Clinical Effectiveness
South East London

South East London
Integrated Care System

NHS

Depression and Anxiety in adults

A guide for Primary Care in South East London©

Key Messages

1. Improving wellbeing is a cornerstone of successful treatment and preventing relapse
2. Treating mental health problems improves physical health outcomes
3. Talking therapies and medication both have a role in the management of depression and anxiety, and should be personalised to patient choice and need
4. Deprescribing should be a shared decision between patient and clinician, planned in advance and drugs tapered very slowly

Always work within your knowledge and competency

March 2024 (review March 2026, or earlier if indicated)

Contents

Why focus on depression and anxiety?

Common
One in four people will experience a mental health problem in any given year[1]

Important
Depression/anxiety is the leading cause of disability worldwide[2]

Long-term condition (LTC) overlap
There is a very significant overlap between LTCs and depression/anxiety[3]

A combination of depression and anxiety with LTC, leads to poor quality of life and poorer outcomes from the LTC[4]

Hidden prevalence
Common mental health disorders are underdiagnosed[5]

Health inequalities
Mental health problems disproportionately impact on those from deprived communities[6]

Wellbeing and Social Prescribing

Wellbeing is a holistic concept including physical, social and mental wellbeing, all of which are interrelated and influenced by each other[7]. Our mind, body and how we interact with people and the environment around us, all contribute to our overall health.

Supporting and encouraging wellbeing should be the cornerstone of mental health management. Primary care (clinicians, social prescribing link workers, community connectors etc.) are good at including a focus on wellbeing. Whilst many drivers of wellbeing are beyond our control, it can be useful to have a framework of wellbeing to reflect on, to help guide patients.

The 'Six Ways to Wellbeing' describe evidence-based personal actions to promote wellbeing[8]:

1. **Connect**: Encourage connection with others e.g. family, friends, and community
2. **Be active**: Suggest activity that your patient enjoys, to suit their level of fitness/mobility
   Even a small amount of activity e.g. 10 minutes, enhances wellbeing
3. **Take notice**: Invite patients to look around and 'be present'
4. **Keep learning**: Try something new or take up an old hobby. Learning increases social interaction and activity. Achieving self-directed goals improves self-esteem and is linked to achieving goals in other areas e.g. LTCs
5. **Give**: Committing an act of kindness once a week for 6 weeks improves wellbeing
6. **Care**: Look after and connect with your environment

Practical tips:

- Support your patients to find ways of **incorporating these actions into their daily life** in a positive way, rather than as a chore
- Suggest varying and **interconnecting actions** e.g. walking with friends or supporting a family member
- Collaborate with your patient to plan and engage in valued activities, **no matter how small**
- Link the actions to the **positive goal of greater happiness and wellbeing**
- **Signpost** your patient to **relevant services** *(see referrals page 19 and resources page 20)* and have an AccuRx message that includes frequently used mental health services to share with patients

Self-Compassion is associated with less anxiety & depression symptoms[9]
Consider for patients *and* for yourself

Self-Compassionate Behaviours[10]

- Attending to yourself
- Understanding the challenges you face
- Empathising or caring for yourself
- Taking wise action to help yourself

*'For someone to develop genuine compassion towards others, first he or she must [have the] ability to connect to one's own feelings and to care for one's own welfare...**Caring for others requires caring for oneself**'*

HH Dalai Lama

Screening and Assessment[11]

Screen

Low mood is part of the normal human condition. It can be difficult to differentiate low mood or distress from depression, particularly on the first visit. Similarly, anxiety is a normal human response to feeling threatened or in danger, even if that threat is a thought or memory. A diagnosis of anxiety or depression should be considered based on frequency of symptoms, as well as degree of distress or functional impairment. Within the spectrum of anxieties, Generalised Anxiety Disorder (GAD) and panic disorder are most common.

Validated screening tools include PHQ-2 and GAD-2 (these consist of the first two 'core' questions of PHQ-9 and GAD-7). A score ≥3 is positive *(see page 5)*.

Consider opportunistic screening for the following groups:

- History of depression or anxiety, any history of significant **mental health problem**, or **dementia**
- Significant **physical illness,** including **cancer**
- History of **neurodevelopmental disorders**
- **Substance or alcohol** misuse
- Medically unexplained symptoms, persistent physical symptoms or frequent attendance
- Significant life stressor/**traumatic event**
- Socially isolated/lonely[12]
- Postnatal period

Explore

Suicide risk assessment

Triggers, strengths & protective factors
Life stressors
Bereavement

Substances
Alcohol
Recreational drugs

Physical cause for symptoms?
Thyroid
Arrhythmias

Other disorders to consider
Dementia
Menopause
Eating disorders
Personality disorders
Bipolar (manic episodes?)
Seasonal Affective Disorder
Psychotic symptoms
Neurodevelopmental disorders

"Talk me through your day"
Sleep
Diet and eating
Exercise

Cognition
Memory
Thought disorder?

Holistic Assessment
These conversations take time and multiple patient contacts

Personal history
Medical/psychiatric history
Recent pregnancy
Previous response to treatment
Abuse
Cultural/religious context

Anxieties
'Fight or flight' panic symptoms
Excessive worry
Specific phobias (incl. social)
Obsessions/compulsions
Trauma: numbness, flashbacks, avoidance (consider other physical causes of anxiety symptoms)

Home
Housing
Domestic violence
Carer/cared for
Children
Immigration status

Work/unemployment
Money/debt
Connections
Family/friends/relationships (supportive or otherwise)
Sources of support
Isolated/lonely

Physical symptoms and degree of functional impairment

'Young' people
Social media
Bullying (physical and online)
Gangs

Diagnosis and Assessment of Severity[11]

To diagnose depression and anxiety, various validated tools are available. However, there are also broader, but less definable considerations, and of course, clinical acumen. The table below gives an idea of how you can combine these.

Diagnosis					
Symptom frequency/intensity		Infrequent/Mild			Frequent/Severe
Symptom duration		Weeks			Longer
Functional impairment		Mild			Severe
Anxiety GAD-7		5-9		10-14	15-21
Depression PHQ-9				16	
Overall Clinical Judgement	Anxiety	Mild		Moderate	Severe
	Depression	Less severe (PHQ-9 <16)			More severe (PHQ-9 ≥16)

Predominantly depressive symptoms

Mixed symptoms: treat most severe first[13]

Predominantly anxiety symptoms

Treat as depression

Treat as anxiety

Consider subtypes of anxiety: GAD, Panic disorder, Post-traumatic stress disorder (PTSD), Obsessive-compulsive disorder (OCD), Social or specific phobias

Over the last 2 weeks, how often have you been bothered by the following problems?	Score
Not at all	0
Several days	1
More than half the days	2
Nearly every day	3

Anxiety: GAD-7 (core symptoms)	
Feeling nervous, anxious, or on edge	GAD-2
Not being able to stop or control worrying	
Worrying too much about different things	
Trouble relaxing	
Being so restless that it is hard to sit still	
Becoming easily annoyed or irritable	
Feeling afraid as if something awful might happen	

Depression: PHQ-9 (core symptoms)	
Little interest or pleasure in doing things	PHQ-2
Feeling down, depressed, or hopeless	
Trouble falling or staying asleep, or sleeping too much	
Feeling tired or having little energy	
Poor appetite or overeating	
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	
Trouble concentrating on things, such as reading the newspaper or watching television	
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	
Thoughts you would be better off dead, or of hurting yourself in some way	

Self-harm[14]

Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress. Self-harm includes suicide attempts as well as acts involving little or no suicidal intent.
There is overlap in the **risk factors** for suicide and self-harm (*see page 7*), but men are at higher risk of suicide, and young women higher risk of self-harm.

Principles of Care:
- Focus on the patient's needs and how to support their immediate and long-term psychological and physical safety
- Develop care plans collaboratively with patients
- Where possible, see patient alone for initial assessment to maintain confidentiality
- Involve family and carers as appropriate

Assessment

Physical Risk
- Examine physical injuries to assess severity
- Explore nature and quantities of ingested substances although this is often unclear so risk assessment can be difficult

Psychological State
- Assess emotional and mental state and level of distress
- Assess risk of further self-harm / suicide (*see next page*)
- Consider presence of other mental health conditions

Protective factors (*see next page*) including:
- Coping strategies
- Supportive relationships
- Dependent children
- Religious beliefs

Safeguarding
- Remember self-harm may be in response to maltreatment, domestic violence or other abuse or exploitation
- Consider any children/young people/vulnerable adults dependent on the patient for their care
- If concerns are identified, follow local procedures

Review Medications
- Consider toxicity of prescribed medications
- Consider wider access to medication
- Assess recreational drug/alcohol consumption.
- Ensure effective communication when multiple prescribers involved

Mental Capacity
- Assessment may be needed if a patient declines or refuses management that is perceived to be in their best interests

Management

Minor self-injury + no significant risk of psychological harm = treatment in Primary Care

Significant self-injury + significant risk of psychological harm consider URGENT referral

Self-poisoning = URGENT referral to Emergency Department for most people*

Manage any **Co-existing mental health problems** that have been identified

Provide **information and support** for patient and family/carers including local and national sources of support (*see referrals page 19 and resources page 20*)

Safety plan/crisis plan
- Develop this collaboratively with the patient
- Involve family and carers as appropriate
- Share with family, carers and relevant professionals as decided by the patient

Refer to a mental health professional when:
- Levels of concern in patient or their family/carers are increasing, high or sustained
- Frequency or degree of self-harm or suicidality is increasing
- You are concerned

Admission may be required when there are concerns about safety, when safeguarding planning needs to be completed or when the patient is unable to engage in psychological assessment, e.g. distressed or intoxicated

Follow-up ensure regular follow-up and risk assessment

***Self-poisoning:** Access **National Poisons Information Service 0344 892 0111** or **Toxbase** ⚠ or refer urgently to A&E depending on drug, quantity and certainty of risk ⚠

Suicide Prevention

Sometimes people who feel down can start to feel hopeless about the future. Has this happened to you?

Have you ever had any thoughts come into your head about life not being worth living?

Have you ever thought about how you might end your life?

⚠ The majority of patients who die by suicide *denied* suicidal thoughts[15] ⚠

Asking about suicide does not increase risk

Factors which may contribute to overall picture of risk:
- **Previous self-harm** behaviour is a key risk factor for future completed suicide
- **Assess ideation, intent, plan and access to lethal means**

Suicide risk assessment tools[14]:

- **Use** to help consider patient needs and prevention strategies
- **Do not use** to predict future suicide or repetition of self-harm
- **Do not use** to determine who should and should not be offered treatment
- Mental health teams may use 'high suicide risk' for triage

Safety Planning in a crisis

- Develop a safety plan collaboratively with your patient
- Give patients the opportunity to discuss signs that they will need additional support, such as, additional stresses in their life
- Involve families and carers
- "Have you considered what might stop you?"

Maintaining continuity of care within a team is important in mitigating suicide risk

'Rethink- how to cope with suicidal thoughts' is a useful crisis plan leaflet

Getting Help

Contacts for professionals:
See page 19 for acute referral information for your borough

Contacts for patients (all available 24 hours a day):
Samaritans call **116 123**
Shout Text 'shout' to **85258**
Papyrus for young people up to age 35 call **0800 068 4141** or text **07860 039967**
SLAM, out-of-hours crisis line: **0800 731 2864**
Oxleas 24-hour Crisis Line 0800 330 8590

Risk Factors	Protective factors and things you can do
Being unmarried or suffering relationship breakdown	Family and social support. Consider referral to Social Prescribing Link Worker *(see other resources page 20)*
Being homeless, in insecure housing or socially isolated. Job or financial loss/economic turmoil	Consider homelessness support services. Consider referral to wellbeing hub (see page 19) for benefits and housing support
Comorbidity: Physical or mental health, substance or alcohol abuse	Treat comorbidities including comorbid substance abuse
Male (particularly young and middle age)	See resources *(page 20)*
Previous history of self-harm or suicide attempt	Consider more frequent review by clinician and referral to assessment and liaison team
LGBTQIA+ patients	National LGBTQIA+ Support Line 0800 0119 100
People affected by suicide of loved ones	Support After Suicide 'Help is At Hand' booklet
Recently commenced or discontinued antidepressants and switching for >75s[16]	Consider more frequent review by clinician Inform patient
Self-harm plans	Crisis planning ('What would I do if?') Reduce access to means (incl. safe prescribing)

Consider urgent discussion or referral

- History of deliberate self-harm[23]
- Levels of distress are rising, high or sustained. In young people, take into account parent/carer's levels of distress/concern
- The risk of self-harm is increasing or
- The person requests help from specialist services
- Patient cannot identify any protective factor that would stop them from acting on their suicidal thoughts

Consider emergency admission if risk not manageable in community

Treatment: Overview[11,13,16,17]

Shared decision

Suicide risk assessment

Less severe depression | **More severe depression** | **Anxiety**

General advice

The goal of treatment should be significant relief of symptoms and improvement in functioning
Reiterate lifestyle and wellbeing advice *(page 3)* **self-help and other sources of support** *(page 20)*
Be aware of social triggering and perpetuating factors *(page 4)*
Minimise alcohol and recreational drugs
Encourage regular physical activity or exercise
Sleep hygiene
Coding: numerous codes, choose clinically appropriate code that is also acceptable to your patient

Complicating factors

History of moderate/severe depression or anxiety?
Prolonged depressive symptoms (>2 years of subthreshold, >3 months of mild)
LTC being complicated by mood symptoms

Yes → Offer treatment

No

Active monitoring or **Offer treatment**

Those that don't want treatment: provide information/support, review 2-4 weeks [QOF: within 10-56 days]

Don't routinely offer drug treatment as first-line unless patient preference.

Match treatment choice to need/preference, options (in order):
Guided self-help, talking therapy, group exercise or mindfulness, SSRI

Ongoing symptoms or marked functional impairment?

Yes → Offer treatment

No

Offer treatment

Match choice to need and preference, all options can be first-line (or combined):

Talking therapy, antidepressants *(pages 9 & 10)*, group exercise, group mindfulness

Step 1: all patients

Education + active monitoring

Step 2: GAD unimproved

Low intensity psychological therapy, self-help or talking therapy

Step 3: GAD unimproved OR GAD + marked function impairment

Talking therapy or medication

Step 4: Complex, treatment refractory GAD and very marked functional impairment, or high risk of self-harm?

Specialist referral

Follow-up

Follow-up timeframe depends on clinical judgement (typically 2-4 weeks) [QOF: within 10-56 days]
Wellbeing advice and support *(see page 3)*, Self-help *(see resources page 20)*

Re-assess social or physical factors which may be triggering/perpetuating symptoms
Continuing primary care support whilst awaiting and receiving treatment is vital
Escalation of treatment (when required) can also include drug changes (*see page 10*) and higher-intensity/alternate psychological therapy and referral for specialist advice or assessment

Depression and anxiety treatment: antidepressant use[11,16]

Start/switch antidepressant

See pages 11-12 to personalise antidepressant choice with your patients e.g. side effects, libido etc

First review: within 2 weeks

Monitor concordance, side-effects, suicidality and effectiveness
Review length depends on clinical judgement
Starting medication may initially worsen symptoms and **increase suicidality**
1 week follow-up if <25y or increased suicide risk and 2 weeks for others
Antidepressant effect usually seen within 4 weeks (if it is going to work), anecdotally up to 6 weeks

Side effects intolerable

Switch to next in line *(see page 10)*

Consider switching class

Poorly tolerated

Review 2-4 weeks later

Watch, wait and reassure
May want to initially mitigate side-effects e.g. change timing, PPI for dyspepsia, short-term benzodiazepine

Not effective/partially effective

Review 2-4 weeks later

Check:
Compliance
Other diagnosis
Perpetuating factors (drugs/alcohol, comorbidities, social factors)

Still not effective?

Consider dose increase

Diminishing returns seen with most dose increases[18]

Review 2-4 weeks later

Still not effective/tolerated?

Switch to next in line *(see page 10)*

Failed second line antidepressant?

Seek specialist advice for third line drug (see page 10) or refer

Effective

Effective

Follow-up regularly

Frequency depends on clinical judgement
Annual drug review

Continue treatment

Continue for 6-9 months **after remission** of first episode, OR **2+ years for recurrent or high-risk before considering deprescribing the drug**

Recurrence prevention

Wellbeing
Address physical health
Psychological intervention with a focus on relapse prevention skills

Suicide risk assessment *(see page 7)*

Treatment: Antidepressants, Talking therapy and Support[11,16,17]

Antidepressant choice (SEL formulary)

For a 4-step shared decision aid, see pages 11 and 12

Depression	Anxiety (specifically GAD and Panic)
First Line **Generic SSRI*:** Sertraline, escitalopram, citalopram, or fluoxetine	**First Line** **Generic SSRI:** GAD - Sertraline Panic – Escitalopram, sertraline, citalopram
Second Line **Alternative SSRI:** Sertraline, escitalopram, citalopram, fluoxetine or **mirtazapine****	**Second Line** **Alternative SSRI or SNRI** (see page 11)
Third Line **Seek specialist advice** **Consider any of:** **TCA** (lofepramine), **SNRI** (venlafaxine, duloxetine), **Other** (trazodone, mirtazapine vortioxetine[18])	**Third Line** **Seek specialist advice** **For GAD** – can consider pregabalin

* For more severe depression, consider SNRI or any other antidepressant based on clinical/treatment history.

**Now recommended in NICE Depression guidance (2022) as 'further line treatment' although commonly used first line. Suggested by Maudsley guidelines (2021) as first line antidepressant when sedation required.

Talking Therapy

When will your patient be contacted?

Initial assessment

- Around **1 week** after referral or self-referral, usually by telephone (face-to-face if requested will increase waiting time)

Following initial assessment

- Wait for treatment varies in SEL depending on which therapy and availability in borough

What therapy is offered?

- Groups, workshops, or a computerised programme by a therapist
- After initial engagement, patients can discuss with their therapist if one-to-one therapy is indicated.
- If you think a patient needs one-to-one therapy, please explain in your referral

Common antidepressant side-effects

See page 11 for relative side-effects, to use as a shared decision aid with patients.
Side-effects are common and tend to improve with time.

Suicidal thoughts: All antidepressants can increase suicidal thoughts and suicide attempts. Be particularly cautious when starting, stopping and switching, especially in adolescents and young adults, and those >75 yrs and anyone with a history of suicidality.

GI: Nausea, vomiting, abdominal pain, constipation (less common), dyspepsia (normally mild)

CNS: Sweating, dizziness, tremor, anxiety, agitation, insomnia

Sexual dysfunction

TCA specific: Antimuscarinic side-effects: dry mouth, blurred vision, hot/flushed skin, decreased gut motility - constipation, tachycardia, urinary retention, sedation, confusion), postural hypotension. Increased risk of falls/impaired cognition in >65 yrs. Most TCAs (not lofepramine) toxic in overdose.

This is not an exhaustive list, please see BNF for full details

When to seek help: discussion or referral? *(See page 19)*

Assessment and Liaison

- Diagnostic uncertainty (in complex, severely symptomatic or high-risk patients)
- Reasonable suspicion of bipolar or EUPD
- Other MH disorder present or complicating
- Severe and/or disabling symptoms
- Treatment resistant: failed 3 different antidepressant trials
- High suicide risk

Local addiction services

Where drugs/alcohol are primary drivers of mental health disorder and where addiction would be an obstacle to treatment

Antidepressants: Shared Decision Aid[5,11,16,20,21, 29]

Use these **4 steps** (continued on page 12) as part of a **shared decision making process** with your patient (taking also **page 10** into account)

Considerations: (a) previous treatment success/failure, (b) discuss side-effects, (c) need for monitoring, (d) eventual drug withdrawal time-frames/symptoms and (e) duration of treatment will be at least 6 months post-remission. Starting medication may initially worsen symptoms and increase suicidality.

	STEP 1: Check indication						STEP 2: Consider patient's views on potential side-effects					
		Depression ◊	GAD	Panic Disorder	OCD	PTSD	Social Phobia	Discontinuation Effects	Weight Gain	Sexual Dysfunction	Sedation	Nausea	Anti-cholinergic effects
SSRI	Sertraline	✓	†	✓	✓	✓	✓	++	+	+++	-	++	+
	Escitalopram	✓	✓	✓	✓		✓	++	++	+++	-	++	-
	Citalopram	✓		✓	†			++	+	+++	-	+	+
	Fluoxetine	✓			✓			+	+	+++	-	+	+
SNRI	Venlafaxine	✓	✓	✓		†	✓	+++	+	+++	-	+++	-
	Duloxetine	✓	✓					+++	+	+++	-	+++	-
Other	Mirtazapine	✓						++	+++	-	+++	-	+
	Trazodone	✓	✓*					+	++	+	++	-	-
	Vortioxetine	✓						+	+	++	-	+++	-
	Pregabalin		✓					++	-	-	++	-	-
TCA	Lofepramine	✓						+	+	+	+	-	+++

For OCD/PTSD/Social phobia – these conditions are beyond the scope of this guide and specific NICE guidance should be referred to for management.

◊ Note that NICE Depression guidelines don't name specific SSRIs/SNRIs or other antidepressants

✓ **Use** - listed in NICE guidance + drug indication in BNF

✓* **Can use** - requires specialist initiation [listed in Maudsley Guidelines + indication in BNF, but not in NICE]

† **Off-label use** - drug recommended by NICE, but indication not in BNF

+++ Severe and/or very frequent

++ Moderate and/or frequent

+ Mild and/or infrequent

- Minimal and/or rare

Antidepressants: Shared Decision Aid[11,16,20,22,23]

There is little evidence of difference in efficacy between different drugs, but there are differences in tolerability, side-effects, interactions and safety

STEP 3: Co-morbidities/special groups

Overdose Risk?

Avoid TCA and venlafaxine
Consider shorter (7 day) scripts

Comorbidities

Epilepsy: SSRIs preferred. Avoid TCAs. If complex or concern about drug interactions, seek advice

Dementia[22]: Consider psychological treatments, but do not routinely offer antidepressants to manage mild/moderate depression in people with mild/moderate dementia

Sexual dysfunction: Common and worsened by many antidepressants *(see page 11)*

Arrhythmias: Caution with TCA and venlafaxine

Post MI: Use sertraline (SSRIs and mirtazapine likely to be safe)

Diabetes: Use SSRI (sertraline, escitalopram, fluoxetine). Avoid TCAs, MAOIs & mirtazapine. Duloxetine may benefit neuropathic pain

Uncontrolled BP: Avoid duloxetine and venlafaxine

Renal: SSRIs (citalopram or sertraline) first line

QTc prolongation: Avoid citalopram or escitalopram

Alcohol excess: Increases bleeding risk, beware SSRI/SNRI

Recreational drug use: many interaction with psychiatric medication

Antenatal and Postnatal

Risks and benefits of use must be considered on a case-by-case basis.
Usually continue current medication, but consider seeking specialist advice – see here for SLAM guidance on antidepressants.

- Sertraline and fluoxetine most commonly used.
- Sertraline has lowest levels in breast milk.
- Small increased risk of post-partum haemorrhage when SSRI/SNRIs used in month before delivery. See MHRA advice.

Use BUMP website

Menopause[23]

For **low mood** as a result of menopause, consider HRT and/or CBT
For **anxiety** arising as a result of menopause, consider CBT
No clear evidence for SSRI/SNRIs for low mood in menopausal women who have not been diagnosed with depression

Young people

Beware increased suicidality when starting antidepressants
Follow-up after 1 week

Elderly

May have slower response and are more sensitive to side-effects.
Generally a **lower dose** is used

SSRIs generally first line but beware multiple drug interactions.
Also beware of increased **bleeding risk** and consider **gastroprotection** in older people who are taking NSAIDs or anticoagulants
Second line - Alternative SSRI or mirtazapine[24]

Avoid TCA due to antimuscarinic effects and cognition
Beware side-effects such as **sedation**, hyponatraemia, postural hypotension and **falls**
Consider calculating **anticholinergic burden** using ACB calculator available on-line or via Ardens
High risk of self-harm and suicide. Consider earlier referral.

STEP 4: Check other medications

This list of important drug considerations and interactions is not exhaustive, please see BNF for further information. Consider signposting to patient leaflet on antidepressants.

Recent meta-analysis has suggested **highest response and lowest dropout rates with: Sertraline, paroxetine, escitalopram and mirtazapine**[25]

Sertraline: generally has lowest risk of drug interactions
Fluoxetine and **paroxetine:** have higher risk of drug interactions than other SSRIs. Avoid concurrent use of either of these with **Tamoxifen** as this may lead to reduced tamoxifen efficacy.

SSRI/SNRIs increase risk of bleeding
Aspirin: Use SSRI/SNRI with caution, consider PPI
NSAIDS: Avoid SSRI/SNRI or use cautiously with PPI
Warfarin/DOACs: Caution with SSRI/SNRI, mirtazapine, TCA. If using SSRI, add PPI. Monitor closely.
Drugs which do not increase clotting time: trazodone, nortriptyline, agomelatine (seek specialist advice)

Antiepileptics: Sertraline is normally best tolerated with least effect on seizure threshold.
Complex, seek advice from neurology

Dosulepin and trimipramine: should no longer be routinely prescribed in primary care (also non-formulary in SEL)[26]

Selegiline (MAO-B inhibitor): Do not offer SSRIs, SNRIs or vortioxetine to patients taking these. Dietary interactions. Seek advice. High risk of Serotonin syndrome when switching to/from

Citalopram and escitalopram prolong QTc: Patients with cardiac history should have ECG prior to initiation

St John's Wort: Poor efficacy and multiple interactions. Not recommended

Triptans: Do not offer SSRIs

Antidepressants: Switching and Stopping/Deprescribing[11,16,29, 32]

Direct switch and cross-tapering recommendations on page 14.

	TO →						
FROM	**Other SSRI**	**Fluoxetine**	**Venlafaxine**	**Duloxetine**	**Mirtazapine**	**TCAs**	**Stopping or deprescribing**
SSRI **Sertraline** **Citalopram** **Escitalopram** **Paroxetine**	Direct switch possible (Stop one, next day start alternative. No dose reduction necessary)	Cross-taper cautiously	Cross-taper cautiously	Cross-taper cautiously	Cross-taper cautiously	Cross-taper cautiously	Paroxetine more commonly causes discontinuation symptoms (NICE) - withdraw cautiously. Other SSRIs *(see page 15)*
Long acting SSRI **Fluoxetine**	Stop fluoxetine. Wait 4–7 days then start low dose		Stop fluoxetine, start SNRI at a low dose 4–7 days later	Stop fluoxetine, start SNRI at a low dose 4–7 days later	Cross-taper cautiously	Stop fluoxetine, start TCA at a low dose 4–7 days later and increase dose very slowly	At 20mg, alternate day dosing for a period of time can provide suitable dose reduction. Higher doses require gradual withdrawal
SNRIs **Venlafaxine**	Cross-taper cautiously	Cross-taper cautiously		Direct switch	Cross-taper cautiously	Cross-taper cautiously with-low dose TCA	Venlafaxine more commonly causes discontinuation symptoms – withdraw drug cautiously.
Duloxetine	Cross-taper cautiously	Cross-taper cautiously	Direct switch		Cross-taper cautiously	Cross-taper cautiously with-low dose TCA	*(see page 15)*
Other **Mirtazapine**	Cross-taper cautiously	Cross-taper cautiously	Cross-taper cautiously	Cross-taper cautiously		Cross-taper cautiously	*(see page 15)*
TCA **Amitriptyline** **Lofepramine**	Halve dose and add SSRI then slow withdrawal (over next 5–7 days)	Halve dose, add SSRI, then slowly withdraw TCA	Cross-taper cautiously starting with low dose	Cross-taper cautiously starting with low dose	Cross-taper cautiously	Cross-taper cautiously	*(see page 15)*

Antidepressants: Switching[11,16,20,32]

Cross-taper if switching between classes of drug. Direct switch if switching within a drug class.

Cross-tapering

Cross-taper if switching between classes, or if the new drug is fluoxetine or vortioxetine (as they have a long half-life).

1. Cross-taper means reduce the dose of one antidepressant, whilst increasing the dose of the other.
2. During the taper, aim for the total combined dose of the two drugs at each stage to be approximately equivalent to the original dose of drug that is being stopped.
3. Calculate equivalence using the percentage of the maximum dose recommended in common clinical practice for the indication, e.g. sertraline 200mg = 100%, citalopram 20mg = 50%
4. Speed depends on drug and patient tolerability.
5. Few studies have been done, so caution is required.
6. Extended periods may be necessary to mitigate withdrawal symptoms. See page 16 for common withdrawal symptoms.
7. As a minimum, each step in the cross-taper should usually take at least one week, and overall typically, 4-6 weeks. E.g.

		Week 1	Week 2	Week 3	Week 4
Stopping Citalopram	40mg OD	20mg OD	10mg OD	5mg OD	2.5mg OD
Starting Mirtazapine	Nil	15mg OD	30mg OD	30mg OD	45mg OD (if required)

Direct switch

Direct switch if switching within class (SSRI to SSRI, or SNRI to SNRI)

1. Direct switch means stop drug on day 1, start the new drug on day 2 at an equivalent dose.
2. Calculate equivalence using the percentage of the maximum dose recommended in common clinical practice for the indication, e.g. sertraline 200mg = 100%, citalopram 20mg = 50%.

Serotonin syndrome (SS) - starting, increasing or switching antidepressant

Serotonin syndrome is a rare but **potentially life-threatening syndrome** caused by excessive central and peripheral serotonergic activity.

- Particularly a problem when the first drug is an irreversible MAOI, or a drug with a long half-life
- More commonly occurs when **antidepressants** are **combined with other serotonergic drugs** such as **tramadol and fentanyl**
- **Recreational drugs also implicated in SS -** cocaine, MDMA, amphetamine, LSD[29]

Symptoms can occur:

- Within hours or days of initiation
- On dose escalation or overdose of a serotonergic drug
- On the replacement of one serotonergic drug by another without adequate washout period.

Neuromuscular activity: tremor, hyperreflexia, clonus, myoclonus, rigidity

Autonomic dysfunction: tachycardia, BP changes, hyperthermia, diaphoresis, shivering, diarrhoea

Altered mental state: agitation, confusion, mania

Refer to A&E for urgent treatment if SS suspected

Antidepressants: Stopping or Deprescribing[11,16,20, 32]

How to stop/deprescribe antidepressants - major new change to clinical practice (NICE 2022)

1. **Antidepressants should not be stopped suddenly as may increase risk withdrawal symptoms** - can be severe, debilitating, and long-lasting (page 16)
2. **Do not stop antidepressants suddenly unless there are exceptional medical circumstances**, such as serious side effects e.g. upper gastrointestinal bleeding
3. **Very slowly reduce drug dose over time (hyperbolic taper –** see below and page 16)
4. **Plan in advance with patients**

When to deprescribe?[32]

- High-dose prescribing
- Polypharmacy - causing interactions or affecting adherence
- Inappropriate prescribing - wrong drug, dose or duration
- Patient preference
- Harms outweigh risks
- Condition improved or alternative coping strategies – especially those with simple depression and have been stable for >6 months, or recurrent/high-risk depression and stable for > 2 years

Principles of deprescribing

1. Plan in advance	Extra support may be required (e.g. check-ins with clinician/therapist, family support)
2. Explain	• Why tapering is required and is slow. • 'Not one size fits all' – pace will be tailored to patient, in agreement with them • Importance of slow tapering and how to do this • Need for regular review - monitor for relapse and withdrawal symptoms
3. Hyperbolic (gradual) tapering is required	**Hyperbolic tapering** = this means the steps by which the dose is reduced become smaller and smaller as the dose is lowered, i.e. reduce at a proportion of the previous dose with smaller reductions at lower doses towards zero *"It's like a playground slide: it becomes less and less steep towards the end, so that people can come down safely without shocks."*[31]

4. Set expectations	• Most people stop antidepressants **successfully**
	• Withdrawal can take between **3 months to 2 years** for those on long term medication
	• Risk of withdrawal symptoms:
	  • Long duration of antidepressant use
	  • High dose of antidepressant
	  • PMH of withdrawal symptoms
	  • History of dependence
	  • Taking paroxetine or SNRIs – recognised to be associated with higher risk of withdrawal

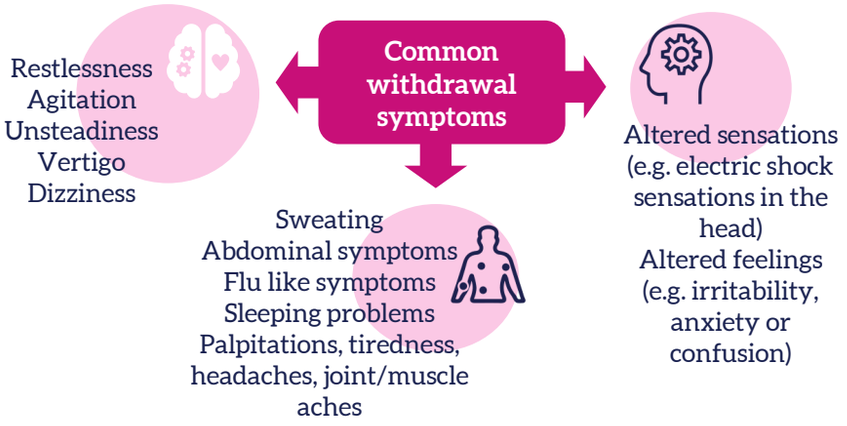
Antidepressants: Stopping or Deprescribing[11,16,20,32]

Stopping or deprescribing antidepressants

How to deprescribe an antidepressant?

1. Consider the **pharmacokinetic profile** (e.g. drug half-life, antidepressants with a short half-life requires slower tapering) and **duration of treatment** (longer treatment duration associated with higher risk of withdrawal symptoms)

2. **Very slowly reduce dose to zero in a step-wise fashion. At each step, prescribing *a proportion* of the previous dose (e.g. reduce dose by maximum of 25% of previous dose)***
   - Consider using smaller reductions as the dose becomes lower
   - Once very small doses have been reached and slow tapering can not be achieved using tablets or capsules (including splitting tablets), *consider* the use of liquid preparations. In some cases, this may involve the use of unlicensed liquid specials. Please liaise with practice, PCN or community pharmacy leads or borough medicines optimisation team for advice if needed.
3. **Ensure the speed and duration of withdrawal is led by and agreed with patient**, ensuring tolerability or resolution of withdrawal symptoms before further dose reductions
   - Consider the broader clinical context e.g. potential benefit of more rapid withdrawal if there are serious or intolerable side effects e.g. hyponatraemia or upper GI bleeding)
   - For switching between antidepressants (*see page 14*)



Withdrawal symptoms

1. Do not imply relapse of depression
2. Common (50%)
3. Onset within days, usually short lived (1-2 weeks), and can be reduced with slow tapering
4. If experienced, consider slowing tapering.
   - If mild: reassure and monitor
   - If severe: consider reintroducing the original antidepressant (or same class drug with longer half-life)

*NICE advocates reducing by 50% of previous dose initially, with 25% of previous dose reductions later on, but Maudsley/Oxleas consensus deemed a slower reduction, i.e. reducing by maximum of 25% of previous dose to be safer for primary care.

Resources for patients and professionals

Resources for patients and professionals
- RCPsych have printable **information** for patients and professionals
- Specialist Pharmacy Service (SPS) provide information and links to resources for professionals and patients
- NHS website Stopping of coming off antidepressants (for patients)
- MIND withdrawal effects of antidepressants (for patients)

Increase in suicide rates are similar for stopping and starting antidepressants, so caution is advised.

Medication: Dosing and Notes[11,16,20]

	Drug		Depression		GAD		Panic Disorder		Notes (Please refer to latest BNF or the Maudsley Prescribing Guidelines for more detailed information, especially - titration increments, cautions, contraindications (CI) and side-effects, and share decision aid)	
			Starting dose	Max. dose	Starting dose	Max. dose	Starting dose	Max. dose		
SSRI	Sertraline	Adults	50mg OD	200mg OD	Off-label	Off-label	25mg OD	200mg OD	• 1st line SSRI for GAD (unlicensed indication, but recommended by NICE as most cost-effective drug) • Safe after myocardial infarction. Good if other LTCs, but elderly at risk of hyponatraemia	• Caution for all SSRIs: Cardiac disease, diabetes, epilepsy (discontinue if convulsions develop), history of bleeding disorders (especially gastro-intestinal bleeding), history of mania, susceptibility to angle-closure glaucoma, small increased risk of postpartum haemorrhage when used in the month before delivery • Increased risk of suicidality for people <30 years, monitor risk regularly especially within first month • See BNF for side-effects: common in the first weeks, but tend to settle
		Elderly								
	Paroxetine	Adults	20mg OD	50mg OD	20mg OD	50mg OD	10mg OD	60mg OD	• Caution: Most likely to cause discontinuation syndrome • Can cause agitation in the elderly	
		Elderly	20mg OD	40mg OD	20mg OD	40mg OD	10mg OD	40mg OD		
	Escitalopram	Adults	10mg OD	20mg* OD	10mg OD	20mg* OD	5mg OD	20mg* OD	• Caution: QT interval prolongation, *adults with hepatic impairment max. dose 10mg	
		Elderly	5mg OD	10mg OD	5mg OD	10mg OD	5mg OD	10mg OD		
	Citalopram	Adults	20mg OD	40mg† OD			10mg OD	40mg† OD	• Caution: QT interval prolongation, †adults with hepatic impairment max. dose 20mg	
		Elderly	10mg OD	20mg OD			10mg OD	20mg OD		
	Fluoxetine	Adults	20mg OD	60mg OD					• Caution: Long half-life, needs more caution in switching *(see pages 13 and 14)*	
		Elderly	20mg OD	40mg OD						
SNRI	Venlafaxine (MR)	Adults	75mg OD	375mg OD	75mg OD	225mg OD	37.5mg OD		• Doses stated for OD Modified Release formulation. Please prescribe generically and choose most cost effective tablets/capsules. • Caution: Discontinuation syndrome, risk of toxicity in overdose • CI: uncontrolled BP	• Caution for all SNRIs: As per SSRIs, and personal history OR family history of mania
		Elderly								
	Duloxetine	Adults	60mg OD	120mg OD	30mg OD	120mg OD			• Caution: Raised IOP, hypertension- if uncontrolled, avoid	
		Elderly								

Notes:
Max. dose **Maximum dose (BNF)**
Off-label **Not listed as an indication in the BNF**
Elderly **BNF recommended dosing, specifically for elderly patients**
For drug doses regarding other anxiety spectrum indications, see BNF
Suggestion **when initiating antidepressants**: prescribe as acute. Change to repeat when clinically appropriate. Prescribe shorter courses if clinical risk present

Medication: Dosing and Notes[11,13,16,20, 27]

	Drug		Depression		GAD		Notes (Please refer to latest BNF or the Maudsley Prescribing Guidelines for more detailed information, especially - titration increments, cautions, contraindications (CI) and side-effects)
			Starting dose	Max. dose	Starting dose	Max. dose	
Pre-synaptic alpha2-blocker	Mirtazapine	Adult	15-30mg OD	45mg OD			• Causes weight gain. If fever, sore throat, stomatitis, or other signs of infection during treatment, do FBC. Stop drug immediately if blood dyscrasia suspected • Cautions: As SSRIs, and in addition, caution in elderly, history of urinary retention, hypotension, psychoses (may aggravate psychotic symptoms)
		Elderly					
Tricyclic antidepressant	Lofepramine	Adult	70mg BD	70mg TDS			• CI: Acute porphyrias, arrhythmias, during manic phase of bipolar disorder, heart block, post-MI • Cautions: Cardiovascular disease, chronic constipation, diabetes, epilepsy, history of bipolar disorder or psychosis, hyperthyroidism, increased intra-ocular pressure, significant risk of suicide, phaeochromocytoma, prostatic hypertrophy, susceptibility to angle-closure glaucoma, urinary retention
		Elderly					
Serotonin Modulator	Vortioxetine	Adult	10mg OD	5-20mg OD			• Cautions: Bleeding disorders, liver cirrhosis (hyponatraemia risk), elderly (hyponatraemia risk), history of mania (discontinue if entering manic phase), history of seizures, unstable epilepsy. Discontinue treatment in patients who develop seizures, or if there is an increase in seizure frequency • Elderly: Caution when treating patients with doses >10 mg OD- limited information
		Elderly	5mg OD	5-20mg OD			
Serotonin antagonist and reuptake inhibitor	Trazodone	Adult	150mg daily in divided doses	600mg daily in divided doses			• Initiation by specialist only • CI: Arrhythmias, during manic phase of bipolar disorder, heart block, post-MI • Cautions: CVD, chronic constipation, diabetes, epilepsy, history of bipolar disorder, history of psychosis, hyperthyroidism (risk of arrhythmias), increased IOP, significant risk of suicide, phaeochromocytoma (risk of arrhythmias), prostatic hypertrophy, susceptibility to angle-closure glaucoma, urinary retention • Use with severe caution in renal impairment
		Elderly	100mg daily in divided doses	600mg daily in divided doses			
Gabapentinoids	Pregabalin	Adult			150mg daily in 2-3 divided doses	600mg daily in 2-3 divided doses	• Caution: Class C Controlled drug (risk of abuse and dependence), potentially fatal risks of interactions between pregabalin and alcohol, and with other medicines that cause CNS depression, particularly opioids. History of substance abuse; severe congestive heart failure • Renal impairment: Adjust dose according to eGFR – see BNF for dosing adjustment
		Elderly					
Beta-blockers	Propranolol	Not recommended by NICE, toxic in overdose.					• CIs/Cautions include: Asthma, decompensated HF, 2nd/3rd degree heart block, HR<60, severe peripheral arterial disease • Drug interactions: Digoxin, amiodarone, diltiazem, verapamil

Notes on other related medications

Z-drugs	Zopiclone	These drugs are not anti-anxiolytics[27]. Indicated for short-term use in insomnia only. Avoid in elderly.	Before starting a benzodiazepine or Z-drug discuss with the patient: • All other suitable management options including non-pharmaceutical approaches • Prolonged use may lead to drug dependence, tolerance and addiction, even at therapeutic doses • What the medicine has been prescribed for and any potential side effects • Agree with the patient a treatment strategy, intended outcomes and plan for end of treatment • Counsel patients and carers on signs and symptoms of overdose • Discuss drug driving advice • Discuss potential interactions when co-prescribing (including risk of respiratory depression) **The above are all included on the Ardens Controlled Drug Risk Assessment template**
Benzodiazepines	Diazepam	The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate. Do not offer a benzodiazepine for the treatment of GAD/panic disorder except as a short-term measure during crises (2–4 weeks, review after 2 weeks). Should be avoided in the elderly. Not recommended by NICE for panic or depression. Dependence can start after 3 weeks of treatment	

Referrals and clinical support

	Lambeth Referral forms on DXS	Southwark Referral forms on DXS	Lewisham Referral forms on DXS	Greenwich	Bexley	Bromley Via Referrals Optimisation Protocol (ROP)
Acute liaison and assessment	**Lambeth Single Point of Access (SPA)** 0800 090 2456 LambethSPAReferrals@slam.nhs.uk to access all Lambeth mental health services (9-5, Mon to Fri) Or advice available via **Consultant Connect**	**Southwark Assessment and Liaison Teams** 020 3228 9454 southwarknorthassessmentandliaisonteam@slam.nhs.uk southwarksouthassessmentandliaisonteam@slam.nhs.uk	Rapid response assessment team 07811 827 2 16 Send referral form to Primary Care Mental Health Team (PCMHT) via form on DXS	**Greenwich Mental Health Hub** 0208 301 8960 **Oxl-tr.referralspcpgreenwich@nhs.net** **Oxleas 24 hour Crisis Line** 0800 330 8590	ADAPT service 0203 668 9490 **Oxleas 24 hour Crisis Line** 0800 330 8590 Older Adults intensive home treatment team 02083019400	Referrals Optimisation Protocol / Mental Health / Mental Health Service Referral Form **Oxleas 24 hour Crisis Line** 0800 330 8590
Wellbeing support*	via **Lambeth Single Point of Access (SPA)**	**Southwark Wellbeing Hub**	**Lewisham Wellbeing Hub**	**Greenwich Mental Health Hub** **Live Well Greenwich**	**Bexley Mental Health Hub**	Social Prescribing or **Bromley Well** via ROP
Talking therapies*	**Talking Therapies Lambeth**	**Talking Therapies Southwark**	**Talking Therapies Lewisham**	**Greenwich Time to Talk**	**Bexley Talking Therapies (Mind)**	**Bromley Talking Therapies** via ROP
Perinatal mental health (non-acute or crisis)	**SLAM Perinatal Service** Slm-tr.perinatalservicereferrals@nhs.net			**Oxleas Perinatal Service** oxl-tr.oxleasperinatalmentalhealthservice@nhs.net		ROP / Mental Health / Perinatal Mental Health Service
	020 7188 6011	020 3299 3234	020 3228 9354 / 9358	0203 961 3610		
Older adults	**Lambeth Community Mental Health Team for Older Adults** 020 3228 8030 / 8300 lambethadminMHOA@slam.nhs.uk Or advice available via **Consultant Connect**	**Southwark Community Mental Health Team for Older Adults** 020 3228 6920 southwarkmhoadteam@slam.nhs.uk	**Lewisham Mental Health of Older Adults and Dementia Directorate** lewishamolderadults@slam.nhs.uk	**Older Adults Community Mental Health Service** 0208 836 8670/1 oxl-tr.cmhtgroa@nhs.net	**Older Adults Community Mental Health Service** 020 8301 9400 oxl-tr.olderpeoplebexleycmhtadmin@nhs.net	ROP / Mental Health / (Older Psychiatric Assessment Referral Form or Memory Services)
Domestic and sexual violence*	**The Gaia Centre** 020 7733 8724 lambethvawg@refuge.org.uk	**Southwark Domestic Abuse Service (SDAS)** 0118 214 7150	**Athena Lewisham** 0800 112 4052 lewishamvawg@refuge.org.uk	**The HER Centre** info@hercentre.org 0203 260 7772	**Bexley Domestic Abuse Services**	**Bromley Domestic Abuse Services** via ROP
Drugs and alcohol*	**Lambeth Drug and Alcohol Treatment Consortium**	**Change Grow Live Southwark**	**Change Grow Live Lewisham**	**VIA Greenwich**	**Pier Road Project**	**Bromley Drug and Alcohol Service** via ROP
Medicines advice	**SLAM Pharmacy Helpline,** For prescribing advice 020 3228 2317 Out-of-hours 020 3228 6000			**Oxleas Medicines Line for clinicians** 01322 625002 (9-5, Mon to Fri)		

*patients can also self-refer

Resources for all

A selection of services available for our patients, colleagues and ourselves
Please print and share this page with your patients and/or practice navigators

Self-help

NTW self-help: A range of excellent self-help leaflets

Books on prescription: Recommended books. Available in libraries without late fines.
An interactive prescription is available to print for patients

Good Thinking: Online resources for Londoners: Adults and children; including CBT, sleep and anxiety

Togetherall (formerly Big White Wall): 24-hour online mental health support community. Includes advice and self-help tools

My Possible Self: Free NHS supported mental health and wellbeing app

The Compassionate Mind Foundation: On-line resources to support personal wellbeing

Self-Compassion resources: Guided meditation and exercises to support personal wellbeing

Citizens Advice Bureau: advice and support including benefits, finances and unfair treatment

Working Age Adults

MIND: for anyone struggling with their mental health or supporting someone who is in Lambeth and Southwark; Bromley, Lewisham and Greenwich; Bexley

Older Adults

AGE UK provides befriending services, training and Healthy Living Centres
Advice line 0800 678 1602

Young People

Young Minds support for young people, parents and those who work with young people

Kooth free anonymous support for young people

Gambling

GambleAware to find local services and access to gambling therapy
National Gambling Helpline 0808 8020 133

Suicidal

See page 7 for 24-hour services

Resources for clinicians

Concerned about your own mental health?

Healthcare professionals have high rates of mental health problems and can sometimes find it difficult to access mainstream services. Do seek advice and support from your own GP. Below are some resources designed specifically for healthcare professionals:

NHS Practitioner Health Programme: Mental health service for NHS doctors and dentists. Offers psychological support, psychiatric assessment and employment advice

BMA Wellbeing Support Services: Counselling or peer support offer for all doctors and medical students

RCGP GP wellbeing

RCN Counselling Service: Counselling for members

Unison 'There for You': Financial and emotional support for members

Pharmacist support: Charity offering financial, emotional and addiction support to pharmacists and their families

Supporting our NHS People access and signposting to a range of support services for employees in health and social care including free access to Apps and coaching for Primary Care colleagues

Text **FRONTLINE** to 85258 for 24/7 confidential support

Calm App: Free for 12 months for healthcare professionals, apply via their website

Training

e-Learning for Healthcare: Register with this site for free online learning for a range of mental health issues targeted at GPs and practice nurses

King's Health Partners Mind and Body: Training for staff to provide joined up mental and physical healthcare

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Guide developed by Clinical Effectiveness South East London

Abbreviations

A&L	Advice and Liaison Team (at SLAM)
BCT	Better Care Together
BMA	British Medical Association
BNF	British National Formulary
BP	Blood pressure
CBT	Cognitive Behaviour Therapy
CGL	Change Grow Live
CI	Contraindication
CNS	Central Nervous System
CVD	Cardiovascular Disease
DIT	Dynamic Interpersonal Therapy
DOAC	Direct Oral Anticoagulant
DXS	A clinical decision making tool embedded in EMIS
EMDR	Eye Movement Desensitisation Reprocessing
EUPD	Emotionally Unstable Personality Disorder
GAD	Generalised Anxiety Disorder
GAD-2	Generalised Anxiety Disorder scale 2-item
GAD-7	Generalised Anxiety Disorder scale 7-item
GFR	Glomerular Filtration Rate
IOP	Intraocular Pressure
IPT	Interpersonal Psychotherapy Treatment
KCL	King's College London
LGBT	Lesbian Gay Bi-sexual Transgender
LTC	Long-term condition
MAOI	Monoamine Oxidase Inhibitor
mg	Milligram
MH	Mental health
MI	Myocardial infraction
MR	Modified release
NICE	National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorder
OD	Once Daily
PACT	Parents and Communities Together
PHQ-2	Patient Health Questionnaire-2 item
PHQ-9	Patient Health Questionnaire-9 item
PPI	Proton Pump Inhibitors
PTSD	Post-Traumatic Stress Disorder
QOL	Quality of Life
QTc	Corrected QT interval
RCN	Royal College of Nursing
SLAM	South London and Maudsley
SNRI	Serotonin Norepinephrine Reuptake Inhibitor
SSRI	Selective Serotonin Reuptake Inhibitor
TCA	Tricyclic Antidepressant

Clinical Effectiveness
South East London

South East London
Integrated Care System

NHS

Making the right thing to do the easy thing to do.

March 2024 (review March 2026, or earlier if indicated)