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Darum: 2 oktober 2020

Onderwerp: Oproep om een eind te maken aan de problemen rond de vergoeding van taperingstrips

Geachte Dr. Prinsen,

Zoals u weet kunnen antidepressiva onttrekkingsverschijnselen veroorzaken als ze abrupt worden afgebouwd of als de dosis te snel wordt verlaagd wat kan leiden tot uiteenlopende klachten. Die klachten kunnen mild maar ook ernstig zijn, lang aanhouden en leiden tot mislukte stoppogingen en langdurig antidepressivagebruik waar mensen geen baat bij hebben maar wel de schadelijke gevolgen van ondervinden.

Dit kan ook gebeuren bij antipsychotica, benzodiazepines, opioïde pijnstillers zoals oxycodon, anti-epileptica en nog andere medicijnen die in Nederland door meer dan 3 miljoen mensen worden gebruikt, vaak langdurig. Dit betekent dat iedereen met deze problemen te maken kan krijgen, als gebruiker van deze medicijnen of als familielid of vriend van iemand die ze gebruikt.

Huisartsen en psychiaters worstelen hier al vele jaren mee. Er wordt van hen verwacht dat ze hun patiënten bij stoppen zo goed mogelijk zullen helpen maar ze beschikten tot nog toe nooit over de middelen die hiervoor nodig waren. Richtlijnen boden geen steun en de medicatie die ze moesten kunnen voorschrijven was er niet. De farmaceutische bedrijven die al deze medicijnen op de markt hebben gebracht hebben die nooit geleverd omdat ze niet hoefden - en niet steeds niet hoeven - te onderzoeken of en hoe mensen verantwoord kunnen stoppen. Hoe dat allemaal kon gebeuren kunt u nalezen in het review "*How user knowledge of psychotropic drug withdrawal resulted in the development of person-specific tapering medication*" dat dit jaar verscheen in het wetenschappelijk tijdschrift Therapeutic Advances in Psychopharmacology.[1]

Het heeft tientallen jaren geduurd voordat er vanuit de psychiatrie erkenning kwam voor problemen bij stoppen en afbouwen. In Nederland was dat te danken aan de komst van taperingstrips in 2013[2] waardoor huisartsen en psychiaters eindelijk de mogelijkheid kregen om te doen wat richtlijnen en bijsluiters van ze vragen: om aan hun patiënten flexibel, op maat en op basis van samen beslissen de medicatie voor te schrijven die voor verantwoord afbouwen nodig is.

Tot onze grote verbazing werd de komst van deze afbouwmedicatie niet van harte verwelkomd maar ontstond er discussie over de vraag of die wel voor vergoeding uit het basispakket in aanmerking kwam. Een discussie die tot op de dag van vandaag voortduurt en waarvan u als voorzitter van de NVvP, die partij is in deze discussie, volledig op de hoogte bent[3].

Ook in Engeland was en is er discussie over problemen bij stoppen en afbouwen maar die verloopt anders dan in Nederland. Het Engelse Royal College of Psychiatrists, de zusterverenging van de NVvP, liet vorig jaar weten dat onttrekkingsverschijnselen, anders dan ze altijd beweerd had, ook ernstig kunnen zijn en lang kunnen duren[4,5] en dat er geen *evidence base* is voor afbouwen, waardoor behandelaars in bestaande richtlijnen geen steun vonden.

Vorige week publiceerde het Royal College het document "*Stopping Antidepressants*"[6]. Daarin wordt ondubbelzinnig gezegd:

1) dat niet kan worden voorspeld welke patiënten bij afbouwen met onttrekkingsverschijnselen te maken zullen krijgen en hoe erg die zullen zijn
2) dat we nog niet goed begrijpen hoe die ontrekkingsverschijnselen precies ontstaan, waarom ze soms pas later optreden en waarom ze soms zo lang kunnen duren
3) dat patiënten in staat moeten worden gesteld om tijdens het afbouwen de dosis te verlagen op een manier die ontrekkingsverschijnselen zoveel mogelijk voorkomt en waar een patiënt zich goed bij voelt.

Over de totstandkoming van dit document gaf de (inmiddels ex-) voorzitter van het Royal College, Professor Wendy Burn, op 25 september uitleg in de British Medical Journal in een stuk met als titel: "*Medical community must ensure that those needing support to come off antidepressants can get it*"[7] (als bijlage bij deze brief gevoegd). Die uitleg maakt duidelijk hoe de aanpak van het Royal College verschilt van de manier waarop de NVvP met deze problemen omgaat.

Prof. Burn begint met de constatering dat '*In my many years of clinical practice, stopping antidepressants had not been a problem that my patients had reported to me*'. Hierin staat ze niet alleen want in de loop van de tijd hebben meer artsen zulke meldingen gedaan. Omdat vooral patiënten maar in toenemende mate ook medische professionals lieten weten dat stoppen in de praktijk wel tot grote problemen leidt wilde Prof. Burn weten hoe het nu echt zat. Ze schrijft hierover (markeringen door ons):

> "*As the President of the College I felt it was my responsibility to find out more from patients who were experiencing these symptoms and consider how they could be supported. . . . . Over the next year,* ***I met patient groups*** *who reported harm from using antidepressants. . . . . It became clear that* ***I had underestimated*** *the number of people experiencing difficulties in stopping antidepressants and* ***that the problem was widely under-recognised*** *across healthcare.* ***I spoke to people who reported feeling abandoned*** *with little or no support for symptoms after stopping their antidepressants. . . . .* ***The College's position in 2018 had not been right***".

Vervolgens beschrijft Prof. Burn de stappen die het Royal College hierna nam:

> "*We worked **together with** patients, GPs, psychiatrists, stakeholders, campaigners, NICE and PHE to produce a statement on antidepressants and depression which changed our position and **gave clear recognition to the difficulties that can arise for some people** when coming off antidepressants. . . . . With this position statement **we put patients at the centre of our work, listening to critics with an open mind** and using this to inform our practice."*

Net als het Royal College heeft in Nederland ook de NVvP stappen gezet om iets aan de problemen bij stoppen en afbouwen te doen. Deze stappen zijn voor een deel vergelijkbaar met de stappen die door het Royal College zijn gezet, maar er zijn ook een paar grote verschillen.

Een eerste belangrijk verschil is dat Prof. Burn namens het Royal College expliciet uitspreekt dat het standpunt dat het Royal College jarenlang had ingenomen — dat er bij afbouwen en stoppen eigenlijk geen problemen waren — niet juist was: "*The College's position in 2018 **had not been right**".* Voor alle patiënten die in de loop der jaren problemen hadden en tevergeefs naar hulp hebben gezocht is die erkenning heel belangrijk. Vanuit de NVvP is deze erkenning (nog) niet gekomen, ook al is daar twee keer expliciet om gevraagd[8,9].

Een tweede belangrijk verschil is dat het Royal College "***worked together with patients** . . . stakeholders, campaigners . . . .".* Ook dat is Nederland niet gebeurd. Er werd in 2017 een Scoping over afbouwen van antidepressiva georganiseerd waarbij partijen die veel kennis hadden opgebouwd door het Zorginstituut **werden uitgesloten**, zonder dat daartegen door de NVvP of enige andere partij werd geprotesteerd. Er kwam een Multidisciplinaire werkgroep[10] waarin deze partijen ook geen inbreng mochten hebben. Commentaar kon pas achteraf worden geleverd, waarbij moest worden afgewacht wat daarmee zou worden gedaan.

Over het document *"Stopping Antidepressants"* schrijft Prof. Burn dat "*It's been written **by a pharmacist and a psychiatrist with their own personal, as well as professional, experience of withdrawal** symptoms, along with input from multiple stakeholders"*.

Ook hier zien we een groot verschil met wat in Nederland gebeurde. De Multidisciplinaire werkgroep wilde niets weten van ervaringen van patiënten die al jarenlang op vele plaatsen te vinden zijn[1] en ook niet van een rapport met ervaringen van patiënten en behandelaars met het gebruik van taperingstrips[11]. De werkgroep had daarentegen wel heel veel aandacht voor de wensen van het Zorginsituut en van een aantal zorgverzekeraars.

U weet waar dit alles inmiddels toe heeft geleid: al 5 jaar lang is er sprake van het doorschuiven van verantwoordelijkheden van de ene partij naar de andere[3,5], waarbij nu, volgens de Minister van VWS, in zijn antwoord op Kamervragen op 1 november 2019, opnieuw "*het veld* [lees: de NVvP] *aan zet is*"[12].

Gedurende al deze tijd hadden en hebben patiënten en hun behandelaars te maken met zorgverzekeraars die steeds meer bureaucratische belemmeringen proberen op te werpen en die op de stoel van de behandelaar gaan zitten, onder verwijzing naar het Multidisciplinair document. Omdat daarin op basis van theoretische overwegingen, maar zonder naar de praktijk te kijken, *one-size-fits-all* afbouwschema's worden genoemd voor patiënten waarbij geen sprake is van zogenaamde risicofactoren. Risicofactoren waarvoor — de werkgroep is hier zelf duidelijk over — geen empirische onderbouwing is.

De Engelse psychiaters zijn in het document "Stopping antidepressants" wel duidelijk: welke patiënt last zal krijgen van onttrekkingsverschijnselen en hoe lang die over het afbouwen moet doen **kan niet worden voorspeld**. Daarom is het begeleiden van patiënten bij afbouwen een zaak tussen arts en patiënt, waarbij de arts over de mogelijkheid moet beschikken om hiervoor de (afbouw)medicatie voor te schrijven die de patiënt nodig heeft.

Hoe belangrijk het is is dat deze problemen worden opgelost bleek de afgelopen dagen opnieuw uit twee belangrijke nieuwe waarschuwingen van de Engelse Medicines and Healthcare products Regulatory Agency (MHRA) over opioïde pijnstillers[13] en van de Amerikaanse FDA over (on)veilig gebruik van benzondiazepines[14].

**OPROEP**

Op 15 oktober staat overleg gepland tussen Minister van Ark en de Vaste Kamercommissie van VWS waarin afbouwmedicatie opnieuw aan de orde zal komen. Op 6 oktober is de NVvP bij overleg van de Vereniging Artsen Volksgezondheid (VAV) met de zorgverzekeraars.

We roepen u, als voorzitter van de NVvP op om, zoals Prof. Burns dat in Engeland als voorzitter van het Royal College of Psychiatrists heeft gedaan, uw verantwoordelijk te nemen. Volgens de Minister van VWS is de NVvP (opnieuw) "*aan zet*". Dat betekent dat de NVvP in de positie is om te helpen om aan de discussie over afbouwen en de vergoeding van taperingstrips een eind te maken.

Door dat te doen kunt u ervoor zorgen dat huisartsen en psychiaters eindelijk kunnen doen wat altijd al van ze gevraagd werd maar wat ze eerder nooit goed konden doen: hun patiënten goed helpen om ze veilig en verantwoord te laten afbouwen, zonder dat ze daarbij worden gehinderd door zorgverzekeraars die op hun stoel gaan zitten.

Omdat wat we u vragen ook voor andere partijen en voor patiënten van belang is maken we deze brief openbaar door die op de website van de Vereniging Afbouwmedicatie te plaatsten.

met vriendelijke groet,

Pauline Dinkelberg,
Jim van Os,
Peter Groot

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# Wendy Burn: Medical community must ensure that those needing support to come off antidepressants can get it

September 25, 2020

In 2018, while I was still President of the Royal College of Psychiatrists (RCPsych), I co-signed a letter to *The Times* which stated that "in the vast majority of patients, any unpleasant symptoms experienced on discontinuing antidepressants have resolved within two weeks of stopping treatment."

To my astonishment the letter sparked a furore. A group of psychologists, psychiatrists and patients complained publicly. They were unhappy as they had found stopping antidepressants led to symptoms in patients that were often misinterpreted as a relapse of depression, which in turn led to taking medication for longer periods of time.

Formal complaints were made to RCPsych and to the General Medical Council. I was widely and upsettingly trolled on social media, as were several of my colleagues.

In my many years of clinical practice, stopping antidepressants had not been a problem that my patients had reported to me. Possibly because I have always slowly tapered any medication that my patients were on.

While our letter had been in line with the NICE guidance on antidepressant discontinuation which states "symptoms are usually mild and self-limiting over about one week" we had not included the further guidance from NICE that stated symptoms "can be severe, particularly if the drug is stopped abruptly."

As the President of the College I felt it was my responsibility to find out more from patients who were experiencing these symptoms and consider how they could be supported

Over the next year, I met patient groups who reported harm from using antidepressants. They describe themselves as the "prescribed harm community."

I visited a charity in Bristol which supports people coming off psychiatric medication, working with their doctors. I attended an event run by a group called "Drop the Disorder" who challenge the culture of medical psychiatric diagnoses.

Many people attending this event told me they had been damaged by antidepressants, particularly by their experiences of coming off them.

I talked to "Altostrata" in San Francisco who founded the Surviving Antidepressants website in 2011, this supports people who are having problems stopping psychiatric medication and has a huge collection of case histories. She describes experiencing acute withdrawal symptoms, followed by Post-Acute-Withdrawal Syndrome (PAWS) with ongoing symptoms.

It became clear that I had underestimated the number of people experiencing difficulties in stopping antidepressants and that the problem was widely under-recognised across healthcare.

I spoke to people who reported feeling abandoned with little or no support for symptoms after stopping their antidepressants. Meanwhile, I feared that heated and often polarised arguments were deterring people with mental illness from speaking about their experiences and seeking support.

The College's position in 2018 had not been right.

We worked together with patients, GPs, psychiatrists, stakeholders, campaigners, NICE and PHE to produce a statement on antidepressants and depression which changed our position and gave clear recognition to the difficulties that can arise for some people when coming off antidepressants.

With this position statement we put patients at the centre of our work, listening to critics with an open mind and using this to inform our practice—a significant step in the right direction.

The following extract from the position statement marks this vital change to our approach: "Whilst the withdrawal symptoms which arise on and after stopping antidepressants are often mild and self-limiting, there can be substantial variation in people's experience, with symptoms lasting much longer and being more severe for some patients. Ongoing monitoring is also needed to distinguish the features of antidepressant withdrawal from emerging symptoms which may indicate a relapse of depression."

We also recommended that better support is provided to people who are stopping antidepressants.

Following this update, NICE changed its guidance to reflect the importance and range of withdrawal symptoms. NICE also advise people on antidepressant medication to talk to their practitioner before stopping and to get their support with managing withdrawal symptoms.

This week RCPsych is launching a Patient Information Resource on withdrawing from antidepressants. The resource offers advice to patients on carefully managing the process for stopping antidepressants.

It's been written by a pharmacist and a psychiatrist with their own personal, as well as professional, experience of withdrawal symptoms, along with input from multiple stakeholders.

The online patient resource, available free on the RCPscych website, has been endorsed by the Royal College of General Practitioners and the Royal Pharmaceutical Society.

I'm hoping that the whole medical community will get behind this work to ensure that those needing support to come off antidepressants can get it. Most of all, I hope the resource proves helpful to people on antidepressants, and that no one experiencing mental illness is shamed or intimidated from seeking help.

***Wendy Burn**, Consultant Old Age Psychiatrist, immediate past president of Royal College of Psychiatrists, National Mental Health Clinical Advisor to Health Education England and Chair of Equally Well Clinical Group.*

***Competing interests**: None declared.*

# Stopping antidepressants

This information is for anyone who wants to know more about stopping antidepressants.

**It describes:**

- symptoms that you may get when stopping an antidepressant
- some ways to reduce or avoid these symptoms.

## Disclaimer

This resource provides information, not advice.

The content in this resource is provided for general information only. It is not intended to, and does not, amount to advice which you should rely on. It is not in any way an alternative to specific advice. You must therefore obtain the relevant professional or specialist advice before taking, or refraining from, any action based on the information in this resource.

If you have questions about any medical matter, you should consult your doctor or other professional healthcare provider without delay.

If you think you are experiencing any medical condition, you should seek immediate medical attention from a doctor or other professional healthcare provider.

Although we make reasonable efforts to compile accurate information in our resources and to update the information in our resources, we make no representations, warranties or guarantees, whether express or implied, that the content in this resource is accurate, complete or up to date.

## What are antidepressants?

They are medications prescribed for depressive illness, anxiety disorder or obsessive-compulsive disorder (OCD). You can find out more about how they work, why they are prescribed, their effects and side-effects, and alternative treatments in our separate resource on antidepressants.

Usually, you don't need to take antidepressants for more than 6 to 12 months. While they can make you feel better, you can get withdrawal symptoms when you stop taking them. Some people will get no symptoms when reducing or stopping an antidepressant – but many do. These symptoms can be physical and mental, although they are different for everyone – and they can be different for individual antidepressants (see Appendix 1).

This resource aims to help you avoid getting any withdrawal symptoms – or get the fewest possible. Talk this over with your doctor so you can find the best way to stop taking them.

# What symptoms might you experience when stopping antidepressants and how severe can they be?

The NICE guidelines suggest that for some, withdrawal symptoms can be mild and go away relatively quickly, without the need for any help. Other people can have more severe symptoms which last much longer (sometimes months or more).

At the moment we cannot predict who will get the more serious withdrawal symptoms.

## Symptoms of antidepressant withdrawal

If you do get any of the symptoms listed below, tell your doctor.

You may notice:

- dizziness (this is usually mild, but can be so bad that you can't stand up without help)
- anxiety which comes and goes, sometimes in intense 'surges'
- difficulty in getting to sleep and vivid or frightening dreams
- low mood, feeling unable to be interested in or enjoy things
- a sense of being physically unwell
- rapidly changing moods
- anger, sleeplessness, tiredness, loss of co-ordination and headache
- the feeling of an electric shock in your arms, legs, or head (those are sometimes called 'zaps' and turning your head to the side can make them worse)
- a feeling that things are not real ('derealisation'), or a feeling that you have 'cotton wool in your head'
- difficulty in concentrating
- suicidal thoughts
- queasiness
- a feeling of inner restlessness and inability to stay still (akathisia).

See Appendix 2 for a list of all reported symptoms.

## What causes antidepressant withdrawal symptoms?

This is still poorly understood. Brain chemicals called neurotransmitters (such as serotonin and noradrenaline) are involved. They allow nerve cells to communicate with each other by acting on nerve endings. Antidepressants increase levels of these chemicals in the space between nerve cells in the brain. Over time, the brain seems to slowly adjust to these increased levels.

If an antidepressant is stopped quickly, the brain will need time to adjust back again. The sudden lowering of neurotransmitter levels seems to produce withdrawal symptoms, while the brain adjusts to the change. The more gradual the changes, the milder and more tolerable symptoms should be – or, indeed, they may not happen at all.

This is why it is usually best to stop an antidepressant slowly.

## Who is affected by antidepressant withdrawal symptoms?

Between a third and half of people who take an antidepressant will experience such symptoms to some extent. We cannot yet predict who will get these symptoms.

The risk seems to be greater if you have taken a high dose for a long time, but it can happen if you have taken an antidepressant for just a month. It can also depend on the type of antidepressant you have been taking. You are more likely to get these symptoms (and for them to be worse) if you stop taking an antidepressant suddenly or if you reduce the dose quickly.

## How can I tell if it is withdrawal symptoms, or my depression/anxiety coming back?

Some withdrawal symptoms can feel like the symptoms you had before you started the antidepressant. The low mood and difficulty in sleeping of withdrawal can feel like the symptoms of depression. Dizziness is a common symptom of anxiety. In this case, you should carry on taking your antidepressant at the prescribed dose – and talk with your doctor.

If you do get withdrawal symptoms, you can still stop your antidepressant – but may need to do so more slowly (see section on 'When and how to stop antidepressants')

These are some of the ways you and your doctor can tell whether you are having withdrawal symptoms or whether it is the symptoms of a return of anxiety or depression:

1. Withdrawal symptoms normally start soon after your medication is reduced or stopped. This may be one or two days for some antidepressants – or even after missing a single dose. Usually they take a few days to start, and then get worse. The return of depression or anxiety usually takes longer – typically weeks or months. Some antidepressants, like fluoxetine, take a lot longer to leave the body. So, with these, symptoms can start days or even weeks after

stopping or reducing your dose. This can make it harder to tell if symptoms are due to withdrawal or the return of your original symptoms of anxiety or depression.

2. Some withdrawal symptoms do not happen in anxiety or depression – such as 'electric shocks' or 'zaps'. People often say, "I've never felt this before" or "This doesn't feel like my depression." Your doctor should ask whether you are getting these symptoms

3. Withdrawal symptoms usually improve quickly (in days or even hours) if you restart your antidepressant. This is much quicker than the weeks that antidepressants will normally take to relieve symptoms of anxiety or depression that have returned.

## Does this mean that antidepressants are addictive or can cause dependence?

Stopping an antidepressant can give you unpleasant withdrawal symptoms – which stop if you start taking it again. It can certainly feel as though you are addicted to the antidepressant – but it's not quite the same as being addicted.

You don't get the craving or constantly having to increase the dose that you do with substances like alcohol, nicotine or benzodiazepines. But it can still be hard to stop taking an antidepressant.

## When and how to stop antidepressants

How long you take an antidepressant for depends on why you were prescribed them and whether you have had to take them before. Ask your doctor when is best to start to reduce and then stop taking your antidepressant.

**You may need to balance:**

- The benefits that you get from an antidepressant such as relief from your symptoms of anxiety or depression.

**Against:**

- The problems that can occur after using them for a long period. These include increased side-effects, weight gain – and sometimes they just seem to stop working.

When you agree that it is time to stop, your doctor can help you put together a withdrawal plan. This must be flexible. It should allow you to reduce the dose at a rate that you find comfortable – as slowly as you need to avoid distressing withdrawal symptoms. This is also called 'dose tapering'. Dose reductions will usually get smaller as the dose decreases – some people need to get down to a very low dose before stopping.

## How slow should the tapering be?

This is different for everyone. If you have been taking an antidepressant for only a few weeks you may be able to reduce, and stop, over a month or so. Even if you have only mild (or no) withdrawal symptoms, it is best to do this over at least four weeks.

If you have been taking antidepressants for many months or years, it's best to taper more slowly (again, at a rate you find comfortable). This will usually be over a period of months or longer. It's also best to reduce the dose slowly if you have had withdrawal symptoms in the past.

Do remember – if you do get withdrawal symptoms it doesn't mean that you can't stop your antidepressant. You will just need to taper more slowly, with smaller reductions in dose, over a longer period of time.

Only occasionally, where an antidepressant causes serious side-effects, should it be stopped suddenly, without tapering. If this does happen, see your doctor urgently.

## How should I gradually reduce my dose?

There is some general advice on how to do this below but it's best to work this out with your doctor, so that they can prescribe the appropriate preparation and dose(s) for you. They will be able to work out any special requirements with your pharmacist, so that the prescription is tailored to what you need.

- If you have been taking antidepressants for only a few weeks then start, as a test, by reducing your regular dose by a quarter (25%) or a half (50%). Allow two to four weeks to adjust to the new dose, to see how things go.
- If you don't get any distressing symptoms, try a further reduction of a quarter (25%) or a half (50%) of the current dose. Allow another 2 to 4 weeks and repeat, with further periods of lowering the dose and waiting.
- If uncomfortable symptoms develop with your first dose reduction, or at any further reduction, stop the reduction. Go back to the last dose at which you felt comfortable and wait until you feel ready to try again – perhaps using a more gradual taper, reducing by smaller amounts – 5% or 10% .
- How you reduce your dose of antidepressant will depend on what dosages are available in tablet and liquid form in the UK. You can switch to a liquid form of your antidepressant – or, if the one you are taking is only available in tablets or capsules, you can change to a similar antidepressant that is available as a liquid. Your doctor and pharmacist can advise you on how best to do this. We don't recommend splitting tablets or capsules yourself, or making your own liquid. It can be difficult to measure the right amount, particularly with small doses. Tapering strips (a roll or strip of pouches containing consecutively slightly lower doses to be taken each day) are prescribed in some countries. They are not yet approved in the UK, so your doctor cannot prescribe them on the NHS.
- Don't try missing medication on some days, this will lead to the amount of the drug in your body fluctuating and make withdrawal symptoms more likely.
- Regular monitoring will allow you and your doctor to recognise any problems quickly, particularly if you have to switch from one antidepressant to another.

- If you have:
  - been taking antidepressants at a high dose for many months or longer
  - developed distressing withdrawal symptoms when you have previously tried to reduce or stop antidepressants

  It is probably best, right from the start, to use more gradual reductions of a twentieth (5%) or a tenth (10%) of the original dose – and to see your doctor regularly, so that they can keep an eye on how it is going.
- Long-acting antidepressants, like fluoxetine, can take weeks to leave your body (most take just days). So, any withdrawal symptoms may develop several days, or even weeks, after reducing the dose. It is best to wait at least four weeks to see if withdrawal symptoms start.
- No matter how low the dose you get to, you can still get withdrawal symptoms when you stop completely. If this happens you may need to re-start the medication at a low dose for a while before completely stopping it. This may be a dose of 1mg or less.
- If you start to get suicidal ideas when reducing and stopping an antidepressant, this could be a withdrawal symptom – or the return of depression. You should go back to the last dose at which you felt well and see your doctor as soon as possible. Make sure you know how to get help quickly if you need it.

## Examples of tapering plans

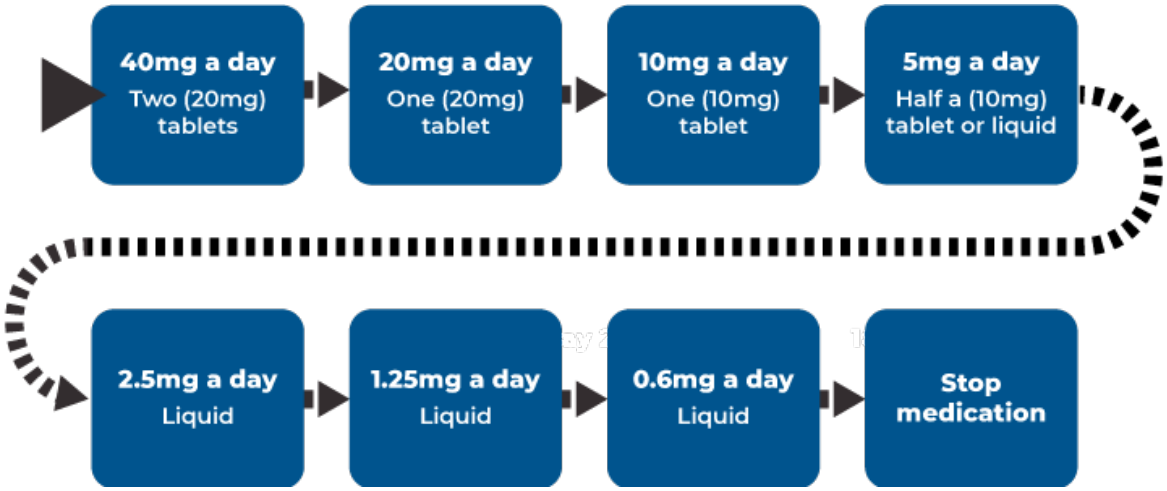
It's best to agree your tapering plan with your doctor and pharmacist. Below you will find example plans for tapering at different speeds. In your plan, you may not want or need to follow every step, but some people will find that they need to. You may want to make even smaller reductions (such as reducing by a quarter of the dose, not half, or even as small as 1/10th or 1/20th of the last dose at each step). The time between dose reductions should be as long as withdrawal symptoms take to disappear.

You may need to use both tablet and liquid (as in the paroxetine example). If so, this will need to be very carefully managed so that there are no mistakes with the dose.

### Citalopram

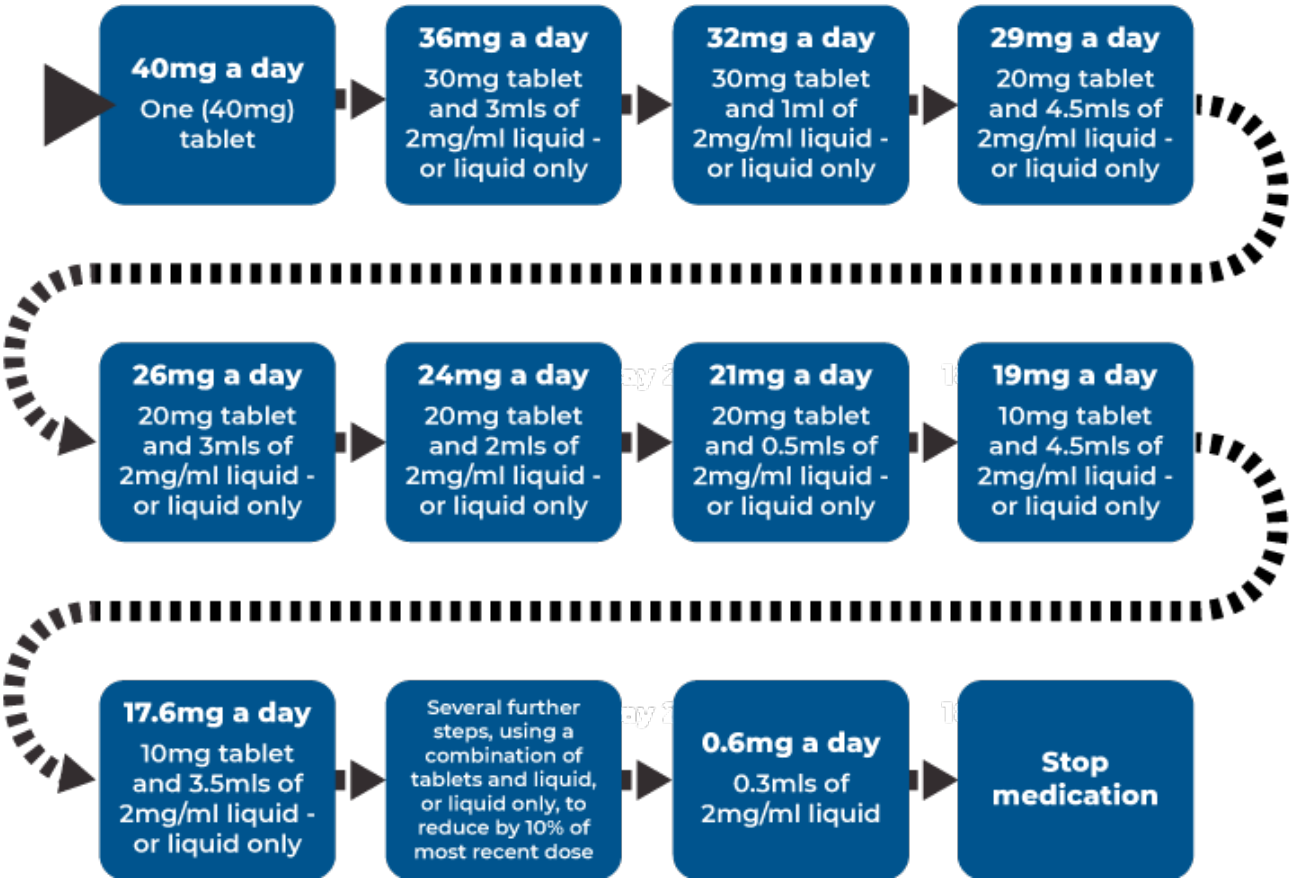
12-24 weeks = a 3 - 6 months taper

Reduction of dose by 50%, every 2-4 weeks. Some people may need to reduce more slowly.



## Paroxetine 20-40 weeks or more = a taper of 5-10 months or longer

Reduction by 10% of the last dose, every 2-4 weeks using tablets and liquid. Some people may need to reduce more slowly.




# Appendix 1: Risk of withdrawal symptoms with individual antidepressant

| Highest Risk | Moderate Risk | Low Risk | Lowest Risk |
|---|---|---|---|
| Amitriptyline | Citalopram | Bupropion | Agomelatine |
| Clomipramine | Escitalopram | Fluoxetine | |
| Paroxetine | Fluvoxamine | | |
| Venlafaxine | Imipramine | | |
| Duloxetine | Lofepramine | | |
| | Nortriptyline | | |
| | Mirtazapine | | |
| | Reboxetine | | |
| | Sertraline | | |
| | Trazodone | | |
| | Vortioxetine | | |

# Appendix 2: Potential types of withdrawal symptoms

| Physical symptoms | Sleep symptoms | Emotional symptoms |
|---|---|---|
| Nausea | Insomnia | Anxiety |
| Headache | Increased dreaming | Depression |
| Dizziness | Vivid dreams | Panic |
| Abdominal cramps | Nightmares | Agitation |
| Diarrhoea | | Irritability |
| Fatigue | | Mood changes |
| Flu-like symptoms | | |
| Electric shock sensations ('zaps') | | |
| Loss of appetite | | |
| Visual disturbances (double vision; visual trailing) | | |
| Palpitations | | |
| Missed beats | | |
| Sweating | | |
| Flushing | | |
| Tremor | | |
| Tinnitus | | |
| A feeling of inner restlessness and inability to stay still (akathisia) | | |

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