

# UKPPG Newsletter

May, 2007



## Chairman's letter

The UKPPG Committee met in February and then again in April.

A very real threat to the continued existence of the UKPPG has been identified — we are losing money on many activities. Not that this is necessarily a bad thing, and the whole committee is pleased to have invested in mental health pharmacy's future with bursaries at undergraduate, pre-registration and postgraduate level. Alongside this there is 'PALS' (patient advice information leaflets), a new website and online membership system development, and we are supporting postgraduate education with weekend courses and running the 2006 conference, but at a loss for the first time in years.... and, of course, the commitment to the College.

Add to this the changing environment around industry sponsorship and a clear vision for the way forward is required. The Committees of both the CMHP and UKPPG spent some hours in November 2006 working with a facilitator to map out the issues. Dawn Price has authored a detailed analysis of present and future activities and Ian Maidment a financial model.

Ian is also working with Fiona Coupar and Dave Branford to develop a new constitution to meet the changing environment.

All these strands need to come together to ensure that we will remain a viable and vibrant organisation to continue to support mental health pharmacy in the future. It's work in progress on which I will be reporting further.

It has been a busy couple of months with the Conference taking shape, an update on NICE Guidance on Anxiety and Depression, the RPSGB consulting on sharing input into national consultations, NICE again on substance misuse and the Workforce Review. The White Paper on professional registration and the 'Royal College of Pharmacy' shows how far-sighted the UKPPG has been with regard to specialist accreditation, and we will be working with the membership to work constructively with the other stakeholders in making the vision a reality.

If you've had a chance to look at the new website, you'll see that Steve has done a fantastic job taking this forward and we should be able to announce shortly that there will be a password-accessible area for members to post material they wish to share, tools and documents. Mick Marven is working up — and integrating with the website — on-line membership records, including facilities for direct debits/ credit cards, real-time updates, news and events. There is still much to do, but the progress is impressive.

Graham Parton  
Chair, UKPPG  
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## Some sessions of interest from the British Association for Psychopharmacology (BAP) meeting, 2006

John Donoghue summarises two presentations from the BAP summer meeting that may be of interest to pharmacists

### Sleep disturbances

There is epidemiological evidence that sleep disturbances affect as many as one third of the adult population; however, prevalence varies across studies because of differences in populations, study designs, and diagnostic criteria. It has long been understood that disturbed sleep is a key feature of depression. DSM-IV estimates that between 40–60% of depressed outpatients may experience sleep disturbances, and subjective self-reports of poor sleep have been reported in as many as 80% of depressed patients. I have to confess that I have taken little personal interest in sleep disturbance, considering it to be a relatively trivial complaint. However, there is a growing awareness of its importance and its health-related and economic impact. It was interesting therefore to hear an overview of the basic neuroscience given by one of the leaders in the field.

Professor Josephine Arendt reviewed the link between disturbed sleep and depression and theorised about a putative role for melatonin.

### Chronobiological concepts and depression

Professor Josephine Arendt, University of Guildford

Humans are a diurnal species, with about 10% of genes showing diurnal functioning; chronobiology is therefore crucial for a full understanding of human wellbeing. There are four distinct categories of biorhythms, of which the daily or circadian rhythm is the most important for optimal functioning, and its disruption can cause serious health problems including, among others, sleep disturbances, affective disorders, and gastrointestinal problems.

The normal circadian cycle is slightly more than 24 hours, so time cues are used to maintain a 24-hour cycle. The most important of these is light and the chronobiological compound melatonin. Melatonin is the 'darkness' hormone. Its secretion is influenced by light transduction in the eye and it defines biological night. Light works in a direct relationship with melatonin on the circadian clock. In the evening, light delays the internal clock, while the secretion of melatonin as a response to fading light advances it, bringing on sleep. In the morning, light advances, while melatonin delays the internal clock.

To measure disorders in the circadian rhythm, the technique most commonly used is to find a rhythm marker of the body's internal clock — usually by measuring the secretion of melatonin and its metabolites. The peak

concentration of melatonin coincides with a number of parameters including maximal sleep propensity, minimum body temperature, minimal alertness and slow reaction time.

However, studies are complicated by the fact that urban populations tend to be light-deprived, and their lifestyles involve varying degrees of desynchrony (shift work, jet lag, etc) so that abnormal circadian phase relationships are common. There is a growing understanding that such circadian disruptions may increase the vulnerability to psychiatric disorders.

There is clear evidence that the circadian rhythm is desynchronised in depression. Sleep disturbances such as difficulty in getting to sleep, early morning waking, and, occasionally, hypersomnia, are common. Mutations on some of the genes that regulate the circadian clock are associated with some sleep disorders and seasonal affective disorder (SAD).

Compounds or treatments which modify the circadian rhythm are known as chronobiotics, and they act by bringing together circadian systems (increasing the magnitude of effect) or by optimising the timing and synchrony of factors that govern the circadian clock. Some antidepressants may modify the circadian rhythm, possibly by influencing either the amplitude or timing of melatonin secretion. Fluvoxamine has an indirect effect by inhibiting the metabolism of melatonin. The novel compound agomelatine (not yet available in the UK) has a direct effect, acting as an agonist on melatonin receptors. Interestingly, research on the use of light therapy in unipolar major depression (rather than SAD) has provided evidence to support its use as an adjunct with an antidepressant or a melatonin agonist.

### Conclusion

Desynchrony of circadian rhythms can lead to serious ill health. The most important influence promoting synchrony, thus providing the clearest target for pharmacological interventions, is melatonin.

### Selective treatments or 'dirty' drugs – where next?

Opinion about the optimal approach to pharmacological interventions changes over time. Selective treatments with a specific pharmacological target have been considered desirable as they (in theory, at least) have the potential for fewer side-effects compared with what have often been called 'dirty' drugs. However, the observation that the 'dirty' drug clozapine is more effective than other treatments in refractory schizophrenia, means we must re-evaluate our opinions as to which approach is best. Interestingly, clozapine is no longer described as being dirty: it has metamorphosed into a drug with a rich pharmacology, or a multi-target treatment. This subject was taken up by Dr Mark Millan, who gave a brief overview of some non-selective approaches in drug development for the treatment of depression.

## Improving the treatment of depressive states: novel multi-target strategies

Dr Mark Millan, Division of Neuropsychiatry, Institut de Recherches Servier, Paris

The brain is a complex structure, and therapeutic strategies should take account of this complexity. Until recently, drug development sought to develop selective treatments. However, clinical experience, which frequently suggests the need for combinations of treatments, points to a multi-target approach: multi-target treatments are often better than selective treatments, for example, clozapine in schizophrenia. Will a similar multi-target approach offer the potential of better treatments in depression?

Key multiple targets include the neurotransmitters dopamine (DA), noradrenaline (NA) and serotonin (5-HT). These transmitters interact in complex ways but, in depression, the equilibrium of their interdependence is disrupted. Targets that might re-establish this equilibrium are multiple and include transporter systems, receptors, and synthetic or catabolic enzymes.

Three promising multiple target strategies include:

- a combined 5-HT<sub>2C</sub> receptor antagonist and melatonin agonist
- a combined SNRI and adrenergic  $\alpha$ -2 receptor antagonist
- a combined SSRI and neurokinin NK1 receptor antagonist

The first of these compounds has demonstrated antidepressant efficacy with improvement in disrupted sleep.

The pharmacological profile of the second compound predicts that it would have efficacy similar to venlafaxine, but with improvements in cognitive function and a reduced liability for sexual dysfunction. Results in pre-clinical animal behavioural models suggest a faster putative antidepressant effect than venlafaxine, and studies involving downregulation of 5-HT<sub>2A</sub> receptors in the frontal cortex show a faster effect than desipramine (the fastest acting antidepressant in this model). The  $\alpha$ -2 receptor antagonist effect should enhance the release of acetylcholine (ACh), thus improving cognitive deficits in depression. In a behavioural model in rats, this compound, but no other antidepressant tested, improved social memory, suggesting a putative cognitive enhancing effect.

Neurokinin (NK) receptor blockers have theoretical antidepressant activity, but no antidepressant effect when used alone. When selective serotonin reuptake inhibitor (SSRI) activity is overlaid on a NK antagonist, it would be predicted to have a theoretical enhanced antidepressant effect with a fast onset of action with rapid and sustained anxiolytic effects. Preclinical transmitter studies show increases in DA and NA as well as the predicted increase in 5-HT. In animal studies, the compound appeared to have

a superior antidepressant effect compared with citalopram, and reversed the anxiogenic effects of SSRIs.

## Conclusion

The multiple target strategy is bearing fruit with one new antidepressant having completed short-term phase 3 clinical trials, and two further putative antidepressant compounds showing promising results in preclinical testing.

## UKPPG and CMHP strategy meeting

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The Committee of the UKPPG and the Council of the CMHP met in November 2006 to develop a future strategy through a facilitated and frank discussion of the issues facing both organisations.

Following on from this discussion, the facilitator provided a report and made a number of recommendations to the Committees of the UKPPG and CMHP on the development of a future strategy. These are summarised below.

- The appointment of sub-groups of the UKPPG to take responsibility for defined activities of the UKPPG.
- A consensus must be agreed on the role of the CMHP and in a way which provides differentiation from the UKPPG.
- A number of eminent pharmacists in mental health appear to be currently disenfranchised from the UKPPG. The UKPPG Committee should discuss ways in which these individuals can be re-engaged.
- Initiatives which can contribute to the ongoing visibility of the UKPPG and CMHP to the outside world should be investigated.
- Procedures should be established on how both organisations will respond to future requests for consultation from external bodies.
- Further discussions should be held on whether retiring UKPPG Chairpersons or College Presidents should have a residual role on the governing bodies of each organisation.
- We recommend that both organisations hold discussions on future financing and agree options for developing new income streams.

The UKPPG Committee also met to discuss and analyse the role of the UKPPG and its goals and objectives and how to best meet the challenges facing the organisation, particularly with regard to finance. Dawn Price undertook to document and present the results of the discussion – and add her unique blend of analysis to tease out the various strands and present strategies which are complementary to the recommendations above. Dawn collated and presented seven detailed strategies; all or some of which are likely to form the basis of UKPPG activity in the future. These are summarised below:

## General news: Information from BAP

### 2007 Summer Meeting (22–25 July, Harrogate )

Programme details, registration and abstract submission information is now on the website at [http://www.bap.org.uk/summer\\_meeting\\_2007/index.html](http://www.bap.org.uk/summer_meeting_2007/index.html)

**Strategy 1.** 'Consolidation and continue as it is at present' with development of the organisational strengths and risks and building on opportunity initiatives. A specialist range of products could be launched to market for income generation — possibly internationally. Product development should be expanded as for the PALs, eg. information aids for disabled people.

**Strategy 2.** To be 'driven commercially'. Income generation is possible, eg. the development and sale of educational material such as PALs and education and training material. Investment to enable development of the web technology to market the current products such as online material, webcasts or media development.

**Strategy 3.** 'Differentiation', ie. providing products or services different to the market competition. This would involve revamping the current products to be 'different' with a more specialist focus. Comparison with other providers is required to map the similarities and differences to avoid duplication/confusion, then a marketing campaign to identify and promote the differentiated products.

**Strategy 4.** 'Focus differentiation strategy' where the selected value-added products and services (such as educational events or modules) are provided to a 'niche market'.

**Strategy 5.** As above, but rather than ceasing to offer some services, a co-specialist approach could be adopted by co-marketing and a 'strategic alliance' or joint venture.

**Strategy 6.** Diversification. This has occurred but there are untapped markets such as non-medical prescribers, pharmacists with a special interest, community pharmacy staff and technicians, and social care staff. Specific conference or education and training material could be commissioned to provide products for the new markets.

**Strategy 7.** Restructure the committee members to operate with a 'Functional Portfolio'. Such a model can enhance value with sharing of information, collaborative approaches and address groups of UKPPG members with key skills and knowledge.

The UKPPG Committee meeting on the 20th April will be dedicated to developing and refining these ideas to enable the UKPPG to continue to meet its goal:

*Promoting quality medicines management provided by specialist mental health pharmacy practitioners for people and carers of people with mental health needs.*

### News from the Committee

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The UKPPG Committee met recently and agreed to increase the annual subscription for the first time in a decade.

Subscription to the UKPPG changes to £25 per annum from 1st April 2007. For new members the joining fee was increased to £40, including the first year of membership from the same date.

This is the first increase in membership fees for years and reflects the recent and ongoing significant developments of benefit to members, including:

- The new improved website — which is planned to have members-only access to resources shortly!
- Continuing development to achieve an on-line membership tool to process membership information and payment processes!
- Improved newsletter.
- Support for postgraduate training (psychiatry 1 and 2, October and April respectively).
- Planning for Psychiatry 3 in November.
- Support for the College of Mental Health Pharmacists.
- Development of networking opportunities through the email group.
- Improving communication and information through electronic media.
- 2007 Conference.
- Expanding opportunities for undergraduate, pre-registration and postgraduate bursaries.
- Representing mental health pharmacy in consultations — NICE, RPSGB, DoH, etc.
- Lobbying for the specialty wherever possible — CSIP/ NIMHE, All Party Pharmacy Group House of Commons, Health Care Commission, etc.

The committee are confident that this increase — while proportionally large — is overdue, realistic and still represents great value for money.

Graham Parton  
Chair UKPPG

## My medicines and me

I am 52 years old and a female incest survivor. I have taken psychiatric medication for unipolar depression for over 35 years after my first suicide attempt when I was 16 years old. During the 1970s I was taking valium. This did not help my condition but I was confused, 'zonked' and more easily managed by other people. During the 1980s and 1990s I was prescribed Prozac®. I continued to feel suicidal, depressed, manic and paranoid as the mood took me. In late 1990s I was prescribed citalopram. For a couple of years my mood lifted and I was able to live a near normal life. By 2002 pressures at work, trying to achieve government targets, had brought me low again. I also gained two stone in weight which made me feel despondent, old, ugly and useless.

In July 2003, after 17 years free from attempts on my life, I made a serious suicide attempt. I was treated at the Becklin Centre and at St Mary's Hospital. Here I was diagnosed as having bipolar disorder and my medication was changed to venlafaxine 300mg and Priadel® 600mg per day. This has had a remarkable effect on my mental well being. My manic behaviour has been suppressed and I am able to act as a rational being rather than on impulses. This has helped me cope with depression by not having a negative viewpoint on occurrences and acting in a realistic way when things go wrong. However, I feel that I pay a high price to achieve what other people regard as normal behaviour and take for granted as an inherent right.

I have numerous physical side-effects from my medication. Some of these are merely irritating, eg. small involuntary muscle twitches when I'm sat down, in my arm, leg or whole body. At other times, when these twitches have occurred in my hands, I have scalded myself with hot tea. Others can be distressing or dangerous. Slight short-term memory loss means I forget to turn off taps, cookers, lights, lock doors, lose my keys or my purse, etc.

Others can be uncomfortable and embarrassing, eg. constipation and incontinence of urine.

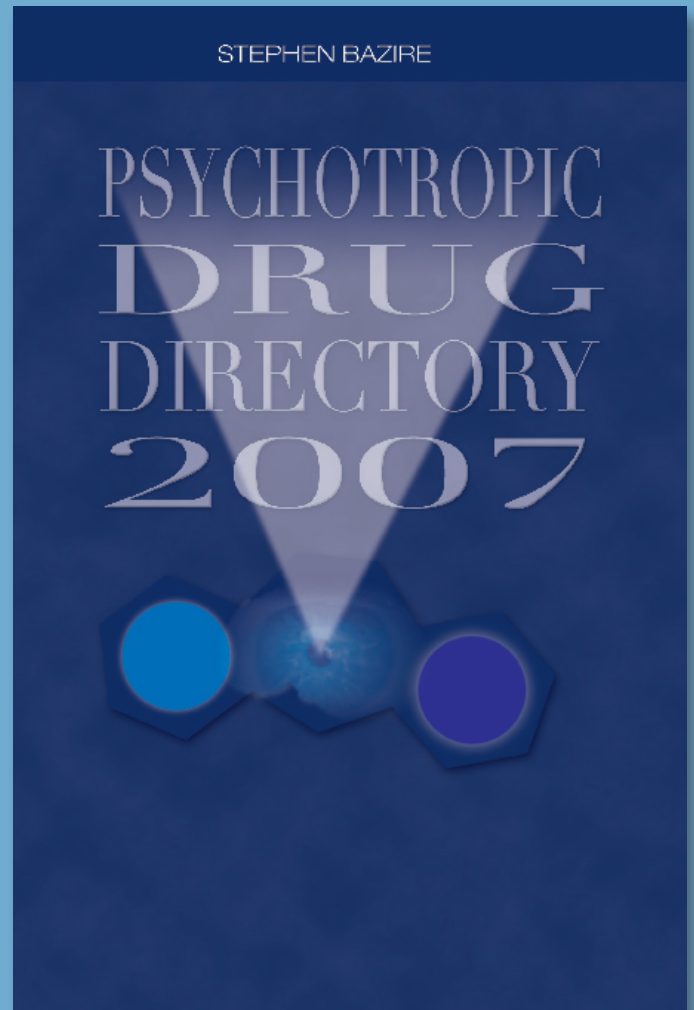
I am a vegetarian, eat fruit, drink water, exercise as much as I can at the gym and yet still need to have help to evacuate my bowels. I go to the gym to try to control my weight and keep fit, I have put on one stone in the ten months I have been on Priadel, but if I try to run on the tread mill, etc I wet myself.

Finally, I and other people have noticed that it takes me longer to do everything. I have slowed down in all my actions and acquired a general lassitude. It takes a great deal of self-motivation accompanied by a great deal of pushing from my partner and carer to get out of bed and then out of the house. This lassitude is accompanied by extreme tiredness in the late afternoon/early evening if I have managed to get out and do anything.

Haing said all this, I cherish my mental well being and will do anything to maintain it. I just wish that the price I have to pay was not so high.

Anonymous

## Psychotropic Drug Directory, 2007



The new 2007 edition of the *Psychotropic Drug Directory* continues its aim to provide for professional practicing clinicians a source of rapidly accessible information, advice and references on psychiatric drugs and to act as an aide memoire.

The chapters include drug treatment options for major mental health conditions; selecting drugs, doses and switching; psychotropics in problem areas; drug interactions; drug-induced psychiatric disorders; managing adverse reactions and finally miscellaneous information.

The underlying aim of the book is to help encourage the positive, optimal and rational use of medicines to their best effect in order to improve the quality of life for people with mental health needs.

### Special offer to UKPPG members

To order your copy today at the special price of £20.00 (usual retail price £24.99) plus p&p, go online to: [www.mental-health-uk.com](http://www.mental-health-uk.com) or call 01747 855 991 (this offer is valid until 15 July 2007).

## Treating self-injury: a practical guide

LifeSIGNS (self-injury guidance and network support), a prominent user-led charity that raises awareness about self-injury, has published their *Self-Injury Awareness Booklet 2007*, and are making it available for free download. Barent Walsh PhD, author of *Treating Self-injury*, states in the foreword:

*This booklet provides a wealth of information about self-injury that benefits from the insider knowledge of the Directors of LifeSIGNS. I agree with the position in this booklet that self-injury should be viewed primarily as a coping mechanism, and concur that it should never be trivialised or disrespected as merely 'attention-seeking', 'a fad', or 'manipulative'.*

The booklet recognises that self-injury may be associated with psychiatric diagnoses, but also may not be. The old notion that self-injury is inevitably associated with sexual abuse trauma is no longer true. Also, there are many individuals who self-injure who function very well in the arenas of school, work and relationships, and who suffer few other major impairments.

This booklet provides a comprehensive discussion of the functions of self-injury, including both its internal affect regulation aspects and its more 'socially contagious' elements. Most importantly, the booklet provides a very helpful roster of alternative coping skills, without which most people will be unlikely to give up self-injury.

The booklet provides many useful ideas about how to communicate with professionals and, in turn, offers suggestions to professionals, as to how they may be more effective in responding to self-injury.

### Leeds Mental Health Trust: A mental health study day for pharmacy technicians

**Date:** Thursday 18 October 2007  
**Cost:** £55 (to include lunch)  
**Venue:** Training Room 3, 2nd Floor Becklin Centre, Leeds.  
**Duration:** 9.00AM–4.00PM

Number of places available, 25; places will be issued on a first come first served basis. The aim of the day is to provide an update on the medications used in the following conditions.

- Addictions
- Gender identity
- Learning disabilities

Enquiries to:  
Ann Andrews  
Pharmacy Department  
The Mount Hospital  
Leeds Mental Health Trust  
Tel: 0113 3055530  
Email: ann.andrews@leedsmh.nhs.uk

The LifeSIGNS *Self-Injury Awareness Booklet 2007* is available from: <http://www.selfharm.org/publications/sia> and can be downloaded or purchased as a hard copy for just £5.

### List of useful names/addresses

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**Treasurer and Membership Secretary:** Mike Marven, Clinical Pharmacy Support Unit, Unit 46, Sandford Lane Business Park, Kennington, Oxford OX1 5RW; e-mail: Michael.Marven@oxmhct-tr.nhs.uk

Membership details and application form available from the website: [www.ukppg.org.uk](http://www.ukppg.org.uk)

### College of Mental Health Pharmacists (CMHP) contacts:

**President:** Celia Feetam, 62 Park Hill, Moseley, Birmingham B13 8DT; email: celiafeetam@madasfish.com

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The UKPPG newsletter is distributed to all UKPPG members. We would welcome any submissions. So, if you have something to say or would like to contribute an article, please email: justine.raynsford@leedsmh.nhs.uk

### Diary

Monday, 4th June 2007: North West Forensic Academic Network: Critical perspectives, Palace Hotel, Manchester. For further details contact: Jane Senior, Research Project Manager on 0151 471 2351 or email: jane.senior@merseycare.nhs.uk

Wednesday, 6th June 2007: NICE Clinical Guidance on Bipolar Disorder, Institute of Physics, London. The programme includes speakers from a variety of fields, including service users involved in the development of the guidelines. For further information contact Emma George on 020 7977 6654 or email: egeorge@xcru.rcpsych.ac.uk

Friday, 8th June 2007: UKPPG Committee Meeting, London. Please let Graham Parton know of any item you would like to raise, email:

graham.parton@awp.nhs.uk

30th June, 2007: Closing date for undergraduate award, pre-registration award and annual travel award. For further information go to: [www.ukppg.org.uk/membership\\_events.htm](http://www.ukppg.org.uk/membership_events.htm)

