite
 - States: "I feel sick all day, maybe I should just stop taking it."
- **Activity:**
 - What questions would you ask?
 - What red flags are present?
 - What actions should the pharmacist take?
 - How would you document this consultation?

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Case Study 1: Discussion & Actions

- **Red Flags:**
 - Severe or persistent diarrhoea → dehydration risk
 - Blood in stool, significant weight loss, or inability to tolerate food/fluids
 - Patient considering abrupt discontinuation
- **Pharmacist actions:**
 - Explore severity, frequency, and impact of GI symptoms
 - Reassure: GI upset is common in early SSRI use, often improves in 1-2 weeks
 - Advise practical measures (take with food, hydration, small frequent meals)
 - Discourage abrupt stopping; explain importance of continuation
 - Escalate to prescriber if severe, worsening, or intolerable symptoms
 - Document dose, side effects reported, advice given, safety-netting, and any referral

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Case Study 2: Physical Safety Concerns (Activity)

- **Scenario:**
 - 72-year-old, citalopram 20 mg OD, initiated 2 weeks ago
 - Also, on naproxen 500 mg BD and aspirin 75 mg OD
 - Reports dizziness, new confusion, dark stools
- **Activity:**
 - What red flags do you identify?
 - What drug interactions/cautions are relevant?
 - What actions should the pharmacist take?
 - How would you safety-net the patient?

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Case Study 2: Discussion & Actions

- **Red Flags:**
 - GI bleed (dark stools, high-risk drug combination)
 - Possible hyponatraemia (confusion, dizziness)
 - MHRA dose alert: citalopram max 20 mg in >65 yrs (correct here, but monitoring needed)
- **Pharmacist actions:**
 - Urgent referral to GP (same-day) for investigation and blood monitoring (Na⁺, Hb)
 - Highlight drug interaction → SSRIs + NSAIDs + aspirin = ↑ bleed risk → GP to consider PPI gastroprotection
 - Counsel patient to seek urgent care if ongoing melaena, haematemesis, or collapse
 - Document symptoms, medicines, risk factors, referral, and safety-netting advice

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Case Study 3: Possible Hypomania (Activity)

- **Scenario:**
 - 35-year-old, started venlafaxine 75 mg OD, Day 14
 - Reports feeling "full of energy," needing only 3 hours' sleep per night
 - Talking rapidly in consultation, difficulty staying on topic
 - Mentions impulsive spending and "grand new business ideas"
- **Activity:**
 - What red flags do you identify?
 - What further questions would you ask?
 - What actions should the pharmacist take?
 - How would you document this consultation?

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Case Study 3: Discussion & Actions



Red Flags:

- Symptoms consistent with hypomania/mania:
 - Reduced need for sleep
 - Pressured speech, flight of ideas
 - Grandiosity, impulsivity
- Suggests possible underlying bipolar disorder, unmasked or triggered by antidepressant

Pharmacist actions:

- Explore timeline and impact: "When did these changes start? How is this affecting daily life/work?"
- Assess for risk-taking or unsafe behaviour (e.g., financial, sexual, driving)
- Escalate urgently to GP / mental health team for psychiatric review – antidepressants may need review/withdrawal under specialist care
- Provide safety-netting advice: if behaviour becomes unsafe, patient/family should seek urgent help (999 / crisis team)
- Document symptoms in detail, verbatim quotes, actions taken, and escalation pathway

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Key Takeaways

NMS is critical in the first month of antidepressant use – supports adherence and safety

Early recognition of red flags (psychiatric & physical) enables timely escalation and prevents harm

Pharmacist role: educate, safety-net, and refer back to GP/mental health team for monitoring or urgent review

Clear, factual documentation protects patients and professionals; retain ≥ 2 years for audit compliance

Effective consultations = **empathy + structured approach** (rapport, explore, educate, screen, follow-up)

Community pharmacists are uniquely positioned to provide **accessible support and reduce stigma** in mental health care



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Resources for NMS – Antidepressants (Community Pharmacy)

CPPE learning

- New Medicine Service (NMS) e-learning and assessment
- Mental health: supporting patients
- Consultation skills for pharmacy practice

NHS England / Community Pharmacy England

- NMS service specification and toolkit
- Patient leaflets and consent forms
- Data capture templates (Sonar, PharmOutcomes, etc.)

NICE guidance

- NG222: Depression in adults – treatment and management
- CG76: Medicines adherence

Specialist Pharmacy Service (SPS)

- Antidepressant information including switching, side effects, cautions

Patient support and signposting

- NHS Talking Therapies (IAPT)
- Mind, Samaritans helpline
- Local ICB referral pathways

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