**Politicians, experts and patient representatives call for the UK Government to reverse the rate of antidepressant prescribing.**

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Dr Mark Horowitz (North East London NHS Foundation Trust, UCL (honorary))

Professor Peter Kinderman (Professor of Clinical Psychology, University of Liverpool)

Dr Lucy Johnstone (Consultant Clinical Psychologist, Bristol)

Luke Montagu (Co-Founder, Council for Evidence-based Psychiatry, London)

Professor Antonio E. Nardi (Professor of Psychiatry, Federal University of Rio de Janeiro)

Sarah Stacey (Co-Founder, College of Medicine Beyond Pills Campaign, London)

Dr Andrew Tresidder (Clinical Lead for Medicines Management NHS Somerset)

Jo Watson (Psychotherapist, Worcestershire)

Stevie Lewis (Lived and professional Experience Advisory Panel for Prescribed Drug Dependence, UK)

Professor Marcantonio Spada (Professor of Addictive Behaviours, London South Bank University)

Professor Rupert Payne, (Professor of Primary Care and Clinical Pharmacology, University of Exeter) Dr Naveed Akhtar (GP. College of Medicine, co-chair Integrated Medicine Alliance)

Today a group of medical professionals, researchers, patient representatives and politicians call for the UK government to commit to a reversal in the rate of prescribing of antidepressants.

Over the last decade, antidepressant prescriptions have almost doubled in England, rising from 47.3 million in 2011 to 85.6 million in 2022/23. Over 8.6 million adults in England are now prescribed them annually (nearly 20% of adults),[[1]](#endnote-1) with prescriptions set to rise over the next decade. Additionally, the average duration of time a person spends on an antidepressant has also doubled between the mid-2000s and 2017,with around half of patients now classed as long-term users.[[2]](#endnote-2) Scotland, Wales and Northern Island have similar rates of antidepressant prescribing.

Rising long-term use is associated with many adverse effects, including increased weight gain, poorer long-term outcomes for some, sexual dysfunction, bleeding and falls. Additionally, withdrawal effects are experienced by around half of patients, with up to half of those describing their symptoms as severe, and a significant proportion experiencing withdrawal for many weeks, months or longer.[[3]](#endnote-3)

Rising antidepressant prescribing is not associated with an improvement in mental health outcomes at the population level, which, according to some measures, have worsened as antidepressant prescribing has risen.[[4]](#endnote-4) Questions remain about the extent to which poor outcomes are fuelled by such adverse effects, and the poor efficacy of antidepressants for many groups. Multiple meta-analyses have shown antidepressants to have no clinically meaningful benefit beyond placebo for all but the most severely depressed patients,[[5]](#endnote-5) which is why NICE guidance states that they should not be routinely prescribed as first-line treatment for less severe depression, while still respecting the importance of shared decision making.

Despite this, rates of prescribing to patients with mild and moderate depression remain high. One study shows 69% of diagnosed depression in older people was of mild severity,[[6]](#endnote-6) and another that of those taking antidepressants 26.4% reported mild depressive symptoms.[[7]](#endnote-7) Furthermore, one UK study showed that 58% of people taking antidepressants (2> years) failed to meet criteria for any psychiatric diagnosis.[[8]](#endnote-8)

Additionally, there are now evidence-based objections to prescribing antidepressants for sufferers of chronic pain, where efficacy is very low,[[9]](#endnote-9) alongside evidence of disproportionate prescribing to women, older people and those living in deprived areas. This raises questions about the extent to which we are wrongly medicalising and medicating the impact of disadvantage and deprivation.

As well as the human costs of unnecessary antidepressant prescribing, there are now significant unnecessary economic costs being incurred by the NHS in England of up to £58 million annually[[10]](#endnote-10) - money that could be better spent boosting non-pharmacological provision. The problem has been recognised by the NHS in its National Medicines Optimisation Opportunities 2023/24 statement.

We believe a reversal in the rate of antidepressant prescribing can be achieved by following through with various public health recommendations, in line with the NHS National Medicines Optimisation Opportunities 2023/24.

These include:

1) Stopping the prescribing of antidepressants for mild conditions for new patients

2) Adhering to the 2022 NICE guidance on safe prescribing and withdrawal management including properly informed consent and regular review of harms and benefits

3) Funding and delivering local withdrawal services integrated with social prescribing, lifestyle medicine & psychosocial interventions

4) Including the reduction of antidepressant prescribing as an indicator in the NHS Quality and Outcomes Framework (QOF)

5) Funding and delivering a national 24 hour prescribed drug withdrawal helpline and website

Finally, we hope other countries with high levels of antidepressant prescribing will also commit to a reversal in prescribing rates.

1. [Medicines Used in Mental Health – England – 2015/16 to 2022/23 | NHSBSA](https://www.nhsbsa.nhs.uk/statistical-collections/medicines-used-mental-health-england/medicines-used-mental-health-england-201516-202223) [↑](#endnote-ref-1)
2. NHS Digital. 2017, Prescriptions dispensed in the community – Statistics for England, 2006–2016

   Website:<https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community/prescriptions-dispensed-in-the-community-statistics-for-england-2006-2016-pas> (Accessed Oct 22nd 2023) [↑](#endnote-ref-2)
3. [Davies, J., Read, J. (2019). A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addictive Behaviours, 97, 111-121](https://pubmed.ncbi.nlm.nih.gov/30292574/) [↑](#endnote-ref-3)
4. Middleton H, Moncrieff J. 'They won't do any harm and might do some good': time to think again on the use of antidepressants? Br J Gen Pract. 2011 Jan;61(582):47-9. doi: 10.3399/bjgp11X548983. [↑](#endnote-ref-4)
5. [Kirsch, I. et al., (2008) Initial severity and antidepressant benefits: a meta-analysis of data submitted to the FDA. PLoS Medicine, 5, 260–268](https://pubmed.ncbi.nlm.nih.gov/18303940/) [↑](#endnote-ref-5)
6. Coupland, C., Dhiman, P., Morriss, R., Arthur, A., Barton, G., & Hippisley-Cox, J. (2011). Antidepressant use and risk of adverse outcomes in older people: Population based cohort study. BMJ (Online), 343(7819), 1–15. https://doi.org/10.1136/bmj.d4551 [↑](#endnote-ref-6)
7. Shim, R. S., Baltrus, P., Ye, J., & Rust, G. (2011). Prevalence, treatment, and control of depressive symptoms in the United States: Results from the National Health and Nutrition Examination Survey (NHANES), 2005–2008. Journal of the American Board of Family Medicine, 24(1), 33–38. https://doi.org/10.3122/jabfm.2011.01.100121 [↑](#endnote-ref-7)
8. [Cruickshank G, et al. (2008). Cross-sectional survey of patients in receipt of long-term repeat prescriptions for antidepressant drugs in primary care. Mental Health and Family Medicine, 5, 105-9](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777559/) [↑](#endnote-ref-8)
9. Birkinshaw H, Friedrich CM, Cole P, Eccleston C, Serfaty M, Stewart G, White S, Moore RA, Phillippo D, Pincus T. Antidepressants for pain management in adults with chronic pain: a network meta‐analysis. Cochrane Database of Systematic Reviews 2023, Issue 5. Art. No.: CD014682. DOI: 10.1002/14651858.CD014682.pub2. Accessed 22 October 2023. [↑](#endnote-ref-9)
10. Davies J, Cooper RE, Moncrieff J, Montagu L, Rae T, Parhi M. The costs incurred by the NHS in England due to the unnecessary prescribing of dependency-forming medications. Addict Behav. 2022 Feb;125:107143. doi: 10.1016/j.addbeh.2021.107143. Epub 2021 Oct 18. PMID: 34674906.

    Declaration of Interests:

    Dr James Davies is a practising psychotherapist, co-founder of the Council for Evidence-based psychiatry and secretariat member of the All-Party Parliamentary Group for Prescribed Drug Dependence. He has royalties on authored and edited books.

    Professor John Read – sent

    Danny Kruger MP -

    Lord Nigel Crisp (Co-Chair, Beyond Pills All Party Parliamentary Group, Houses of Parliament, London)

    Dr Michael Dixon (Chair, College of Medicine, London)

    Professor Sir Sam Everington (G.P. Vice President BMA, Deputy Chair, College of Medicine, London)

    Baroness Professor Sheila Hollins (Professor of Psychiatry, St Georges, University of London, House of Lords, London)

    Professor Joanna Moncrieff - sent

    Dr Bogdan Chiva Giurca - sent

    Prof Guy Chouinard – Non to Declare

    Michael Dooley (Treasurer, College of Medicine, London)

    Dr Anne Guy - sent

    Dr Mark Horowitz - MAH is a collaborating investigator on the NHMRC and MRFF funded RELEASE and RELEASE+ trials in Australia investigating supported, hyperbolic tapering of antidepressants. MAH is a co-founder of Outro Health, a digital clinic which aims to help people who wish to stop no longer needed antidepressant medication in North America using supported, hyperbolic tapering. MAH has received honoraria for lectures on deprescribing from NHS Trusts, Washington University and the University of Arizona.

    Professor Peter Kinderman - sent

    Dr Lucy Johnstone – None to Declare

    Luke Montagu - sent

    Professor Antonio E. Nardi – None to Declare

    Sarah Stacey -- sent

    Dr Andrew Tresidder (Clinical Lead for Medicines Management NHS Somerset)

    Jo Watson - sent

    Stevie Lewis – sent

    Professor Marcantonio Spada – None to Declare

    Professor Rupert Payne, (Professor of Primary Care and Clinical Pharmacology, University of Exeter)

    MAH is collaborating investigator and a member of the DSMB (both unpaid positions) for the RELEASE trial in Australia evaluating hyperbolic tapering of antidepressants, funded by the Medical Research Future Fund (MRFF). MAH reports consulting for and being the co-founder of Outro Health, a digital clinic supporting people to safely stop unnecessary antidepressants. MAH reports honoraria received from various NHS Trusts and the University of Washington for lectures on deprescribing. SH is an officer, All-Parliamentary Group for Prescribed Drug Dependence. JM receives research grants from NIHR, royalties on authored and edited books, lecture fees received from Alberta Psychiatric Association, British Psychological Association, Universite de Sherbrooke, Case Western Reserve University, University of Basal, co-chair person of the Critical Psychiatry Network. NC is co-chair, All Party Parliamentary Group for Prescribed Drug Dependence. LM is co-founder of the Council for Evidence-based psychiatry and secretariat member of the All-Party Parliamentary Group for Prescribed Drug Dependence. AG is a member of the Council for Evidence-based psychiatry and secretariat member of the All-Party Parliamentary Group for Prescribed Drug Dependence. MPH receives royalties from Palgrave Macmillan for a book about antidepressants. JR, MS, PG, FC, ST, AEN, GC none declared [↑](#endnote-ref-10)