Antidepressants

This bulletin provides information to support the evidence-based, safe and cost-effective choice of antidepressants to treat depression. Concerns have been raised over an increase in antidepressant prescribing and so guidance is provided on the review of therapy.

Key recommendations

- Antidepressant medication is not routinely recommended as first-line treatment for less severe depression (scoring less than 16 on the Patient Health Questionnaire (PHQ-9) scale), unless that is the person's preference.
  - First-line options include non-pharmacological therapy, e.g. cognitive behavioural therapy (CBT).
  - If a person's preference is an antidepressant, Selective Serotonin Reuptake Inhibitors (SSRIs) are recommended as a treatment option for people with less severe depression.
- Treatment options for a new episode of more severe depression (scoring 16 or more on the PHQ-9 scale) include a combination of individual CBT and an antidepressant. This can be an SSRI, Serotonin Noradrenaline Reuptake Inhibitor (SNRI), or other antidepressant if indicated based on previous clinical and treatment history.
- Choice of antidepressant should be based on the individual person's requirements, including the presence of concomitant disease, existing therapy, suicide risk, and previous response to antidepressant therapy.
- SSRIs are generally well tolerated, have a good safety profile and should be considered as the first choice for most people.
- Patients should be counselled to continue treatment for at least six months after the remission of symptoms.
- Sertraline, escitalopram and mirtazapine compared with other antidepressants are less costly and have both a higher response and a lower dropout rate for the acute treatment of adults with major depressive disorder. They should be considered for formulary inclusion and as first choices in new patients where suitable for the individual.
- Dosulepin and trimipramine should not be initiated in primary care for any new diagnosis and should be deprescribed where appropriate see, PrescQIPP 310: Dosulepin and PrescQIPP 311: Trimipramine.
- When changing from one antidepressant to another, abrupt withdrawal should be avoided unless there has been a serious adverse event. Cross-tapering is preferred where possible.
- In agreement with the patient, when stopping a person's antidepressant medication take into account the pharmacokinetic profile and the duration of treatment. Slowly reduce the dose to zero in a stepwise fashion, at each step prescribing a proportion of the previous dose.
- In England (and Wales, Northern Ireland and Scotland where appropriate), review and implement the five actions listed for Integrated Care Systems to optimise personalised care for adults prescribed medicines associated with dependence and withdrawal symptoms.

Costs and savings

Based on prescribing data from NHSBSA (May 22 to April 23) and Public Health Scotland (April 22 to March 23) for England, Wales, Scotland and Isle of Man.

- £276.9 million is spent annually on the prescribing of antidepressant medication in England, Wales, Isle of Man and Scotland.
- Reviewing patients on long term antidepressants and stopping (after tapering) the antidepressant in 10% of patients could **save £18 million annually or £25,207 per 100,000 population**.
- Using the cost-effective antidepressants (sertraline, escitalopram and mirtazapine) instead of dosulepin, trimipramine, clomipramine, fluvoxamine, reboxetine, and trazodone, **could provide savings of £11.8 million annually or £16,538 per 100,000 population.**
- Using fluoxetine 20mg dispersible tablets instead of fluoxetine oral solution and sugar free oral solution could **save £3 million annually or £4,207 per 100,000 population**.

National guidance

- NICE - Depression in adults: treatment and management [NG222]
- NICE - Depression in adults with a chronic physical health problem: recognition and management [CG91]
- NICE - Depression in children and young people: identification and management [NG134]

Clinical effectiveness

There is little to choose between the different classes of antidepressants in terms of efficacy. SSRIs are better tolerated and are safer in overdose than other classes of antidepressants.[1]

Safety

Be aware of contraindications, cautions, side effects and risk of interactions with antidepressants (especially for those on multiple medications for chronic physical health problems). Refer to the BNF and SPCs for advice.

References

1. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press. https://www.medicinescomplete.com/ accessed on 16/02/2023.

Additional resources available	Bulletin	https://www.prescqipp.info/our-resources/bulletins/bulletin-330-antidepressants
	Tools	

Support with any queries or comments related to the content of this document is available through the PrescQIPP help centre https://help.prescqipp.info

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