Assessment and treatment of depression in adults in primary care

South West London
Croydon Borough Team

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STEP 1

Recognition, assessment and initial management

STEP 2

- **Recognised depression**
- **Persistent subthreshold depressive symptoms**
- **Mild to moderate depression**

STEP 3

- **Persistent subthreshold depressive symptoms not benefited from low intensity psychological intervention**
- **Mild to moderate depression with inadequate response to initial interventions**
- **Moderate & severe depression**

STEP 4

Complex & severe depression

See Table 1 for definitions

The stepped-care model provides a framework for organising the provision of services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions. The least intrusive, most effective intervention is provided first; if a person does not benefit from this, or declines an intervention, they should be offered an appropriate intervention from the next step.

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STEP 1 – Recognition and Assessment

Be alert to possible depression

1. **Ask the patient the following depression identification questions (QOF DEP1):**

   During the last month have you been bothered by:-
   - Feeling down?
   - Having little interest or pleasure in doing things?

2. **If the answer is yes to either question carry out mental health assessment to include the following:**

   - Take a thorough history to assess degree of associated functional & occupational impairment, disability and/or self neglect (See Table 1)
   - Use a validated tools e.g. PHQ-9 or HADs (QOF DEP2) to assess severity of symptoms (See Table 1)
   - Reassessment of severity (using same tool) 5-12 weeks after first questionnaire is recommended.

3. **Consider how the following may have affected the development, course and severity of a person's depression:**

   - **Chronic Physical Health Problem**
   - Living conditions and social isolation
   - Quality of interpersonal relationships
   - Past history of depression or mood elevation
   - Women in ante-natal period & up to 12 months post childbirth
   - Drug and alcohol use
   - Prescribed medicines e.g. anti-hypertensives, H2-blockers, oral contraceptives, corticosteroids
   - Past history of suicide attempt / deliberate self harm
   - Recent bereavement
   - History of domestic violence or sexual abuse
   - Employment and immigration status

4. When depression is accompanied by symptoms of anxiety, usually treat the depression first, but if the person has an anxiety disorder and comorbid depression or depressive symptoms, consider treating the anxiety first.

Provide written & verbal information for patients in an appropriate format

For people with significant language or communication difficulties, for example, people with sensory impairments or a learning disability, consider asking a family member or carer about the person's symptoms to identify possible depression.

Patient information Example 1 & Example 2

Chronic physical health problem

If the person has a physical health problem ask the following to improve the accuracy of the assessment:

During the last month, have you often been bothered by:

- Feelings of worthlessness?
- Poor concentration?
- Thoughts of death?

Consider the role of the physical health problem and any prescribed medication in the depression

Check the optimal treatment for the physical health problem is being provided and adhered to; seek specialist advice if necessary.

REMEMBER - Review risk at all stages

- **Always ask patients directly about suicidal ideas and intent, and advise patients and carers to be vigilant for changes in core features.**
- **If the person presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services or out of hours – nearest accident & emergency department**
- **Make contact with patients with depression who do not attend follow-up.**
- **Starting drug treatment can sometimes increase suicide risk.**

STEP 2 - Persistent subthreshold depressive symptoms or mild to moderate depression (See definitions – Table 1)

AND

General Measures

Offer advice on the following and re-assess with in 2 weeks:

- Sleep hygiene including establishing regular sleep and wake time; avoiding excess eating, smoking or drinking alcohol before sleep; creating a proper environment for sleep; taking regular physical exercise if possible
- Focussing on small goals/pleasurable activities
- Self help materials
- Structuring the day
- Diet
- Physical exercise
- Books on prescription
- Refer to Guideline Support Pack on Treating Patients Dependent on Benzodiazepines in Primary Care - Part 2 contains useful aids to support sleep hygiene

For depression related to a particular cause:

- Drug and alcohol referral Scheme
- Bereavement Counselling – self referral:
  - Woodside Bereavement Service (The Listening Ear) **020 8662 1648**
  - CRUSE - **020 8916 0855**

Refer to MIND directory for full list of available services in Croydon

* * *

For people with depression & a chronic physical health problem consider referring to an appropriate voluntary group

Low Intensity Psychosocial and Psychological Interventions

Offer **one or more** of the following guided by individuals preference:

Individual guided self help (CBT based)	Croydon IAPT: Psychological Therapies and Wellbeing Service **02032284040** provide the following: • guided self help • behavioural activation groups Other guided self help e.g. • MoodGYM • Living life to the full
Counselling services	MIND (Self referral - Charges apply) **020 8668 2210** Off the Record for 14-25 year olds (Self referral) **020 8251 0251** CPF Counselling – Individual Psycho-Dynamic Counselling (Self referral - Charges apply) **020 8760 0665**
Structured group physical activity programme	Active Lifestyle Team

Drug treatment

Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk benefit ratio is poor, but consider them for people with:

- A past history of moderate or severe depression or
- Initial presentation of subthreshold depressive symptoms present for at least 2 years or
- Subthreshold depressive symptoms or mild depression persisting after other interventions.
- Mild depression that complicates the care of a physical health problem

See STEP 3 Box B

Provide written & verbal information for patients in an appropriate format Patient information Example 1 & Example 2

REMEMBER - Review risk at all stages

- **Always ask patients directly about suicidal ideas and intent, and advise patients and carers to be vigilant for changes in core features.**
- **If the person presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services or out of hours – nearest accident & emergency department**
- **Contact patients with depression who do not attend follow-up.**
- **Starting drug treatment can sometimes increase suicide risk**

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STEP 3 - (See definitions – Table 1)

Provide written information for patients in an appropriate format at appropriate stages
Patient information Example 1 & Example 2

Moderate depression and a chronic physical health problem

Box A

- Persistent subthreshold depressive symptoms not benefited from low intensity psychological intervention
- Mild to moderate depression with inadequate response to initial interventions
- Moderate & severe depression

Box A OR Box B

- Initial presentation with moderate or severe depression
- Severe depression and a chronic physical health problem

Box A AND Box B

REMEMBER - Review risk at all stages

- Always ask patients directly about suicidal ideas and intent, and advise patients and carers to be vigilant for changes in core features.
- If the person presents considerable immediate risk to themselves or others, refer them urgently to specialist mental health services or out of hours – nearest accident & emergency department
- Contact patients with depression who do not attend follow-up.
- Starting drug treatment can sometimes increase suicide risk

STEP 3 - (See definitions – Table 1) For advice on specific patient groups see Appendix 1

BOX A

HIGH INTENSITY PSYCHOLOGICAL INTERVENTIONS

Choose one of the following:

- Croydon IAPT: Psychological Therapies and Wellbeing Service **02032284040**
- MIND Counselling Services (Self referral - Charges apply) **020 8668 2210**
- Off the Record (Self referral) for 14-25 year olds **020 8251 0251**
- CPF Counselling – Individual Psycho-Dynamic **020 8760 0665** Counselling (Self referral - Charges apply)

Box B ANTIDEPRESSANT TREATMENT

Base selection of drug on:-

- Duration of the episode and trajectory of symptoms
- Previous illness course and response to treatment including response time
- Likelihood of adherence and potential adverse effects, (see Appendix 2) e.g. gastric bleeding with SSRIs
- Discuss with patient: choice of drug, previous antidepressants taken, likely time to respond, therapeutic & adverse effects, discontinuation/withdrawal symptoms risks
- Existing co-morbidities (See Appendix 1)
- Possible drug interactions – e.g. NSAIDs, aspirin, warfarin. Higher risk of drug interactions with fluoxetine, fluvoxamine & paroxetine. See BNF

Rate of improvement - highest during weeks 1-2 and lowest during weeks 4-6.

FIRST LINE TREATMENT - SSRI - generic sertraline or citalopram

- SSRIs better tolerated and safer in overdose than other classes of antidepressants
- Titrate to therapeutic dose within licensed doses
- Use lowest dose possible for maintenance therapy
- Assess patients at increased risk of suicide or < 30yrs old after 1 wk for suicidality, restlessness, agitation, and frequently until risk is considered no longer significant
- Assess efficacy for all other patients after **2 weeks**
- ↑risk of bleeding with SSRIs – consider gastroprotection in older people on NSAIDs

For patients currently stabilised on or previously responsive to other antidepressants e.g. fluoxetine, continue therapy.

NOTE:

- **Dosulepin DO NOT** prescribe due to cardiac side effects and toxicity in overdose. Tricyclic antidepressants (TCAs), except lofepramine, associated with greatest risk in overdose. Venlafaxine associated with greater risk of death from overdose compared with other equally effective antidepressants recommended in primary care.
- Venlafaxine/TCAs/MAOIs may be less well tolerated than other agents
- **St Johns' Wort - Not recommended** due to potential drug interactions
- **Reboxetine – Not recommended** by SLAM due to it's inefficacy & intolerability

No effect

Effective

Poorly tolerated

Check adherence. Assess weekly for a further 1-2 weeks – if still no response, consider dose increase within licensed doses

Effective

- Review regularly - every 2-4wks for at least the first 3 months
- If benefit seen (patient at remission), continue full treatment dose for 6-9 mths to reduce relapse risk, then review with patient the need for continuation
- Continue treatment for up to 2 years if significant risk of relapse (includes patients who have had 2 or more recent episodes of depression and have experienced significant functional impairment during these episodes)
- Review need to continue, considering number of previous episodes, residual symptoms, concurrent health problems

Still no effect

Effective

Effective

SECOND LINE TREATMENT

Try alternative first line SSRI (citalopram or sertraline) (see Appendix 3 for advice on swapping).
Note: Risk of discontinuation symptoms increased in patients prescribed short half life drugs such as paroxetine and venlafaxine.

No effect or poorly tolerated

THIRD LINE TREATMENT

Mirtazapine - particularly for older patients avoiding SSRI problems of hyponatraemia and increased bleeding risk; also if early insomnia or anorexia are troublesome

If 2 of 3 drugs above have been tried and adhered to at optimum dosage but have not managed depression successfully - consider other agents**, by discussion with/or referral to a specialist/consultant psychiatrist.** Note:

- **Venlafaxine** - prescribe as generic immediate release tablet. Where there are compliance issues, consider generic modified release tablets (rather than capsules) as an alternative
- **Duloxetine/escitalopram**: initiation in secondary care (See Appendix 3)

Combining/augmenting treatment – discuss/referral with specialist/consultant psychiatrist

Consider specialist services for people at step 3 with:

- **no or limited response to psychological or drug treatment alone or in combination**
- **a chronic physical health problem**

STEP 4 - If no response to various augmentation and combination of drug and psychosocial treatments or in the case of complex and severe depression - Refer to secondary care specialist mental health services

Table 1 - Definitions

Depression is a broad and heterogeneous diagnosis. Severity of the disorder is determined by both:

- the number and severity of symptoms
- the degree of functional impairment.

Two diagnostic systems for depression are in use. The revised NICE guidance CG90 & CG91 use **DSM-IV**. The original NICE guidance CG23 used ICD-10. Both systems require at least one (DSM-IV) or two (ICD-10) key symptoms (low mood, loss of interest and pleasure or loss of energy) to be present. Increasingly, it is recognised that symptoms below the DSM-IV and ICD-10 threshold criteria can be distressing and disabling if persistent.

The **PHQ-9** tool is diagnostic instrument for common mental disorders to monitor the severity of depression and has been validated for use in primary care. It scores each of the 9 DSM-IV criteria as 0 (not at all) to 3 (nearly every day).

<table>
<tr>
<td>Key Symptoms of Depression

• Persistent sadness or low mood
(In both ICD-10 and DSM-IV).

• Loss of interests or pleasure
(In both ICD-10 and DSM-IV).

• Fatigue or low energy (In ICD-10 only)

At least one of these, most days, most of the time for at least 2 weeks.</td>
<td>Associated Symptoms

• Disturbed Sleep
• Poor concentration or indecisiveness
• Low self-confidence
• Poor or increased appetite
• Suicidal thoughts or acts
• Agitation or slowing of movements
• Guilt or self blame</td>
</tr>
<tr>
<td colspan="2">Subthreshold depressive symptoms (DSM-IV - fewer than 5 symptoms, ICD-10 – fewer than 4 symptoms)

At least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria for full diagnosis. Symptoms are considered persistent if they continue despite active monitoring and/or low-intensity intervention, or have been present for a considerable time, typically several months. (For a diagnosis of dysthymia, symptoms should be present for at least 2 years[1].)</td>
</tr>
<tr>
<td>Mild Depression

ICD-10 - 4 out of10 symptoms in total including at least 1 key symptom

DSM-IV - Few, if any, symptoms in excess of the 5 required to diagnosis, and symptoms result in only minor functional impairment.

SEVERITY ASSESSMENT

PHQ-9 Score 5-9 – minimal symptoms but if symptoms present for 2 or more years follow chronic depression pathway</td>
<td>Moderate Depression

ICD-10 - 5-6 symptoms (out of 10) in total including at least 1 key symptom

DSM-IV - Symptoms or functional impairment are between ‘mild’ and ‘severe’.

SEVERITY ASSESSMENT

PHQ-9 score 10-14
• Minor depression over a month or severe functional impairment – watchful waiting
• Dysthymia – antidepressant or psychotherapy
• Major depression, mild - antidepressant or psychotherapy

PHQ-9 score 15-19
Major depression, moderately severe - antidepressant or psychotherapy</td>
<td>Severe Depression

ICD-10 - 7 or more symptoms in total, including at least 1 key symptom

DSM-IV – Most symptoms & marked interfere with functioning. Can occur with or without psychotic symptoms

SEVERITY ASSESSMENT

PHQ-9 score Above 20 antidepressant and psychotherapy especially if not improved on monotherapy</td>
</tr>
</table>

[1] Both DSM-IV and ICD-10 have the category of dysthymia, which consists of depressive symptoms that are subthreshold for major depression but that persist (by definition for more than 2 years). There appears to be no empirical evidence that dysthymia is distinct from subthreshold depressive symptoms apart from duration of symptoms, and the term ‘persistent subthreshold depressive symptoms’ is preferred in this guideline.

References

National Institute for Health & Clinical Excellence (NICE), The treatment and management of depression in adults (update) CG90, October 2009

National Institute for Health & Clinical Excellence (NICE), Depression in adults with a chronic physical health problem: treatment and management. CG91, October 2009.

National Institute for Health & Clinical Excellence (NICE), Quality Standard on Depression Adults, March 2011

National Institute for Health & Clinical Excellence (NICE), Antenatal and postnatal mental health (CG45), February 2007

National Institute for Health & Clinical Excellence (NICE), Common mental health disorders (CG123), May 2011

MHRA/CSM Expert Working Group on SSRIs 2004

Cipriani A. et al. Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis. Lancet 28 2009; 373: 746-758.

Choosing between venlafaxine preparations. Quality and Productivity Bulletin Jan 2011.

Useful Links for Patient Information

Self help booklets. Northumberland, Tyne and Wear NHS Foundation Trust

Patient Information Leaflet on Depression. Royal College of Psychiatrists

Patient UK - Depression

NHS Choices – Depression

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- NHS Surrey - NHS Surrey Depression and Anxiety Disorders Spectrum Care Pathway
- Taylor D, Paton C, Kapur S. The South London and Maudsley NHS Foundation Trust, Oxleas NHS Foundation Trust, Prescribing Guidelines. 10th ed. London: Informa Healthcare, 2009.

Appendix 1 Antidepressants of choice in specific patient groups

Specific groups	Information/Link
Elderly	• No ideal antidepressant. • SSRIs generally better tolerated than TCAs but increase risk of GI & other bleeds. • Elderly prone to develop hyponatraemia with SSRIs, postural hypotension & falls. • Base choice on individual clinical circumstances.
Coronary Heart disease	NELM Q&A 55.4c Antidepressants in coronary heart disease • Limited data. • SSRIs are the agents of choice in CHD. They are generally safe and well tolerated in patients with CHD when appropriate precautions are taken. • Tricyclic antidepressants have the most data on their use in depression but are known to be cardiotoxic. Therefore, TCAs are best avoided in patients with CHD and are contraindicated in patients who have had a recent MI. NICE advises that tricyclic antidepressants, except for lofepramine, are associated with the greatest risk in overdose. • Potential interactions with the SSRIs should be taken into account when prescribing in CHD. NICE recommends for people with depression who also have a chronic physical health problem to consider using citalopram or sertraline as these have a lower propensity for interactions. • Sertraline is safe post MI and considered the drug of choice. • Mirtazapine is a suitable alternative in cardiac disease if SSRIs cannot be used but it should be used with caution. There is evidence of safety post MI. • Venlafaxine is contraindicated in patients with an identified high risk of a serious cardiac ventricular arrhythmia or with uncontrolled hypertension. It should be used with caution in established cardiac disease that may increase the risk of ventricular arrhythmias (e.g. recent myocardial infarction). Venlafaxine is associated with a greater risk of death from overdose compared with other equally effective antidepressants.
Epilepsy	NELM Q&A 24.4 Antidepressants in epilepsy • Check the patients' anticonvulsant regimen for potential drug-induced depression. It may be that the patient would benefit from changing the anticonvulsant to another agent with a more favourable effect on mood rather than adding in an antidepressant. • Risk of seizures with most antidepressants is low, but is probably not zero for any of them, and patients should be made aware of this when prescribing. The risk of seizures increases with increasing doses. • SSRIs are considered the first line antidepressant option in patients with epilepsy. Published data do not support the recommendation of a specific SSRI, although fluoxetine is not the best choice due to its long half-life, a possibly greater incidence of seizures and an increased risk of drug interactions. Citalopram or sertraline may be considered the better options due to safety and reduced interaction potential with the anticonvulsants. • Moclobemide, is a good alternative, as it has a low incidence of seizures but due to limited data it should be reserved as a second choice. • TCAs should be used cautiously in patients with epilepsy and reserved for patients who poorly respond to or are intolerant of other antidepressants. Where a TCA is needed, doxepin would be the agent of choice. • Clinicians should be aware of the possibility of interactions between antidepressants and anticonvulsants and should monitor carefully patients with epilepsy who are prescribed antidepressants. • Introducing the antidepressant gradually, starting with a low dose, and not exceeding the maximum recommended doses may reduce the risk of a seizure. • If seizures occur or if the incidence of seizures increases, the antidepressant should be discontinued.

Diabetes		• The presence of depression has a negative impact on metabolic control and likewise, poor metabolic control may worsen depression. In those who are diabetic: • Use SSRIs first line. • Avoid TCAs and MAOIs if possible due to their effect on weight gain & glucose homeostasis. • Monitor blood glucose carefully when antidepressant is initiated, when dose is changed and after discontinuation.
Parkinson's Disease		NELM Q&A 71.2 Antidepressants in Parkinson's disease • Depression is the most common psychiatric complication in Parkinson's disease. • Limited evidence from randomized controlled trials on the efficacy or safety of antidepressant therapy in Parkinson's disease patients. • When choosing treatment consider the possibility of increasing or inducing parkinsonian symptoms, the adverse effect profile and the potential for interactions with concurrent medication. • SSRIs are considered to be first choice antidepressants in Parkinson's disease patients. • TCAs are effective in treating depression in Parkinson's disease but their adverse effect profile may limit their use. • Exercise caution when combining antidepressants with selegiline. • Other therapies, such as dopamine agonists, may have a role in the treatment of depression in Parkinson's disease patients.
Pregnancy **Refer to NICE CG45 for specific details**	**Pre-conceptual care**	Discuss risk-benefit ratio of therapy. Risks to consider: • Lowest known risks during pregnancy: tricyclic antidepressants (TCAs) such as amitriptyline, imipramine, nortriptyline; but most are more likely to cause death if taken in overdose than selective serotonin reuptake inhibitors (SSRIs). • Lowest known risk with an SSRI during pregnancy: fluoxetine. • Fetal heart defects with paroxetine taken in the first trimester. • Persistent pulmonary hypertension in the neonate with SSRIs taken after 20 weeks' gestation. • High blood pressure with venlafaxine at high doses, together with higher toxicity in overdose than SSRIs and some TCAs and increased difficulty in withdrawal. • Withdrawal or toxicity in the neonate with all antidepressants (in most cases the effects are mild and self-limiting). • Advise a woman taking paroxetine who is planning pregnancy or has an unplanned pregnancy to stop the drug.
	Peri-natal care	Discuss risk-benefit ratio of therapy – see risks to consider above. For information on drugs in pregnancy refer to BNF/SPC first. For women with moderate depression consult the peri-natal community mental health team - Tel: 020 3228 0304
	Postnatal depression	Treat in accordance with this guideline. See below for advice regarding breastfeeding.
Breastfeeding		NELM Q&A 255.1 Management of depression in breastfeeding mothers - an overview NELM Q&A 252.2 Management of depression in breastfeeding mothers – are selective serotonin reuptake inhibitors (SSRIs) safe? • After individualised risk assessment, most mothers of full term, healthy infants will be able to be treated for depression whilst breastfeeding. • SSRIs are first line agents for the management of depression in breastfeeding mothers. Of this group, sertraline &paroxetine are preferred. • With the exception of doxepin, TCAs may be used in lactation in mothers of full term, healthy infants. The non-sedating agents imipramine or nortriptyline are preferred, if clinically appropriate. • Data for other antidepressants is very limited and these are not considered first line agents in lactation. • All infants exposed to antidepressant via milk should be monitored for sedation, poor feeding and behavioural changes. • Co-therapy with other sedating agents is best avoided. • Mothers should be advised not to self medicate.

Appendix 2 Medication Side Effect Summary Chart

Drug	Anticholinergic	Cardiac	Postural Hypotension	Nausea	Sedation	Insomnia	Procon-vulsant	Sexual dysfunction	Weight gain	Withdrawal symptoms	Inhibition of hepatic	Toxicity in overdose	Specific problems
Selective Serotonin Re-uptake Inhibitors (SSRIs)													
Sertraline	●	●	●●	●●●	●	●●●	●	●●●	●●	●●●	●●	Low	All SSRIs can: a. increase nervousness in first three days of treatment b. possibly increase risk of suicide attempts in depressed children and adolescents c. increased risk of gastrointestinal bleeding
Citalopram	●	●	●●	●●●●	●	●●●	●	●●●	●●	●●●	●●	Low	
Fluoxetine	●	●	●●	●●●	●	●●●	●	●●●	●●	U	●●●●	Low	
Escitalopram (hospital initiation)	●	●	●●	●●●	●	●●●	●	●●●	●●	●●●	●●	Low	
Paroxetine	●	●	●●	●●●	●	●●●	●	●●●●	●●●	●●●●	●●●●	Low	
Receptor Agonist / Antagonist													
Mirtazapine	●	●	●●	●	●●●	●●	●●●	●●●	●●●●	●●	U	Low	Blood dyscrasia
Agomelatine	Hospital Only prescribing in Croydon												
Trazodone	●●	●●	●●●	●●●●	●●●	●●●	●	●●●	●●●●	U	U	Low	
Serotonin Noradrenaline Re-uptake Inhibitors (SRNIs)													
Venlafaxine	●	●●●	●●	●●●	●●	●●●	●●	●●●	●●	●●●●	●●	Medium	Hypertension. BP and ECG monitoring suggested.
Duloxetine (hospital initiation)	●	●	●●	●●●	●●	●●●	U	●●●	●●	U	●●	U	
Tricyclic Antidepressants (TCAs)													
Amitriptyline	●●●●	●●●●	●●●●	●●●	●●●●	●●	●●●	●●●	●●●●	●●●	●●●●	High	All TCAs: Potentially cardiotoxic in therapeutic dosage and in overdose.
Clomipramine	●●●●	●●●	●●●●	●●●	●●●	●●●	●●●	●●●●	●●●	●●●	●●●●	High	
Imipramine	●●●	●●●	●●●●	●●●	●●	●●●	●●●	●●●	●●●	●●●	●●●●	High	
Lofepramine	●●●	●●	●●●	●●	●●	U	●	●●●	●●●●	U	U	Low	
Dosulepin	Do not prescribe – cardiac side effects and toxicity in overdose (NICE CG 90 & 91)												
Monoamine Oxidase Inhibitors (MAOIs)													
Phenelzine	●●	●●	●●●●	●●●	●●	●●●	●	●●	●●●	●●●●	●●	High	Hypertensive crisis with sympathomimetics.
Reversible Monoamine Oxidase Inhibitors (RIMAs)													
Moclobemide	●●	●	●●	●●	●	●●●	U	●●	●●	●●	●●	Low	
Noradrenaline Re-uptake Inhibitors (NRIs)													
Reboxetine (Not recommended)	●●	●●	●●	●●	●	●●	●	●	●●	U	●●	Low	Not recommended by SLAM. Inefficacy & intolerability

Adapted from NHS Surrey Depression and Anxiety Disorders Spectrum Care Pathway v2

Key: ●●●●= **Marked effect** ●●● = Moderate effect ●● = Mild effect ● = Little or minimal effect U = No information or little reported

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Appendix 3 Antidepressants - Swapping and Stopping

- All antidepressants have the potential to cause withdrawal phenomena when taken continuously for 6 weeks or longer.
- Antidepressants should NOT be stopped abruptly UNLESS a serious adverse event occurs
- When changing from one antidepressant to another abrupt withdrawal should usually be avoided - cross tapering is preferred (see table). In certain cases cross-tapering may NOT be considered necessary e.g. when switching from one SSRI to another (see table).
- Cross tapering: dose of the ineffective / poorly tolerated drug is slowly reduced whilst the new drug is slowly introduced (see table)
- The speed of cross-tapering is best judged by monitoring patient tolerability. No clear guidelines are available.

Note: Advice given in this table is partly derived from manufacturers' information and partly theoretical. Caution is required in every instance.

TO / FROM	Sertraline	Citalopram	Mirtazapine	Escitalopram	Duloxetine	Venlafaxine	Fluoxetine	Paroxetine	MAOIs i.e. Phenelzine	Moclobemide	Trazodone	Tricyclics	Stopping
Licensed Dose range (refer to SPC) Electronic Medicines Compendium (eMC)	50mg daily. Dose increments 50mg/week. Max 200mg daily	20mg daily. Max. 40mg daily. Elderly: max 20mg daily	15-30mg daily. Up to 45mg daily	10-20 mg daily (elderly-half dose)	(Cymbalta) 60mg daily. Max 120mg daily	75mg daily (in 2 divided doses) up to 300mg daily. Higher doses - specialist supervision	20mg daily. Max 60mg daily	20mg daily. Max 50mg daily					
Sertraline		Taper and stop then start citalopram 10mg/day	Cross taper cautiously	Taper and stop then start escitalopram	Abrupt switch possible. Start at 60mg/day	Cross taper cautiously. Start venlafaxine at 37.5mg/day. ↑ very slowly	Taper and stop then start fluoxetine at 10mg/day	Taper and stop then start paroxetine 10mg/day	Taper and stop then wait for 1 week	Taper and stop then wait for 1 week	Cross taper cautiously starting with low dose trazodone	Cross taper cautiously with very low dose of tricyclic *2	Reduce over 4 weeks
Citalopram	Taper and stop then start sertraline at 25mg/day		Cross taper cautiously	Cross taper cautiously	Abrupt switch possible. Start at 60mg/day.	Cross taper cautiously. Start venlafaxine at 37.5mg/day. ↑ very slowly	Taper and stop then start fluoxetine at 10mg/day	Taper and stop then start paroxetine at 10mg/day	Taper and stop then wait for 1 week	Taper and stop then wait for 1 week	Cross taper cautiously starting with low dose trazodone	Cross taper cautiously *2	Reduce over 4 weeks
Mirtazapine	Cross taper cautiously	Cross taper cautiously		Cross taper cautiously	Cross taper cautiously, start at 30mg/day. ↑ slowly	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Taper and stop then wait for 2 weeks	Taper and stop then wait for 1 week	Cross taper cautiously	Cross taper cautiously with very low dose of tricyclic	Reduce over 4 weeks
Escitalopram	Taper and stop then start sertraline at 25mg/day	Cross taper cautiously	Cross taper cautiously		Abrupt switch possible. Start at 60mg/day.	Cross taper cautiously. Start venlafaxine at 37.5mg/day. ↑ very slowly	Taper and stop then start fluoxetine at 10mg/day	Taper and stop then start paroxetine 10mg/day	Taper and stop then wait for 1 week	Taper and stop then wait for 1 week	Cross taper cautiously starting with low dose trazodone	Cross taper cautiously*2	Reduce over 4 weeks
Duloxetine	Cross taper cautiously. Start sertraline at 25mg/day	Cross taper cautiously. Start citalopram 10mg/day	Cross taper cautiously	Cross taper cautiously		Taper and stop then start venlafaxine	Taper and stop then start fluoxetine	Taper and stop then start paroxetine	Taper and stop then wait at least 5 days	Taper and stop then wait at least 5 days	Cross taper cautiously starting with low dose trazodone	Cross taper cautiously with very low dose of tricyclic *2	Reduce over 4 weeks
Venlafaxine	Cross taper cautiously. Start sertraline at 25mg/day	Cross taper cautiously. Start citalopram 10mg/day	Cross taper cautiously	Cross taper cautiously	Taper and stop, start at 30mg/day. ↑ slowly		Taper and stop then start fluoxetine at 10mg/day	Cross taper cautiously. Start paroxetine 10mg/day	Taper and stop then wait at least 1 week	Taper and stop then wait at least 1 week	Cross taper cautiously	Cross taper cautiously with very low dose of tricyclic *2	Reduce over 4 weeks or longer if necessary *4

TO / FROM	Sertraline	Citalopram	Mirtazapine	Escitalopram	Duloxetine	Venlafaxine	Fluoxetine	Paroxetine	MAOIs ie. Phenelzine	Moclobemide	Trazodone	Tricyclics	STOPPING
Fluoxetine *3	Taper and stop fluoxetine. Wait 4-7days. Start sertraline at 25mg/day and ↑ slowly	Stop fluoxetine. Wait 4-7 days. Start citalopram at 10mg/day and ↑ slowly	Cross taper cautiously. Start mirtazapine at 15mg/day	Stop fluoxetine. Wait 4-7 days. Start escitalopram and ↑ slowly	Abrupt switch possible start at 60mg/day	Taper and stop. Start venlafaxine at 37.5mg/day. ↑ very slowly		Taper and stop fluoxetine. Wait 4-7days. Start paroxetine 10mg/day and ↑ slowly	Taper and stop then wait 5-6 weeks	Taper and stop then wait at least 5 weeks	Cross taper cautiously starting with low dose trazodone	Taper and stop fluoxetine. Wait 4-7 days. Start tricyclic at very low dose and ↑ very slowly *2	At 20mg/day, just stop. At higher doses reduce over 2 weeks
Paroxetine	Cross taper cautiously. Start sertraline at 25mg/day	Taper and stop then start citalopram 10mg/day	Cross taper cautiously	Taper and stop then start escitalopram	Abrupt switch possible. Start at 60mg/day	Cross taper cautiously. Start venlafaxine at 37.5mg/day. ↑ very slowly	Taper and stop then start fluoxetine at 10mg/day		Taper and stop then wait for 2 week	Taper and stop then wait for 1 week	Cross taper cautiously starting with low dose trazodone	Cross taper cautiously with very low dose of tricyclic *2	Higher risk of withdrawal symptoms. Reduce over 4 weeks or longer if necessary *4
MAOIs ie. Phenelzine	Taper and stop then wait 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	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 2 weeks*1	Reduce over 4 weeks
Moclobem-ide	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		Taper and stop then wait 24 hours	Taper and stop then wait 24 hours	Reduce over 4 weeks
Reboxetine	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Cross taper cautiously	Taper and stop then wait at least 1 week	Taper and stop then wait at least 1 week	Cross taper cautiously	Cross taper cautiously	Reduce over 4 weeks
Trazodone	Cross taper cautiously. Start sertraline at 25mg/day	Cross taper cautiously. Start citalopram 10mg/day	Cross taper cautiously	Cross taper cautiously.	Cross taper cautiously, start at 30mg/day. ↑ slowly	Cross taper cautiously starting with venlafaxine 37.5mg/day	Cross taper cautiously. Start fluoxetine at 10mg/day	Cross taper cautiously. Start paroxetine 10mg/day	Taper and stop then wait at least 1 week	Taper and stop then wait at least 1 week		Cross taper cautiously with very low dose of tricyclic	Reduce over 4 weeks
Tranyl-cypromine	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	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 *1	Reduce over 4 weeks
Tricyclics	Halve dose and add sertraline then slow withdrawal *2	Halve dose and add citalopram then slow withdrawal *2	Cross taper cautiously, start at 30mg/day. ↑ very slowly *2	Halve dose and add escitalopram then slow withdrawal *2	Cross taper cautiously, start at 30mg/day. ↑ very slowly *2	Cross taper cautiously starting with venlafaxine 37.5mg/day *2	Halve dose and add fluoxetine then slow withdrawal *2	Halve dose and add paroxetine then slow withdrawal *2	Taper and stop then wait for 2 weeks *1	Taper and stop then wait for 1 week	Halve dose and add trazodone then slow withdrawal	Cross taper cautiously	Reduce over 4 weeks

*1 3 weeks in case of imipramine/clomipramine
*2 Do not co-administer clomipramine and SSRIs, venlafaxine or duloxetine
*3 Beware: interactions with fluoxetine may still occur for 5 weeks after stopping fluoxetine because of its long half-life
*4 Withdrawal effects seem to be more pronounced. Slow withdrawal over 1 – 3 months may be necessary. Some patients may prefer abrupt withdrawal (to shorten overall duration of discontinuation effects

Adapted from: Taylor D, Paton C, Kapur S. The South London and Maudsley NHS Foundation Trust, Oxleas NHS Foundation Trust, Prescribing Guidelines. 11th ed. London: Informa Healthcare
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