I believe that as a GP we should not prescribe antidepressants to children as it has become apparent that the brain is still developing and they can interfere with this. All efforts should therefore be made to treat the child with talking therapies.

With patients with mild depression I will always attempt an alternative route to anti-depressants, but fairly commonly in my experience the patient has already decided that medication is the answer or that they can find no alternative to it. As an example the following patient, a 29 year old married mother of 2 young children, came to see me, because she felt depressed. Her father had died suddenly from an MI at 48 just over a year previously and she had never fully got over it. She knew she was shouting at the children too much and though life was always a bit of a financial struggle, there were no major debts. Her husband was supportive and she felt guilty about what a poor mother she was being. She was not suicidal and managing to function in daily life, but at nowhere near a level she was previously.

I started by explaining to her how after terrible events such as had happened to her, with the death of her father, the brain can often go into a defensive mode and could then start imagining lots of bad things that could possibly happen to her and her family (Negative Introspection). Yet the brain then gets this wrong as the imagined events never come to pass. We all have bad things happen to us in life, yet they nearly all just come out of the blue and we can rarely anticipate them. Because she spent a lot of her time imagining all these negative things that were never going to happen to her, she would constantly feel low and anxious and this would affect her sleep, in particular by making her dream more.

Depressed people dream about 70% of their sleep time as opposed to about 30% in healthy people. This uses as much energy as the waking state and the reduction in restorative sleep caused by the excess dreaming, I explained, was why she awoke every morning feeling shattered and with no will to start the day. A good night's sleep, was the route to recovery, but to get there she would have to make some Herculean efforts to start living again, as she wouldn't get anything out of life, unless she put something in. Life wouldn't come to her, she would have to go out and get it, if she wanted to recover. She used to know how to find happiness, what was she doing then, that she wasn't doing now?

I explained to her why we need to dream and explaining of the latest theories that dreaming is how we empty our brains of the emotions that we have not dealt with during the day, so we can start the day afresh. Therefore to start sleeping she needed to break her negative thought patterns, by learning to relax and re-learning how to have some fun. I asked her when she last had some fun and she couldn't remember. When I asked how many times her children laughed a day (a 3 year old laughs about 300 times a day) and if they were depressed, she seemed to take the point. So I then suggested she took her kids out and just joined in their fun a couple of times in the next week, negotiating a goal. She felt she could do that. I then suggested she be referred to a counsellor to both learn relaxation and come to terms with the sudden death of her father but she was averse to this.

I then explained that if she could have a brisk walk or similar exercise three times a week this would raise the level of a chemical in the brain called serotonin, which was a calming chemical, as effectively as anti-depressant tablets. She didn't see how she

could achieve this and wanted to know about anti-depressants. I explained both their potential dangers and their potential benefits, explaining also how they can take a couple of weeks to really start working, but then she'd start noticing better sleep and eating patterns and she'd start having good days again. These good days would just then get more and more frequent. She should then continue on the medication for 6 months after recovery to prevent relapse. At this point it had become obvious that she wanted to choose medication, as she couldn't see another route out of her depression, without them and I was happy to prescribe having given all the alternatives..

Two weeks later she was picking up and had taken the children on a day out which she had enjoyed. We set another goal of having coffee around her sisters twice a week and she never looked back. Two months later she decided to stop her anti-depressants, despite my explaining that she was twice as likely to relapse, as she felt fine and that she would know if she was slipping back and could restart the tablets then.

Sometimes patients can be referred to local services, many PCT's have resource books but these are often not kept up to date. My most useful resources include in-house Citizen's Advice particularly their debt counselling service, as often depression is precipitated by debt and Relate for its couples' therapy.

If a patient wants to be referred to a specialist CBT therapist and this is normally in my experience precipitated by a secondary care doctor or insurance company, they are likely to have a longish wait. I however do not go by the "one size fits all CBT is everything" philosophy, especially as there is lots of evidence to show that the quality of the therapist is at least as important as the type of therapy and our in-house counselling teams who work closely with our psychologists, use a variety of psychological approaches which include CBT. They are fully audited and have proved their effectiveness. I would explain this to any patient requesting CBT. Most will then accept referral into our in-house service, where we have control over the waiting list. Some decide to wait 6 months or longer for the specialist CBT service and I would normally see them every 1 or 2 months as appropriate until they get their therapy and each time we'd review the decision.

I realise how fortunate I am to work in Rowley Regis and Tipton. Most GP's have few alternatives to prescribing or depression. Our PCT has been very forward thinking and has invested in Primary Care Mental Health right from the start, even when it was only a Commissioning group. We have increased our investment by relatively small amounts every year, yet shown that small amounts of investment in Primary Care can go a long way towards easing our patient's pain.