RACGP
Royal Australian College of General Practitioners

For GPs – Long-term use of antidepressants without careful review

For GPs

An approach to deprescribing antidepressant medications (eg serotonin reuptake inhibitors [SSRIs] and serotonin and noradrenaline reuptake inhibitors [SNRIs]) to minimise withdrawal syndrome and relapse.

RACGP position

Do not continue to prescribe long-term medications for anxiety and depression without carefully reassessing their ongoing need and appropriateness.

Traffic lights

Red – Do not take this action

- Do not continue or discontinue prescribing medication for anxiety and depression without careful review and shared decision-making with the patient.[1]

Orange – Under specified circumstances, take this action

- If you continue to prescribe the medication, establish regular reviews at appropriate intervals, based on individual patient factors.[1]
- When considering deprescribing the medication, use shared decision-making with any active members of the care team.[1,2]

Green – Take this action

- When initially prescribing antidepressants, discuss the risk of antidepressant withdrawal syndrome with the patient as part of informed consent, ensuring that they understand that for some patients it can be severe, prolonged and debilitating.[1,3]
- During reviews, use shared decision-making to assess whether the medication remains clinically indicated and if the benefits outweigh the potential risks of continuing.[1]
- Continue to use non-pharmacological management and, where possible, avoid medications that may worsen mood.[1,2]

- Continue to provide all patients with education about their condition, management options and the risks associated with SSRI/SNRI withdrawal, side effects and relapse.[1,2]
- Particularly consider deprescribing for patients whose original indication was mild to moderate or where their symptoms of anxiety or depression were short term.[1,2]
- When deprescribing, adopt a tapering approach and arrange regular follow-up during and after weaning to monitor for risks, withdrawal and relapse.[1,2] Follow guidelines about tapering (see Overview) and consider the patient's support networks, current life stressors and stability when timing tapering.[1,2]
- Educate the patient and their supports about safe tapering, potential withdrawal effects and signs of relapse. Provide an action plan they can follow to seek help if the withdrawal effects are severe or if there is a relapse.[1–3]

Patient harms and risks

- **Withdrawal symptoms:** These may occur when antidepressant medication is ceased or reduced. Treatment for more than 12 months is associated with an increased risk of experiencing significant symptoms of antidepressant withdrawal syndrome.[1]
- **Recurrence of symptoms:** This can be difficult to distinguish from symptoms of antidepressant withdrawal syndrome.[1,2]

Alternatives: What can I do for the patient?

Take the time to provide education, explore barriers and build the patient's understanding and confidence to discontinue in the future.[1]

Consider psychological intervention, including e-mental health resources.[2,4]

Encourage positive lifestyle practices, particularly relating to sleep, nutrition, exercise, alcohol, smoking, stressors and substance misuse.[2]

Implement social prescribing.[2]

Recommend non-drug interventions:[5]

- HANDI, Internet based or computerised CBT (iCBT or CCBT): depression and anxiety
- HANDI, Bibliotherapy: depression
- HANDI, Exercise: depression
- Behavioural activation (handout and module)

Overview

SSRIs, SNRIs and other antidepressant medications are commonly used for the treatment of conditions such as mood disorders. In the period from 2023 to 2024, 14% of the population in Australia was dispensed an antidepressant medication.[4] Although most guidelines recommend that these medications be used for only 6–12 months for an episode of anxiety or depression, the average duration of use is four years.[1]

If you are considering prescribing these medications, you need to also understand when and how to deprescribe them, and the possibility of antidepressant withdrawal syndrome. Earlier descriptions of symptoms of this syndrome may have underemphasised the frequency and severity of the syndrome in some people.[1]

Deprescribing should be a process of planned and supervised dose reduction that leads to the cessation of the medication. It should be implemented when the potential harms of continuing outweigh the current or anticipated benefits of continuing, and may also be implemented if the patient indicates they would like to cease taking the medication.[1,6]

Before deciding whether to deprescribe or not, assess the patient's symptoms so that you can:

- determine whether there has been a significant improvement since beginning the medication and, if so, whether there are any ongoing symptoms of concern
- identify risk factors that might lead to a relapse.[1,2]

Risks of harm from continuing SSRIs/SNRIs are often greater where there is polypharmacy, pregnancy,

advanced age or the patient is on a high dose.1,2

Patients should be told that:

- they may experience discontinuation and withdrawal symptoms
- such symptoms are commonly mild, but rarely may be severe, prolonged and debilitating[1,6]
- they should not stop taking antidepressants abruptly and should discuss stopping their antidepressant with their treating physician.[6]

The following resources are useful handouts and discussion tools:

- Stopping antidepressants
- RELEASE resources (REdressing Long-tErm Antidepressant uSE).

Reviews of ongoing medication

Review intervals

The interval for review will depend on patient factors, such as their current symptoms, side effects, comorbid conditions, risk factors for relapse, severity of initial presentation and ongoing life stressors.[1,2]

Conducting the review

At each review:

- consider the ongoing need for the medication based on the patient's individual circumstances[1]
- consider exploring the patient's perceptions about their condition and the effectiveness of the medication
- consider educating the patient about antidepressants and exploring barriers to discontinuing
- encourage self-efficacy and maximising non-pharmacological management (decision aid tools and education, such as RELEASE resources, may be helpful).[7]

Continuing to prescribe

Continue to prescribe only if:

- there is shared decision-making with the patient
- it remains clinically indicated
- the benefits of continuing outweigh the potential risks of continuing.

Commencing deprescription

Discontinuation at 6–12 months may be appropriate for many patients, but patients with previous episodes or residual symptoms of depression have been shown to be at higher risk of relapse and may benefit from use beyond 12 months.[2] There is no clinical trial evidence regarding maintaining antidepressant treatment beyond three years.[2]

If you decide to decrease or deprescribe the medication:

- explain and make sure the patient understands the risk of withdrawal and the recommendation to taper with medical supervision
- assess what supports the patient has or needs; ensure their family/carer understands the risks and what to look out for
- provide clear guidelines about the tapering (see Tapering below)
- establish regular follow-up appointments during and after weaning to monitor for risks, withdrawal and relapse.[1,2]

Tapering

The rate of reduction must be based on what the patient can tolerate. For many patients, this may be a 10% reduction (or less) of the previous dose every 2–4 weeks.[1]

If the patient does not tolerate any withdrawal symptoms they experience, halt any further weaning or increase the dose slightly until the patient's symptoms settle.[1]

Follow guidelines (e.g. RELEASE tapering protocols from the University of Queensland) to ensure the tapering is appropriate.

Consider:

- how the tapering of the medication can be practically achieved (eg tablet cutters, liquid preparations, compounding[1,7,8]).
- the lower the current dose, the slower the tapering should be[1,7]
- 'every other day dosing' is not suitable unless the medication has a long elimination half-life.[1]

Withdrawal and relapse

Onset of withdrawal symptoms

Usually, withdrawal occurs within hours or days of a dose reduction, but if the drug has a longer half-life (eg fluoxetine), it can take weeks to occur.

Monitoring for withdrawal and relapse

Monitor the patient, and educate them to self-monitor, for withdrawal symptoms described below.

Physical symptoms:

- Changes in sleep (eg insomnia, excessive dreaming or nightmares)
- Flu-like symptoms (eg sweating, fatigue, malaise, headache)
- Gastrointestinal upset (eg anorexia, nausea, vomiting, diarrhoea)
- Neurological symptoms (eg tremor, paraesthesia, electric shock-like sensations, rushing noises, blurred vision, palinopsia, vertigo, disequilibrium)
- Mood changes (eg irritability, anxiety, agitation, low mood).[1]

Psychological symptoms:

- Psychological symptoms of withdrawal may differ from the original mood disorder presentation and can be severe in nature.
- Symptoms such as electric zaps are highly suggestive of withdrawal.[1]
- One of the most distressing withdrawal symptoms is akathisia, which is a neuropsychiatric presentation of severe restlessness, agitation and sense of terror.[1]

Assessing whether symptoms indicate withdrawal or relapse

Where symptoms occur, thoroughly assess the patient to decide whether the symptoms are likely related to withdrawal or relapse.

Taking a history of the time of onset, the physical and psychological symptoms and the patient's response to reinstatement of the drug may help you differentiate between withdrawal symptoms and a relapse.[1]

What we understand about withdrawal syndrome

Withdrawal syndrome is not well understood, but we are beginning to understand that it can sometimes be severe and persistent, lasting months or even years. It seems that for some patients the effects of withdrawal syndrome can be extremely slow to resolve, or may even be permanent.[1,9]

Consequently, it may be that many studies overestimate the rate of relapse because they underestimate the duration of withdrawal syndrome.[1]

Resources and information for patients

The Royal Australian College of General Practitioners, First do no harm: reducing or ceasing your antidepressants

Better Health Channel, Depression – treatment and management

Healthdirect, Antidepressants

Royal College of Psychiatrists, Stopping antidepressants

University of Queensland, RELEASE resources

Resources for GPs

The Royal Australian College of General Practitioners, *Guidelines for preventive activities in general practice* (the Red Book), Depression

The Royal Australian College of General Practitioners, *Guidelines for preventive activities in general practice* (the Red Book), Perinatal mental health

The Royal Australian College of General Practitioners and National Aboriginal Community Controlled Health Organisation, *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people,* Depression

The Royal Australian College of General Practitioners, HANDI, Internet based or computerised CBT (iCBT or CCBT): depression and anxiety

The Royal Australian College of General Practitioners, HANDI, Bibliotherapy: depression

The Royal Australian College of General Practitioners, HANDI, Exercise: depression

The Royal Australian College of General Practitioners, RACGP aged care clinical guide (the Silver Book), Deprescribing

The Royal Australian College of General Practitioners, *2022 RACGP curriculum and syllabus for Australian general practice*, Mental health

General Practice Mental Health Standards Collaboration, Resources for GPs

Mark Horowitz, David M. Taylor, The Maudsley Deprescribing Guidelines: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs

National Institute for Health and Care Excellence (NICE) guidelines, Depression in adults: treatment and management

The Royal Australian and New Zealand College of Psychiatrists, The 2020 RANZCP clinical practice guidelines for mood disorders

University of Queensland, RELEASE resources (includes tapering guides and patient information)

University of Queensland, RELEASE 3As brief intervention: Ask, Advise, Assist

University of Western Australia, Clinical practice guidelines for deprescribing in older people - Antidepressants

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