Antidepressant Guide — Choice & Switching

Choosing, switching & stopping antidepressants

CLINICAL PATHWAY

20+ antidepressants are available — choose by patient profile, not a flowchart. Cross-reference with the severity-based stepped-care framework in **MH-05**. Always taper to stop; never stop abruptly, even after a short course.

CHOOSING BY PATIENT PROFILE

By clinical scenario

1	**Most adults (default)** — escitalopram; commonly favoured for a tolerability/efficacy balance
2	**Pregnancy / breastfeeding** — sertraline; most evidence for safety and the lowest relative infant dose via milk
3	**Cardiovascular disease or elderly/frail** — sertraline or escitalopram; start low, watch for hyponatraemia & falls
4	**Insomnia, weight loss wanted, or sexual side-effects a concern** — mirtazapine or agomelatine
5	**Chronic pain comorbid** — duloxetine or venlafaxine (SNRI); dual mood and pain benefit
6	**Adolescent (<18) or OCD** — fluoxetine; the only PBS-listed SSRI for adolescent depression, often needs a higher dose/longer trial for OCD
7	**Treatment-resistant** — venlafaxine plus augmentation (lithium or aripiprazole) — psychiatry input

TYPICAL STARTING DOSES

Starting and target doses vary by agent and indication — confirm current dosing and titration in the **Australian Medicines Handbook (AMH)** or eTG, and PBS-listed strengths at pbs.gov.au.

SWITCHING STRATEGIES

- **Direct switch** — stop drug 1, start drug 2 next day at usual dose; suits same-class, short half-life agents
- **Cross-taper (most common)** — taper drug 1 over 1–2 weeks while titrating drug 2 up; suits switching classes
- **Washout** — stop, wait roughly 5 half-lives, then start; required before/after an MAOI (commonly ~2 weeks, longer after fluoxetine) to avoid serotonin syndrome

KEY INTERACTIONS TO AVOID

- MAOI + SSRI/SNRI — serotonin syndrome risk; needs a washout period
- Tramadol or pethidine + antidepressant — serotonin syndrome risk; consider alternative analgesia
- Warfarin + SSRI — increased INR/bleeding risk; monitor INR after starting or stopping
- NSAIDs + SSRI — increased GI bleeding risk; consider PPI cover
- Citalopram/escitalopram + other QT-prolonging drugs — check ECG if combining multiple agents

STOPPING — TAPERING APPROACH

Withdrawal symptoms are common (not ‘addiction’) and can start within 24–72 hours of stopping abruptly. A standard taper (reduce 25–50% every 2–4 weeks) suits many shorter courses; a slower, hyperbolic taper with smaller reductions at lower doses suits long-term use or a prior history of withdrawal symptoms — see the Maudsley deprescribing guidance or the AMH switching/stopping tool for drug-specific detail.

■ SAFETY

- MAOI combinations need a washout (commonly ~2 weeks; longer after fluoxetine) — confirm before switching
- Never stop abruptly — taper, even after a short course
- Sertraline/escitalopram are commonly preferred in pregnancy, breastfeeding, and frail/elderly patients
- Generic brands are bioequivalent — a brand switch is not the same as a drug switch

■ RED FLAGS / REFER

- Treatment-resistant after two adequately dosed trials — consider augmentation or psychiatry referral
- Suspected serotonin syndrome — same-day medical assessment
- Complex polypharmacy or multiple QT-prolonging agents — pharmacist or specialist review
- Diagnostic uncertainty about bipolar features before starting an antidepressant