Hertfordshire Partnership University NHS Foundation Trust

HPFT

# Guidelines on Choice and Selection of Antidepressants for the Management of Depression

HPFT Guideline

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| Version | 2 |
| Executive Lead | Executive Director of Quality and Medical Leadership |
| Lead Author | Principal Clinical Pharmacist |
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| **Title of document** | Guidelines on Choice and Selection of Antidepressants for the Management of Depression | | |
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| 2 | February 2025 | February 2027<br>& post national updates | Principal Clinical Pharmacist |
| **Staff need to know about this policy because (complete in 50 words)** | These guidelines have been developed to provide clinical staff with guidance on prescribing antidepressants for the management of depression to ensure safe and cost-effective care of service users in line with the current NICE guidance (June 2022) and Trust formulary. | | |
| **Staff are encouraged to read the whole policy, but I (the Author) have chosen three key messages from the document to share:** | 1. HPFT guideline has been updated to reflect latest NICE guidance (NG222), which includes thresholds on validated scales as an indicator of severity of depression.<br>2. Emphasis on shared decision making between clinician and patient and/or carer, to enable improved adherence to medication, thereby improving long-term outcomes, reduction in GP appointments as patients/carers are better informed, reduction in medicines wastage, and ultimately a reduction in NHS costs.<br>3. Appropriate advice to be provided to patients/carers when starting, stopping, or switching antidepressant medicines and expectations during these processes, to include use of resources such as choice and medication information leaflets, regular initial reviews, to achieve maximum information provision, increase likelihood of adherence to medication, and minimise discontinuation symptoms. | | |
| **Summary of significant changes from previous version are:** | Latest guidance (NG222 - June 2022) on pharmacological management and treatment of depression incorporated into the guidelines.<br>Incorporation of Traffic Light (RAG) status for antidepressant prescribing.<br>Addition of following appendices:<br>a. The Antidepressant Side Effect Checklist (ASEC)<br>b. Patient Health Questionnaire (PHQ-9)<br>c. Antidepressant medicines patient counselling advice<br>d. Glasgow Depression Scale in Learning Disability<br>e. Prescription Safe Plan<br>f. Equality Impact Assessment | | |

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N.B: Some links within this document may not be accessible to non-HPFT staff.

## 1. Recommended Pharmacological Treatment for Depression

**Choice of treatment[1]** alongside shared decision making, will depend on preference for specific medication effects such as sedation, concomitant illnesses or medications, suicide risk and previous history of response to antidepressant medicines.

**SSRIs** potentially interact with concomitant medication used for physical illness (see section 5 below)

**Paroxetine(SSRI)** associated with a higher incidence of discontinuation symptoms than other SSRIs, and **fluvoxamine** with greater potential of drug interactions hence both less preferred.

Risk of a dose dependant **QT prolongation** with **citalopram and escitalopram**, do NOT prescribe in patients with known QTc prolongation, congenital long QT syndrome or in those prescribed medications known to prolong QTc.

# Pharmacological Treatment of Depression in Adults

**(Antidepressants NOT routinely recommended as first-line treatment for less severe depression unless it is the person's preference or if they have previously responded to a drug and they wish to restart it**

## FIRST LINE (or less severe depression)

SSRI –Citalopram, Fluoxetine, Sertraline

## SECOND LINE

Alternative above SSRI, SNRI (venlafaxine, duloxetine) or mirtazapine

## THIRD LINE (or more severe depression)

- Alternative 2nd line agent (see above)
- Reboxetine (NRI) or Escitalopram (specialist initiation only)
- Vortioxetine (when no or limited response to ≥ 2 previous antidepressants)
- TCAs and related or MAOI (both classes for specialist initiation only)

**Combination or augmentation treatments include:**

- Adding an antidepressant from a different class
- Adding a second generation antipsychotic or lithium
- Augmenting with ECT, lamotrigine, triiodothyronine (secondary care only)

**For specialist initiation only**

**Older Adults >65 years**
Recommend monitoring for antidepressant – induced hyponatraemia; increased risk of GI bleeding; increased risk of postural hypotension after starting all antidepressants particularly SSRIs. **See section 7.1.[1,2]**

**Patients under 18 years**
Fluoxetine is the recommended first line treatment in patients under 18 years[3]. It is licensed for the treatment of more severe depression from 8 years onwards.
**See section 7.2.[1,2,3]**

**Antenatal and Postnatal Prescribing**
SSRIs have low known risk, most experience with fluoxetine and sertraline. TCAs also have low teratogenic risk.
Imipramine, nortriptyline, and sertraline considered safest in breastfeeding.
**See section 7.3.[2,4,5]**

**ABBREVIATIONS:**
SSRI - selective serotonin reuptake inhibitor
SNRI - serotonin – noradrenaline reuptake inhibitor
NRI - Selective inhibitor of noradrenaline re-uptake
TCA - tricyclic antidepressant
MAOI - monoamine oxidase inhibitor
IR - immediate release
MR - modified release
SPC – summary of product characteristics

**PART 1**

## 2. Introduction

This guidance should be considered as part of a stepped care approach (the least intrusive and least resource intensive effective treatments should be offered first, taking into account accessibility of non-pharmacological interventions) in the management of depressive disorders[1]. Current NICE guidance should always be consulted wherever possible to obtain the most up to date information.

Please see HWE clinical guidance: HPFT have developed a 'Depression Pathway' alongside e-learning for HPFT staff via ESR and the NHS learning HUB. This navigates from screening and assessing to prevention and treatment including detail of non-pharmacological interventions.

Latest NICE guidance (NG222 – June 2022) has reclassified severity of depression to **less severe** (encompassing subthreshold and mild depression, defined as depression scoring less than 16 on the PHQ-9 scale) and **more severe** (encompassing moderate and severe depression, defined as depression scoring 16 or more on the PHQ-9 scale), as a consequence of the following 3 elements:

- symptoms (which may vary in frequency and intensity)
- duration of the disorder
- the impact on personal and social functioning

NG222 recommends that for less severe depression, practitioners ask patients to consider less intensive treatment first (e.g., guided self-help) and **not routinely offer antidepressant medication** as first line treatment unless requested by person (or if they have previously responded to an antidepressant medication and wish to restart it), and for more severe depression, that interventions with more therapist contact be tried first, or psychological therapies continued alongside pharmacological treatment.

## 3. Purpose and Scope

To provide guidance on the safe and effective prescribing of antidepressant medication to patients with depression. (Medicines for specialist initiation and continuation are excluded from this guideline).

Brief guidance on prescribing treatment for depression in:

- older adults can be found in section 7.1.
- children and adolescents can be found in section 7.2.
- antenatal/postnatal (perinatal) service users can be found in section 7.3.
- learning (intellectual) disability can be found in section 7.4.

It does not cover prescribing for depression in bipolar disorder and psychotic depression, or detail chronic depression treatment. Please see NG222, HPFT Depression Pathway, visual summaries, and other resources for latest information.
*This document refers to the use of medicines for patients who are considering medicines as a treatment for depression.*

*Other treatments for depression such as psychological treatments and digitally enabled therapies, vagus nerve stimulation, repetitive transcranial magnetic stimulation (rTMS) and electroconvulsive therapy (ECT), are available and play important roles in the treatment of depression. This guidance does not make specific reference to their use or place in therapy, nor does it aim to promote the use of medicines over other treatments. For guidance on their use and place in therapy refer to:*

- NICE Guideline – NG222 Depression in adults: treatment and management
- HPFT Electroconvulsive Therapy (ECT) Policy v5.1 – viewable by HPFT staff
- NICE Health Technology Evaluation (HTE) – HTE 8 Digitally enabled therapies for adults with depression: early value assessment
- NICE, Interventional Procedures Guidance (IPG) – IPG542 Repetitive transcranial magnetic stimulation for depression
- NICE, Interventional Procedures Guidance (IPG) – IPG679 Implanted vagus nerve stimulation for treatment-resistant depression

Latest editions (at time of writing)) of following reference sources to be used alongside the most current NICE guidance:

- Maudsley Prescribing Guidelines in Psychiatry (2021)
- Psychotropic Drug Directory (2020/21)
- BNF
- Lactmed Database: https://www.ncbi.nlm.nih.gov/sites/books/NBK501922/ for medication during breastfeeding enquiries
- UK Teratology Information Service (UKTIS) (for pregnancy and some breastfeeding information) - https://uktis.org/ and https://www.medicinesinpregnancy.org/: Healthcare professionals can contact UKTIS on 0344 892 0909 between 09:00-17:00 Mon-Fri (excluding bank holidays) for routine enquiries. Urgent enquiries are answered 24/7.

## 4. Basic principles of prescribing in depression[2]

- Discuss with the patient choice of drug and **availability** of other non-pharmacological treatments.
- Discuss with the patient likely outcomes, such as gradual relief from depressive symptoms over several weeks.
- Prescribe **generic** antidepressant, unless specific brand/generic required, and at dose, (after titration, if necessary) likely to be effective.
- Be aware that higher doses of antidepressants may not be more effective and can increase the frequency and severity of side effects.
- Review to check for tolerance and symptom improvement within 2 weeks, or 1 week in the under 25-year-olds or those with suicide risk, and then again as often as needed (but no later than 4 weeks after initiation).
- For a single episode, ensure providing information that treatment might need to be taken for at least 6 months after symptom remission, (those at risk of relapse should continue for at least 2 years).
- Review treatment for people continuing with antidepressant medication to prevent relapse at least every 6 months[1], although frequency should be based on individual assessments, monitoring:
    - Mood – appetite, sleep, energy
    - For side effects including sexual dysfunction

    - If they wish to stop antidepressant
    - Other causative factors that may affect risk of relapse.
- Withdraw antidepressants gradually (see pages 20-21 for further advice) always inform patients on the risk and nature of discontinuation symptoms.
- Advise people that if they stop taking antidepressant medication abruptly, miss doses or do not take a full dose, they may have discontinuation symptoms (refer to Appendix 2), such as:
    - restlessness or agitation
    - problems sleeping
    - abdominal symptoms (such as nausea)
    - altered sensations (for example electric shock sensations in the head)
    - altered feelings (for example irritability, anxiety, or confusion).
    - palpitations, tiredness, headaches, and aches in joints and muscles.
    - unsteadiness, dizziness
    - sweating

## 5. Choice of Antidepressant[1,2]

Consider a baseline assessment for severity of depression and regularly review symptoms both clinically and using a standard severity rating scale such as PHQ-9 form[1] (see Appendix 3). Choose an antidepressant taking the following into account:

- If prescribing an SSRI, please note fluoxetine, fluvoxamine and paroxetine have a higher propensity for drug interactions (fluvoxamine and paroxetine are the least preferred SSRIs). It may be appropriate to consider sertraline, citalopram or fluoxetine in patients who have chronic health problems, as these have a lower propensity for interactions with medications used for physical health conditions.
- Paroxetine has a higher incidence of discontinuation symptoms (consider half-lives) and greater effect on muscarinic receptors.
- SSRIs and SNRIs (those affecting serotonin transporters) are associated with an increased risk of bleeding – consider prescribing a gastro-protective drug (e.g. proton pump inhibitor) in adults at high risk of an upper GI bleed, or those taking NSAIDs and/or blood thinning medications when combined with an SSRI/SNRI.
- Toxicity in overdose should be considered when selecting an antidepressant for patients at significant risk of suicide - venlafaxine, tricyclic antidepressants (except for lofepramine) and mirtazapine are associated with highest absolute risk of death from overdose.

Discuss choice of antidepressant, involving shared decision making between prescriber and patient and/or carer, covering:

- Patient choice - consider using tools to support patients to be involved in decision making such as handy charts and information leaflets on the choice and medication website; NICE have produced a patient decision aid for managing depression, (September 2024).
- The perception of the efficacy and tolerability.
- Importance of treatment adherence.
- The importance of taking the medication as prescribed and need to continue beyond remission.
- Existing co-morbid psychiatric disorders such as obsessive-compulsive disorder, anxiety etc., through accurate history taking.

- Anticipated adverse events, e.g. agitation, nausea and vomiting with SSRIs, and discontinuation symptoms. See appendix 1 for table of relative side effects of antidepressants. Consider using structured side effect rating scale such as the antidepressant side effect checklist (ASEC), (see appendix 4).
- Potential interactions with concomitant medication for physical illnesses[2] below (list is not exhaustive – please refer to individual medication SPCs; there is currently no evidence to support using specific antidepressants in particular physical health problems:

| MEDICATION FOR PHYSICAL HEALTH PROBLEM | RECOMMENDED ANTIDEPRESSANT(S)[2,7,8] |
|---|---|
| Regular use of NSAIDs (non-steroidal anti-inflammatory drugs) | Do not normally offer SSRIs because of the increased risk of gastrointestinal bleeding. If no suitable alternatives can be identified, offer gastro-protective medicines (e.g., proton pump inhibitor) together with the SSRI.<br>Consider mirtazapine, moclobemide or trazodone. |
| Aspirin | Use SSRIs with caution because of the increased risk of gastrointestinal bleeding. If no suitable alternatives can be identified, offer gastro-protective medicines (e.g., proton pump inhibitor) together with the SSRI.<br>Consider mirtazapine when aspirin is used as a single agent. |
| Warfarin or heparin | Do not normally offer SSRIs, because of the increased risk of gastrointestinal bleeding.<br>Consider mirtazapine. |
| Direct Oral Anticoagulants e.g. apixaban, rivaroxaban, dabigatran | Prudent to exercise caution on the concurrent use of a direct oral anticoagulant and an SSRI or SNRI, if the benefit outweighs the bleeding risk. Patients should be monitored closely for signs and symptoms of bleeding (especially if other risk factors for bleeding are present). |
| 'Triptan' drugs for migraine | The SSRIs generally do not interact with the triptans, but there are a few rare cases of dyskinesias when sumatriptan was given with an SSRI, and there is some evidence to suggest that serotonin syndrome might occasionally develop. The SNRIs are predicted to interact similarly. Findings do not imply that concurrent use should be avoided, but that caution, and close monitoring should be used, or offer mirtazapine or trazodone. |
| Monoamine-oxidase B inhibitors, e.g. selegiline or rasagiline | UK (and US) manufacturers contraindicate concurrent use of SSRIs/SNRIs and MAO-B due to rare possibility of serotonin syndrome.<br>Offer mirtazapine or trazodone. |
| Theophylline or methadone | Do not normally offer fluvoxamine - offer citalopram or sertraline (sertraline may increase methadone levels). |
| Clozapine | Consider fluoxetine, citalopram or sertraline (small to modest increases in plasma clozapine levels may occur, particularly with sertraline). |
| Flecainide or propafenone | Offer sertraline as the preferred antidepressant, mirtazapine or moclobemide may also be used. |
| Atomoxetine | Do not offer citalopram, fluoxetine, or paroxetine as they can increase atomoxetine concentrations, thereby increasing incidence of adverse effects. Offer sertraline or mirtazapine. |

Please note: some antidepressants have been used **off license** to treat certain physical health illnesses, hence advise carrying out a thorough medicine's reconciliation, before prescribing the antidepressant for depression.

- Antidepressants have a prompt onset of action and non-response at 2-6 weeks is a good predictor of overall response.
- Switch treatments early (e.g. after 1-2 weeks) if adverse effects are intolerable or if no improvement at all is seen by 4 weeks of treatment with a therapeutic dose of an antidepressant.
- However, if there is some improvement, continue antidepressant medication at a recognised therapeutic dose (check the antidepressant SPC for minimum period before dose can be increased), and reassess for symptom improvement.

**Risk of clinical worsening, suicidal Ideation, suicidal attempts, and suicide**

- The period when someone **starts** an antidepressant has been associated with an increase in suicidal thoughts, antidepressants all carry a warning about the increased risk of suicide, suicidal thought, suicidal attempts, clinical worsening.
- In the early stages of treatment, the **motivation** tends to improve first whilst **mood improvement** may take longer, therefore there is a risk that the motivation for suicide may increase, hence should be closely monitored, and ensure that a risk management strategy is in place.
- For people considered to be at **increased risk of suicide** or who are **younger than 25 years** assess their mental state and mood before starting the prescription, ideally in person (or by video call or by telephone call if in-person assessment is not possible, or not preferred)
- Consider toxicity in overdose for people at significant risk of suicide particularly when initiating antidepressants, especially SSRIs.
- Base the frequency and method of ongoing review on their circumstances (for example, the availability of support, unstable housing, new life events such as bereavement, break-up of a relationship, loss of employment), and any changes in suicidal ideation, self-harming thoughts and/or assessed risk of suicide but as a minimum, review to check for tolerance and symptom improvement within 2 weeks, or 1 week in the <25-year age group or if there is concern for risk of suicide.
- Consider prescribing a shorter duration of supply whilst patient is high risk of suicidal ideation to reduce stockpiling.
- Psychoeducation and engaging carers are important to reduce the risk of suicide or attempted suicide.
- Consider routine outcome monitoring (using appropriate validated sessional outcome measures, for example PHQ-9) and follow up.
- Please see Prescription Safe Plan (appendix 7) formulated by The Ollie Foundation as a tool to support healthcare professionals to ensure patients are well informed about suicide risk and better able to keep safe while taking antidepressant medications.

Comparative **Toxicity in Overdose[12] – Highest risk to lower risk:**

1. TCAs - Dosulepin: particularly high; lofepramine: relatively low toxicity
2. MAOIs
3. Venlafaxine
4. Trazodone
5. Duloxetine
6. Mirtazapine
7. SSRIs - Escitalopram and citalopram: higher risk of cardiac toxicity.

## 6. HPFT Antidepressant Formulary for the treatment of Depression in Adults[2,6,10,11,12,13,14]

Please note: Some strengths/formulations may not be readily available or are non-formulary (in red) but awareness useful for gradual withdrawal of antidepressant (inc. via hyperbolic dose tapering), to minimise discontinuation symptoms, as well as for higher dosing to aid compliance; consult BNF/SPC for more detailed information and advice re: prescribing, particularly in those with co-morbidities and/or those prescribed multiple drug regimens.

| | RAG STATUS | DRUG | DRUG CLASS | FORMULATION | ADDITIONAL PRESCRIBING INFORMATION |
|---|---|---|---|---|---|
| 1 | RED | Agomelatine | Melatonin receptor agonist | • 25mg tablets | • **Named patient request ONLY.** Prescribing to remain with HPFT – not to be transferred to primary care.<br>• Risk of dose related hepatotoxicity and liver failure, see MHRA Agomelatine (Valdoxan): risk of liver toxicity<br>• Least likely to cause discontinuation symptoms or sexual dysfunction. |
| 2 | AI | Amitriptyline | Tricyclic antidepressant (TCA) | • 10mg, 25mg, 50mg tablets<br>• 25mg/5ml and 50mg/5ml oral solution | • **For specialist initiation only.**<br>• TCAs are at greatest risk in overdose except for lofepramine.<br>• TCAs are cardiotoxic defined as causing 25% increase in baseline QTc interval – even at therapeutic intervals.<br>• Avoid in patients at risk of arrhythmias.<br>• Consider ECG at higher dose above 150mg of amitriptyline (in adults <65 years) and doses of 100mg upwards when given in association with other drugs that prolong QT interval, especially with therapeutic doses of antipsychotic medication and methadone.<br>• Increased anticholinergic burden, especially when co-prescribed with other anticholinergic drugs.<br>• Also indicated for treatment of neuropathic pain, chronic tension headaches and migraine prophylaxis. |
| 3 | GREEN | Citalopram | Selective serotonin reuptake inhibitor (SSRI) | • 10mg, 20mg, 40mg tablets<br>• 40mg/ml oral drops<br><br>(Each mL contains 20 drops)<br>4 drops (8mg) ≡ 10mg tablet | • SSRI with lowest propensity for drug interactions.<br>• Suitable choice in renal impairment.<br>• Most toxic of SSRIs in overdose (coma, seizures, arrhythmia).<br>• QT interval prolongation:<br>  ○ Contraindicated with other QT prolonging medications.<br>  ○ Baseline ECG advised in patients with cardiac disease.<br>  ○ Bioequivalence to drops- see citalopram tablets to drops conversion. |

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| 4 | AI | Clomipramine | TCA | • 10mg, 25mg, 50mg capsules | • **For specialist initiation only.**<br>• TCAs are at greatest risk in overdose except for lofepramine.<br>• TCAs are cardiotoxic defined as causing 25% increase in baseline QTc interval – even at therapeutic intervals.<br>• Avoid in patients at risk of arrhythmias.<br>• Consider ECG when co-administered with other drugs that may increase the QTc interval.<br>• Increased anticholinergic burden, especially when co-prescribed with other anticholinergic drugs. |
| 5 | DOUBLE RED | Dosulepin | TCA | • 25mg capsules<br>• 75mg tablets | • Do NOT SWITCH TO or START **dosulepin** because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose: CKS - Antidepressant toxicity in overdose \| Prescribing information \| Depression \| CKS \| NICE |
| 6 | GREEN | Duloxetine | Serotonin and noradrenaline reuptake inhibitor (SNRI) | • 20mg, 30mg, 40mg, 60mg, 90mg, 120mg capsules | • 20mg and 40mg strengths are **not** licensed for depression.<br>• Duloxetine is contraindicated in patients with **uncontrolled** hypertension that could expose patients to a potential risk of hypertensive crisis, hence important to monitor blood pressure at initiation (first month) and regularly during treatment.<br>• The standard dose is 60 mg/day but a lower starting dose of 20 mg/day and slower titration improves tolerability and reduces drop-outs.<br>• An alternative to venlafaxine (SNRI); also licensed to treat generalised anxiety disorder, nerve pain, such as fibromyalgia, and can be used to treat stress urinary incontinence in women |
| 7 | AI | Escitalopram | SSRI | • 5mg, 10mg, 20mg tablets<br>• 20mg/ml oral drops<br><br>1 drop = 1mg<br>(10 drops = 10mg tablet) | • **For specialist initiation**<br>• Suitable choice in mild to moderate renal impairment.<br>• Most toxic of SSRIs in overdose (coma, seizures, arrhythmia).<br>• QT interval prolongation:<br>  ○ Contraindicated with other QT prolonging medications.<br>  ○ Baseline ECG advised in patients with cardiac disease.<br>• **Escitalopram** is an isomer of citalopram.<br>• Demonstrated similar-to-better efficacy than citalopram.<br>• Has similar tolerability to citalopram and other SSRIs.<br>• Escitalopram may be useful in patients with overlapping generalized anxiety disorders with depression. |

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| 8 | GREEN | Fluoxetine | SSRI | • 10mg, 20mg, 30mg, 40mg, 60mg capsules<br>• 20mg/5ml oral liquid (can also be used sublingually) | • Good option for patents with poor medication compliance due to its long half-life. |
| 9 | AI | Flupentixol dihydrochloride | Antipsychotic (neuroleptic) | • 0.5mg, 1mg tablets | • **For specialist initiation only.**<br>• Not appropriate choice as sole treatment of depression. |
| 10 | GREEN | Fluvoxamine | SSRI | • 50mg, 100mg tablets | • Less cost-effective choice, lowest efficacy and tolerability compared to the other SSRIs.<br>• Use only when other SSRIs are not suitable. |
| 11 | AI | Imipramine | TCA | • 10mg, 25mg tablets<br>• 25mg/5ml oral solution (*restricted to those unable to take tablets as per ICB formulary)* | • **For specialist initiation only.**<br>• TCAs are at greatest risk in overdose except for lofepramine.<br>• TCAs are cardiotoxic defined as causing 25% increase in baseline QTc interval – even at therapeutic intervals.<br>• Avoid in patients at risk of arrhythmias.<br>• Increased anticholinergic burden, especially when co-prescribed with other anticholinergic drugs. |
| 12 | AI | Isocarboxazid | Irreversible Monoamine oxidase inhibitor (MAOI) | • 10mg tablets | • **For specialist initiation only.**<br>• Potential for major food and drug interactions with MAOIs to varying degrees. Alcohol should also be avoided. See BNF for further details on interactions, side-effects and withdrawal. Patients should be provided with appropriate written information.<br>• Most hepatotoxic.<br>• A less preferred choice of medicine.<br>• See BNF for details on initiating treatment after another antidepressant has been stopped, also see appendix 2 for stopping/switching antidepressants advice.<br>• MAOIs contraindicated in severe cardiovascular disease. |
| 13 | AI | Lofepramine | TCA | • 70mg tablets<br>• 70mg/5ml oral suspension | • **For specialist initiation only.**<br>• TCAs are cardiotoxic defined as causing 25% increase in baseline QTc interval – even at therapeutic intervals.<br>• Avoid in patients at risk of arrhythmias.<br>• Better safety profile than other TCAs:<br>  ○ lower incidence of side-effects<br>  ○ less dangerous in overdose. |

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| | | | | | ○ less cardiotoxic.<br>• It is an option in SSRI induced hyponatraemia.<br>• Can cause raised liver function tests. |
| 14 | GREEN | Mirtazapine | Noradrenaline and specific serotonergic antidepressant (NaSSa) | • 15mg, 30mg,45mg tablets<br>• 15mg, 30mg, 45mg orodispersible tablets<br>• 15mg/ml oral solution | • Oral solution should **only** be used when orodispersible tablets are unsuitable.<br>• Safer option in patients at high risk of GI bleed e.g. older adults taking NSAIDs.<br>• Good choice if sedation required; improves appetite.<br>• Consider if SSRI ineffective or SSRI not appropriate.<br>• Use alternative in overweight patients or make patient aware of potential for weight gain.<br>• Exercise caution when prescribed in patients with:<br>○ known cardiovascular disease or<br>○ family history of QT prolongation, and<br>○ in concomitant use with other medicinal products thought to prolong the QTc interval. |
| 15 | AI | Moclobemide | **Reversible** MAOI | • 150mg, 300mg tablets | • **For specialist initiation only.**<br>• There is potential for major food and drug interactions with MAOIs. Alcohol should also be avoided.<br>• See BNF for further details on initiating treatment after another antidepressant has been stopped (also appendix 2), interactions, side-effects and withdrawal. Patients should be provided with appropriate written information. |
| 16 | AI | Nortriptyline | TCA | • 10mg, 25mg, 50mg tablets<br>• 10mg, 25mg capsules<br>• 10mg/5mL, 25mg/5mL oral solution | • **For specialist initiation only.**<br>• TCAs are at greatest risk in overdose except for lofepramine.<br>• TCAs are cardiotoxic defined as causing 25% increase in baseline QTc interval – even at therapeutic intervals.<br>• Avoid in patients at risk of arrhythmias.<br>• Increased anticholinergic burden, especially when co-prescribed with other anticholinergic drugs. |
| 17 | GREEN | Paroxetine | SSRI | • 10mg, 20mg, 30mg, 40mg tablets<br>• 10mg/5ml oral suspension | Less preferred choice:<br>- given its greater tendency to cause sexual dysfunction and weight gain.<br>- SSRI with greatest risk of discontinuation syndrome |
| 18 | AI | Phenelzine | Irreversible MAOI | • 15mg tablets | • **For specialist initiation only.** |

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| | | | | | • There is potential for major food and drug interactions with MAOIs. Alcohol should also be avoided.<br>• See BNF for further details on initiating treatment after another antidepressant has been stopped (also appendix 2), interactions, side-effects, and withdrawal. Patients should be provided with appropriate written information.<br>• Preferred MAOI – safest of MAOIs.<br>• More likely to cause hepatotoxicity than tranylcypromine |
| 19 | AI | Reboxetine | Selective inhibitor of noradrenaline re-uptake (NRI) | • 4mg tablets | • **For specialist initiation only.**<br>• Use with caution in patients with renal or hepatic impairment.<br>• It should also be used under close supervision in patients with bipolar disorder, urinary retention, benign prostatic hyperplasia, glaucoma, or a history of epilepsy or cardiac disorders. |
| 20 | GREEN | Sertraline | SSRI | • 25mg, 50mg 100mg, 150mg, 200mg tablets<br>• 100mg/5mL oral solution | • Drug of choice for those with cardiovascular disease (recent - MI or unstable angina) or renal impairment.<br>• Reduced propensity for drug interactions.<br>• Grapefruit juice — levels of sertraline may be modestly increased. Manufacturer advises avoid. |
| 21 | AI | Tranylcypromine | Irreversible MAOI | • 10mg tablets | • **For specialist initiation only.**<br>• There is potential for major food and drug interactions with MAOIs. Alcohol should also be avoided.<br>• See BNF for further details on: initiating treatment after another antidepressant has been stopped (also appendix 2), interactions, side-effects and withdrawal. Patients should be provided with appropriate written information.<br>• Has a greater stimulant action than other MAOIs and is more likely to cause a hypertensive crisis.<br>• Less hepatotoxic than phenelzine.<br>• A less preferred choice of medicine. |
| 22 | AI | Trazodone | Tricyclic-related Antidepressant | • 50mg, 100mg capsules<br>• 50mg, 100mg, 150mg tablets<br>• 50mg/5ml, 100mg/5mL sugar free oral solution | • **For specialist initiation only.**<br>• Oral liquid (and tablets) significantly more expensive than capsules – restricted to those unable to swallow solid dose forms.<br>• **Cardiac effects**:<br>  ○ Can cause significant postural hypotension<br>  ○ Can prolong QTc interval |

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| | | | | | ○ Contraindicated in patients with acute MI<br>○ May be arrhythmogenic in pre-existing cardiac disease |
| 23 | DOUBLE RED | Trimipramine | TCA | • 10mg, 25mg tablets<br>• 50mg capsules | • Do NOT SWITCH TO or START **trimipramine**.<br>• Not a cost-effective choice of TCA – see HWE ICB guidance on stopping and switching guidance |
| 24 | GREEN<br>AI – at doses > 300mg/day | Venlafaxine | SNRI | • 37.5mg, 75mg IR tablets<br>• 37.5mg, 75mg, 150mg, 225mg, 300mg MR tablets<br>• 37.5mg, 75mg, 150mg, 225mg MR capsules<br>• 37.5mg/mL and 75mg/mL sugar-free oral solution | • Avoid use in patients with high risk of cardiac arrhythmia.<br>• Monitor blood pressure at initiation, regularly during treatment (particularly during dose titration), and in doses above 150mg.<br>• Doses ≥ 300 mg daily should be prescribed under supervision/advice of specialist mental health practitioner.<br>• Consider ECG before treatment commenced:<br>○ if a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure)<br>○ there is a personal or family history of cardiovascular disease,<br>○ a history of collapse, or other cardiovascular risk factors such as cardiac arrhythmia.<br>• Greater risk of discontinuation symptoms due to shorter half-life.<br>• NB: Only the XL formulation of venlafaxine is licensed for social anxiety and generalised anxiety disorder. |
| 25 | GREEN | Vortioxetine | Serotonin modulator and stimulator (SMS) | • 5mg, 10mg, 20mg tablets | • NICE recommends that vortioxetine is an option for treating major depression in adults who have responded inadequately to two antidepressants within the current episode of depression.<br>• Low toxicity in overdose.<br>• Trial data suggest no effect on QTc or on coagulation parameters.<br>• Treatment can be stopped abruptly as it has a long half-life (66 hours) and there is no evidence of clinically important discontinuation symptoms. |

## RAG STATUS:

DOUBLE RED - Not recommended for prescribing by either Community/Secondary/Tertiary or Primary care.
RED – Not recommended for prescribing in Primary Care (for prescribing by Community/Secondary/Tertiary care as agreed).
AMBER INITIATION (AI) – Recommended for **initial** prescribing by specialists in Community, Secondary and Tertiary care (as agreed) with prescribing and monitoring, where applicable, continued by GPs.
GREEN – Recommended for: prescribing; treatment considered to be suitable for initiation in Primary, Community, Secondary or Tertiary care; continuation of prescribing and monitoring (where applicable) in Primary Care.

## 7. Prescribing antidepressants in specialist groups

### 7.1 Older Adults (>65 years) [1,2]

When prescribing antidepressant medication for older people:

- consider the person's general physical health, comorbidities, and with the average older adult taking at least four or more types of medicines, leading to a significant potential for drug-drug and drug-disease interactions,
- prescribe an age-appropriate dose, antidepressants should be initiated at lower doses than used for younger adults,
- due to changes in pharmacodynamic sensitivity and pharmacokinetics, older adults usually take longer to respond to antidepressants, therefore, a minimum of six weeks treatment should be given before considering the treatment to be ineffective,
- are more sensitive to their side effects, hence require careful monitoring,
- be alert to side effects such as sedation and consequent increased risk of falls and fractures, including anticholinergic burden (ACB),
- be alert to the risks of hyponatraemia (particularly in those with other risk factors for hyponatraemia, such as concomitant use of diuretics).

SSRIs are generally used first-line; they offer considerable advantages over TCAs including potentially:

- fewer side effects,
- safety in overdose,
- less dosage titration,
- once a day administration
- and greater patient adherence.

Fluoxetine may not be considered first line in this patient group, due to its longer duration of action, risk of accumulation and multiple drug interactions.

SSRIs increase the risk of gastrointestinal (GI) bleeds, and should be avoided, if possible, in patients aged over 80 years, and those with established risk factors such as history of bleeds or treatment with non-steroidal anti-inflammatory drugs (NSAID), steroids or blood thinning agents.
The elderly are also particularly prone to developing hyponatraemia with SSRIs as well as postural hypotension and falls.
QT interval prolongation is an established risk with citalopram and escitalopram and is dose dependent, therefore maximum dose is restricted (lower) in those older than 65 years.

TCAs (except lofepramine) may be less suitable due to the antimuscarinic adverse effects and potentially inappropriate (STOPP criteria):

- if prescribed in those with dementia, narrow angle glaucoma, cardiac conduction abnormalities, prostatism, or history of urinary retention (risk of worsening these conditions);
- if initiated as first-line antidepressant treatment (higher risk of adverse drug reactions than with SSRIs or SNRIs).

## 7.2 Children and Adolescents (<18 years) [2,3]

Do not offer antidepressant drugs to a child or young person except in combination with a psychological therapy.

The current NICE Guidelines recommend that children and young people presenting with moderate to severe depression should be reviewed by the local Child and Adolescent Mental Health Services (CAMHS) team.

If an antidepressant is to be prescribed, this should only be following the review by a Child and Adolescent Psychiatrist.

For young people with moderate to severe depression, the updated NICE guidelines recommend psychological therapy with or without fluoxetine.
Fluoxetine is the first line SSRI (licensed ≥ 8 years) to treat more severe depression which is unresponsive to psychological therapy after 4-6 sessions. NICE reports fluoxetine as the only antidepressant for which trials show the benefit outweighs the risks. It is recommended that pharmacotherapy should be administered in combination with a concurrent psychological therapy.

Sertraline and citalopram may be considered as second line agents by specialists with caution. NICE specifically excludes paroxetine, venlafaxine, and TCAs for the treatment of depression in this age group.

It is important to note that suicide-related behaviours (suicidal attempt and suicidal thoughts), and hostility (predominantly aggression, oppositional behaviour and anger) were more frequently observed in clinical trials among children and adolescents treated with antidepressants compared to those treated with placebo[14].

A child or young person prescribed an antidepressant should be closely monitored **after one week**[1] after starting an antidepressant by the prescribing doctor and the healthcare professional delivering the psychological therapy for the emergence of suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment or when the dose is increased. Monitor as often as needed thereafter, but no later than 4 weeks after the appointment at which the antidepressant was started.

## 7.3 Antenatal and Postnatal Prescribing [2,4]

Antenatal (or prenatal = before birth, during or relating to pregnancy)[2,4.]

Maternal mental health must be treated appropriately. As such, antidepressants may be suitable for use in pregnancy, but consider risks and benefits of use on a case-by-case basis.
**Initiation of antidepressant medication in pregnancy is for specialist initiation only.**
Approximately 10% of pregnant women develop or have a pre-existing depressive illness.

Antidepressants should be considered for women with mild depression during pregnancy if they have a history of severe depression and they decline, or their symptoms do not respond to psychological treatments.

Refer to the MHRA warning (2021) for SSRI and SNRIs, about the small increased risk of postpartum haemorrhage when used in the month before delivery. Prescribers should consider this risk in the context of an individual patient's bleeding and thrombotic risk assessment during the peripartum period and the benefits of antidepressants for the patient's mental health during this time.

SSRIs appear not to be major teratogens, with most data supporting the safety of fluoxetine. Sertraline appears to have the lowest placental exposure. The risk of intrauterine growth retardation (although low) is greater in untreated major depression than with e,g. SSRIs, hence it is advisable to continue the antidepressant drug in major depression.

Paroxetine has been specifically associated with cardiac malformations particularly >25mg/day, first trimester exposure.

Persistent pulmonary hypertension in the neonate is noted when SSRIs are taken after 20 weeks gestation.

High blood pressure with venlafaxine at high doses is noted, together with higher toxicity in overdose compared to SSRIs and some TCAs.

Withdrawal or toxicity in the neonate with all antidepressants, in particular paroxetine and venlafaxine (usually self-limiting).

Always obtain the most up-to-date advice by contacting a member of your pharmacy team or ring UKTIS specialist centre on 0344 892 0909; use BUMPS, https://www.medicinesinpregnancy.org/ for patient information leaflets.

Postnatal (or postpartum = after childbirth)[2,4,15]
Much post-partum depression begins before birth. There is a significant increase in new psychiatric episodes in the first 3 months after delivery.

**In each case, the benefits of breastfeeding to the mother and infant must be weighed against the risk of drug exposure to the infant.**

Lowest levels in breast milk are noted with imipramine, nortriptyline, and sertraline.
Highest levels in breast milk are noted with citalopram, escitalopram and fluoxetine.

Always obtain the most up-to-date advice by contacting a member of your pharmacy team or access the UKMI Lactmed database: Drugs and Lactation Database (LactMed®) - NCBI Bookshelf (nih.gov).
https://www.ncbi.nlm.nih.gov/books/NBK501922/

## 7.4 Learning Disability [17] (Intellectual Disability – a term used internationally).

When assessing depressive symptoms in an adult with learning disabilities, consider using a formal measure of depression to monitor change over time, such as the Glasgow Depression Scale (the self-report for people with milder learning disabilities or the carer supplement for people with any degree of learning disabilities), see appendix 6. Common mental health problems such as depression are often overlooked and therefore untreated in people with learning disabilities.

For pharmacological interventions for depression in people with learning disabilities, refer to the NICE guidance NG222 and NG54, and take into account the principles for delivering pharmacological interventions:

- Only specialists with expertise in treating mental health problems in people with learning disabilities should start medication to treat a mental health problem in:
    - adults with more severe learning disabilities (unless there are locally agreed protocols for shared care)
    - children and young people with any learning disabilities.
- Before starting medication for a mental health problem in children, young people or adults with learning disabilities:
    - take account of:
        - potential medication interactions
        - the potential impact of medication on other health conditions
        - the potential impact of other health conditions on the medication
    - when necessary, consult with specialists (for example, neurologists providing epilepsy care when prescribing antipsychotic medication that may lower the seizure threshold), to minimise possible interactions
    - establish a review schedule to reduce polypharmacy
    - provide support to ensure adherence
- If needed, adjust the method of delivery or length of the intervention, and address any barriers to the delivery of treatments to take account of the person's ability to communicate, disability or impairment.
- When deciding the initial dose and subsequent increases, aim for the lowest effective dose. Take account of both potential side effects and difficulties the person may have in reporting them, and the need to avoid sub-therapeutic doses that may not treat the mental health problem effectively.
- When switching medication, pay particular attention to discontinuation or interaction effects that may occur during titration. Only change one drug at a time, to make it easier to identify these effects.
- Reasonable adjustments may be needed (in line with the Equality Act 2010), to enable staff to support them, such as a buddy system, transport, or advising local facilities on accessibility.

## 8. About deprescribing antidepressants [16]

The national medicines optimisation opportunities 2024/25 supports the appropriate use of antidepressants. However, antidepressant use may be considered inappropriate when:

- the antidepressant is not working.
- the depression or anxiety has resolved.
- the harms of the antidepressant outweigh the benefits.
- the patient wants to stop taking the antidepressant, hence often non-adherent.
- the patient has experienced previous difficulties with withdrawing.

Inappropriate use may lead to patient harm from problematic polypharmacy, adverse-effects, or both.

**Deprescribing in practice means reducing the dose at a pace that is tolerable for the patient, which for some patients can mean tapering for several months or longer**.

NICE guidelines on medicines associated with dependence or withdrawal symptoms gives further recommendations on withdrawing antidepressants, including withdrawal strategies, interventions to support withdrawal, and the management of unsuccessful antidepressant withdrawal, and advises using a shared decision making approach to discuss the deprescribing of antidepressants with the patient.

## 9. Switching/Stopping Antidepressants

Switching (or discontinuing) antidepressants (see appendix 2), factors to consider:

- Clinicians must be aware of switching from one antidepressant to another can present unexpected problems, so to eliminate avoidable adverse events.
- Switching may be effective if a full therapeutic trial of a previous antidepressant has failed, although not always.
- The speed at which the switch is needed as led by the person taking the prescribed medication, ideally with less urgency a more cautious regimen can be used; hyperbolic dose tapering, (to reduce the drug in a way that produces an 'even' amount of reduction in effect on target receptors[2]), which entails making minute dose adjustments during the gradual dose reduction, offering a smoother transition for individuals discontinuing antidepressants.
- Only, if necessary, faster switches can be made with additional monitoring.
- For advice on switching treatments please refer to the Psychotropic Drug Directory[6], The Maudsley Prescribing Guidelines[2], CKS – switching antidepressants, Specialist Pharmacy Service, or contact the pharmacy team for advice.

Stopping antidepressant treatment[9]

- Patients should be advised not to stop treatment suddenly or omit doses, and forewarned about possible symptoms that may occur when treatment is discontinued.
- Consider scheduling more frequent reviews during occurrence of serious side effects (for example upper gastrointestinal bleeding).

- Factors that might increase person's risk of problems during withdrawal include:
  - long duration of antidepressant use; for > 8 weeks
  - high dose of antidepressant
  - a previous history of withdrawal symptoms
  - a previous history of problems associated with dependence
  - taking an antidepressant recognised to be high risk of withdrawal, those with shorter half-lives and cholinergic or noradrenergic effects, such as paroxetine or SNRIs (venlafaxine and duloxetine)
  - children and adolescents
- Discontinuation symptoms:
  - vary widely in type and severity.
  - can affect both physical and mental health,
  - may occur at any time during withdrawal or be delayed in onset (which could take weeks or longer),
  - can change over time or persist over a prolonged period of months or years.
- Discuss a **flexible** discontinuation plan with the patient, reducing the dose at a rate comfortable for them, often requiring liquid formulations to minimise distressing withdrawal symptoms.
- Consider re-introducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) if symptoms are severe, and taper dose more slowly in smaller dose increments over a longer duration while monitoring symptoms; cognitive behavioural therapy or mindfulness-based cognitive therapy can help patients discontinue antidepressants without increasing the risk of relapse/recurrence but are resource intensive[28].

**RESOURCES -** further advice on stopping antidepressants:

**NICE Guideline [NG215]**
Overview | Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults | Guidance | NICE

**RESOURCES for PATIENTS**
Useful resources to signpost to patients who might be considering withdrawing their antidepressant with professional support, include the following:

**Royal College of Psychiatrists**
Provides patient information on stopping antidepressants including expected discontinuation symptoms and ways to reduce or avoid these. Prescribers may find this resource useful as it also contains examples of tapering plans.

**Choice and Medication leaflet** – coming off antidepressants.
handyfactsheetstoppingantidepressantsuk.pdf (choiceandmedication.org)

**Mind**
Provides patient information and experiences on withdrawal effects of antidepressants, coming off psychiatric medication and alternatives to antidepressants.

**NHS website**
Brief summary: stopping or coming off antidepressants, possible discontinuation symptoms.

## Part 2 – Document Control & Standards Information

### 10. Version control for the Procedural Document Management System

| Version | Date of Issue | Author | Status | Comment |
|---|---|---|---|---|
| V1 | October 2016 | Claire Hazel | Pharmacist | New Guideline |
| V1.1 | December 2018 | Harsha Patel | Pharmacist | Minor amendment to V1 |
| V2 | | Paulami Shah | Principal Clinical Pharmacist | Full review and update of guidelines.<br>Update of relevant resources.<br>Addition of RAG statuses to antidepressants<br>Appendices added:<br>• Patient Health Questionnaire<br>• Antidepressant Side Effect Checklist<br>• Glasgow Depression Scale in Learning Disability<br>• Prescription Safe Plan |

### 11. Relevant Standards

1. NICE – Depression in adults: treatment and management. NG222. June 2022
2. NICE Quality Standard [QS8] Depression in adults. Last updated June 2023.

### 12. Associated Documents

1. British National Formulary (BNF)
2. Summary of product characteristics (SPC)
3. Maudsley Prescribing Guidelines in Psychiatry
4. Psychotropic Drug Directory (PDD)

### 13.Supporting References

1. National Institute for Clinical Excellence (NICE) NG 222, Depression in Adults: treatment and management. Published 29 June 2022. Depression in adults: treatment and management (nice.org.uk)
2. The Maudsley Prescribing Guidelines in Psychiatry 14th Edition 2021, Taylor, D., Barnes, T.R.E., Young, A.H. Wiley Blackwell
3. NICE NG 134, Depression in children and young people: identification and management. Published 25 June 2019. Depression in children and young people: identification and management (nice.org.uk)
4. NICE CG 192, Antenatal and postnatal mental health: clinical management and service guideline. December 2014. https://www.nice.org.uk/guidance/cg1925
5. UK Teratology Information Service (UKTIS). www.uktis.org. Tel 0344 892 0909
6. Medicinescomplete.com. (2023). *Medicines Complete — Log in*. PDD [online] Available at: https://www.medicinescomplete.com/#/browse/pdd/u16a [Accessed 13 Sep. 2024].
7. https://www.nice.org.uk/guidance/cg91/resources/depression-in-adults-with-a-chronic-physical-health-problem-recognition-and-management-pdf-975744316357
8. Stockley's Drug Interactions. Last accessed February 2024 – requires paid subscription to access: MedicinesComplete — Log in
9. Scenario: Ongoing management | Management | Depression | CKS | NICE
10. HPFT Medicines Formulary. Medicines Formulary Contents (hpft.nhs.uk)
11. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis - The Lancet
12. Antidepressant toxicity in overdose | Prescribing information | Depression | CKS | NICE
13. NICE TA 367, Vortioxetine for treating major depressive episodes. 25 November 2015. https://www.nice.org.uk/guidance/ta367.
14. Summary of Product Characteristics (SPC) for antidepressant medicines: Home - electronic medicines compendium (emc)
15. Lactmed Database. Drugs and Lactation Database (LactMed®) - NCBI Bookshelf (nih.gov)
16. Deprescribing of antidepressants for depression and anxiety – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice - https://www.sps.nhs.uk/articles/deprescribing-of-antidepressants-for-depression-and-anxiety/
17. NICE (2016). *Mental health problems in people with Mental health problems in people with learning disabilities: pre learning disabilities: prevention, assessment and management NICE guideline*. [online] Available at: https://www.nice.org.uk/guidance/ng54/resources/mental-health-problems-in-people-with-learning-disabilities-prevention-assessment-and-management-pdf-1837513295557.
18. Public Health England (2019). *Psychotropic drugs and people with learning disabilities or autism: introduction*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/psychotropic-drugs-and-people-with-learning-disabilities-or-autism/psychotropic-drugs-and-people-with-learning-disabilities-or-autism-introduction.
19. Branford, D. and Shankar, R. (2022). Antidepressant prescribing for adult people with an intellectual disability living in England. *The British Journal of Psychiatry*, pp.1–6. doi:https://doi.org/10.1192/bjp.2022.34.
20. BNF online, last accessed February 2024. Drugs A to Z | BNF | NICE
21. Rodrigues-Amorim, D., Olivares, J.M., Spuch, C. and Rivera-Baltanás, T. (2020). A systematic review of efficacy, safety, and tolerability of duloxetine. *Frontiers in Psychiatry*, 11(1). doi:https://doi.org/10.3389/fpsyt.2020.554899.
22. Central and North West London NHS Foundation Trust, Pharmacological Management of depression (children, adolescents, older adults & adults) guidelines, January 2022.
23. NHS England » National medicines optimisation opportunities 2023/24
24. Depression in primary care: part 2—management | The BMJ
25. Microsoft Word - 18. Guideline for Prescribing Tricyclic Antidepressants.doc (hpft.nhs.uk)
26. Concomitant Use of Selective Serotonin Reuptake Inhibitors With Oral Anticoagulants and Risk of Major Bleeding | Cardiology | JAMA Network Open | JAMA Network
27. Formulary and Prescribing Guidelines SECTION 1: THE TREATMENT OF DEPRESSION. (n.d.). Available at: https://eput.nhs.uk/media/13qlwuqm/section-1-treatment-of-depression-may-2021.pdf.
28. Maund E, et al. Managing antidepressant discontinuation: a systematic review. Ann Fam Med 2019; 17 :52– 60.

## 14. Consultation

| Job Title of person consulted |
|---|
| Drug and Therapeutics Committee |
| HWEICB – Pharmacy and Medicines Optimisation Team |

## Part 3 Appendices

Appendix 1: Table of relative side effects of Antidepressants
Appendix 2: Stopping and Swapping chart
Appendix 3: Patient Health Questionnaire (PHQ-9)
Appendix 4: Antidepressant Side Effect Checklist (ASEC)
Appendix 5: Antidepressant medicines counselling advice to patients
Appendix 6: Glasgow Scale for depression and anxiety in learning disability
Appendix 7: Prescription Safe Plan

## Appendix 1 - Table of relative side effects of Antidepressants[6]

The following table can be used by prescribers in conjunction with patients to help guide choice of antidepressant therapy. Alternatively, the Choice and Medication website provides information for patients on medicines used in mental health, although may include information on medicines that have not been approved in Hertfordshire.

Reference: Stephen Bazire – Psychotropic Drug Directory, Online Publication, 2024

| **Selective Serotonin Reuptake inhibitors(SSRI's)** | Adult max dose mg/d | Elderly max dose mg/d | Anti-cholinergic | Cardiac | Nausea | Sedation | Overdose | Pro-convulsant | Sexual dysfunction |
|---|---|---|---|---|---|---|---|---|---|
| Citalopram | 40 | 20 | ○ | ○ | ●●● | ○ | ● | ○ | ●● |
| Escitalopram | 20 | 10 | ○ | ○ | ●● | ○ | ○ | ○ | ●● |
| Fluoxetine | 60 | 60 | ○ | ○ | ●● | ○ | ○ | ○ | ●● |
| Fluvoxamine | 300 | 300 | ● | ○ | ●●● | ● | ○ | ○ | ● |
| Paroxetine | 50 | 40 | ○ | ○ | ●● | ○ | ○ | ○ | ●●● |
| Sertraline | 200 | 200 | ○ | ○ | ●● | ○ | ○ | ○ | ●● |
| **Tricyclic Antidepressants (TCA's)** | Adult max dose mg/d | Elderly max dose mg/d | Anti-cholinergic | Cardiac | Nausea | Sedation | Overdose | Pro-convulsant | Sexual dysfunction |
| Amitriptyline | 150 | 100-150 | ●●● | ●●● | ●● | ●●● | ●●● | ●● | ●● |
| Clomipramine | 250 | 75 | ●●● | ●● | ●● | ●● | ● | ●● | ●●● |
| Imipramine | 300 | 50 | ●● | ●● | ●● | ● | ●●● | ●● | ●● |
| Lofepramine | 210 | <Adult | ●● | ● | ● | ● | ○ | ○ | ●● |
| Nortriptyline | 150 | 50 | ●● | ● | ●● | ● | ●● | ● | ●● |
| **Monoamine Oxidase Inhibitors (MAOI's)** | Adult max dose mg/d | Elderly max dose mg/d | Anti-cholinergic | Cardiac | Nausea | Sedation | Overdose | Pro-convulsant | Sexual dysfunction |
| Moclobemideg (reversible) | 600 | 600 | ● | ○ | ● | ○ | ○ | ? | ● |
| Isocarboxazid (irreversible) | 60 | < Adult | ●● | ●● | ●● | ○ | ●● | ○ | ● |
| Phenelzine (irreversible) | 90 | (90) | ● | ● | ●● | ● | ●●● | ○ | ● |
| Tranylcypromine | Care > 30 | < Adult | ● | ● | ●● | ● | ●●● | ○ | ● |
| **Others** | Adult max dose mg/d | Elderly max dose mg/d | Anti-cholinergic | Cardiac | Nausea | Sedation | Overdose | Pro-convulsant | Sexual dysfunction |
| Duloxetine | 120 | 120 | ○ | ○ | ●● | ● | ? | ? | ●● |
| Flupentixol dihydrochloride | 3 | 1.5 | ●● | ○ | ○ | ● | ● | ? | ● |
| Mirtazapine | 45 | 45 | ○ | ○ | ○ | ●● | ○ | ●● | ○ |
| Reboxetine | 12 | NR | ● | ● | ● | ○ | ○ | ○ | ○ |
| Trazodone | 600 | Care > 300 | ● | ● | ●●● | ●● | ● | ○ | ●● |
| Venlafaxine | 375 | 375 | ○ | ○ | ●● | ○ | ● | ○? | ●● |
| Vortioxetine | 20 | Care > 10 | ○ | ○ | ●● | ○ | ● | ○ | ○ |

••• marked effect •• moderate effect • mild/ transient effect ○ little or minimal effect ? no information available or little reported NR not recommended

Overdose = Based on UK Fatal Toxicity Index (Henry *et al*, *BMJ* 1995; 310: 221–4; FFT).

**Appendix 2 - STOPPING AND SWAPPING CHART [2]** – Adapted from The Maudsley Prescribing Guidelines in Psychiatry, 14th Edition (2021)

| To / From | MAOIs (Phenelzine Tranylcypromine (Selegiline)) | Moclobemide | Tricyclics (except Clomipramine) | Clomipramine | Fluoxetine | Fluvoxamine[1] | Other SSRIs[2], Vortioxetine[3] | SNRIs (Venlafaxine Duloxetine Desvenlafaxine) | Mirtazapine | Trazodone | Reboxetine[4] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **MAOI's** (Phenelzine Tranylcypromine (Selegiline)) | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks then start moclobemide | Taper and stop then wait for 2 weeks | Taper and stop then wait for 3 weeks | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks | Taper and stop then wait for 2 weeks |
| **Moclobemide** | Taper and stop then wait 24 hours then start MAOI | | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours | Taper and stop then wait 24 hours |
| **Tricyclics** | Taper and stop then wait for 2 weeks[5] | Taper and stop then wait 1 week then start moclobemide | Direct switch possible - cross-taper cautiously | Direct switch possible – cross-taper cautiously | Halve dose & add fluoxetine then slow withdrawal | Direct switch possible - cross-taper cautiously | Halve dose & add SSRI then slow withdrawal | Cross-taper cautiously starting with low dose SNRI | Cross-taper cautiously | Halve dose & add trazodone then slow withdrawal | Cross-taper cautiously |
| **Clomipramine** | Taper and stop and wait for 3 weeks then start MAOI | Taper and stop and wait 1 week then start moclobemide | Cross-taper cautiously | | Taper and stop then start fluoxetine at 10mg/day | Taper and stop and then start with low dose fluvoxamine | Taper and stop then start with low dose | Taper and stop then start with low dose SNRI | Cross-taper cautiously | Cross-taper cautiously starting with low dose | Cross-taper cautiously |
| **Fluoxetine[6]** | Stop fluoxetine Wait 5-6 weeks then start MAOI | Stop fluoxetine Wait 5-6 weeks then start moclobemide | Stop fluoxetine Wait 4-7 days then start low dose TCA | Stop fluoxetine Wait for 2 weeks then start low dose clomipramine | | Stop fluoxetine Wait 4-7 days then start fluvoxamine | Stop fluoxetine Wait 4-7 days then start low dose | Stop fluoxetine Wait 4-7 days then start low dose SNRI[7] | Cross-taper cautiously starting with low dose | Cross-taper cautiously starting with low dose | Cross-taper cautiously |
| **Fluvoxamine[1]** | Taper and stop then wait 1 week then start MAOI | Taper and stop then wait 1 week then start moclobemide | Cross-taper cautiously starting with low dose | Taper and stop then start with low dose clomipramine | Direct switch possible – start fluoxetine at 10mg/day[7] | | Direct switch possible –- start with low dose[7] | Direct switch possible –- start with low dose[7] | Cross-taper cautiously start mirtazapine at 15mg | Cross-taper cautiously –- start with low dose[7] | Cross-taper cautiously |
| **Other SSRIs[2], Vortioxetine[3]** | Taper and stop then wait 1 week[9] | Taper and stop then wait 1 week then start moclobemide | Cross-taper cautiously starting with low dose TCA | Taper and stop then start with low dose clomipramine | Direct switch possible –- start fluoxetine at 10mg/day[7] | Direct switch possible –- start with low dose[7] | Direct switch possible –- start with low dose[7] | Direct switch possible –- start with low dose[7] | Cross-taper cautiously | Cross-taper cautiously –- start with low dose[7] | Cross-taper cautiously |
| **SNRI** (Venlafaxine Duloxetine Desvenlafaxine) | Taper and stop then wait 1 week | Taper and stop then wait 1 week then start moclobemide | Cross-taper cautiously starting with low dose | Taper and stop then start with low dose clomipramine | Direct switch possible –- start fluoxetine at 10mg/day[7] | Direct switch possible ---- start with low dose[7] | Direct switch possible –- start with low dose[7] | Direct switch possible –- start with low dose[7] | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously |
| **Mirtazapine** | Taper and stop then wait for 2 weeks | Taper and stop then wait 1 week then start moclobemide | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | | Cross-taper cautiously | Cross-taper cautiously |
| **Trazodone** | Taper and stop then wait 1 week | Taper and stop then wait 1 week then start moclobemide | Cross-taper cautiously starting with low dose TCA | Cross-taper cautiously starting with low dose clomipramine | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | | Cross-taper cautiously |
| **Reboxetine[4]** | Taper and stop then wait 1 week then start MAOI | Taper and stop then wait 1 week then start moclobemide | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | Cross-taper cautiously | |
| **Stopping** | Reduce over 4 weeks or longer if necessary | Reduce over 4 weeks | Reduce over 4 weeks | Reduce over 4 weeks | Reduce over 2 weeks to 20mg/day then stop | Reduce over 4 weeks | Reduce over 4 weeks | Reduce over 4 weeks or longer if necessary[8] | Reduce over 4 weeks | Reduce over 4 weeks | Reduce over 4 weeks |

Please note that these tables include treatments that are non-formulary within HPFT.

**Note[2]**: Advice given in table (appendix 2) is partly derived manufacturers' information and available published data, and partly theoretical. There are several factors that affect individual drug handling and caution is required in every instance.
Cross taper cautiously providing a personalised, flexible reduction plan to the patient, which may involve longer periods than 2-4 weeks.

**Notes:**
[1] Fluvoxamine is a potent inhibitor of CYP1A2, and to a lesser extent of CYP2C and CYP3A4 and has a high potential for interactions hence extra precaution is required.
[2] Includes citalopram, escitalopram, paroxetine, and sertraline.
[3] Limited experience with vortioxetine and extra precaution required. Particular care when switching to or from bupropion and other CYP2D6 inhibitors such as fluoxetine and paroxetine.
[4] Reboxetine as monotherapy or switching to reboxetine antidepressant is no longer recommended.
[5] Wait 3 weeks if switching from imipramine.
[6] Beware: interactions with fluoxetine may still occur for 5 weeks after stopping fluoxetine because of its metabolite's long half-life.
[7] Abrupt switches between SSRIs and SNRIs is possible at standard doses e.g. citalopram 20 mg and starting the standard dose of another, e.g. duloxetine 60mg.
[8] Discontinuation effects seem to be more pronounced. Slow withdrawal over 1-3 months may be necessary.
[9] Wait 3 weeks in the case of vortioxetine.

## ANTIDEPRESSANT DISCONTINUATION SYMPTOMS[2]

| | MAOIs | TCAs | SSRIs and related |
|---|---|---|---|
| **Symptoms** | **Common:**<br>Agitation, irritability, ataxia, movement disorders, insomnia, somnolence, vivid dreams, cognitive impairment, slowed speech, pressured speech.<br><br>**Occasionally:**<br>Hallucinations, paranoid delusions | **Common:**<br>Flu-like symptoms (chills, myalgia, fever, sweating, headache, nausea), insomnia, vivid dreams.<br><br>**Occasionally:**<br>Movement disorders, mania, cardiac arrhythmia | **Common:**<br>Flu-like symptoms, 'shock-like' sensations, dizziness exacerbated by movement, insomnia, excessive (vivid) dreaming, irritability, crying spells.<br><br>**Occasionally:**<br>Movement disorders, problems with concentration and memory |
| **Medicines most often associated with discontinuation symptoms** | All<br><br>(Tranylcypromine is partly metabolised to amphetamine and is associated with a true 'withdrawal' syndrome) | Amitriptyline<br>Imipramine | Paroxetine<br>(all SSRIs have propensity to cause discontinuation syndrome)<br>Venlafaxine (↑ risk of NMS),<br>Duloxetine |

## Appendix 3

### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | add columns | | + | + |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL:

**10.** If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



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## Appendix 3 – continued

### PHQ-9 Patient Depression Questionnaire

**For initial diagnosis:**

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

***Consider Major Depressive Disorder***
- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

***Consider Other Depressive Disorder***
- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

**To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

**Scoring: add up all checked boxes on PHQ-9**

**For every** ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

**Interpretation of Total Score**

| | Depression Severity |
|---|---|
| 1-4 | Minimal depression |
| 5-9 | Mild depression |
| 10-14 | Moderate depression |
| 15-19 | Moderately severe depression |
| 20-27 | Severe depression |



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## Appendix 4

### The Antidepressant Side-Effect Checklist (ASEC)

Please score the following list of symptoms 0 = absent, 1 = mild, 2 = moderate, 3 = severe.

Please indicate if the symptom is likely to be a side-effect of antidepressant medication (Y = YES, N = NO). Write a comment to provide relevant information if the item is **not** a side-effect.

| Symptom | Score (0–3) | | | | Linked to antidepressant? | | Comment |
|---|---|---|---|---|---|---|---|
| **1** Dry mouth | 0 | 1 | 2 | 3 | Y | N | |
| **2** Drowsiness | 0 | 1 | 2 | 3 | Y | N | |
| **3** Insomnia (difficulty sleeping) | 0 | 1 | 2 | 3 | Y | N | |
| **4** Blurred vision | 0 | 1 | 2 | 3 | Y | N | |
| **5** Headache | 0 | 1 | 2 | 3 | Y | N | |
| **6** Constipation | 0 | 1 | 2 | 3 | Y | N | |
| **7** Diarrhoea | 0 | 1 | 2 | 3 | Y | N | |
| **8** Increased appetite | 0 | 1 | 2 | 3 | Y | N | |
| **9** Decreased appetite | 0 | 1 | 2 | 3 | Y | N | |
| **10** Nausea or vomiting | 0 | 1 | 2 | 3 | Y | N | |
| 1 slight nausea, 2 = more nausea, 3 = with vomiting | | | | | | | |
| **11** Problems with urination | 0 | 1 | 2 | 3 | Y | N | |
| **12** Problems with sexual function | 0 | 1 | 2 | 3 | Y | N | |
| **13** Palpitations | 0 | 1 | 2 | 3 | Y | N | |
| **14** Feeling light-headed on standing | 0 | 1 | 2 | 3 | Y | N | |
| **15** Feeling like the room is spinning | 0 | 1 | 2 | 3 | Y | N | |
| **16** Sweating | 0 | 1 | 2 | 3 | Y | N | |
| **17** Increased body temperature | 0 | 1 | 2 | 3 | Y | N | |
| **18** Tremor | 0 | 1 | 2 | 3 | Y | N | |
| **19** Disorientation | 0 | 1 | 2 | 3 | Y | N | |
| **20** Yawning | 0 | 1 | 2 | 3 | Y | N | |
| **21** Weight gain | 0 | 1 | 2 | 3 | Y | N | |

B1: What other symptoms have you had since commencing the antidepressant medication (or since last completing the ASEC) that you think may be side-effects of the medication?

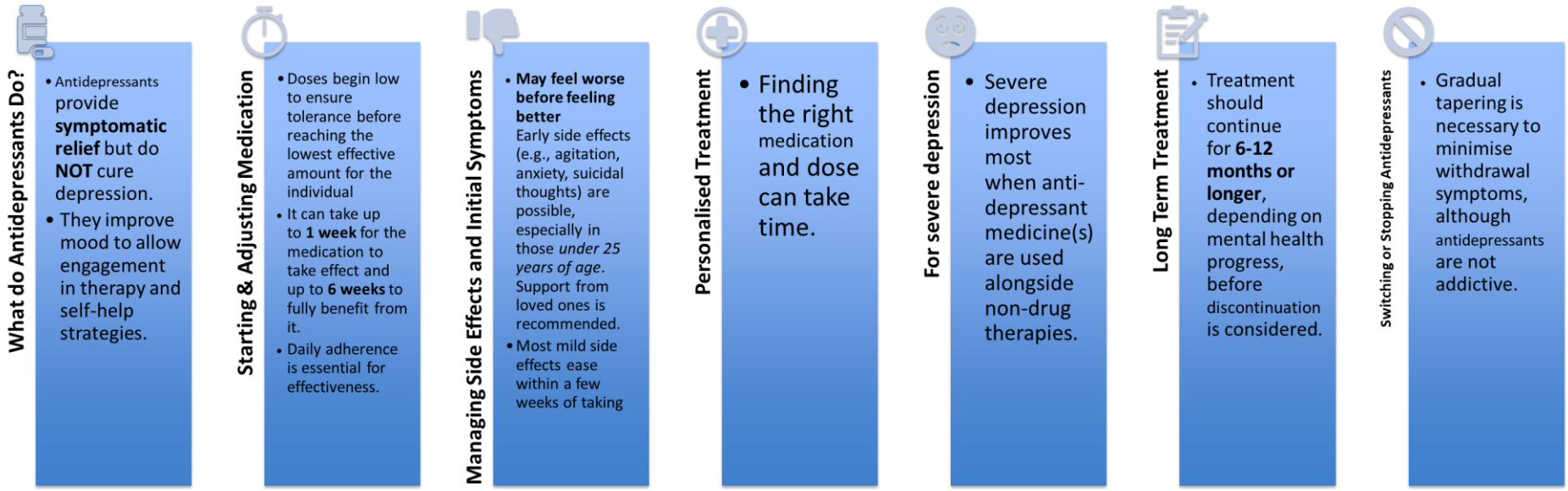
B2: Have you had any treatment for a side-effect?

B3: Has any side-effect led to you discontinuing the antidepressant medication?

## Appendix 5

### Antidepressant Medication Counselling Advice

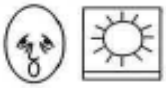
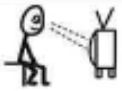
Please discuss the following with the patient **BEFORE** commencing an antidepressant medication – advice with regards to commonly prescribed antidepressants:



**Appendix 6**
Glasgow Depression Scale for those with a Learning Disability

# Glasgow Depression Scale

( score of 13 or over indicates depression).

| In the last week... | | Prompts | no | some times | a lot |
|---|---|---|---|---|---|
| 1.  | Have you felt sad? | Have you felt upset, depressed, miserable, fed up, low? | 0 | 1 | 2 |
| 2.  | Have you been in a bad mood? | Have you felt bad tempered, wanted to shout at people? | 0 | 1 | 2 |
| 3.  | Have you enjoyed doing things? | Have you had fun? | 2 | 1 | 0 |
| 4.  | Have you enjoyed talking and being with people? | Have you liked having people around? | 2 | 1 | 0 |
| 5.  | Have you had a bath/shower and changed your clothes? | Have you taken care of the way you look / appearance? | 2 | 1 | 0 |
| 6.  | Have you felt tired during the day? | Have you gone to sleep during the day, found it hard to stay awake? | 0 | 1 | 2 |
| 7.  | Have you cried? | What made you cry? | 0 | 1 | 2 |
| 8.  | Have you felt people don't like you? | Have you felt you are a horrible person? | 0 | 1 | 2 |
| 9.  | Have you been able to concentrate, such as watch TV? | What is your favourite TV programme? Are you able to watch it all? | 2 | 1 | 0 |
| 10.  | Have you found it hard to choose things? | Have you found it hard to decide what to wear, eat or do? | 0 | 1 | 2 |

**Appendix 6 – continued**

| In the last week... | | Prompts. | no | some times | a lot |
|---|---|---|---|---|---|
| 11.  | Have you found it hard to sit still? | Have you fidgeted, moved around a lot more? | 0 | 1 | 2 |
| 12.  | Have you eaten less? Have you eaten more? | Have people said you should eat more or less? | 0 | 1 | 2 |
| 13.  | Have you found it hard to get a good night's sleep? | Have you found it hard to fall asleep, woken up a lot or too early? | 0 | 1 | 2 |
| 14.  | Have you wished you were dead? | Have you wanted to stop living? | 0 | 1 | 2 |
| 15.  | Have you felt everything is your fault? | Have you felt people blame you for things? | 0 | 1 | 2 |
| 16.  | Have you felt people are looking at you, talking about you? | Have you worried about what other people think of you? | 0 | 1 | 2 |
| 17. X | Have you been upset if people say you have done something wrong? | Do you feel sad, or feel like crying if someone tells you off? | 0 | 1 | 2 |
| 18.  | Have you felt worried? | Have you felt nervous, tense, wound up or on edge? | 0 | 1 | 2 |
| 19.  | Have you thought that bad things will happen to you? | Have you felt nothing nice happens to you? | 0 | 1 | 2 |
| 20.  | Have you felt happy when something good happens? | What makes you feel happy? | 2 | 1 | 0 |

Cuthill, F. M., Espie, C. A. , Cooper, S (2003) Development and psychometric properties of the Glasgow Depression Scale for people with a learning disability: Individual and carer supplement versions. The British Journal of Psychiatry 182:347-353. Adapted by MK, GB, GW, DHCFT 2008.

**Appendix 7**

Prescription Safe Plan: To support better outcomes for those using medications that list ‘suicidal thoughts’ as a side effect, in particular antidepressants.

**Appendix 7 - continued**

# MY PRESCRIPTION SAFE PLAN

A **prescription safe plan** is a brief document that aims to ensure:

- You are aware of the side-effects of your medication
- You feel happy to progress with your treatment
- You are confident in what you should do, if you experience any side-effects.

Your healthcare provider will discuss all this with you, including:

- The potential side-effects that some patients experience
- When to seek help or advice
- Who to contact if you should experience a deterioration in your physical or mental health after starting a new medication.

**A prescription safe plan is based on the idea of a safe plan. A safe plan is a longer document that creates a personalised strategy to help someone stay safe when their mental well-being declines, especially when experiencing suicidal thoughts. You can download one by scanning this QR code:**

**Appendix 7 - continued**

# MY PRESCRIPTION SAFE PLAN

Date: _____

This page covers the conversation your healthcare provider will have with you about your medication. Ideally, you will complete this with them, ticking the boxes as you cover each point.

**I have discussed the following with my healthcare provider, having been prescribed a medication that lists suicidal thoughts as a side-effect.**

- ☐ I understand that all medication has side-effects, and while my medication may be very effective, most users experience some side-effects ranging from mild and manageable to more problematic.
- ☐ I understand that initial improvements may not be noticeable, and I might even experience temporary side-effects like nausea or a slight worsening of symptoms at the start of treatment.
- ☐ I understand that a small number of patients can feel much worse, and some can even experience suicidal thoughts.
- ☐ I understand the importance of seeking immediate medical guidance in the unlikely situation I experience such severe side-effects. My healthcare provider may need to promptly adjust my medication or dosage.
- ☐ I understand I shouldn't stop taking this medication unless advised by my prescriber, as stopping suddenly can also cause issues.
- ☐ I will talk to a trusted friend or relative about starting this medication and the possible side-effects some patients experience.

My prescriber today was: _____

**Remember, should you feel worse after starting your medication, and especially if you experience suicidal thoughts, it is vital you speak with your health team so they can consider if it is a side-effect of the medication. While you are waiting to speak with them, you can download a safe plan by scanning this QR code:**

**Appendix 7 - continued**

# MY GP AND SERVICE PROVIDER CONTACTS

I can ring these numbers for advice and support. I understand how important this is should my mood deteriorate:

| | Name of organisation and website | Opening times | Telephone | Text |
|---|---|---|---|---|
| Monday – Friday In hours | | | | |
| Monday – Friday Out of hours | | | | |
| Weekends and Bank Holidays | | | | |
| In an emergency | | | | |

Befriending Discharge Service: **www.mindinmidherts.org.uk/befriending-discharge-service/**

Note: This is a confidential remote and face-to-face support service for individuals aged 18+ with experiences of suicidal thoughts or attempts.

**Appendix 7 - continued**

# HELPLINES AND APPS

I can contact the following for help and support at any time, especially if my mood deteriorates whilst using my medication.

## NHS 111 option 2

Call NHS 111 and press 2.

This is a self-referral service and provides a single point of contact for anyone facing a mental health crisis. It will give you access to care 24/7.

## Single Point of Access (SPA)

Search online to find your local SPA contact number. An SPA call handler will be able to put you in contact with the Mental Health Helpline Team. They can provide help 24/7 if you are experiencing a mental health crisis, need direct support, or just want someone to talk with.

## Helplines

If you don't feel you know anyone that you would want to speak to, or you need to talk but nobody is available, please know that there are lovely people who are literally sitting by a phone waiting to speak with you, listen to you and be there for you.

**Befrienders World-Wide**
www.befrienders.org

**Papyrus Hopeline247**
Call 0800 068 4141

**Samaritans**
Call 116 123

**Shout**
Text the word 'SHOUT' to 85258 to start a conversation.

**Switchboard LGBT+ Helpline**
Call 0800 0119 100

**The Silver Line**
0800 4 70 80 90

## Web based support

**Calm**
www.thecalmzone.net

**HCC's Mental Health webpage:**
www.hertfordshire.gov.uk/mentalhealth

R;pple

If you notice that you are searching online for harmful content, please consider downloading **R;pple** on all compatible compatible devices. It will help keep you safe.

www.ripplesuicideprevention.com/information/install

## Apps

**Stay Alive**
This app provides a safe plan on your phone:
www.stayalive.app

**Appendix 7 - continued**

# MY PRESCRIPTION SAFE PLAN: NOTES

**The following notes are for reference.** Feel free to discuss them with your healthcare provider or research them further when time allows.

**Understanding medication:**

- All medications have potential side-effects, but when a condition can be improved through medication, the benefits will often outweigh the risks.
- Over a hundred drugs list severe side-effects such as akathisia, PSDD, and suicidal ideation. These include widely used medications like antidepressants, antipsychotics, steroids, and drugs for specific conditions like Roaccutane for acne and Montelukast for asthma.
- These medications are used by millions of people and most people benefit from using them. However, some do not, and although it may not be medication-related, it's important to consult with a healthcare provider should you feel worse after starting treatment.

**Safety considerations:**

- Be particularly aware of increased anxiety, restlessness, agitation, or suicidal thoughts. These may or may not be side-effects of your medication, so it's vital to seek advice from your healthcare team. They can help you consider whether to adjust or discontinue the medication.
- Antidepressants are typically prescribed alongside or after talking therapies like counselling or CBT, rather than as a standalone treatment.
- Understanding that temporary worsening of symptoms can occur may help prevent disappointment and distress. Knowing that overwhelming thoughts could be a side-effect is crucial and you should always seek medical advice if you experience this.

**Appendix 7 - continued**

# MY PRESCRIPTION SAFE PLAN: NOTES

We hope the following **additional notes from The OLLIE Foundation** will help you too. Feel free to discuss them with your healthcare provider or research them further when time allows.

**Making informed decisions:**

- You'll find support for your decision whether you choose to take medication or not.
- Remember, this is your personal choice. Our intention is that you feel informed about the medication you want/need and feel clear on potential side effects and what to do if you experience any of them. Your safety is our primary concern.
- We created this guide because many patients were unaware of potential side-effects, which raised concerns for their safety.

**Alternative approaches:**

- Medication isn't the only route out of depression or anxiety by any means, but it has supported many people. Not taking medication means you may continue as you are, you may find other ways to heal or you may feel worse. You alone know how hard that will be for you.

**Seeking help:**

- We hope these notes will help you navigate your treatment more safely and confidently and know to request a medication review if you experience overwhelming thoughts – this could actually be life-saving, so please always speak to a healthcare provider about any concerns you may have.
- Whatever your decision, discuss it with a trusted health advisor. Most side-effects can be managed, but not if you don't know about them!

**Appendix 7 - continued**


**The Ollie Foundation** provide a 45-minute session full of essential information for prescribers and those supporting someone in a professional capacity who is starting, changing, or tapering from antidepressants.

Hertfordshire Partnership University NHS Foundation Trust

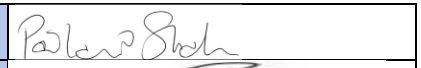
**Appendix 8**

# EQUALITY IMPACT ASSESSMENT FORM
## STAGE 1 – INITIAL ASSESSMENT

| **For each of the protected characteristics listed answer the questions below using**<br><br>**Y** to indicate Yes and<br><br>**N** to indicate No | **Sex / Gender** (Male / Female / Transgender) | **Age** | **Race / Ethnicity** | **Disability** (hearing / visual / physical / learning disability / mental health) | **Religion, Belief & Spirituality** | **Relationships & Sexual Orientation** (Gay/Lesbian/ Bisexual) | **Gender Re-Assignment** | **Marriage / Civil Partnership** | **Pregnancy & Maternity** | **Carers** | **Other Inclusion Groups** | **List Negative / Positive Impacts Below** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Does the policy have the potential to affect individuals or communities differently in a negative way? | N | N | N | N | N | N | N | N | N | N | N | The policy promotes Connected Lives protected principles which are based on the concept of personalization and strengths-based approaches, therefore no negative impact to any of the groups. |
| Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities. | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | The policy is based on principles of strengths-based practice and personalisation, thus should encourage practice which focuses on the needs of individuals and their unique circumstances, promoting access to services and resources which support them to access their community and improve their social care outcomes |
| In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed? | N | N | N | N | N | N | N | N | N | N | N | **If Yes**: Please state how you are going to gather this information. |

**If 'YES a NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed.**

**In completing the above, I confirm that I have discussed the detail with relevant colleagues and have made further enquiries and/or addressed any specific concerns that have emerged during this process.**

| | | | | | |
|---|---|---|---|---|---|
| **Lead Manager** | Paulami Shah | **Signed** |  | **Date** | 30.01.2025 |
| **SRO** | Prashant Sanghani | **Signed** |  | **Date** | 11 Feb 2025 |

**Please send the completed form to: hpft.healthequity@nhs.net**


Our Values

Welcoming Kind Positive Respectful Professional