Monitoring the use of antidepressants: the role of mental health nurses

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The role of mental health nurses in monitoring the use of antidepressants: fundamentals of safe and effective practice.

Abstract

Antidepressants are the most commonly prescribed psychiatric medications globally. There has been an upward trajectory in prescriptions of these medicines for a number of years, and prescribing is widespread across both primary and secondary care. Recent evidence has highlighted the issues of long-term prescriptions, side effect burden, and the impact of withdrawal. Supporting safe and effective medicines management is an integral part of the mental health nursing role, but the complexity of these drugs and their effects can be overlooked. This article aims to update nurses on key principles of practice in relation to antidepressants and refresh knowledge and awareness.

Aims and intended learning outcomes:

This article aims to refresh and enhance mental health nurses' understanding of antidepressant use in contemporary practice. It discusses commonly used antidepressant drugs, the key principles of best practice, and the role of the nurse in monitoring and reviewing antidepressants and enabling patients to make fully informed treatment choices.

After reading this article and completing the time out activities, you should be able to:

- Identify a range of antidepressants most commonly used in contemporary practice.
- Apply the principles of updated practice guidance in relation to prescribing and discontinuation.
- Identify and address significant side effects of commonly prescribed antidepressants.
- Reflect on your nursing role in medication management, specifically antidepressants.

Introduction

Antidepressant medications are recommended as treatment for clinical depression of varying severity, as well as a range of other conditions such as anxiety, post-traumatic stress, and obsessive-compulsive disorder (National Institute of Clinical Excellence 2022). Although they have been in use since their inception in the early 1950s, prescribing prevalence has increased year on year since the 1980s. In 2022/23, 86 million antidepressant items were prescribed to an estimated 8.6 million patients in England alone, an increase of 2% on the previous year (NHS Business Services Authority (NHSBA) 2023). By comparison in the same year, 1.76 million referrals were

made to NHS Talking Therapies, a 2.9% decrease on the previous year (NHS Digital 2024), suggesting that provision of pharmacological treatment continues to outstrip non-pharmacological options (Bagri 2023).

Despite this, evidence regarding efficacy is variable (Iniesta et al, 2016), and more recently concerns around long term prescription, side effects burden, and an underestimation of the impact of withdrawal, have led to closer scrutiny of their use. These evolving concerns have been reflected in an update to national guidance for depression (NICE 2022) which among other things, strengthens the emphasis on non-pharmacological treatment in the first instance.

Given this clinical landscape, mental health nurses have a key role to play in the management of antidepressants. They will often be the professionals responsible for ongoing review and follow up. As per the NMC standards (Nursing and Midwifery Council 2018) monitoring of both efficacy and side-effect burden is an essential component of care, as is considering how best to support individuals to make informed choices about treatment within the context of a therapeutic relationship.

Time Out 1

Take time to reflect on the use of antidepressants in your area of practice. How prevalent is their use? What do you think about their efficacy? How long do patients typically remain on them?

<u>Commonly used antidepressants</u>

There are three major classes of antidepressant drugs: selective serotonin re-uptake inhibitors (SSRIs), tricyclics (TCAs), and monoamine oxidase inhibitors (MAOIs). In addition, there are several other antidepressant medications which, whilst they might share characteristics with the drugs in the main classes, are different in their composition and action. These medicines are categorised in three further sub-classes: serotonin – noradrenaline reuptake inhibitors (SNRIs), serotonin antagonist and reuptake inhibitors (SARIs), and noradrenaline and specific serotonergic antidepressants (NaSSAs). Such are the small range of UK licensed drugs contained in these sub-classes, they are sometimes referred to as ‘others’ in guidance and studies.

Whilst SSRIs are recommended as the preferred class for first line treatment, they are not necessarily more effective than TCAs (Wollf et al 2013). However, evidence suggests that the SSRI side effect burden is smaller, and there is less associated risk of toxicity in overdose (Carvalho et al 2016). TCAs and drugs in the sub-classes are generally considered as an alternative when SSRIs are not well tolerated. MAOIs are rarely used in contemporary practice given their serious side effects, and there is a well-established downward trend in their use (Bogowicz et al 2021).

The following table lists the ten most prescribed antidepressant drugs dispensed in England in 2022 according to NHSBSA (2023) data, as well as the conditions that they are licensed to treat as outlined in the current British National Formulary (BNF) (Joint Formulary Committee (JFC) 2023)

Table 1: 10 Most commonly prescribed antidepressants in England (NHSBSA 2023)

DRUG	CLASS	WHAT IS IT LICENSED FOR? (JFC 2023)
Sertraline	SSRI[1]	Depressive Illness, obsessive compulsive disorder, panic disorder
Amitriptyline	TCA[2]	Major depressive Illness, neuropathic pain, migraine prophylaxis, prophylaxis of tension headaches.
Citalopram	SSRI	Depressive illness, panic disorder
Mirtazapine	NASSA[3]	Major depression
Fluoxetine	SSRI	Major depression, bulimia nervosa, obsessive compulsive disorder
Venlafaxine	SNRI[4]	Major Depression, generalised anxiety disorder, social anxiety disorder, panic disorder.
Duloxetine	SNRI	Major depressive disorder, generalised anxiety disorder, diabetic neuropathy, urinary incontinence,
Escitalopram	SSRI	Depressive illness, generalised anxiety disorder, obsessive compulsive disorder, panic disorder, social anxiety disorder.
Paroxetine	SSRI	Major depression, social anxiety disorder, post-traumatic stress disorder, generalised anxiety disorder, obsessive compulsive disorder, panic disorder.
Trazadone	SARI[5]	Depressive illness, anxiety.

It is important to note that the licensed uses are variable from drug to drug, even within the same class. This might affect the choice that prescribers make, and that which is offered to individual patients. For example, the pain relief potentially offered by amitriptyline might be the reason that it is used where co-morbid physical conditions exist, or escitalopram might be favoured due its more expansive licensing for anxiety, if that is an additional feature of someone's presentation. Arguably though, these nuanced differences in licensed utility might well be overlooked, with different

[1] Selective serotonin reuptake inhibitors
[2] Tricyclic
[3] Noradrenaline and specific serotonergic antidepressants
[4] Serotonin- noradrenaline reuptake inhibitors
[5] Serotonin antagonist and reuptake inhibitors

practitioners favouring specific drugs across the spectrum of presentations based on subjective preference (Davies et al 2013). There is also an acknowledged culture of trial and error when considering treatments with multiple medications tried before an individual preference is met (Cacabelos 2016).

Additionally, it is not uncommon for antidepressants to be prescribed 'off-licence', or for 'off label' use. This is where a clinician has prescribed a medication in a different way to that indicated by the licence. For example, it is noted in the BNF (JFC 2023) that paroxetine, fluoxetine, and venlafaxine may be used to treat certain menopause symptoms, however this is not indicated in the licence. This does not necessarily mean that these uses are not supported by evidence, but that the extent of that evidence has not resulted in a licence change (Morales and Guthrie, 2017).

Age is also a key factor in choice of antidepressant. For older adults there may be consideration of frailty, differing metabolic rates and multiple co-morbidities (Gers et al 2018). In children and young people, fluoxetine is specified as the best evidenced choice, but only after, or concurrently with psychological therapy, and with significant caution (NICE 2019). Prescribing for this age group remains controversial with ongoing debate over the balance of risk and benefit (Dubicka and Wilkinson 2018).

Overall, the choice of antidepressant should be strongly influenced by personal circumstances, history, vulnerability, and physical comorbidity, considered within a biopsychosocial approach (Boyce and Ma 2021). However, given time pressures, particularly within primary care, attention to person centred variables might be limited. It is important to acknowledge that individual responses and tolerance can vary significantly. It is not uncommon for people to feel no real benefit of antidepressant therapy, and as nurses it is important to consider and address this to ensure ineffective prescriptions do not remain in the long term.

Time Out 2

Think about the patients you have been working with recently. What is the most prescribed antidepressant in your patient group? Take some time to research this antidepressant and consider why it is initiated more frequently than others. What has the impact been for different individuals?

National Institute for Health and Care Excellence (NICE) guidance and best practice

In 2022, NICE updated its guideline on depression. This was a response to growing evidence that not only had the prevalence of depression increased, but so had the prescribing of antidepressants in the longer term (Kendrick et al 2022). In addition, in 2019 Public Health England (PHE) commissioned a review of available evidence regarding withdrawal which concluded that whilst there is insufficient evidence to conclude that antidepressants are dependence forming, there were growing concerns

about withdrawal symptoms, with a wide range of variable issues reported on cessation (Taylor et al 2019). Essentially, the updated guidance gives a greater sense that pharmacological treatment should be considered more cautiously given the prolific nature of antidepressant prescribing in the contemporary clinical landscape.

Firstly, and of particular importance is the language around condition severity. In the NICE (2009) guidance reference was to 'mild to moderate' and 'moderate to severe' presentations which led to a lack of clarity around the threshold for moderate depression. The updated guidance (NICE 2022) refers to 'less severe' and 'more severe' classifications with the former referring to mild and sub-threshold depression and the latter replacing the moderate to severe category. Severity is determined by considering the intensity of the symptoms, the duration of the problem and the impact that it has on functioning (Kendrick et al 2022).

This change has seen a more vociferous assertion in the guidance that antidepressant medication should not be routinely offered as first line treatment for less severe depression unless it is a patient preference. It is of course essential that a preference for medication over other treatments is informed by clear information about risks, benefits, and efficacy.

In relation to more severe presentations, antidepressants are deemed to be a first line treatment, but ideally in combination with cognitive behavioural therapy (CBT) or other non-pharmacological interventions. Arguably though, whilst non-pharmacological interventions might be subject to waiting times – the provision of a prescription can be relatively instantaneous, and this may account for antidepressant prevalence in an increasingly pressured health service (Kendrick 2021).

Despite this pressure, the NICE (2022) guidance is clear about the need to take a considered approach to treatment initiation and review. It recommends taking adequate time to consider all treatment options available to the individual, with involvement from family members or carers where appropriate. There is a strong emphasis on shared decision making and the value of therapeutic relationship and care continuity (Iacobucci, 2021).

Where medication is the chosen treatment, the focus is on quality of shared information to ensure how well-informed the patient is, including advice on risks as well as benefits tailored to manage expectation. The provision of both verbal and written information is advised, with considerable detail to be included in respect of the dose, timing, and duration of treatment.

The guideline further advocates that review should usually be within 2 weeks, with monitoring of both positive and negative impact. This should be within one week if there is concern over suicide risk or if the patient is between the ages of 18-25 and in receipt of antidepressant prescription for the first time. The patient should be made aware of

when that review will take place, and 'regular' monitoring is required for the duration of treatment. It is also essential to advise as to when the treatment is likely to take effect which is stipulated as usually within four weeks of initiation (NICE 2022).

There are a number of recommendations in the guidance that are cited as relative to all treatment options and advocate a consistent approach to both pharmacological and non-pharmacological treatments for depression. These include taking account of co-morbidities, previous treatment history, barriers to treatment, and engagement (NICE 2022). These cross-domain standards are pertinent to nurses given the holistic nature of practice. It is likely that monitoring of antidepressant impact and efficacy will occur in the context of an ongoing therapeutic relationship and/or care plan, especially in secondary care where individuals may have complex needs and ongoing interventions with antidepressants being just one constituent of a broader treatment strategy. Despite the detailed nature of the guidance this can be a challenge. It is often difficult to isolate the monitoring of antidepressants alone, and both positive and negative impact might be attributed to other medicines or treatments. NICE (2022) suggest the routine use of standardised outcome measures to assist with review and monitoring, citing PHQ-9 (Spitzer et al 1999) as an example. Whilst this tool and others may be helpful in quantifying progress against symptom severity, they do not necessarily take account of broader impact on quality of life and self-determined goals of the patient. As a result, capturing and documenting individual patient narratives of risk, benefit and value are an essential part of the nursing review that offers an important recovery- orientated addition to the narrow parameters of a biomedical lens.

Evidently, the guidance on the use of antidepressants is expansive, and implicitly does not lend itself to brief consultation. Adherence to best practice requires clinicians to monitor and review throughout the treatment episode, and mental health nurses have a fundamental role to play in that process if they are actively involved in the care of those in receipt of antidepressants either as a singular treatment or as part of a holistic response to more complex needs.

Time Out 3

Take some time to read the pharmacological treatments section of the NICE guideline – Treatment and Management of Depression in Adults (NICE 2022). Reflecting on your practice, think of three ways that you can embed the guidance into your clinical approach. Are there elements that are particularly difficult to adhere to? How might these be overcome?

<u>Side effect burden</u>

The side effect burden of antidepressant medication has long been a significant topic of debate, and indeed controversy. Whilst evidence supporting positive impact is well-established and referenced, that pertaining to negative impact has often not been as

well acknowledged or indeed available (Moncrieff 2020). In terms of physical health, national policy is detailed in respect of the monitoring required to manage the negative impact of antipsychotics (NICE 2014), but in respect of antidepressants this is less clear, despite side effects such as weight gain and QT prolongation being associated with some of these medicines. Whilst negative biological and physiological effects such as gastro-intestinal impact are commonly accepted, there are many patient- reported instances of psychological, relational, and emotional detrimental effects that are less universally described or understood (Read et al, 2014).

An increasingly amplified critical psychiatry movement has long alleged that the pharmaceutical industry has no vested interest in actively researching the negative impact of these medications, and some literature makes the case that there remains a significant side effect burden that is voiced, but not acknowledged or investigated (Cartwright et al, 2016). However, there is also a view that the intensifying focus on negative effects of antidepressants could result in those who would genuinely benefit from treatment not seeking it out with confidence in the therapeutic benefits being undermined (Nutt and Malizia, 2008).

This ongoing debate is contentious, however, on balance, there is a general acknowledgement that given how commonplace these medications have become, they have historically been perceived to be more innocuous than they actually are – and that consequently recipients of antidepressant medication are not always made fully aware of the potential for significant adverse effects.

There is a plethora of side effects listed in the BNF against each individual antidepressant. For example, in respect of the SSRI sertraline, 38 common or very common effects are listed, along with a further 20 listed across uncommon and rare categories (JTF, 2023). By contrast the public facing NHS website lists just 11 effects associated with SSRIs/SSNIs and 9 associated with TCAs – as well as citing that these are likely to improve after a few weeks (NHS 2021). The majority of those listed are physiological in nature such as indigestion and nausea in relation to SSRIs and constipation relative to TCAs. However, there are also some significant effects related to sexual dysfunction that are cited in a perfunctory manner despite the potential for significant emotional impact.

There is a fierce debate around why certain side effects have not been as actively researched as others, or did not initially emerge from clinical trials, but a regularly proffered argument is that which highlights the difficulty in distinguishing whether certain adverse effects are attributable to the drugs, or whether they are symptoms of the depressive condition itself (Healy, 2020). Sexual dysfunction falls into this category, as do insomnia, emotional blunting, fatigue and listlessness amongst others. Most seriously, so does suicidality.

For some time, there has been a largely unresolved issue of the link between antidepressants and increased suicidality. This concern gained momentum in the UK in 2004, when previously unpublished trial data evidencing a link between paroxetine and suicidal behaviour in children and young people was brought in to the public domain via a television documentary (Sharma et al 2016). Since then, guidance has reflected this concern in relation to young people, however the correlation between antidepressants and suicidal behaviour in the adult population is less certain – and whilst cited as a rare side effect of SSRIs and SNRIs there remains a lack of scientific consensus (Witt-Doerring and Mathew 2019).

The most expansive bodies of evidence in relation to antidepressants and their effects, are anchored in randomised control trials, and arguably there is still much to be learnt by focusing more directly on individual patient experiences. Smaller, qualitative studies tend to reveal a greater breadth of reported adverse emotional effects that do not garner the same acknowledgement in the wider evidence base (Cartwirght et al 2016).

In the context of a holistic nursing approach, focus on the reported experiences of each individual can therefore be essential to ensuring safety, and reviewing treatment effectively. This approach best reflects the current NICE guidance (2022) which advises discussion of the potential harms as well as the benefits of pharmacological treatment, including considering side effects that individual patients would particularly prefer to avoid.

Time Out 4

Think about one case where side effects have been a significant factor in the decision to change treatment?

Were side effects immediately acknowledged as problematic, or were they overlooked? Is there anything that you could do differently when supporting an individual who is expressing difficulty tolerating the side effects of their antidepressants?

<u>Serotonin syndrome</u>

Whilst rare, serotonin syndrome is a potentially lethal reaction to serotonergic drugs. It is caused by elevated levels of Serotonin in the brain synapses (Foong et al 2018). Given its rarity, it can be easily overlooked, especially given the fact that initial symptoms in mild cases might easily be mistaken for other common medical conditions. This being the case, the true incidence of serotonin syndrome has not been determined, however given the significant increase in antidepressant prescribing, it is likely that reported cases are increasing (Mikkelsen et al, 2023). It is also important to remember that antidepressant drugs are not the only medicines that increase concentration or availability of serotonin, so awareness of other treatments that might have been introduced to a regime is also very important. The syndrome is more likely to occur

when a combination of serotonergic drugs has been prescribed (Scotton et al 2019) but should always be considered when symptoms manifest following initiation of a new medication that acts on serotonin, even if it is the only drug that patient is taking. Onset is generally rapid but will subside with cessation of the causal medication and severe symptoms should be considered a medical emergency.

There is debate in the literature regarding clear diagnostic criteria for serotonin syndrome, given the variability in presentations, but Mikkelsen et al (2023) provide a summary of potential manifestations of the problem as follows:

- Possible symptoms: sweating, shivering, diarrhoea, agitation, high temperature, confusion, muscle twitches, muscle rigidity, tachycardia
- Severe symptoms: arrythmia, seizures, unconsciousness, hypothermia, respiratory failure.

Not all will necessarily be present in any given case, and this is not an exhaustive list. Essentially, presenting symptoms should be considered in combination with recent prescribing history to determine a working diagnosis.

Case example:

Sarah has a long history of episodes of depression and has been on fluoxetine 20mg for many years. She has recently felt that her bouts of depression are becoming longer and more severe and has been on an increased dose of 40mg for two months with a positive effect.

Sarah has telephoned to cancel the review with her nurse as she is feeling 'under the weather'. She has been suffering with back pain for a number of weeks which has improved since her GP prescribed some pain killers this week but she now feels like she is going down with a nasty cold. She says she has a bit of a temperature and feels shivery and achy and is going to take herself off to bed. The nurse advises that she will ring tomorrow and see if Sarah is feeling better and well enough to have a telephone review.

The following day the nurse rings and speaks to Sarah's husband who says that she is getting more unwell – he thinks she has a serious flu like illness. She is feverish and confused and can't stop shivering. When the nurse asks what Sarah has been taking for pain, he advises that she has been taking tramadol for the last few days.

In this case, it is unlikely that serotonin syndrome would be attibutable to the increase of Fluoxetine alone as this has been in place for two months, however the tramadol that has been prescribed by the GP is serotonergic. Given the nature of the symptoms, the fact that they are rapidly worsening, and as tramadol is a newly introduced agent, it would be reasonable to assume that this might be serotonin syndrome requiring an immediate cessation of medication and urgent medical assessment.

Time Out 5

If you have encountered serotonin syndrome in practice, reflect on what steps led to it being identified. If you have not, think about the key signs and symptoms, and try and put together a basic checklist that you could use in practice or share with colleagues.

Discontinuation of antidepressants

There has been a growing concern over the last decade that withdrawing from antidepressants carries significantly more risk than previously understood (Hengartner et al, 2019). With this concern, supporting evidence for the notion of a specific withdrawal syndrome has increased, and despite perhaps being viewed sceptically in the past, symptomology associated with the process of discontinuation is now widely acknowledged. This change in discourse is reflected in the updated NICE (2022) guidance, and in 2024 the first Maudsley Deprescribing Guidelines were published which notably cover antidepressants as well as benzodiazepines, gabapentinoids and z-drugs.

Cited symptoms of withdrawal are extensive, and vary across guidelines, but sleep disturbance, fatigue, emotional changes, anxiety, and irritability are commonly referenced (Sørenson et al 2022). Guy et al (2020) also argue that many symptoms are not fully documented as patient experience may have been dismissed when reported due to a lack of understanding of the impact of withdrawal at that point in time. Again, a crucial feature of a holistic nursing approach should be observance for known side effects, as well as capturing the patient narrative of withdrawal experience in order to inform other interventions that might mitigate impact.

A significant issue in terms of identifying withdrawal issues is linked to the fact that potential manifestations of the effects can be confused with relapse. This has historically added weight to the notion that longer term prescribing of the antidepressant medication will defend against reoccurrence of symptoms during the course of treatment, which implies that staying well without them is harder to achieve.

However, Horowitz and Taylor (2022) argue that this assumption of relapse is attributable to clinical trials which have abruptly withdrawn the drugs and are also likely to have conflated a number of cross-domain withdrawal effects with relapse, assuming that reported symptoms identified at discontinuation are indicative of re-emerging depressive symptoms. It is further argued that this has been compounded by the fact that many psychological and physical withdrawal symptoms will feature in rating scales designed to support diagnosis or measurement of depression, and this again presents a confused picture, potentially rendering a proportion of the established data unreliable.

Withdrawal is characterised by a range of physical and psychological symptoms, but it is important to note that this does not mean that those struggling to discontinue antidepressants have an addiction. Craving and compulsion to keep taking the drugs is

not characteristic of antidepressant withdrawal, although other physical effects can be present. In addition, not every individual will experience issues with withdrawal, and each person's experience is variable. This is reflected in the NICE guidance update which acknowledges the variance in both symptom type and severity between individuals and advocates reassurance regarding potential relapse, as well as promoting the need to ensure that the rate of withdrawal is led by the patient and informed by their ongoing tolerance (NICE 2022).

Primarily evidence and guidance advocate a slow and gradual discontinuation, taking account of medication half-life, as well as the reported effects on the patient. Increased support is indicated to mitigate impact, as well as the provision of additional written resources that might support the process.

Time Out 6

Think about your clinical area. How might you best support an individual who feels that they no longer want to take their antidepressants. What would it be important to know and understand? Try and draft a care plan that reflects a possible approach to the issue.

Conclusion

Antidepressants are a mainstay of pharmacological treatment for a range of mental health conditions and prescribing prevalence has been on a continuously upwards trajectory for many years. Recently, more expansive evidence regarding efficacy, clinical appropriateness, side effects and withdrawal has seen a gradual change in the discourse relating to risks and benefit of these medications, and this has been reflected in changes to established guidance and indeed clinical attitudes.

Nurses have a pivotal role in medicines management and are likely to interact with a significant proportion of patients who are being treated with antidepressants. It is essential therefore that practice reflects contemporary guidance, and that individual experiences are acknowledged, discussed, and responded to through out the course of treatment.

Time Out 7

Identify how supporting the medicines management of antidepressants applies to your practice and the requirements of your regulatory body

Time Out 8

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account

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