Medication in depression/anxiety

- Discuss with the patient and *decide together* whether to prescribe antidepressants
- If medication is prescribed, this should just be as **part of treatment** alongside:
  - guided self-help
  - counselling/CBT (depending on availability)
  - active follow-up

Mild to moderate depression (PHQ<15)	Often no pharmacological treatment necessary but depends on duration of the disorder, impact on personal and social functioning
Mod to severe depression (PHQ>15)	Pharmacological treatment recommended as part of treatment, especially if there are thoughts of suicide
Predominantly anxiety/panic	SSRI or adjuncts can be useful to help with symptoms, start with low dose

Counselling before prescribing an SSRI

- It is important to take the medication every day as prescribed
- It takes a few weeks to see improvement in mood, interest or energy
- Some side effects may be experienced in the first few days, but they usually resolve
- Anxiety symptoms can worsen before starting to improve (usually just a few days)
- Medication should continue for at least 6 months (or better 1 year) after improvement
- Medication is not addictive
- Medication should not be stopped suddenly, but little by little with the doctor's supervision

MEDICATION	DOSING	SIDE EFFECTS	CAUTIONS
FLUOXETINE (a selective serotonin reuptake inhibitor = SSRI)	Start 20mg daily. If no response in 6 weeks, increase to 40mg. (If severe side effects, or concern about side effects, try alternate days or 10mg daily for 1-2 weeks to begin with) Elderly/medically ill: preferred choice. Start 10mg daily if possible (or 20mg alternate days), then increase to 20 mg if no response in 6 weeks Adolescents Start 10mg daily if possible (or 20mg alternate days). Increase to 20 mg daily if no response in 6 weeks	Common: restlessness, nervousness, insomnia, headache, dizziness, gastrointestinal disturbances, changes in appetite, and sexual dysfunction. Serious: bleeding abnormalities in those who use aspirin or other non-steroidal anti-inflammatory drugs, low sodium levels.	Caution in persons with history of seizure. Drug-Drug interactions: Avoid combination with warfarin (may increase bleeding risk). May increase levels of TCAs, antipsychotics, and beta-blockers. Caution in combination with tamoxifen, codeine, and tramadol (reduces the effect of these drugs).

- Follow up – initially after 2 weeks (or 1 week if 18-25y or high risk)
- **If not improving** after an increase in fluoxetine dose, then **discuss with consultant** in order to review diagnosis and to consider a further increase in dose or a switch to an alternative treatment. In general, it is better to try a second SSRI (e.g. citalopram, sertraline) rather than a medication from another group
- If fluoxetine is not affordable or available, then amitriptyline *can be considered* in some patients, but **discuss with consultant.**
- **Other possible medication**
  - **Diazepam** - if severe anxiety, can use for a few days (<2 weeks). Risk of addiction if longer. e.g. Diazepam 2.5mg qds prn
  - **Beta-blockers** (propranolol or atenolol) can be useful if symptoms of anxiety with palpitations, or chronic headaches
- **Stopping antidepressants**
  Consider stopping antidepressants after the person has been free of depressive symptoms for 6-9 months AND has been performing their usual activities during this time.
  Discuss with consultant if considering stopping medication
  Medication needs to be stopped gradually!

Discuss with consultant if:

- suicidal ideation
- unsure about diagnosis
- not improving with treatment
- Fluoxetine not affordable or available
- pregnant or breast-feeding
- age <18y
- considering stopping medication

References: mhGAP Intervention Guide, WHO, 2018 (version 2); Oxford Handbook of Tropical Medicine, chapter 19, 4th edition, Oxford University Press, 2014; NICE 2022, NG222; National clinical guidelines for management of common mental disorders, MOH 2024