DEPRESCRIBING GUIDE FOR SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) AND SEROTONIN NORADRENALINE REUPTAKE INHIBITORS (SNRIs)

(including SSRIs [e.g. citalopram, escitalopram, paroxetine, sertraline, fluoxetine, fluvoxamine] and SNRIs [e.g. venlafaxine, desvenlafaxine, duloxetine])

This guide provides deprescribing information that can be applied to written and/or verbal communication (in the form of "preferred language") between clinicians, patients and/or carers. Adapt appropriately for individual patients.

CONSIDER TWO STEPS WHEN DEPRESCRIBING:

1 Should I deprescribe?

2 How do I deprescribe?

STEP 1: SHOULD I DEPRESCRIBE? (PATIENT ASSESSMENT)

Deprescribing triggers:

- Inappropriate indication, no current indication, presence or risk of adverse events, drug interaction, drug-disease interaction, high drug burden index (DBI),[1] poor adherence, or patient preference.

1a) Is there a documented indication or symptoms supporting continued use?

Inappropriate indication for continued use:

- No current depression >6 months. Consult or review with treating psychiatrist.

Do not deprescribe if:

- Recurrent or severe depression or other psychiatric condition such as obsessive compulsive disorder or generalised anxiety disorder. Discuss with the treating psychiatrist.

1b) Are there adverse effects?

Consider potential adverse effects:

- Falls, dizziness, agitation, headaches, nausea, diarrhoea, insomnia, tremor, dry mouth, sweating, weakness, sexual dysfunction, rhinitis, myalgia, rash, palpitations, tachycardia, hypotension, hyponatraemia, confusion, anxiety, drowsiness, or sedation.[2]

1c) Is this medication likely to cause more harm than benefit?

See Evidence-based advice for additional information on risks of harm and benefits of continued use.

1d) Does the patient/carer agree with the recommendation to deprescribe?

Following provision of information, discussion and shared-decision making, the patient or carer has communicated that they would like to proceed with or decline the deprescribing recommendation.

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

_____ is currently taking _____
(patient name) (drug name: e.g. citalopram 20mg daily)

for _____ , and is currently experiencing/at risk of _____.
(indication: e.g. mild depression) (patient issue: e.g. adverse effects)

The _____ outweighs the _____ for continued use of _____.
(risk/benefit + rationale) (risk/benefit + rationale) (drug name: e.g. citalopram)

Discussed with _____ and _____ deprescribing recommendation.
(patient /carer name) (agreed/willing to trial/considering/declined)

STEP 2: HOW DO I DEPRESCRIBE? (RECOMMENDATION AND MANAGEMENT)

2a) How to wean

Key Points

- Establish a supportive and trusting relationship with the patient to engage in complex/sensitive discussions.
- Accompany weaning with commencement of relevant non-pharmacological therapy. See Alternative management recommendations.
- In general, wean gradually by 25% of the daily dose every 1-4 weeks.
- If reason for deprescribing is due to serious adverse effects, consider weaning faster.
- Provide advice to patient/carer on self-monitoring and what to do if symptoms re-occur.
- Organise appropriate follow up appointments with general practitioner (GP) (frequency determined by rate of weaning).

Initiation

Reduce dose slowly by 25-50% of the daily dose each week to month.

Adjustments depend on response

Adjust according to response (see Monitoring recommendations).

- If no withdrawal symptoms occur, continue to wean and stop.
- Consider slower weaning (e.g. 12.5%) when reducing to the final lowest dose. End treatment 2 weeks after administering the lowest dose.
- Consider alternate day dosing to aid with weaning if dosage forms are limited.

Adjustments in the case of recurrent symptoms

In the case of recurrent/withdrawal symptoms, revert to the previous lowest tolerated dose. Recommence weaning after 6-12 weeks at a lower weaning rate (e.g. 5-12.5% of daily dose each month) then stop.

(Based on recommendations in References[2-9])

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

Recommend non-pharmacological replacement therapy to reduce reliance on antidepressants.

Recommend gradually reducing to _____ (drug: e.g. citalopram 15mg daily) **for** _____ (timeframe: e.g. 1 week) **and reassess,**

then reduce to _____ (e.g. citalopram 10mg daily) **for** _____ (e.g. 1 week) **and reassess,**

then reduce to _____ (e.g. citalopram 5mg daily) **for** _____ (e.g. 1 week) **and reassess,**

then reduce to _____ (e.g. citalopram 2.5mg daily) **for** _____ (e.g. 2 weeks) **and stop.**

Follow up with GP _____ (e.g. fortnightly) **after discharge.**

2b) Alternative management

Non-pharmacological support

Psychological therapy, social support, cognitive behavioural therapy, interpersonal therapy, supportive counselling and problem solving techniques, physical activity.

For non-pharmacological treatment advice, refer to [AMH Aged Care Companion-Depression].

Switching within drug class or consider alternative therapy

If there is a current indication, consider dose reduction or consider switching to another antidepressant that may be better tolerated. Care must be taken when switching between antidepressants to avoid drug interactions and serotonin syndrome. To consider other options, refer to [AMH-Antidepressants] or [table].[4]

PREFERRED LANGUAGE:

Use **psychological therapy (e.g. counselling) therapy** and **social support** concurrently.

2c) Monitoring

Monitor within 1-3 days	Monitor >7 days
Monitor for withdrawal symptoms Symptoms can occur within 1-3 days of dose reduction.	**Monitor for recurrence of symptoms** Recurrence of previous or new symptoms (e.g. anxiety, depression) may occur within 1-2 weeks of dose reduction.

- Common withdrawal symptoms, often called 'discontinuation syndrome' (e.g. irritability, anxiety, insomnia, sweating and gastrointestinal effects) are usually mild, highly variable and can last up to 6-8 weeks.
- If severe symptoms (e.g. impaired concentration, motor restlessness, tremor, muscle pain, muscle twitching, tachycardia, hypertension, sweating, generalised tonic-clonic seizures, perceptual disturbance, nausea, bloating, anorexia, severe anxiety, or severe insomnia) occur, restart at the previous lowest effective dose.
- There may be a delay before withdrawal symptoms present for patients on higher doses of fluoxetine because of the longer half-life.

PREFERRED LANGUAGE:

Within 1-3 days of dose reduction, monitor for **withdrawal** symptoms which can be **mild** (e.g. irritability, insomnia, sweating and gastrointestinal effects) or **severe** (e.g. *tachycardia, hypertension, sweating, generalised tonic-clonic seizures, perceptual disturbance, nausea, bloating, anorexia, impaired concentration, motor restlessness, tremor, muscle pain, muscle twitching*).

Monitor for **recurrence** of symptoms within 1-2 weeks of dose reduction, including *anxiety or depression*.

Restart at the lowest effective dose with retrial weaning after *6-12 weeks*.

EVIDENCE-BASED ADVICE

Effectiveness and safety

A Cochrane meta-analysis of studies predominantly lasting 6-8 weeks, estimated that seven patients with depression needed to be treated with a SSRI in order to obtain a benefit in one (number needed to treat [NNT] = 7). Whereas, compared to placebo, 20-90 patients needed to be treated with a SSRI in order to suffer harm (withdrawal due to side effects) (number needed to harm [NNH] = 20-90).[10]

The risk of recurrence after the first episode of depression (after stopping 2 years of maintenance therapy) is approximately 60% over 2 years.[3]

Cognitive therapy has shown to be at least as effective in major depression as antidepressants, with sustained effects.[11,12]

Treatment with antidepressants in patients with depression and dementia should be reconsidered. A randomised control trial comparing sertraline, mirtazapine, and placebo, at 13 and 39 weeks, did not show treatment benefit compared to placebo (sertraline: mean difference 1.17, [95% CI, 0.23-2.58; p=0.10]; mirtazapine: 0.01, [95% CI, -1.37-1.38; p=0.99]). However, the study showed increased risk of adverse events in treatment groups (sertraline: 46 of 107, 43%, p=0·010; and mirtazapine: 44 of 108, 41%, p=0·031), versus placebo (29 of 111, 26%, p=0.003) which had fewer adverse events rated as severe.[13]

Over 90% of people would be willing to stop their medicines if recommended by their physician.[14]

Recommended duration of use

Limit drug treatment to short-term use. SSRIs and SNRIs are associated with significant harm (e.g. falls, fractures), and long-term use is not recommended, especially in older adults.

SUMMARISED PHRASING DURING HOSPITAL ADMISSION AND/OR AT DISCHARGE

When communicating deprescribing decisions to GPs at discharge, written and verbal communication should include information in the sequence of:

"Medicine, Intention, Rationale, Clear Plan (dose change, duration, follow up), Patient agreement"

PREFERRED LANGUAGE

(write in GP follow up plan and medication list):

_____ : _____ due to_____ outweighing effects _____.

current medication (e.g. citalopram) | stopped/ reduced with aim of stopping | specific rationale (e.g. improved mood) | of/on current indication (e.g. on depression)

_____ reduced to _____ for _____, then _____. Patient/Carer agreed.

If weaning, old dose changed to new dose (e.g. Citalopram 20mg mane reduced to Citalopram 15mg mane) | if weaning, time frame (e.g. 2 weeks) | follow-up action (e.g. view by GP, continue taper by 5mg every 2 weeks if tolerated)

Refer to www.nswtag.org.au/deprescribing-tools/

Example:

Citalopram: reduced with aim of stopping due to improved mood outweighing effects of continued use for depression. Citalopram 20mg mane reduced to citalopram 15mg mane for 2 weeks then view by GP, continue taper by 5mg every 2 weeks if tolerated. Patient agreed. Refer to www.nswtag.org.au/deprescribing-tools/

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1. Hilmer SN, Mager DE, Simonsick EM, et al. A drug burden index to define the functional burden of medications in older people. Arch Intern Med. 2007; 167(8):781-787. Available at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/412262 **2.** Australian Medicines Handbook (AMH): Antidepressants. 2018. **3.** AMH Aged Care Companion: Major depressive disorder. 2018. **4.** Australian Prescriber. Guidelines for switching between specific antidepressants. NPS Medicinewise 2016. Available at https://cdn0.scrvt.com/08ab3606b0b7a8ea53fd0b40b1c44f86/7633e26c9dc20484/d13a5a83c319/Guidelines-switching-antidepressants_A3.pdf **5.** Therapeutic Guidelines Limited. eTG complete: Failure to respond to initial antidepressant therapy/Failure to respond to adequate antidepressant therapy; Antidepressant Discontinuation. 2018. **6.** Kouladjian O'Donnell L, Gnjidic D, Nahas R, et al. Anticholinergic burden: considerations for older adults. J Pharm Pract Res. 2017; 47(1): 67-77 **7.** RACGP Handbook of Non-Drug Interventions (HANDI): making non-drug interventions easier to find and use. Available at https://www.racgp.org.au/your-practice/guidelines/handi **8.** BPAC NZ Better Medicines. A practical guide to stopping medicines in older people. BPJ. 2010; 27. Available at https://bpac.org.nz/BPJ/2010/April/stopguide.aspx **9.** Medstopper. Available at http://medstopper.com **10.** Arroll B, Elley CR, Fishman T, et al. Antidepressants versus placebo for depression in primary care. Cochrane Database of Sys Rev. 2009; 3: CD007954. **11.** Zhang Z, Zhang L, Zhang G, et al. The effect of CBT and its modifications for relapse prevention in major depressive disorder: a systematic review and meta-analysis. BMC Psychiatry. 2018; 18(1):50. **12.** DeRubis RJ , Hollon SD, Amsterdam JD, et al. Cognitive therapy vs medication in the treatment of moderate to severe depression. Arch Gen Psychiatry. 2005; 62(4): 409-416. **13.** Banerjee S, Hellier J, Dewey M, et al. Sertraline or mirtazapine for depression in dementia (HTA-SADD): a randomised, multicentre, double-blind, placebo-controlled trial. The Lancet. 2011; 378(9789):403-11. **14.** Reeve E, Wiese MD, Hendrix I, et al. People's attitudes, beliefs, and experiences regarding polypharmacy and willingness to deprescribe. J Am Geriatr Soc. 2013; 61(9):1508-1514.

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- How to wean
- Alternative management
- Monitoring
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- Summarised phrasing during admission and/or at discharge
- References