Clinical

Best Practice Guidance for the Prescribing and Monitoring of Antidepressants in Primary Care

Guidance Author	Review Group
Mental Health and Learning Disabilities Medicines Management Group	NHS Tayside Medicines Policy Group

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This Guidance applies to Medical/Dental Staff

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Guidelines for the Prescribing and Monitoring of Antidepressants in Primary Care
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APPENDICES

1. INTRODUCTION

Antidepressants are the main pharmacological treatment for individuals with depression where non-pharmacological interventions have been unsuccessful as a single treatment.

Depression refers to a number of mental health symptoms that are often fluctuating spectrum that include:

- Absence of positive affect
- Low mood
- A range of associated emotional, cognitive, physical and behavioral symptoms for example changes to sleep pattern, fatigue and suicidal ideation.

2. SCOPE

These guidelines have been developed through the Mental Health and Learning Disabilities Medicines Management Group to support the appropriate prescribing and monitoring of antidepressants where clinically indicated in Primary Care prior to referral to Community Mental Health Services.

The aims are:

- To support safe, clinically appropriate and cost-effective use of antidepressants in Primary Care.

- To promote effective monitoring and review of individuals prescribed antidepressants in Primary Care.

- To support clinicians to safely switch or withdraw antidepressants where clinically indicated.

It is not within the scope of this clinical guidance to define how different services e.g. Health and Social Care Partnerships, GP Practices etc. deliver this service.

3. INITIATION OF TREATMENT

3.1 Shared Decision Making

Treatment options should be fully discussed with the individual to support shared decision making. Individuals should be provided with information on the possible treatment options and given time to decide how they wish to proceed. Any agreement should be based on clinical presentation, and this may include no active treatment if this is what the individual chooses. Appendix 1 contains further information to support shared decision making.

3.2 Individual Education

To support individuals to make informed decisions around treatment for their depression it is important that they are given sufficient information to allow them to understand the benefits and the risks of any treatment options. Collaborative discussions with the individual should encompass setting realistic targets for their treatment and ensure there is mutual understanding of the expected outcomes. It is also important to ensure individuals aware that antidepressants do not work instantly and may take 3-4 weeks before the start to notice some improvement in symptoms. The individual should be made aware of the potential for discontinuation symptoms when antidepressants have been prescribed and are subsequently stopped.

If an antidepressant is the choice of treatment, individuals should be provided with written information on the proposed treatment. Printable Individual Information Leaflets can be found on the Choice and Medication website here.

3.3 Non-Pharmacological Treatment of Depression and Anxiety

Antidepressants are not considered first line treatment for individuals presenting with symptoms of depression or anxiety which is considered less severe, although they may be preferred by some individuals alongside non-pharmacological options. Non-pharmacological options for supporting individuals presenting with less severe depression and anxiety should be considered first line and tried prior to prescribing medication. NICE Guideline 222 “Depression in adults: Treatment and Management” provides further information on this including a useful diagram showing treatment options listed in order of recommended use which can be found here The Scottish Government and NHS Education for Scotland (NES) have also produced the Psychological Therapies Matrix which can be found here which highlights which interventions are evidenced based for each mental health condition.

For individuals presenting with a first episode of depression or anxiety which is more severe antidepressant therapy should be considered as part of a wider treatment plan for a individual.

It is also important to recognize that individuals have a right to decline treatment.

Information on local arrangements for third sector support can be found through the Health and Social Care Partnerships at the links below.

Angus Health and Social Care Partnership

Dundee Health and Social Care Partnership

Perth and Kinross Health and Social Care Partnership

3.4 Antidepressant Choice

If the individual has not responded to the recommended non-pharmacological interventions or it is agreed that an antidepressant is clinically indicated then general points that should be considered prior to any prescribing include;

- Previous treatment response (efficacy and tolerability)
- Likely Adverse Effect Profile
- Concurrent Physical Illness
- Concurrent Medication
- Associated Mental Health Conditions which respond to specific drugs
- Individual Preference.

The Selective Serotonin Reuptake Inhibitors are considered the first-line choice antidepressants for individuals who present with symptoms of depression and anxiety on the NHS Tayside formulary. This is also in line with NICE Guidance.

In some clinical instances, SSRIs would not be appropriate and an alternative should be considered. These circumstances may include;

- The individual has increased levels of agitation associated with their depression
- The individual is intolerant of SSRIs, or has previously suffered adverse effects
- Individual has a contraindication to SSRI treatment
- Specific Drug Interactions

If an alternative antidepressant is required, consideration should be given to mirtazapine, venlafaxine or vortioxetine(must be 3rd line option) in line with the NHS Tayside formulary.

Further guidance on selecting the appropriate antidepressant can be found in Appendix 2 and 3.

4. MONITORING

Individuals prescribed an antidepressant should be regularly monitored and reviewed throughout their treatment with an antidepressant.

When treatment is first initiated, there is a risk of increased suicidality. This should not preclude individuals from being commenced on treatment and NICE recommends reviewing an individual within a week of starting treatment with an antidepressant if the individual is aged 18 to 25 years or if there is a particular concern for risk of suicide. Otherwise, individuals should be reviewed within 2 weeks to check for efficacy and side effects. Individuals should then be reviewed again no later than at four weeks after starting the antidepressant.

The frequency of review should then be based on the individual's presentation and adjusted as required in conjunction with the individuals wishes.

As part of monitoring response to treatment, prescribers should ensure that individuals have had a trial of at least 4-6 weeks on an antidepressant at a minimum effective dose before considering lack of benefit or potential dose increases. Appendix 4 highlights the minimum effective dose of commonly used antidepressants.

In the treatment of a first episode of depression,, individuals should be reviewed after six months and consideration given to reducing and stopping the antidepressant if their symptoms have resolved. Guidance on this can be found in section 5.

Where individuals are continued after the initial six months, or in individuals who are prescribed for another indication e.g. recurrent depression, reviews should occur at a minimum of six-monthly intervals. All individuals who are prescribed an antidepressant should be reviewed after 6 months of treatment to consider reducing and stopping the antidepressant.

At all reviews, consideration should be given to the use of rating scales to assess individuals symptoms, adverse effects and overall response to treatment.

5. DISCONTINUATION

Discontinuation symptoms with antidepressants are common, but can be minimized or avoided by careful downward titration of the medication and the right support. When someone is discontinuing antidepressant medication, they should be advised that withdrawal symptoms do not affect everyone and can vary in type and severity between individuals. Potential symptoms may include.

- Unsteadiness, vertigo and dizziness
- Electric shock sensations through the body
- Symptoms which may present as those of depression
- Restlessness, agitation and tiredness
- Problems sleeping
- Sweating
- Nausea and stomach cramps
- Palpitations
- Headaches
- Joint and muscle aches

Among other factors, it is important to consider the risk of relapse should for individuals looking to discontinue their antidepressant. There is increased risk of relapse where there is a history of;

- recurrent episodes of depression, particularly if these have occurred frequently or within the last 2 years
- an incomplete response to previous treatment, including residual symptoms
- unhelpful coping styles e.g. avoidance
- severe depression
- other chronic physical health or mental health conditions
- personal, social and environmental factors contributing to their depression

Where discontinuation is considered appropriate, this should be done gradually and the speed of the discontinuation adjusted based on the individual's response and tolerability. Further advice on this can be found through the Royal College of Psychiatrists and the NICE Clinical Guidance and through the Maudsley Prescribing Guidance.

6. SWITCHING

In most cases antidepressants can be switched using a cross-titration schedule however in some specific switches may require a washout period.

Guidance on switching can be found on the Specialist Pharmacy Service or through the Psychotropic Drug Directory which is available through Medicines Complete. Advice on more complex switches can be sought from the Specialist Mental Health Pharmacy Service within the local Community Mental Health Teams.

7. KEY CONTACTS

For clinical queries regarding any aspect of antidepressant treatment please contact the local Community Mental Health Team.

For comments specifically related to the content of the guidance document please contact:
David Morrison, Lead Clinical Pharmacist Adult Mental Health and Learning Disabilities
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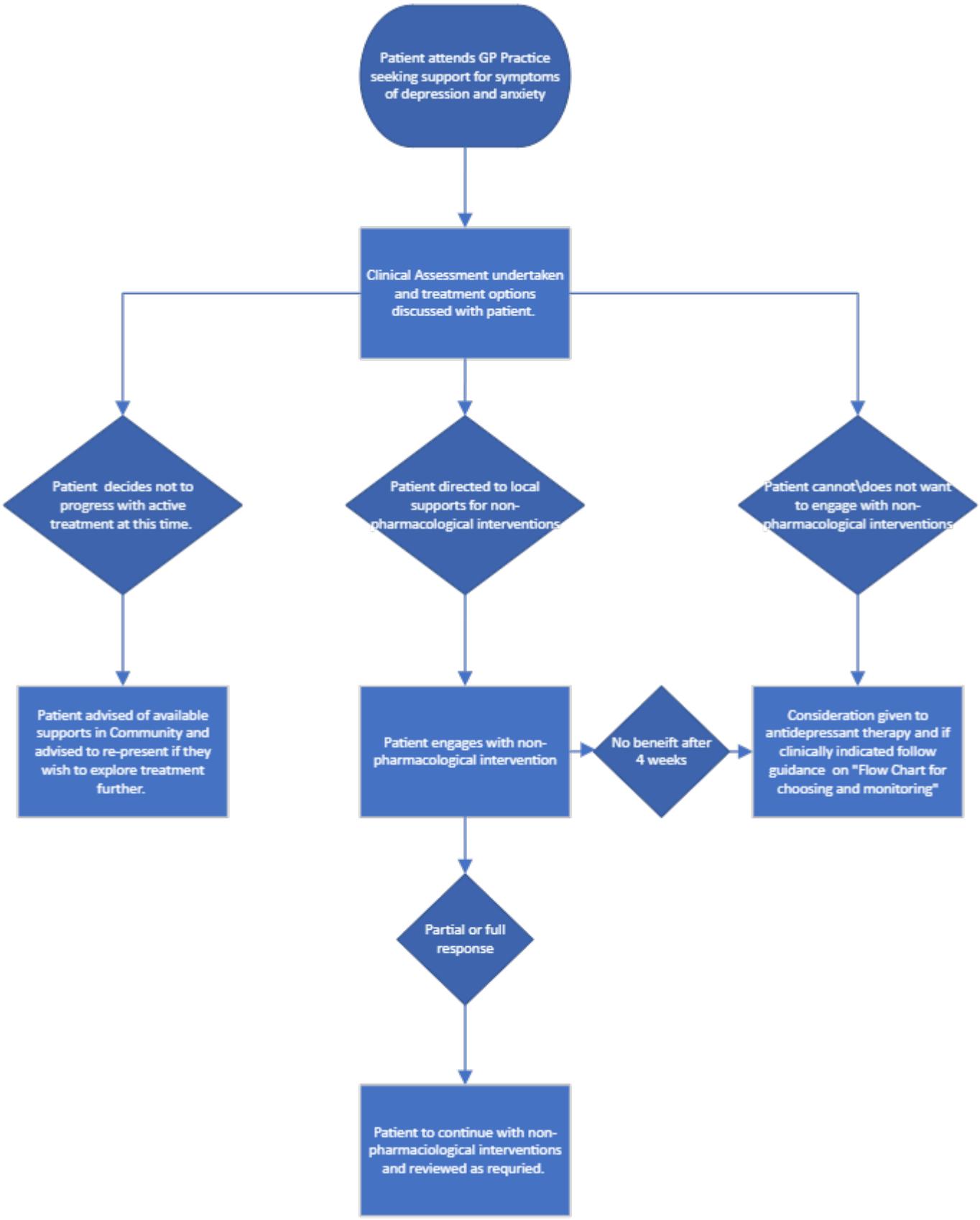
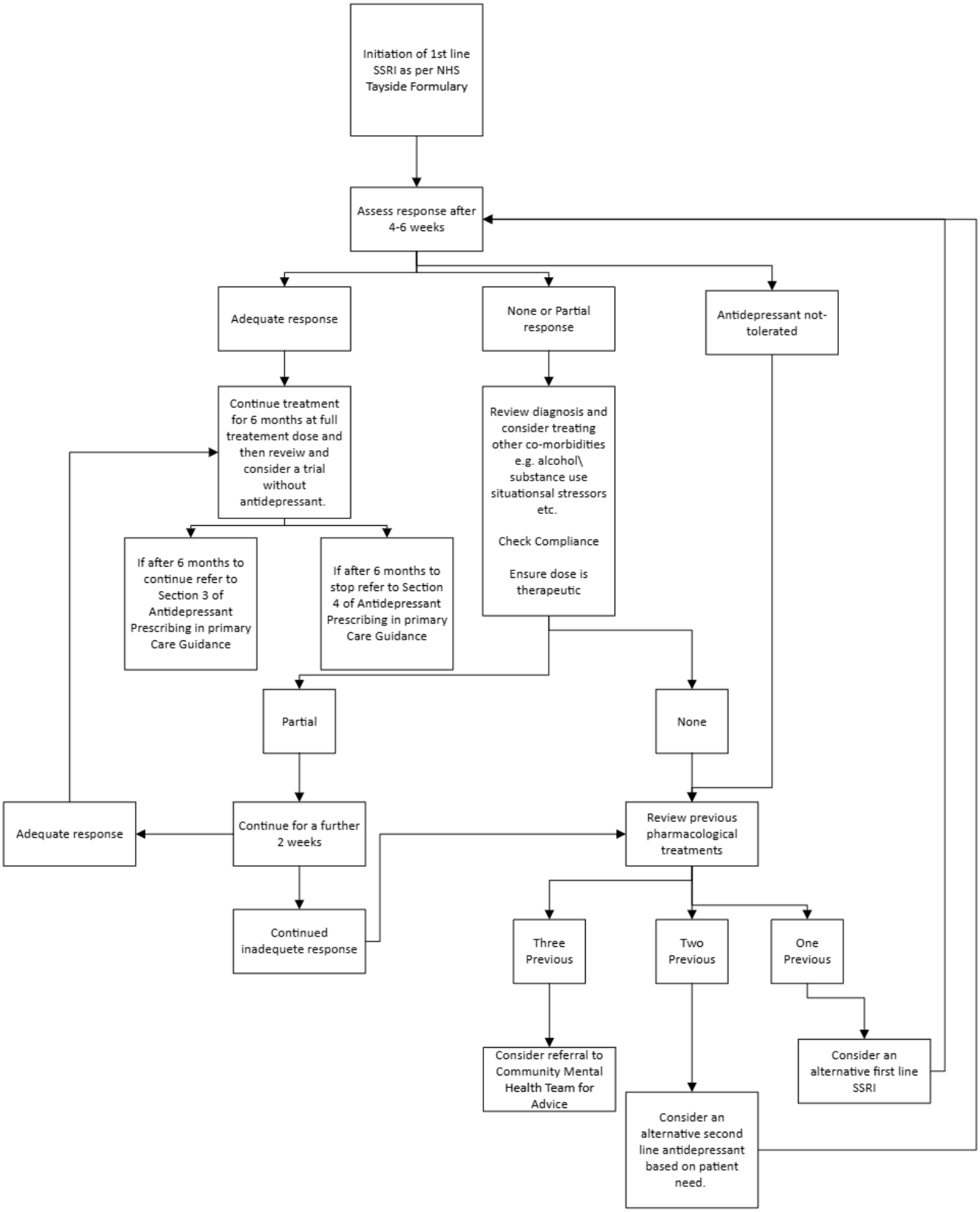
Appendix 1 – Choice of Treatment



Appendix 2 – Flow Chart for choosing and monitoring



Appendix 3: Choice of Antidepressant Table

Antidepressant	Contraindications	Advantages / Benefits	Disadvantages / Cautions
Citalopram	• Contraindicated with other QTc prolonging medicines • Concomitant use of MAO-Inhibitors	• Low propensity for drug interactions • Usually well tolerated	• Dose-related QTc prolongation – maximum of 20mg daily in elderly individuals • Most toxic of all SSRIs in overdose
Fluoxetine	• Contra-indicated in combination with metoprolol used in cardiac failure • Concomitant use of MAO-Inhibitors	• Good choice for individuals with poor compliance due to long half life • Good tolerability • Licensed in OCD *[note not in other anxiety disorders]* • SSRI of choice in pre-menstrual disorder • Licensed for use in children and young people (≥ 8 years)	• Higher risk of drug interactions than other SSRIs due to strong CYP2D6 inhibition
Sertraline	• Concomitant intake of pimozide is contraindicated • Concomitant use of MAO-Inhibitors	• Drug of choice in cardiovascular disease • Good dosage range • Licensed across anxiety disorders including OCD and PTSD • Usually well tolerated • Low propensity for drug interactions	• Risk of gastro-intestinal side effects • Risk of GI bleed – caution in individuals with increased bleeding risk

Tricyclic Antidepressants (TCAs)			
Lofepramine	• Acute porphyrias • Arrhythmias • During manic episodes • Heart block • Immediately after a myocardial infarction	• TCA of choice in depression - has a lower incidence of anticholinergic and sedative side-effects and is less dangerous in overdose compared to the other TCAs • Has weak serotonin reuptake inhibition, so can be useful choice where other serotonergic agents have not been tolerated or effective	• Can cause raised Liver Function Tests (LFTs) • Lower risk of arrhythmias than other TCAs but ECG monitoring still recommended
Serotonin and Noradrenaline Reuptake Inhibitors (SNRIs)			
Venlafaxine	• Uncontrolled hypertension • Recent myocardial infarction • High risk of cardiac arrhythmia • Concomitant use of MAOIs	• Where anxiety is prominent – good evidence base	• Avoid use in individuals with high risk of cardiac arrhythmia. • Monitor blood pressure in doses above 150mg and consider ECG at higher doses. • Significant risk of withdrawal symptoms so careful discontinuation required • Relatively high risk of sexual problems and gastrointestinal side effects

Other			
Vortioxetine	• Concomitant use of MAO-Inhibitors	• Good choice in cardiac co-morbidities • Drug interactions are low • Some supportive evidence for improving cognitive symptoms of depression • Low toxicity in overdose	• 3rd line option – individual should have tried 2 other antidepressants which either failed or not tolerated prior to commencing • Nausea and vomiting can be limiting side effect • Some limited data, e.g. in severe renal or hepatic impairment – caution required.
Mirtazapine	• Concomitant use of MAOIs	• Good option where there is a risk of GI bleed with SSRIs (e.g., older people or co-prescribed medications) • Sedative effect can be beneficial where there are sleep difficulties	• Over-sedation can be problem • Risk of appetite increase and weight gain can be limiting • Evidence base for anxiety disorders is small

Appendix 4 – Minumum Effective Dose and Maximum Dose of Antidepressants

Antidepressant	Minimum Effective Dose as Antidepressant	Maximum Licensed Dose of Antidepressant
Tricyclics	75 – 100mg per day	Please refer to SPC
Lofepramine	140mg per day	210mg per day
Citalopram	20mg per day	Please refer to SPC.
Escitalopram	10mg per day	Please refer to SPC
Fluoxetine	20mg per day	60mg per day
Paroxetine	20mg per day	50mg – 60mg per day (dependent on diagnosis)
Sertraline	50mg per day	200mg per day
Duloxetine	60mg per day	120mg per
Mirtazapine	30mg per day	45mg per day
Moclobemide	300mg per day	600mg per day
Trazodone	150mg per day	300mg per day 600mg under advice of Mental Health Team
Venlafaxine	75mg per day	375mg per day
Vortioxetine	10mg per day	20mg per day