Selective serotonin reuptake inhibitor prescribing in primary care

The following questions can be used as discussion points for peer groups or self-reflection of practice. The questions for this peer group discussion relate to the use of selective serotonin reuptake inhibitors (SSRIs) in primary care.

It is strongly recommended that the following article is read before considering the questions.

"Depression or distress? Examining SSRI prescribing in primary care" available from: **www.bpac.org.nz/2019/ssri.aspx**

Every day, primary care clinicians around New Zealand see people who present with psychological distress. Deciding to seek help is a major step for many people and it is crucial that they feel validated and supported. It can be difficult to differentiate short-term psychological distress from depression; avoid making a diagnosis of depression at the first consultation unless the patient has severe symptoms with marked functional impairment or has a history of depression. If there is immediate concern for the patient's safety, refer them to emergency mental health services.

Patients with short-term distress can score highly on a depression inventory such as the Patient Health Questionnaire-9 (PHQ-9), which could lead to initiation of pharmacological treatment. Many of these people will experience a substantial improvement in their symptoms in the following weeks, and will have a lower score on the PHQ-9 when re-screened. Clinicians often see patients when their symptoms are at their worst and discussing their mental health with an empathetic practitioner can provide substantial relief.

Non-pharmacological strategies, e.g. sleep hygiene, exercise, re-engaging with hobbies, connecting with family/friends, should be recommended to all patients with distress or depression.

Active follow-up is important for all patients presenting with distress. Put a plan for review in place, e.g. a phone call from the practice nurse after 24–48 hours and a follow-up appointment in one week to assess their symptoms.

Combined pharmacological and psychological treatment is recommended for people with moderate to severe depression or persistent symptoms. Pharmacological treatment can also be considered for patients presenting with mild symptoms who have a previous history of severe depression, depending on their preferences for treatment. SSRIs are generally recommended first-line for the treatment of depression due to the more favourable adverse effect profile compared to other antidepressants.

If an antidepressant is indicated, provide patients with information about potential adverse effects and how to manage these, and arrange a follow-up appointment within two weeks to assess tolerance, with a further visit at four to six weeks. In some situations it may be necessary to review the patient sooner than this or more closely, e.g. if there is a risk of suicidal ideation and worsening anxiety in young people, particularly within the first two months after being initiated on a SSRI; or in older people who are at higher risk of adverse effects such as hyponatraemia, falls and insomnia.

It is recommended that antidepressants are continued for at least one year following recovery from a single episode of depression, or for at least three years following recurrent episodes. However, it may be possible to discontinue use after six months in some patients following a single episode of depression.

Questions for discussion

1. Do you usually initiate patients on antidepressants at the first consultation? What factors do you take into consideration when making the decision to delay or prescribe immediately?
2. How confident do you feel in differentiating between distress and depression? What are the particular clinical features that you use to help distinguish and why?
3. Time is often a limiting factor during consultations. Prescribing can sometimes be seen as an "easy way out"– a way to wrap things up faster and move on, but in many cases it is not the most effective or safest course of action. How to do manage the limitation of time within a consultation for a mental health issue?
4. What strategies do you use during a consultation to convey the message that pharmacological treatment is not necessarily required? What other issues have you come across with the "talk first" approach and how did you deal with them?
5. Antidepressant use nationally is highest among people aged over 80 years and older people are less likely to be referred for psychological treatment. Is your threshold for prescribing an antidepressant to an older person lower than for someone younger? Do you consider non-pharmacological interventions as effective and accessible for older people?
6. Do you review patients who have been on antidepressants long-term to see if treatment is still indicated?

If you are a primary care prescriber, have you seen your personalised antidepressant prescribing data in the article linked above? Consider your prescribing. How does it compare to that of your peers in terms of number of patients and their demography?