



Medicines & Healthcare products
Regulatory Agency

Antidepressants – Updated safety communications on the risk of suicidal thoughts and behaviours and sexual dysfunction where symptoms continue after stopping treatment

Public Assessment Report

Expert Working Group on Antidepressant Risk Minimisation Recommendations and the Commission on Human Medicines (CHM) Advice

Medicines and Healthcare products Regulatory Agency

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1. Plain Language Summary

An Expert Working Group (EWG) of the Commission on Human Medicines (CHM), which advises the Medicines and Healthcare Products Regulatory Agency (MHRA), was established in response to concerns raised by patients and families that the current patient information leaflets (PILs) for antidepressants do not effectively communicate the risk of suicidal thoughts and behaviours, or sexual dysfunction where symptoms continue after stopping treatment with the antidepressant.

The EWG listened to the views of patients, families, and mental health support organisations. The group considered the real-world experiences of those affected, together with the scientific literature, to understand how warnings could be made clearer and more accessible to patients.

Following this review, several updates to existing safety messaging will be implemented. These include the introduction of a boxed warning in the PILs to direct patients and carers to the updated warnings on suicidal thoughts and behaviours. A patient card will be introduced which is expected to be credit card sized, portable and will be included on or in the box of medicine to reinforce safety messages and provide information on where to get help. A new safety (ancillary) leaflet is being developed with wider healthcare system partners to support discussions at the patient's first or next consultation, and provide clear information about treatment risks and benefits, and support available.

Introduction

The Expert Working Group (EWG) on Antidepressant Risk Minimisation was established after the MHRA requested advice from the Commission on Human Medicines (CHM). The purpose of the group was to consider concerns raised by patients, families, coroners, Yellow Card reports, parliamentarians and the media, that the warnings on the risks of suicidal thoughts and behaviours in the Patient Information Leaflets (PILs) for antidepressants were not always being understood or acted upon effectively.

PILs are statutory documents, owned by the relevant marketing authorisation holders (MAHs). Their format is defined in legislation, and the content of each PIL is approved by the MHRA. This regulatory framework is important to understanding both the opportunities and limitations for updating safety information within PILs.

The EWG comprised experts from a range of disciplines, including general practice, pharmacy, nursing, psychiatry, epidemiology and lay representation.

The MHRA recognises the important contributions made by patients and families, whose experiences helped shape the review and the resulting recommendations. The EWG listened carefully to the views of families, patients, and mental health support organisations, considering their real-world experiences, together with the scientific literature. This approach helped the EWG identify ways to make safety information clearer, more accessible and easier for patients and carers to understand.

During the review, the scope of the EWG was expanded to include persistent sexual dysfunction in patients taking antidepressants which doesn't stop when the medication is discontinued. Some patients refer to this condition as Post SSRI sexual dysfunction ("PSSD"), although the symptoms have been reported with antidepressants other than selective serotonin reuptake inhibitors (SSRIs), and may also include non-sexual symptoms.

The review involved 28 antidepressants currently authorised in the UK¹. The MHRA expects that all future antidepressants licensed in the UK will incorporate the updated regulatory material resulting from this review, ensuring a consistent approach to communicating important safety information to patients and healthcare professionals.

These 28 antidepressants are associated with a wide range of licensed indications including depression, anxiety, obsessive compulsive disorder, panic disorder, eating disorders, post-traumatic stress disorder, chronic headache/migraine and pain.

Based on the group's recommendations, the CHM has advised the MHRA that the wording in the antidepressant PILs should be strengthened to provide greater clarity on the risk of suicidal thoughts and behaviours and to provide clearer signposting to sources of support. The revised text for the PIL has been developed with input from patients and families, the MHRA's Patients Information Quality Unit, and a focus group of patients with a range of mental health conditions convened by The Patients Association. This collaborative approach aimed to ensure the revised warnings are clear, accessible and effective.

Regulatory communication updates include the following:

- the introduction of a boxed warning in the PIL to direct patients and carers to the new relevant section of the PIL containing the updated warning on suicidal thoughts and behaviours.
- the introduction of a portable patient card to reinforce key safety messages regarding suicidal thoughts and behaviours, and provide information on where to seek help. The

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fluvoxamine, fluoxetine, citalopram, escitalopram, sertraline, paroxetine, venlafaxine, duloxetine, reboxetine, amitriptyline, clomipramine, dosulepin, doxepin, imipramine, lofepramine, nortryptiline, trimipramine, trazodone, isocarboxazid, tranylcypromine, moclobemide, phenelzine, agomelatine, vortioxetine, L-tryptophan, esketamine, mianserin, mirtazapine

expectation is for the card to be on the box or in the medicine pack, and it will be available digitally.

- updates to the PIL wording for certain antidepressants to include reference to the term post-SSRI sexual dysfunction (“PSSD”), where appropriate.
- updates to the PIL wording to remove reference to “chemical imbalance” and describe the mechanism of action of antidepressants in line with current clinical understanding and advice
- updates to prescribing information to ensure that these changes are maintained and continue to be reflected in PILs over time

In addition to the PIL updates, a new safety (ancillary) leaflet is being developed in partnership with healthcare system organisations to support discussions between patients and healthcare professionals regarding the risks and benefits of antidepressant treatment. The aim is for this ancillary leaflet to be provided to patients during their first consultation about antidepressant treatment, or at a subsequent consultation for patients who are already receiving an antidepressant.

The leaflet will provide more detailed information on the potential risks and benefits of treatment and is intended to support informed decision making and improve the consistency of safety messaging.

The MHRA is also working with the National Institute for Health and Care Excellence (NICE), the British National Formulary (BNF), and the Royal Colleges of General Practice and Psychiatrists and Pharmacy to promote greater alignment of safety messaging across relevant clinical communications and guidance. As part of this work, the BNF has removed the phrase “where necessary” from its advice on monitoring patients for suicidal thoughts and behaviours, so that monitoring is no longer presented as conditional and applies to all patients receiving antidepressants. Relevant partner organisations are considering updates to clinical guidance where appropriate.

The impact of these regulatory and communication measures will be monitored through an established risk management framework.

2. Introduction

The Medicines and Healthcare products Regulatory Agency (MHRA) is the regulator of medicines, medical devices and blood components for transfusion in the UK. The MHRA is responsible for making sure these products meet acceptable standards for safety, quality and efficacy. The Commission on Human Medicines (CHM) advises the government about medicines safety. The CHM is independent – it is not part of the government or the pharmaceutical industry.

In our safety Public Assessment Reports, we discuss evidence-based assessments of safety issues associated with a particular medicine or group of medicines.

This report presents the MHRA's review of safety data for 28 antidepressants and expert advice on the management of risks, as advised on by the CHM. Changes have been made to the ordering and wording used in the original assessment report to aid readability and presentation.

A [glossary of terms](#) is provided to explain technical terminology and abbreviations used throughout this report.

The information and analyses contained in this report reflects evidence that was available at the time of the review between 2022 and 2026. The MHRA and CHM will continue to monitor the safety of antidepressants closely, however the information in this report will not be actively updated with new data or studies published after its completion.

Background

In April 2022, the CHM considered a proposal to establish an Expert Working Group (EWG) on antidepressant risk minimisation. The CHM were informed that, despite extensive user testing of the existing warnings on suicidal thoughts and behaviours in the PILs for selective serotonin reuptake inhibitors (SSRIs), and clinical guidance recommending monitoring patients, reports of suicide continue to be received through the Yellow Card scheme. Some families reported that neither they or their relative were given appropriate information about these risks, and that monitoring during antidepressant treatment had been inadequate.

The CHM endorsed the proposal to convene an EWG and advised that the range of medicinal products evaluated within the review should be expanded to include all antidepressants: SSRIs, serotonin noradrenaline reuptake inhibitors (SNRIs), noradrenaline and specific serotonergic antidepressants (NASAs) and tricyclic antidepressants (TCADs) and others. The CHM considered that, although the usage of some antidepressant classes was lower than SSRIs, their overall use remained sufficiently widespread to warrant inclusion in the review.

In March 2024, the scope of the EWG review was expanded to include assessment of the evidence for the risk of sexual dysfunction which continues on stopping treatment with antidepressants, alongside the review of suicidal thoughts and behaviours.

The EWG held its first meeting on 4 July 2024. At this meeting, members reviewed the regulatory history and current regulatory position for the 28 antidepressants within scope, agreed the group's terms of reference and work plan, considering arrangements for patient involvement, and discussed the strategy for the literature review.

The following terms of reference of the EWG were published in December 2024:

- To review the views of patients and patients' families about the effectiveness of warnings on the risks of suicidal thoughts and behaviours as presented in the current patient information leaflets and any significant new primary data published since 2019 (acknowledging the quality of evidence) on the risk of suicidal thoughts and behaviours.
- To review the views from patients about the effectiveness of warnings about the risk of sexual dysfunction where symptoms continue on stopping treatment for those products with existing warnings in the current patient information leaflets and any new primary data published since 2019 (acknowledging the quality of evidence) on the risk of sexual dysfunction where symptoms continue after treatment with an antidepressant is stopped.
- To consider whether additional measures are required to raise awareness of the advice and warnings about the risk of suicidal thoughts and behaviours, and sexual dysfunction where symptoms continue after stopping for those products with existing warnings.
- And to advise the CHM on any recommendations for additional risk minimisation measures on the risk of suicidal behaviour associated with all antidepressants and sexual dysfunction which may continue on stopping treatment, and to advise on the monitoring of the impact of any introduced additional regulatory action.

Patients, families and patient support organisations attended online meetings on 1 May and 1 July 2025 to emphasise to the EWG key concerns, reinforcing issues they had raised in written submissions previously considered by the EWG.

3. EWG CONSIDERATIONS

The EWG meeting held on 1 May 2025 focussed on how the risk of suicidal thoughts and behaviours are communicated in the existing PILs. The meeting held on 1 July 2025 focussed on how the risk of sexual dysfunction where symptoms continue after stopping antidepressants is communicated in the PILs for those antidepressants that already contain warnings on this risk.

The EWG heard directly from patients and families who had requested to participate in the review. In accordance with its terms of reference, the EWG also considered evidence from a structured literature review, including an assessment of the impact of the black box warnings in the United States on suicidal thoughts and behaviours. This evidence was reviewed in response to several requests for the introduction of a similar warning in the UK.

The EWG discussed proposals from the patients and families for additional measures to raise awareness of the risks, including ways to record the risk discussions, and explored how best to monitor the impact of any regulatory action. The views of patients, families and the recommendations of the EWG from each of the meetings is summarised below.

3.1 EWG Meeting on 1 May (suicidal thoughts and behaviours)

Views of patients and families

Concerns raised by patients and families attending the meeting on 1 May are summarised below:

Patient Information Leaflet (PIL)

- The PIL is considered too long, information on suicidal behaviour is not considered prominent enough and is lost in its current position.
- The PIL does not mention that energy levels may increase early in treatment but that mood does not lift, and that medication might cause a chemically induced change with fatal consequences.
- Suicidal behaviour timing in relation to starting the medication is not predictable and can happen at any time point during treatment.

Medication carton

- There is no empirical evidence anyone reads the PILs and they are written in an unhelpful way like the “may contain nuts” warnings on food labelling, therefore warnings should be on the outer box.
- The risk of suicide should be labelled on the box especially for those aged under 25 years where it is recognised there is some increased risk from clinical trial data in 18-25 year olds.

Clinical guidance

- Initial antidepressant prescriptions are being issued over the phone without follow up appointments.
- Antidepressants should not be prescribed for less severe mental health conditions and reserved for severe depression.
- There is a lack of awareness amongst prescribers of the clinical guidance published by National Institute for Care Excellence (NICE) e.g. NG 222 and a lack of compliance with the recommended monitoring.
- Patients should be signing “something” (a proforma) to confirm they are aware of the risk of suicidal behaviour. Doctor and patient must sign to record risks have been discussed.
- Monitoring at 1-2 weeks (after starting antidepressants) is too late and patients should be told to go back to their prescriber at any time they feel more unwell after starting antidepressants.

Additional Resources

- The PIL warnings are too late in the treatment pathway, as the patient already has the medication in their hands. Patients should be provided with information before the decision to prescribe. An antidepressant should never be prescribed at the first appointment and patients must be given written information to take away and confirm they understand the risks.
- Prescription Safe Plans such as those from the Ollie foundation are considered helpful.
- NHSE ‘Making Decisions on Managing Depression’ ([Making decisions about managing depression](#)) currently contains no warning on suicidal behaviour and should be updated to contain a warning on the risk of suicidal behaviour.

Additional Patients and Families' Views

- It is morally and ethically wrong to base risk communication decisions on concerns that a patient won't take antidepressants if they need them
- There is a lack of acceptance that the patient knows best.
- The General Medical Council (GMC) allows prescription of antidepressants for patients with less severe mental illness, if in the prescriber's clinical judgement it is best for the patient.
- Patients and families should be allowed to be part of the EWG.
- Patients are not told about the risk of withdrawal reactions and current PIL wording on the risk of withdrawal should be updated as it is not helpful. *It was noted that the MHRA is taking forward a review of the communication of the risk of withdrawal reactions separately.*
- When patients present with worsening symptoms, it is often seen as a failure to respond rather than an adverse reaction to the medicine, so the medication dose is increased or switched.
- The PIL wording describing antidepressants treating a "chemical imbalance" should be removed as this is considered misleading. Wording to describe that we don't really understand exactly how these drugs work, as is present on the Royal College of Psychiatrists website would be suitable.

Literature review

In line with the terms of reference, a literature review was undertaken to identify any significant new primary data published since 2019 relating to the risk of suicidal behaviours with antidepressants. The review considered the quality and strength of the evidence.

No substantial new primary data was identified through the ProQuest search that altered the existing understanding of the risk of suicidal thoughts and behaviours or associated risk factors for the 28 antidepressants included in the review. Most of the identified publications were systematic reviews which focussed on a limited number of antidepressants and were broadly consistent with the current regulatory position.

One network meta-analysis¹ of double-blind randomised trials, which included 29 such studies, suggested that SSRIs may provide short-term protection against suicidal ideation. By week two, paroxetine, fluoxetine, escitalopram, and non-SSRI treatments were associated with a reduced risk of suicide risk compared with placebo, whereas sertraline was

not. However, this apparent effect diminished by week eight. In contrast, data on suicidal behaviour between weeks one and ten found no significant differences in efficacy between SSRIs, non-SSRIs, and placebo. These findings indicate that while SSRIs may temporarily reduce suicidal ideation, their longer-term effectiveness in preventing suicidal ideation and behaviours remains limited. Additionally, one target trial emulation study ⁱⁱsupported the findings of the 2004 review by the Committee on Safety of Medicines, confirming an increased risk of suicidal behaviour among individuals under the age of 25. In recognition of the gaps in current knowledge, and the need to monitor the impact of updates to the PIL and new patient card the MHRA proposed a Clinical Practice Research Datalink (CPRD) study..

Black Box Warnings

Given the strength of views expressed by patients and families regarding the introduction of a “Black Box Warning” for suicidal thoughts and behaviour, the MHRA undertook a review of the available evidence on this issue and presented its findings with to the EWG.

The EWG noted that boxed warnings, commonly referred to as black box warnings, have a specific legal basis within the United States Food and Drug Administration (FDA) regulatory framework but do not have an equivalent legal basis in the UK medicines regulatory system.

The MHRA explained that the FDA introduced the boxed warning on suicidal behaviour for antidepressants in the US in 2005 for patients younger than 18 years and that this was expanded in 2007 to include young adults up to the age of 24 years. The boxed warning applies to prescribing information intended for healthcare professionals rather than patient-facing information.

The MHRA also presented evidence from a 2024 systematic reviewⁱⁱⁱ examining the impact of the antidepressant boxed warning in the United States. The review reported that while the warnings were intended to reduce suicide risk, they were associated with unintended consequences, including reductions in depression diagnoses and antidepressant prescribing, alongside increases in suicide attempts and deaths in paediatric patients.

However, the review also highlighted important methodological limitations within the study which included the potential for bias arising from the data-driven model specification and inadequate control for time-varying confounding factors. The MHRA highlighted to the EWG that they were not aware of any plans by the FDA to reconsider or remove boxed warnings for antidepressants in response to this publication.

The EWG discussed differences in UK and US healthcare, legal and regulatory contexts. Members expressed concern that introducing boxed warnings could discourage some patients from seeking or continuing treatment and might inadvertently increase the risks associated with untreated depression.

The EWG therefore recommended that boxed warnings around the updated text for the risk of suicidal thoughts and behaviours should not be introduced in the UK. In reaching this conclusion, the group considered the available evidence, the absence of a corresponding UK regulatory framework, the widespread use of antidepressants, and the fact that most patients taking antidepressants do not experience suicidal thoughts or behaviours.

The EWG also noted that antidepressants are associated with other serious adverse reactions such as bleeding or QT interval prolongation, for which boxed warnings are not used. The EWG concluded that introducing boxed warnings for individual severe adverse reactions would not represent a practical or risk proportionate approach to risk communication within the UK regulatory system.

Proposal for a Clinical Practices Research Datalink (CPRD) study

To address the uncertainties around magnitude of risk of suicidal thoughts and behaviours from the scientific literature and risk factors relating to the suicidal behaviours which may be associated with the 28 antidepressants included in this review, and to inform regulatory decisions and impact monitoring, a comprehensive observational study using data from CPRD is proposed. CPRD anonymised primary care data enables the MHRA to investigate real-world patterns of antidepressant use across patient populations and link these to outcomes (including through secondary care and death registration data) to self-harm and suicide. By leveraging CPRD data, this study could potentially help the MHRA better understand any potential associations and identify the risk factors that could guide safer prescribing practices and targeted interventions to better support the benefit and risk discussions between the prescriber and patient.

It is proposed the study would contain three phases:

- Descriptive drug utilisation phase, to identify patterns and trends in prescribing patterns over time (e.g. indication, off-label use, duration of treatment, dosage, dose escalation, switching, withdrawal, and cumulative exposure).
- Exploratory hypothesis generating phase, to estimate the incidence of self-harm, suicidal behaviours, and suicide following antidepressant initiation, to inform the hypotheses to be tested in the third phase.
- Hypothesis testing phase, to make statistical conclusions about the associations of antidepressants prescribing patterns with self-harm, suicidal behaviours, and suicide.

A retrospective cohort design would be used to look at the association between antidepressant use and the risk of self-harm, suicidal behaviours, and suicide in a broad population of antidepressant initiators. Patients newly prescribed antidepressants would be selected and followed up over time for the occurrence of self-harm, suicidal behaviours, or

suicide. Patients would be followed from initiation, until the first of an included outcome, death, end of registration, or end of the study period. Incidence rates and hazard ratios would be calculated using survival analyses (e.g. Cox proportional hazards models). Comparisons could be made between different classes of antidepressants, and/or between users and non-users, matched/stratified/adjusted for confounders including age, sex, ethnicity, indication, mental health history (including previous history of self-harm), comorbidities, concurrent medications, geographical region, and socioeconomic status.

- **EWG Recommendations from Meeting of 1 May 2025**

A) Communication in the PILs

Taking into account the views of patients and families, together with the findings in the scientific literature review, the EWG made a series of recommendations to improve how the risks of suicidal thoughts and behaviours are communicated in the PILs accompanying antidepressant medicines. The recommendations of the EWG are summarised below (1-10):

Recommendation 1. Appropriate use of antidepressants

The EWG recommended that PILs should reinforce the appropriate use of antidepressants by advising patients that these medicines should be used under the supervision of a suitably qualified healthcare professional for licensed indications. Patients who have questions about why an antidepressant has been prescribed for them should be encouraged to discuss this with their prescriber.

Recommendation 2. Mechanism of action

The EWG recommended that PILs should no longer describe antidepressants as correcting a "chemical imbalance", as this is an oversimplification of current scientific understanding.

The group recommended that future wording should align with the explanation published by the Royal College of Psychiatrists, which states that although antidepressants affect neurotransmitters such as serotonin and noradrenaline, their therapeutic effects are likely to involve multiple biological and psychological mechanisms that are not yet fully understood.

Recommendation 3. Accessibility of technical terminology

The EWG noted feedback from patients regarding the accessibility of technical terminology used within PILs. The group recommended that opportunities should be explored to improve explanations of technical terms and medicine interactions to support patient understanding.

Where appropriate, supplementary educational materials and webpages could provide additional explanations of specialist terms.

Recommendation 4. Applicability of suicide-risk warnings

The EWG recommended that existing wording on suicidal thoughts and behaviours should be revised so that it applies to all patients taking antidepressants, regardless of the condition for which the medicine has been prescribed.

The group also recommended clarifying that, although the risk is highest in young adults aged 18 to 25 years, the advice applies to patients of all ages receiving antidepressant treatment.

Recommendation 5. Patient testing of revised wording

The EWG recommended that the proposed updates to PIL wording relating to suicidal thoughts and behaviours should be tested with a focus group of patients representing a range of mental health conditions to ensure that the information is clear, accessible and understandable.

Recommendation 6. Positioning of suicide-risk warnings

The EWG recommended that warnings relating to suicidal thoughts and behaviours should be positioned more prominently within PILs than is currently the case.

However, the group did not support the introduction of a boxed or "black box" warning. In reaching this conclusion, the EWG considered both the UK regulatory context and evidence suggesting that black box warnings may have unintended consequences.

Recommendation 7. Additional risk-minimisation measures

The EWG recommended the introduction of additional risk-minimisation measures to support existing safety communications. This should include the development of a portable patient card containing key safety messages relating to suicidal thoughts and behaviours, signposting to sources of support, and guidance on when to seek urgent help.

The EWG further recommended that the content and format of the warning in both the PIL and the patient card should be refined following consultation with a focus group of patients to ensure that the information is clear, accessible and understandable to people with a range of mental health conditions.

Recommendation 8. Warnings on outer packaging

In response to requests from families for a short warning on the outer packaging of antidepressants, the EWG concluded that the available space would not allow sufficient context to be provided for a serious but relatively uncommon risk.

The EWG considered that a portable patient card would provide a more effective approach, enabling clear safety messaging, practical advice on staying safe, and signposting to appropriate sources of help.

Recommendation 9. Patient acknowledgement forms

In response to requests from families that patients should sign a document acknowledging their awareness of the risk of suicidal thoughts and behaviours, the EWG expressed concern about the absence of a clear legal basis for such a requirement.

The EWG also noted that a standardised acknowledgement form may not adequately address the individual circumstances, concerns and treatment considerations that influence a patient's decision to start or continue antidepressant treatment. In addition, members were concerned that requiring patients to sign such a document could be perceived as transferring responsibility for prescribing decisions from the healthcare professional to the patient.

Instead, the EWG recommended that emphasis should be placed on the quality of discussions between healthcare professionals and patients, ensuring that conversations about risks and benefits are tailored to individual circumstances. This approach should be supported by relevant Royal College of General Practitioners (RCGP) guidance, updated NICE guidance, and the provision of supporting written information, including an ancillary leaflet.

B) Additional measures required to raise awareness of the advice and warnings about the risk of suicidal thoughts and behaviours.

Taking into account the views of patients and families, together with the findings of the scientific literature review, the EWG made a series of recommendations on additional risk minimisation materials to better communicate the risk of suicidal thoughts and behaviours with antidepressants. The recommendations of the EWG are summarised below (11-20):

Recommendation 11. Safety (Ancillary) leaflet and supporting resources

The EWG recommended the development of an ancillary leaflet to support the updated PIL and patient card. The leaflet should be provided during the initial consultation and could provide links to additional information and support resources for patients and carers.

Recommendation 12. Training and guidance for primary care professionals

The EWG recommended that the MHRA engage with the RCGP to explore wider access to suicide prevention skills training, and to review existing guidance relating to the diagnosis of depression and the monitoring of patients receiving antidepressant treatment in primary care.

Recommendation 13. Consistent messaging on diagnosis and prescribing

The EWG recommended that the MHRA, NICE, the RCGP and the Royal College of Psychiatrists (RCPsych) work collaboratively to promote consistent messaging on the diagnosis and management of depression in primary care. This should support appropriate prescribing and reduce the risk of antidepressants being used where alternative approaches may be more appropriate.

Recommendation 14. Coordinated communications

The EWG recommended that the MHRA, NICE, RCGP and RCPsych communicate a consistent position on the diagnosis, treatment and monitoring of depression in primary care. This should be reflected through relevant organisational communications, including the MHRA Drug Safety Update publications and updates to the MHRA antidepressant webpages.

Recommendation 15. Follow-up monitoring recommendations

The EWG recommended that NICE review the evidence underpinning the recommendations in Guideline NG222 relating to antidepressant follow-up reviews at one and two weeks following treatment initiation, particularly where these recommendations vary by age group.

Recommendation 16. NHS Decision Aid

The EWG recommended that the NHS depression decision aid be reviewed to determine whether information on suicidal thoughts and behaviours should be included. This recommendation should be discussed with the relevant NHS England teams responsible for maintaining and updating the resource.

Recommendation 17. British National Formulary (BNF) wording

The EWG recommended removal of the phrase "*where necessary*" from BNF guidance relating to the monitoring of suicidal thoughts and behaviours in patients receiving antidepressants. This would reinforce the expectation that monitoring should be considered a standard component of care for all patients prescribed antidepressants.

Recommendation 18. Consultation practices

The EWG recommended that communications from the MHRA, NICE, RCGP and RCPsych should emphasise the importance of direct discussions between healthcare professionals and patients. These consultations should take place face-to-face where possible, while recognising that remote consultations, including video consultations, may also be appropriate.

Recommendation 19. Mental health crisis services

The EWG supported feedback from patients and families that mental health crises should receive greater prioritisation within urgent and emergency care services. However, the group recognised that this issue falls outside the EWG's remit and therefore made no specific recommendations for implementation.

Recommendation 20. New Medicines Service

The EWG recommended that depression should be included within the conditions covered by the New Medicines Service. Following the meeting, it was confirmed that depression would be incorporated into the service from October 2025.

C) Impact Monitoring

The EWG considered the finding of the literature review, which did not identify any new evidence published since 2019 that altered the current understanding of the magnitude of risk of suicidal thoughts and behaviours associated with all 28 antidepressants included in the review. The EWG concluded that the available data was consistent with the current regulatory position.

Given the limitations in the published data across all 28 antidepressants, the MHRA presented a proposal for an epidemiological study using the Clinical Practices Research Datalink (CPRD). The proposed study aims to provide additional information on the magnitude of risk of suicidal thoughts and behaviours, as well as potential risk factors that may be relevant to future risk minimisation activities. It is proposed that the CPRD study could form part of the framework for monitoring the impact of any regulatory action.

The EWG supported the proposed CPRD study and recommended that time variant confounding is factored into the analysis given the fluctuation in mood during the treatment course and that results are interpreted with caution. The EWG agreed with a staged approach to conducting the study.

3.2 EWG Meeting on 1 July (Sexual Dysfunction where symptoms may continue)

Views of Patients

The views of the patients who attended the meeting on 1 July are summarised below:

- Initial antidepressant prescriptions are being issued without a discussion of the risk of sexual side effects which might continue after the medication is stopped.

- There is a lack of awareness amongst prescribers of the term Post SSRI Sexual Dysfunction (“PSSD”), and many doctors dismiss patient concerns or attribute their symptoms to underlying depression or anxiety.
- There is no mention of the risks of “PSSD” on the NHS websites or any NICE guidelines.
- The irreversible nature of the condition “PSSD” is not currently clear from the PIL warning and that this must be communicated.
- Patients must be informed about the lack of treatment options to treat some of the symptoms of sexual dysfunction, to support making an informed treatment choice.
- The most common symptoms reported as “PSSD” are genital numbness, loss of libido, numb orgasm, erectile dysfunction in men, lack of vaginal lubrication in women and lack of sexual response, no pleasure in anything and cognitive slowing and other problems. Patients report they feel lobotomised, castrated and dehumanised. Patient support groups are aware of people who have taken their own lives due to these effects.
- Unlike depression where people don’t function well, people with “PSSD” function; e.g. they eat well, exercise and engage in activities such as going to concerts and playing music but that they can’t enjoy or feel any of it.
- Children who have been prescribed antidepressants may not develop their sex drive as adults and as a result consider themselves asexual. Parents of some of these children have contacted patient support organisations and express guilt as they had not understood the longer-term implications of their child taking antidepressants.
- The PIL information about sexual dysfunction which may continue after stopping treatment with the antidepressant is not prominent enough and given the life changing consequences, this risk should have a prominent warning.
- NHS websites should inform doctors of the risk and how to warn patients about “PSSD”.
- Materials should be developed to help doctors understand the irreversibility and life-changing nature of “PSSD” in order that they can explain this to patients.
- There should be a study to track patients on SSRIs to identify those who develop the condition of “PSSD” and any common risk factors or treatment.
- Diagnostic tests should be developed to predict which patients may develop “PSSD”.

- Written informed consent or an acknowledgement of risk form is the best way to record patients have been informed of the risk of “PSSD.”
- A boxed warning about “PSSD” is required due to the severity.
- Patients should be signposted to more information about “PSSD”, this could include a QR code on the PIL.
- There is an urgent need for more research on the risk of sexual dysfunction and “PSSD”.
- There is an urgent need to raise awareness of the risk of sexual dysfunction and “PSSD”.

Literature review

In line with the terms of reference, all new primary data published since 2019 relating to persistent sexual dysfunction following antidepressant treatment was reviewed. Evidence on the magnitude of the risk remains limited, in part because there is currently no specific diagnosis for post-SSRI sexual dysfunction (“PSSD”) within the International Classification of Disease (ICD) 11 or the Diagnostic Statistical Manual (DSM) V.

Only one study published since 2019 reported data on the magnitude of risk^{iv}. This study focussed on erectile dysfunction in male patients and ongoing erectile dysfunction was determined by the prescription for a PDE- 5 Inhibitors. “PSSD” is defined in this study, as suffering erectile dysfunction after stopping treatment with serotonergic antidepressants for at least one month (as evidenced by taking PDE-5 Inhibitors). The results showed 4 out of 866 patients (0.46%) had symptoms persisting for one month or longer after stopping antidepressants as evidenced by a prescription for a PDE- 5 Inhibitor. However, the study used a one month cut off rather than 3 months as used in the definition by Healy et al.,2022^v. Other symptoms apart from erectile dysfunction were not reported in the study therefore the term “PSSD” has been reduced to just one symptom in this study. Therefore, the magnitude of risk cannot be extrapolated to both sexes in the wider “PSSD” patient population, as the data are not fully representative.

Two additional publications identified through the review were survey-based studies. One survey^{vi} published since 2019, is a self-reported survey of sexual and gender minority youth in Canada and the US reporting persistent post-treatment genital hypoaesthesia (PPTGH) among past antidepressant users. The authors state that persistent posttreatment genital hypoaesthesia (PPTGH) is a primary symptom of “PSSD.” Of the 2179 survey participants, 574 reported genital hypoesthesia. They were older and more likely to report male sex assignment at birth, hormonal therapy history, and psychiatric drug history. The frequency of

PPTGH among antidepressant users was 13.2% (93/707) compared to 0.9% (1/102) among users of other medications; adjusted odds ratio: 14.2 (95% CI: 2.92 to 257).

The second survey was a retrospective survey^{vii} that characterised the symptoms of “PSSD” and captured quality of life outcomes. The survey found that persistent sexual dysfunction can occur after just one dose of a serotonin reuptake inhibitor and that after discontinuing of treatment with a serotonin reuptake inhibitor, 45% of respondents reported some improvement and 37% experienced continued or worsening symptoms. The survey found that individuals with “PSSD” have tried a variety of different medications and therapies to alleviate symptoms. This study found that at least one non-sexual symptom was reported in 70% of cases. In written answers, individuals with “PSSD” reported new diagnoses of depression, anxiety, and post-traumatic stress disorder as a result of their condition. There were also reports of past suicide attempts, current suicidal ideation, and knowledge of friends or loved ones with “PSSD” who had ended their lives. A concerning theme among written responses is a willingness to experiment with potentially harmful and illicit substances to treat symptoms of “PSSD”.

Proposal for a CPRD study to further research into “PSSD” and Monitor Impact

To address the gaps identified from the literature review and remaining uncertainties around the magnitude and natural history of sexual dysfunction which continues after stopping antidepressants, a comprehensive observational study using data from CPRD is proposed. CPRD – the anonymised primary care data base enables the MHRA to investigate real-world patterns of antidepressant use across patient populations and link these to outcomes related to sexual dysfunction. CPRD data could potentially help the MHRA better understand any potential associations between antidepressant use and sexual dysfunction which continues after stopping. The data may also have the potential to identify the risk factors that could improve better information provision to patients and guide safer prescribing practices, as well as targeted interventions to better support the benefit and risk discussions between prescriber and patient.

It is proposed the research would build upon the foundations of the descriptive drug utilisation study currently being undertaken in relation to antidepressants and suicide, which would constitute phase one a. This research would add three further stages:

- A feasibility study (phase one b) to assess coding practices before and after the introduction of dedicated codes. This would assess the feasibility of identifying cases of persistent sexual dysfunction following antidepressant withdrawal in CPRD primary care data and compare recording patterns before and after the introduction of specific MedDRA and SNOMED terms.

- Exploratory hypothesis generating phase (phase 2), to estimate the incidence and persistence of sexual dysfunction following antidepressant withdrawal, to inform the hypotheses to be tested in the third phase.
- Hypothesis testing phase (phase 3), to make statistical conclusions about the associations of antidepressant prescribing patterns with sexual dysfunction.

A retrospective cohort design would be used to look at the association between antidepressant withdrawal and the risk of sexual dysfunction (e.g., “PSSD”, persistent sexual dysfunction following antidepressant withdrawal, decreased libido, anorgasmia, erectile dysfunction, dyspareunia, prescriptions for sildenafil/tadalafil/topical oestrogen, referrals to sexual health/urology/gynaecology) in a broad population of antidepressant users. Patients stopping antidepressants would be selected and followed up from the estimated withdrawal date until the first of an occurrence of persistent sexual dysfunction, death, end of registration, or end of the study period. Incidence rates and hazard ratios would be calculated using survival analyses (e.g. Cox proportional hazards models). Comparisons could be made between different classes of antidepressants, and/or between users and non-users, matched/stratified/adjusted for confounders including age, sex, ethnicity, indication, mental health history, previous history of sexual dysfunction, comorbidities (e.g. diabetes, cardiovascular disease), concurrent medications, smoking status, geographical region, and socioeconomic status.

- **EWG Recommendations from Meeting of 1 July 2025**

A) Communication in the PILs

Taking into account the views of patients and families, together with the findings of the scientific literature review, the EWG made a series of recommendations to improve how the risk of Post SSRI Sexual Dysfunction (“PSSD”) is communicated in the PILs accompanying the relevant antidepressant medicines.

Recommendation 21. Reflect the term PSSD in the relevant PILs

The EWG recommended that updates to the current PILs for antidepressants should be implemented to include the term Post SSRI Sexual Dysfunction (“PSSD”) to help raise awareness of the condition. The EWG recommended that these updates should apply to those antidepressants with current warnings in their product information regarding sexual dysfunction and the additional antidepressants identified as having a potential association based on the review of Yellow Card data (amitriptyline and nortriptyline).

The EWG recommended wording to reflect that published by the Royal College of Psychiatrists which states: “Rarely people can experience more persistent sexual side-effects after they have stopped taking SSRIs. The term post SSRI sexual dysfunction

“PSSD”) has been used by some people to describe these symptoms. For these people, “PSSD” can have a significant and distressing impact on their lives. More research is needed to understand why this happens and how common it is. It is important that people experiencing ongoing sexual side-effects receive appropriate and timely support.”

Table 1: Current PIL warning for the risk of sexual dysfunction where symptoms continue after stopping and MHRA proposed updates

Current Warning (in section 2) of the PIL SSRI/SNRI² (What you need to know before you take [invented name])	Proposed Warning for section 2 of the PIL³ (What you need to know before you take [invented name])
Medicines like [Invented name] (so called SSRIs/SNRIs) may cause symptoms of sexual dysfunction (see section 4). In some cases, these symptoms have continued after stopping treatment.	Medicines like [Invented name] may cause symptoms of sexual dysfunction (see section 4). Rarely people can experience more persistent sexual side-effects after they have stopped taking SSRIs. The term ‘post SSRI sexual dysfunction’ (PSSD) has been used by some people to describe these symptoms. For these people, PSSD can have a significant and distressing impact on their lives. Research is needed to understand why this happens and how common it is. It is important that people experiencing ongoing sexual side-effects receive appropriate and timely support.

B) Additional Measures to Raise Awareness of “PSSD”

Taking into account the views of patients and families, together with the findings of the scientific literature review, the EWG made a series of recommendations on additional risk minimisation materials to better communicate the risk of “PSSD” with some antidepressants. The recommendations of the EWG are summarised below (22-26):

² Desvenlafaxine; duloxetine; milnacipran; venlafaxine Citalopram; escitalopram; fluoxetine; fluvoxamine; paroxetine; sertraline

³ The above medicines minus desvenlafaxine and milnacipran which are not available in the UK and adding in amitriptyline and nortriptyline

Recommendation 22. Patient card

The EWG did not reach a consensus on the need for a patient card specifically addressing the risk of post-SSRI sexual dysfunction (“PSSD”). Some members considered that a dedicated card could help raise awareness and provide patients with an additional source of information. However, others considered that any patient card should also address other important risks associated with antidepressants. The EWG noted that inclusion of multiple risks may reduce the effectiveness of the card if the information becomes overly condensed or simply duplicates content already included in the PIL.

Recommendation 23. Patient acknowledgement forms

The EWG recommended that requiring patients to sign a form acknowledging the risk of “PSSD” would not be appropriate at the present time, given the uncertainties regarding the frequency, risk factors and natural history of the condition. The group considered that further research is required before such an approach could be justified.

Recommendation 24. Ancillary leaflet and supporting resources

The EWG recommended the development of an ancillary safety leaflet providing more detailed information on symptoms associated with “PSSD” than can reasonably be included within a PIL. The leaflet should include links to additional information and support resources.

The EWG further recommended that the leaflet should be jointly developed and co-branded by the MHRA, the Royal College of Psychiatrists (RCPsych) and the Royal College of General Practitioners (RCGP), rather than by marketing authorisation holders. The information provided should align with NHS communications and supporting patient resources.

Recommendation 25. Clinical guidance

The EWG recommended that relevant NICE guidance should be reviewed following publication of the MHRA Drug Safety Update communicating the outcome of the review.

Recommendation 26. Further research

The EWG concluded that further research into “PSSD” remains necessary. The group supported the MHRA proposal to undertake a CPRD feasibility study and to collaborate with the Centre for Quality Improvement of the Royal College of Psychiatrists. The EWG recommended that the study should also contribute to monitoring the impact of any future regulatory actions.

4. CHM Advice - September 2025

The CHM discussed the recommendations of the EWG and carefully considered the feedback from the patients and families on the inconsistency of advice they had read, or their family member had received from the prescriber, the National Health Service (NHS) website, the National Institute for Health and Care Excellence (NICE) guidelines, Making Decisions about Managing Depression support tool, the British National Formulary (BNF), and the antidepressants' PILs.

The CHM advised that several excellent leaflet resources exist about depression such as that available on the Royal College of Psychiatrists (RCPsych) website and advised MHRA to explore available resources and consider a video version of a leaflet or the possibility of adding the information developed to the NHS App.

The CHM advised that the GP training modules reflect the clinical challenges of providing balanced warnings to patients who are unwell and anxious, and who may lack insight, without causing undue alarm which may prevent them from engaging with treatment.

Patient Card

The CHM advised that a patient card to communicate the risk of "PSSD" could not be applied to all antidepressants and that the magnitude and nature of risk required further research, but that this position could be kept under review by the MHRA as the data evolve.

The CHM discussed that a patient card explaining the risk of suicidal thoughts and behaviours and signposting to help is important especially given that patients in distress at the time of prescription may not be in the frame of mind to read all of the information in the PIL. The CHM also advised the MHRA to explore a digital patient card for warnings on suicidal behaviour in addition, or instead of, a cardboard tear off card, which may be lost.

PIL Updates

The CHM provided specific advice on the PIL text regarding the risk of suicidal behaviour, and noted the technical comments from the MHRA on future proofing updates. The CHM advised that antidepressants may also be prescribed for pain and that the recommended EWG text of starting section 2 of the PIL with "antidepressants are indicated for people with a diagnosed mental illness. If you have no diagnosis, please speak to your doctor" should be amended so it is more inclusive of non mental health indications. The MHRA will seek to take this forward in developing the ancillary leaflet.

The CHM discussed the proposal for a short statement boxed warning as a headline at the top of the PIL to sign post patients to the relevant section for more information on the risk of

suicidal behaviour. The CHM advised that the proposed wording “warning- suicidal behaviour-see section 2” should be expanded to include advice to call 999 or 111 or 112. The MHRA has taken this advice forward in the proposed text for the patient card.

The CHM advised that section 2 should state “if you feel worse after starting this medication, contact your prescriber”. Additionally, it was noted that the bullet pointed symptoms in the proposed PIL text require further thought given that several symptoms would not qualify through the Emergency Department triage system to enable patients to be seen at the hospital - such as trouble sleeping. The CHM advised the MHRA seek focus group testing of the proposed updates on the risk of suicidal thoughts and behaviours with a group of patients with a range of mental health conditions.

The CHM discussed the proposed text for expressing the risk of “PSSD” in the PIL and advised that the text from the RCPsych website should be adopted for those antidepressants with existing warnings and the three additional products with Yellow card evidence. The CHM advised that the term “PSSD” should be added to section 4.4 of the SmPC for drugs without existing warnings given that the PIL wording should align with the SmPC.

Patient Acknowledgement Form

The CHM advised that a risk form for documenting discussions about the risk of suicidal behaviour or “PSSD” would not be appropriate risk minimisation for the reasons outlined by the EWG.

Risk Communication

The CHM advised that a Drug Safety Update (DSU) article should be published to raise awareness of the risk of suicidal thoughts and behaviour and “PSSD”, and to reinforce the importance of reporting adverse events to the Yellow card scheme. The CHM acknowledged that a DSU article will trigger a review by NICE of relevant clinical guidelines to support consistent messaging about prescribing, monitoring and reporting side effects.

The CHM advised the MHRA to meet with the NHS to discuss the updates recommended by the EWG to add suicidal behaviour and “PSSD” to information on their website and to update the Managing Depression decision tool. They also advised meeting with the BNF to remove the reference to “where necessary” from their advice on monitoring for suicidal behaviour patients on antidepressants.

The CHM endorsed updates to the MHRA website and publication of a public assessment report providing the evidence considered by the EWG, which underpinned their recommendations, and the final Commission advice.

Research

The CHM discussed and endorsed the EWG recommendations on the MHRA proposals for Clinical Practice Research datalink (CPRD) studies to generate data to bridge gaps in information on the risks identified in the literature search, and to serve as a platform for monitoring the impact of regulatory action going forwards.

5. Finalisation of the Updated Regulatory Position

A) Thoughts of self-harm and suicidal behaviour

In May 2026, the MHRA commissioned The Patients Association to convene a focus group of patients with a range of mental health conditions, to review the MHRA proposals for updates to the antidepressants PILs following the EWG recommendations and CHM advice.

Overall, the focus group members felt that the MHRA's proposed updates to the PIL, informed by feedback from patients, families and the EWG, represented a meaningful improvement on the current wording. Participants felt that the tone of the wording was clearer, friendlier and more aimed at the patient. The language was simpler and it was easier to read than the current version.

Some participants felt that the new wording risked scaring/alarming patients. Using the term suicidal could be triggering for some people living with mental health conditions.

The importance of using simple language was highlighted repeatedly. The key to this was keeping sentences short and giving each one a new line. Where terms are used that some patients might be unaware of – such as clinical trials – these could be explained in lay terms.

The two-week window for antidepressants to start to work did not reflect the experience of several participants in the focus group, who found they took longer. Citing a longer time frame could help manage patient expectations and create a bigger safety net.

The importance of monitoring was emphasised by participants. Keeping a close eye on how antidepressants impact a patient, particularly in the early stages of using them, was seen as something that the PIL should cover. This could be framed as looking after wellbeing. Support with this, could come from someone close to the patient and help them avoid panic because of how they feel, or from the patient's prescriber.

The focus group suggested that patients may benefit if the PIL states how long they may need to take the medication for before they start to see the full effects, and the likely length of time they may need to take them for. Participants felt that people taking antidepressants the first time may believe that they will need to it forever.

The focus group advised that the PIL could also be used to give patients hope, even if there may be difficulties for them in the short-term. Without an understanding that the medication is designed to help them, some patients may be reluctant to use antidepressants and could miss out on potential benefits.

Participants highlighted the importance of making the PIL accessible to different groups of people. People who are colour blind or short-sighted were highlighted in particular. More broadly some patients may not read the entirety of the information in the PIL, so bolding key text could help make sure patients don't miss the most important points.

Amendments to the language on age-related risk in the proposed wording were welcomed. The changes meant that although the risks to younger people remained clear, they were no longer presented as a definite. The changes also meant it was clearer that the risks could apply to people of any age.

The participants agreed that telling someone a patient trusts about their antidepressant use was seen as a positive step, even though some patients may not have that person. This is likely to be more suitable in the first instance than calling a GP or hospital for many people. The PIL could suggest that the patient's trusted person views the leaflet themselves.

Participants felt that patients are unlikely to want to speak to either their GP or a hospital when they are feeling unwell. Moments of crisis are more likely to occur for patients outside of working hours and if they did call either their GP or hospital, they may not be able to get through to someone who can help.

The insertion of telephone numbers where patients can go for help was welcomed. NHS 111 could offer the chance for a patient to speak to someone trained in mental health, whilst signposting to websites or support agencies could provide additional help. The latter would be particularly useful for those seeking information at a slower pace who are not in crisis. Conversations with pharmacists may also be beneficial.

There was some confusion over where the risks from using antidepressants apply. At one point the PIL discusses the risks associated with starting medication, and at another it talks about the risks when someone stops. Although the bullet point list was welcomed, the order of more and less alarming information was mixed. It was also more focused on anxiety and actions, rather how a patient may feel when they experience the symptoms.

The addition of the boxed warning was seen as positive, but some concerns were expressed over the wording it used. Some participants felt that having a clear, simple, and eye-catching warning of the risks was needed even if it was unpleasant. Others did not like the term suicidal behaviour but struggled to find a more suitable alternative, though some different wording options were put forward in the discussion.

Alternatives to 'suicidal behaviour': Some in the group felt that the term suicidal behaviour was too sensitive and risked triggering patients. 'Behaviour' also implied that patients were acting (pretending). Gentler language, such as harming or hurting yourself, deep pain, and thoughts of ending your life was suggested. The Samaritans work on alternative language

was referenced. Examples of what suicidal behaviour could be, other than someone taking their life, could be given to soften the impact of the terminology, if it is used.

The importance of the PIL was noted in the discussion, as some patients may never have a discussion with a health professional about the risks of taking antidepressants. The difficulty of trying to make the risks clear to patients, whilst at the same time trying not to frighten them, was also acknowledged.

The finalised updated PIL warning following the Patient Association patient focus group meeting held on 21st May 2026 and shared with the marketing authorisation holders (MAHs) for agreement or the provision of reasons not to implement is below. The vast majority of MAHs welcome the updates to the PIL and introduction of the patient card. A small number raised objections and reasons why they would not implement the changes, which have been considered and addressed by the MHRA.

- Boxed Warning

A boxed warning which appears above any headlines or existing boxed warnings to signpost patients and carers to the important section of the PIL:

Warning – Thoughts of self-harm and suicidal behaviour – see section 2
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- Update to section 2 of the PIL:

This medicine may be associated with thoughts of self-harm and suicidal behaviour in some people.

Tell someone you trust, who can help you in an emergency, that you are taking this medicine and ask that they read this leaflet

Talk to your trusted person, prescriber or go to a hospital straight away, if after starting this medicine, you have new or worse:

- Feelings of anxiety or irritability
- Feelings of restlessness and agitation
- Extreme increases in activity and difficulty sleeping
- Thoughts of acting on dangerous impulses to harm yourself
- Thoughts about suicide or dying
- Changes in behaviour or mood you, or someone you trust, notices and is worried about

In some people, thoughts of self-harm and suicidal behaviour may be increased when first starting antidepressants. Antidepressants all take time to work; and

sometimes side effects occur before you or others notice improvements in your mood.

Never stop taking an antidepressant suddenly without first talking to a healthcare professional. Stopping an antidepressant medicine suddenly can cause other symptoms related to withdrawal to occur.

Information from clinical trials has shown the highest risk of thoughts of self-harm and suicidal behaviour, is in adults aged less than 25 years who were treated with an antidepressant, but the risk applies to people of all ages treated with these medicines.

Call NHS 111 who can offer you support, until you can be with someone who can help you in person

- **Patient Card**

- This medicine is an effective treatment but can take time to work.
- You may experience some side effects before your symptoms improve
- Please read the leaflet provided in the box of your medicine for more information

Warning- Thoughts of self-harm and suicidal behaviour

- Do not suddenly stop taking this medicine without talking to a healthcare professional
- Tell someone you trust you are taking this medicine
- Ask your trusted person to read the leaflet
- Contact your trusted person or go to a hospital or call NHS 111, or your local NHS mental health crisis team, if you have new or worse thoughts of harming yourself

B) Sexual Dysfunction where symptoms continue after stopping.

For those antidepressants for which there is sufficient evidence of an association between the antidepressant use and symptoms, the new PIL text will state:

Medicines like [Invented name] may cause symptoms of sexual dysfunction.
Rarely people can experience more persistent sexual side-effects after they have

stopped taking SSRIs. The term 'post SSRI sexual dysfunction' (PSSD) has been used by some people to describe these symptoms. For these people, PSSD can have a significant and distressing impact on their lives. Research is needed to understand why this happens and how common it is. It is important that people experiencing ongoing sexual side-effects receive appropriate and timely support.

C) Update to Section 1 of the PIL

Where they currently exist, any reference to antidepressants "correcting certain chemical imbalances" has been removed and replaced with:

"As with many other kinds of medications and treatments, we don't know for certain how antidepressants work. We do know that they affect the activity of certain chemicals in our brains. These are called neurotransmitters, and pass signals from one brain cell to another. The neurotransmitters most affected by antidepressants are serotonin and noradrenaline. However, research suggests that antidepressants work on the brain in multiple ways that go beyond simple chemical reactions. This research suggests that they:

- influence how the body responds to stress
- improve our negative thinking
- stop or even reverse damage to brain cells."

6. Next Steps

The MHRA continues to work closely with healthcare system partners to develop a safety (ancillary) leaflet for patients prescribed antidepressants. The leaflet is intended to be provided to patients at the first consultation, or at a subsequent appointment for patients already receiving antidepressant treatment. It will support discussions between patients and healthcare professionals by providing information on the potential benefits and risks of antidepressants, allowing patients time to reflect on their treatment choices and make informed decisions.

The updated PILs will be introduced through the standard regulatory update process and will start to appear in the medicine boxes within the next 6 months. The electronic versions of PILs will be available sooner.

A patient card containing key safety messages will also be made available in both electronic and printed formats. The expectation is for the printed cards to be introduced through routine packaging updates. During the implementation period, the MHRA encourages dispensing practices and pharmacies, where feasible, to provide patients with a printed copy of the card on request or provide a link to the electronic version, using the QR code included in the Direct Healthcare Professional Communication (DHPC) or by directing patients to the electronic versions available through the Electronic Medicines Compendium (eMC) at www.medicines.org.uk.

The MHRA will continue to work closely with healthcare system partners to review clinical guidance and communications, with the aim of improving the consistency of safety messaging relating to antidepressants.

Further information and updates are available on the MHRA antidepressants webpage which can be found [here](#).

The MHRA will continue to monitor the impact of these measures through established pharmacovigilance and risk-management activities, including the proposed Clinical Practice Research Datalink (CPRD) study. The risks of suicidal thoughts and behaviours and persistent sexual dysfunction following antidepressant treatment will remain under close review, and further regulatory action will be taken where appropriate in light of emerging evidence.

7. Glossary of Terms

<https://www.gov.uk/guidance/find-product-information-about-medicines>

Term	Definition
Ancillary leaflet	Additional information provided to support discussions between patients and healthcare professionals. It supplements, but does not replace, the Patient Information Leaflet.
CHM	Commission on Human Medicines. An independent advisory body that provides expert advice to ministers and the MHRA on the safety, efficacy and quality of medicines.
EWG	Expert Working Group. A group convened to provide specialist advice on a specific safety issue.
HCP	Healthcare Professional. Includes doctors, pharmacists, nurses and other regulated healthcare practitioners.
MAH	Marketing Authorisation Holder. The company responsible for maintaining the licence for a medicine.
MHRA	Medicines and Healthcare products Regulatory Agency. The UK regulator of medicines, medical devices and blood components for transfusion.
PIL	Patient Information Leaflet. The statutory leaflet supplied with a medicine that provides information for patients about safe use, risks and benefits.
PSSD	Post-SSRI Sexual Dysfunction. Persistent sexual dysfunction that continues after stopping antidepressant treatment.
SSRI	Selective Serotonin Reuptake Inhibitor. A class of antidepressant medicines.
SmPC	Detailed information that accompanies every licensed medicine, listing its composition and characteristics and conditions attached to its use, aimed at healthcare professionals and available at: https://www.gov.uk/guidance/find-product-information-about-medicines
SNRI	Serotonin and Noradrenaline Reuptake Inhibitor. A class of antidepressant medicines.
TCA	Tricyclic Antidepressant. A class of antidepressant medicines.
MAOI	Monoamine Oxidase Inhibitor. A class of antidepressant medicines.
Yellow Card Scheme	The UK system for collecting and monitoring reports of suspected adverse drug reactions and other medicine-related safety concerns.

8. References

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