Long-term antidepressant treatment: time for a review?

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Antidepressant use in Western countries doubled between 2003 and 2013.1 By 2014, 11 per cent of adults in England were taking them, costing £280 million annually.2,3 While antidepressants can be used for pain and insomnia, the large majority are prescribed for depression and anxiety disorders.5 GPs in England are now giving out more than 50 million prescriptions a year6 and have been accused of over-diagnosing and over-treating depression.4,5

Poor targeting
In the early 2000s we found evidence of poor targeting of antidepressant treatment – GPs were prescribing inappropriately for patients with mild symptoms, yet failing to treat some patients with more severe depression.6,7 Subsequently, the 2004 NICE depression guideline emphasised the need to assess severity, and advised against treating mild depression.8 Then a performance indicator was introduced in the GP quality and outcomes framework (QOF) rewarding the use of symptom questionnaires to assess depression severity, aimed at improving targeting of treatment.9 Following the introduction of the QOF indicator, we found that decisions to prescribe antidepressants were more appropriately related to greater severity at diagnosis,10 and a study of GPs’ initial prescribing decisions found them justified in most cases, against the 2004 NICE guidance.11

However, antidepressant prescription numbers have continued to rise year on year. To investigate the cause, we recently analysed anonymised data from 142 English practices contributing to the Clinical Practice Research Datalink (CPRD) from 2003–2013.12 We found that GPs were not diagnosing many more people with depression. There was a small increase in consultations for depression following the economic recession (around 4 per cent between 2008 and 201312) but antidepressant use increased by 48 per cent during the same period.3

Change in initial prescribing decisions
We did find evidence, however, to suggest that GPs’ initial prescribing decisions had changed following the introduction of NICE guidance and the QOF indicator. Rates of treating incident (first-ever) episodes of depression fell from 72 per cent in 2003 to 61 per cent in 2012. Time trend analysis showed sustained reductions occurred in treatment rates for first-ever episodes of 4.2 per cent following the publication of the NICE guideline and another 4.4 per cent following the introduction of the QOF indicator, so it appeared GPs had changed their practice. However, treatment rates for recurrent episodes increased from 74 per cent to 78 per cent in the same period, so overall prescribing rates remained around 70 per cent. Meanwhile, prescription numbers continued to rise but this was due to GPs giving longer courses of treatment – prescriptions per patient doubled over the 10 years. We concluded that guidelines need to address recurrent and long-term treatment to impact on increasing rates of GP antidepressant prescribing.13

UK studies show half the people on antidepressants have been taking them for two years or more,14,15 echoing similar findings in the USA.16,17 It has been suggested that increasing long-term prescribing is simply the result of correcting what was previously inadequate duration of treatment,18 and it may be that long-term antidepressants are appropriate for some patients to minimise the risk of relapse19 – NICE recommends treating people for two years in the first instance if there is a history of recurrent depression, or the risk of relapse is significant.20 However, studies of long-term antidepressant users have concluded that a third to a half have no evidence-based indications to continue them, and could try stopping treatment.21 Unfortunately, reviews of patients taking antidepressants have been found to decline in frequency with longer use,22,23 reducing the opportunity to reassess the appropriateness of treatment and increasing the likelihood of continuing it unnecessarily.

Is long-term treatment harmful?
Does long-term treatment do any harm? The SSIs can cause significant side-effects including weight gain, sleep disturbance, sexual dysfunction, and gastrointestinal bleeding, which increase with longer-term use.24 Long-term treatment may also impair patients’ autonomy and resilience, increasing their dependence on medical help, so no patients should be treated unnecessarily. In theory, stopping antidepressants is straightforward, tapering them under supervision,25 but in practice patients are often anxious about stopping. Many have tried and encountered withdrawal symptoms, including sensory symptoms, dizziness, anxiety, mood swings, lethargy, and sleep disturbance, which may appear to be a recurrence of the original problem requiring treatment.26 Restarting medication before withdrawal symptoms can resolve spontaneously quickly relieves the symptoms, reinforcing this perception. Patients may be on repeat prescriptions, reviewed only infrequently, and just assume they are expected to continue treatment.27 The rationale for taking SSIs commonly presented by GPs is a deficiency of serotonin in the brain, so patients may conclude they have to remain on treatment for life.28 Many are prepared to continue indefinitely, due to fears of relapse and a perception that discontinuation would be a threat to their stability.29 So
patients need proactive review, and may need persuading to try withdrawing from treatment.

All practices should audit their use of antidepressants and mark the records of patients taking them for longer than two years for proactive review. Community pharmacists can help them – a trial of pharmacist-prompted GP review of long-term users in Scotland resulted in 7 per cent of patients tapering and stopping their antidepressants, and a further 13 per cent reducing their dose. Patients who find they cannot taper treatment due to emerging anxiety about withdrawal symptoms should be referred for psychological therapy, through the Improving Access to Psychological Therapies (IAPT) programme. Cognitive and mindfulness-based therapies have been shown to help patients stop antidepressants while preventing relapse in anxiety disorders and depression, and one in six patients treated through IAPT are able to stop their antidepressants.

Practices should act now to review their long-term users of antidepressants and stop or reduce inappropriate treatment, with the help of pharmacists and psychotherapists if necessary.

References
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Declaration of interests
Professor Kendrick chaired the expert committee that recommended the depression indicator be included in the 2006 QOF. He is also a member of the committee reviewing the NICE guidelines for an update in 2017. The views expressed are his own and do not represent the views of the DH, the NIHR, or NICE.

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