Why are so many Australians taking antidepressants?

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Around one in seven Australians take antidepressants; more than 3.5 million of us had them dispensed in 2021–22. This is one of the highest antidepressant prescribing rates in the world.

Guidelines mostly recommend antidepressants for more severe depression and anxiety but not as first-line treatment for less severe depression. Less commonly, antidepressants may be prescribed for conditions such as chronic pain and migraine.

Yet prescription rates continue to increase. Between 2013 and 2021, the antidepressant prescription rate in Australia steadily increased by 4.5% per year. So why are so many Australians taking antidepressants and why are prescriptions rising?

The evidence suggests they're over-prescribed. So how did we get here?

Enter the antidepressant 'blockbusters'

In the 1990s, pharmaceutical companies heavily promoted new selective serotonin reuptake inhibitor (SSRI) antidepressants, including Prozac (fluoxetine), Zoloft (sertraline) and Lexapro (escitalopram).

These drugs were thought to be less dangerous in overdoses and seemed to have fewer side effects than the tricyclic antidepressants they replaced.

Pharmaceutical companies marketed SSRIs energetically and often exaggerated their benefits, including by paying "key opinion leaders"—high-status clinicians to promote them. This prompted substantial growth in the market.

SSRIs earned billions of dollars for their manufacturers when on patent. While now relatively cheap, they still prove lucrative because of high prescribing levels.

Why are antidepressants prescribed?

The majority (85%) of antidepressants are prescribed in general practice . Some are prescribed for more severe depression and anxiety. But contrary to clinical guidelines, GPs also prescribe them as a first-line treatment for less severe depression.

GPs also prescribe antidepressants to patients experiencing distress but who don't have a psychiatric diagnosis. A friend dealing with her husband's terminal illness, for example, was encouraged to take antidepressants by her long-term GP, even though her caring capacity wasn't impaired. Another, who cried when informed she had breast cancer, was immediately offered a prescription for antidepressants.

There are several reasons why someone may take antidepressants when they're not needed. A busy GP might be looking for a convenient solution to a complex and sometimes intractable problem. Other times, patients request a prescription. They may be encouraged by an acquaintance's good experience or looking for other ways to improve their mental health.

Most patients believe antidepressants restore a chemical imbalance that underpins depression. This is not true. Antidepressants are emotional (and sexual) numbing agents—sometimes sedating, sometimes energizing. Those effects suit some people, for example, if their emotions are too raw or they lack energy.

For others, they come with troubling side effects such as insomnia, restlessness, nausea, weight gain. Around half of users have impaired sexual function and for some, this sexual dysfunction persists after stopping antidepressants.

How long do people take antidepressants?

Most experts and guidelines recommend specific prescribing regimes of

antidepressants, varying from months to two years.

However, most antidepressants are consumed by two categories of people. Around half of patients who start antidepressants don't like them and stop within weeks. Of those who do take them for months, many continue to use them indefinitely, often for many years. Long-term use (beyond 12 months) is driving much of the increase in antidepressant prescribing.

Some people try to stop taking antidepressants but are prevented from doing so by withdrawal symptoms. Withdrawal symptoms—including "brain zaps", dizziness, restlessness, vertigo and vomiting—can cause significant distress, impaired work function and relationship breakdown.

Across 14 studies that examined antidepressant withdrawal, around 50% of users experienced withdrawal symptoms when coming off antidepressants, which can be mistaken for recurrence of the initial problem. We are conducting a survey to better understand the experience in Australia of withdrawing from antidepressants.

Antidepressants should not be stopped abruptly but gradually tapered off, with smaller and smaller doses. The recent release in Australia of the Maudsley Deprescribing Guidelines provides guidance for the complex regimes required for the tapering of antidepressants.

We need to adjust how we view mental distress

Overprescribing antidepressants is a symptom of our lack of attention to the social determinants of mental health. It's depressing to be poor (especially when your neighbors seem rich), unemployed or in an awful workplace, inadequately housed or fearful of family violence. It's wrong to locate the problem in the individual when it belongs to society.

Overprescribing is also symptomatic of medicalization of distress. Most diagnoses of depression and anxiety are descriptions masquerading as explanations. For each distressed person who fits the pattern of anxiety or depression, the meaning of their presentation is different. There may be a medical explanation, but most often meaning may be found in the person's struggle with difficult feelings, their relationships and other life circumstances such as terrible disappointments or grief.

GPs' overprescribing reflects the pressures they experience from workload, unrealistic expectations of their capacity and misinformation from pharmaceutical companies and key opinion leaders. They need better support, resources and evidence about the limited benefits of antidepressants.

GPs also need to ensure they discuss with their patients the potential adverse effects of antidepressants, and when and how to safely stop them.

But the fundamental problem is social and can only be properly addressed by meaningfully addressing inequality and changing community attitudes to distress.

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