Antidepressant prescribing in general practice

A call to action

Katharine A Wallis, Maria Donald, Joanna Moncrieff

The *Mental health: Productivity Commission inquiry report* (2020) recommended as a 'priority reform' that we '[a]ddress adverse outcomes from prescribing practices of mental health medication'.[1] The report states that 'while antipsychotic prescribing in aged care facilities is one element of this ... arguably a greater concern, given its frequency, is antidepressant prescribing'.[1] The report recommends that general practitioner (GP) 'mental health training and professional development' be improved to increase 'adherence to evidence-based clinical practices (including the clinical appropriateness of GP's [sic] prescribing practices for mental health medication, management of medication side effects and de-prescribing)'.[1] This article discusses antidepressant prescribing in Australian general practice, adverse drug effects and withdrawal symptoms, and the changes we might make to improve patient outcomes.

Australia is the second highest user of antidepressants per capita (around one in 10 adults) among Organisation for Economic Co-operation and Development (OECD) countries excluding the USA.[2] In the year to June 2020, for the first time an antidepressant (sertraline) was in the top 10 Pharmaceutical Benefits Scheme/Repatriation Pharmaceutical Benefits Scheme medications by defined daily dose/1000 population/day.[3] Evidence suggests long-term use (>12 months), rather than new diagnoses, is driving the increase.[4–6] GPs prescribe most antidepressants in Australia (86.3%).[7]

Often, antidepressant prescribing is not consistent with clinical guidance. According to the most recent Bettering the Evaluation and Care of Health (BEACH) survey data, 12.4% of general practice encounters are mental health–related, and most of these encounters are managed with medication (61.6%).[7] Clinical guidelines recommend psychological therapies for mild depression and anxiety, and 6–12 months of antidepressant therapy for a single episode of moderate-to-severe depression.[8,9] Yet in Australia the average duration of therapy is now approximately four years,[4] and half of users are long-term users.[5] There is also concerning variation in antidepressant prescribing, with rates higher for people in lower socioeconomic or inner regional areas and nearly double in older (≥65 years) when compared with younger people.[10] Nearly one in three older Australians admitted to residential care in 2008–15 was taking antidepressants on admission, and this only increased after admission.[11]

There remains ongoing debate about what constitutes appropriate prescribing, but every GP knows that antidepressants cannot treat common social issues such as grief, loneliness, unemployment or poverty. There is general agreement that antidepressants are no more effective than medication placebo in less severe depressive disorders,[12] and there remain questions regarding whether antidepressants have any useful effects against more severe depression over and above the placebo effect.[13] It has never been substantiated that antidepressants reverse an underlying chemical (serotonin) deficiency or other brain abnormality, yet they modify the brain in ways that are not fully understood, with potentially harmful consequences.[14–16]

Adverse drug effects include lethargy; sexual dysfunction, which may be persistent, including failure to orgasm in both sexes;[17,18] and emotional numbing described as 'feeling emotionally detached', 'reduced sympathy and empathy'[19] and 'caring less about others'.[20] The relational and societal consequences are uncharted. Antidepressants also cause weight gain, increase the risk of falls and fractures[21] and are associated with higher rates of severe COVID-19.[22] Long-term use can lead people to 'feeling addicted' or dependent on medication, increasing

reliance on health services and potentially reducing people's intrinsic resilience.[20]

A physiological withdrawal syndrome often makes it difficult for people to stop long-term antidepressants (Table 1). Withdrawal symptoms include anxiety, irritability, dizziness, confusion, low mood, headache and electric shock sensations described as 'brain zaps'.[23] These symptoms are readily misconstrued as impending relapse, prompting fear and perpetuating prescribing.[24] A range of evidence suggests approximately half of people may experience antidepressant withdrawal symptoms, which can last for weeks or months, with severity and duration likely proportional to duration of use.[23] The incidence, severity and duration of withdrawal symptoms have only recently become widely known, prompting an update of the Royal College of Psychiatrists clinical guidelines to encourage slow tapering to mitigate withdrawal.[9]

To curb unnecessary and prolonged prescribing of antidepressants, we need to support GPs to initiate antidepressants less often and to review and stop antidepressants more often. Reviewing and stopping medication when it is no longer indicated is an essential part of good prescribing practice, but in the time-pressured context of general practice it is sometimes overlooked and has been described as 'swimming against the tide'.[25] Barriers for GPs include time constraints, reluctance to destabilise a stable situation and poor access to non-pharmaceutical alternatives; barriers for patients include an expectation that doctors would suggest stopping if it were warranted, fear of relapse and unpleasant withdrawal symptoms.[24] Ready access to social, financial and psychological supports will be part of the equation, but helping patients to stop antidepressants is also important, especially as the withdrawal process can be complex, often requiring slow tapering, tailored support and regular follow-up (Table 2).[26–28] The Productivity Commission recommends 'more research focused in these areas, and uptake of its resulting lessons among treating clinicians'.[1] As the fallout from the COVID-19 pandemic continues, there has never been a more pressing time to address the issue of unnecessary and potentially harmful prescribing of antidepressants in general practice.

Table 1. Antidepressant withdrawal symptoms, differentiating withdrawal from relapse and risk of withdrawal by antidepressant medication[29]

Withdrawal symptoms	
Physical	Dizziness, headache, nausea, loss of appetite, flu-like symptoms/feeling unwell, loss of coordination, electric-shock sensations, difficulty concentrating, feeling that things are not real, akathisia/inner restlessness, tremor, sweating, palpitations, abdominal cramps, diarrhoea, fatigue, visual disturbance, tinnitus
Emotional	Anxiety, panic, agitation, irritability, anger, low mood, rapidly changing moods, suicidal thoughts
Sleep	Insomnia, vivid dreams, nightmares
Differentiating withdrawal from relapse	
Withdrawal	**Relapse**
Often starts within a day or two of reducing or stopping antidepressants but can start after days or weeks for longer-acting antidepressants	Usually takes weeks or months for anxiety/depression symptoms to recur
Often feels different, 'not like my depression'	Do not get some symptoms such as 'electric shocks' or 'zaps'
Improves quickly on restarting antidepressants	Usually takes weeks for symptom relief with antidepressants
Symptoms are wave-like: onset, worsen, peak, improve, resolve	Symptoms tend to persist
Risk of withdrawal by antidepressant medication	
Highest	Paroxetine, venlafaxine, duloxetine
Moderate	Citalopram, escitalopram, fluvoxamine, sertraline
Lower	Fluoxetine

Authors

Katharine A Wallis MBChB, PhD, MBHL, Dip Obst, FRNZCGP, FACRRM, General Practitioner and Associate Professor, Primary Care Clinical Unit, Faculty of Medicine, University of Queensland, Brisbane, Qld

Maria Donald PhD, Senior Research Fellow, Primary Care Clinical Unit, Faculty of Medicine, University of Queensland, Brisbane, Qld

Joanna Moncrieff MD, Psychiatrist and Professor of Psychiatry, Division of Psychiatry, University College London, London, UK

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Correspondence to:
k.wallis@uq.edu.au

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Table 2. When and how to stop antidepressants[29]

When to stop	When there is no indication for ongoing use and/or the risks and harms (sexual dysfunction, weight gain, falls, fractures etc) outweigh the potential benefits.
How to stop	Reduce dose by 25–50% of most recent dose, wait 2–4 weeks, repeat.
	Dose reductions become incrementally smaller. A compounding chemist or liquid medication may be required.
	Monitor withdrawal symptoms, wait until they have dissipated, then commence next reduction. This may be longer for longer-acting antidepressants.
	A flexible individualised plan often involving slow taper over months is key to success.
Examples	Citalopram 50% dose reduction every 2–4 weeks: 40 mg, 20 mg, 10 mg, 5 mg, 2.5 mg, 1.25 mg, 0.6 mg, 0.3 mg, stop.
	Paroxetine 10% dose reduction every 2–4 weeks using tablets and liquid: 40 mg, 36 mg, 32.4 mg, 29.2 mg, 26.2 mg, 23.6 mg, 21.3 mg, 19.1 mg, 17.2 mg, 15.5 mg, 13.9 mg, 12.6 mg, 11.3 mg ... 0.6 mg, stop.
If withdrawal symptoms occur and are distressing	Return to pre-reduction dose until comfortable. When ready to try again, use a more gradual taper (eg 5–10% of most recent dose).
	People who have been taking antidepressants at higher doses for longer periods are more likely to experience withdrawal symptoms. More gradual taper (5–10%) may be necessary.
	People who have experienced withdrawal symptoms previously will likely need more gradual taper (5–10%).

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correspondence **ajgp@racgp.org.au**