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Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

What factors influence long-term antidepressant use in primary care? Findings from the Australian *diamond* cohort study



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ARTICLE INFO

Article history:

Received 26 August 2014

Received in revised form

11 December 2014

Accepted 25 January 2015

Available online 2 February 2015

Keywords:

Depression

Depressive disorder

Antidepressive agents

Treatment outcome

ABSTRACT

Background: Antidepressants are one of the most commonly prescribed drugs in primary care. The rise in use is mostly due to an increasing number of long-term users of antidepressants (LTU AD). Little is known about the factors driving increased long-term use. We examined the socio-demographic, clinical factors and health service use characteristics associated with LTU AD to extend our understanding of the factors that may be driving the increase in antidepressant use.

Methods: Cross-sectional analysis of 789 participants with probable depression (CES-D \geq 16) recruited from 30 randomly selected Australian general practices to take part in a ten-year cohort study about depression were surveyed about their antidepressant use.

Results: 165 (21.0%) participants reported < 2 years of antidepressant use and 145 (18.4%) reported \geq 2 years of antidepressant use. After adjusting for depression severity, LTU AD was associated with: single (OR 1.56, 95%CI 1.05–2.32) or recurrent episode of depression (3.44, 2.06–5.74); using SSRIs (3.85, 2.03–7.33), sedatives (2.04, 1.29–3.22), or antipsychotics (4.51, 1.67–12.17); functional limitations due to long-term illness (2.81, 1.55–5.08), poor/fair self-rated health (1.57, 1.14–2.15), inability to work (2.49, 1.37–4.53), benefits as main source of income (2.15, 1.33–3.49), GP visits longer than 20 min (1.79, 1.17–2.73); rating GP visits as moderately to extremely helpful (2.71, 1.79–4.11), and more self-help practices (1.16, 1.09–1.23).

Limitations: All measures were self-report. Sample may not be representative of culturally different or adolescent populations. Cross-sectional design raises possibility of “confounding by indication”.

Conclusions: Long-term antidepressant use is relatively common in primary care. It occurs within the context of complex mental, physical and social morbidities. Whilst most long-term use is associated with a history of recurrent depression there remains a significant opportunity for treatment re-evaluation and timely discontinuation.

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1. Background

Depression is mainly managed in primary care (Australian Bureau of Statistics, 2007; Mojtabai and Olfson, 2011) and antidepressant medication is currently the most common treatment used in this setting in the developed world (Marcus and Olfson, 2010). General Practitioners (GPs) prescribe the vast majority of all antidepressants used in Australia (Australian Institute of Health and Welfare, 2012) and antidepressants are the third most frequent therapeutic drug ordered, supplied or administered in US primary care (Hsiao et al.,

2010). In the UK, between 1998 and 2010, antidepressant prescribing increased, on average, by 10% per year at a cost of £220 million (Ilyas and Moncrieff, 2012). Similar increases have occurred in the USA where approximately 8.69 million people were prescribed antidepressants in 2007 at a cost of \$USD 1.46 billion (Marcus and Olfson, 2010) and in Australia which reported a 41% increase in antidepressant prescribing from 2002 to 2007 (Australian Institute of Health and Welfare, 2012; Hollingworth et al., 2010).

Despite increases in the use of antidepressants, the prevalence of depression within the community has remained static (Wittchen et al., 2011; Baxter et al., 2014). The rise in antidepressant use is thought to be mainly due to small changes in the proportion of patients receiving long term treatment (Moore et al., 2009). It is generally accepted that antidepressants should be taken for six months following the resolution of a documented major depressive

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episode and longer-term use is being encouraged to prevent recurrence in particular high-risk groups, although the size of this population is difficult to determine (American Psychiatric Association, 2010; Bauer et al., 2007; DGPPN, 2012; Hirschfeld, 2001; National Institute for Health and Clinical Excellence, 2009; Vos et al., 2004).

Current evidence around mean length of use of antidepressants in primary care is limited. One large Scottish study using routine data from 78 urban general practices reported a mean length of use of 5.5 years (Johnson et al., 2012). Another US study found that around 60% of Americans taking antidepressant medication reported use for 2 years or longer, with 14% reporting use for 10 years or more (Pratt et al., 2011).

Despite long-term users accounting for the large increase in antidepressant prescribing we currently know little about their characteristics, experience of care or their clinical history. To date, only one study has investigated factors associated with long-term use of antidepressants (Meijer et al., 2004). This study used the large Netherlands PHARMO prescribing database to examine duration of antidepressant use over a six-year follow-up. Whilst limited by the data available (age, sex and prescribing data) this study reported that being female, older, previously using benzodiazepines and being treated by a psychiatrist all increased the probability of long-term antidepressant use.

Previous findings suggest that antidepressant use in primary care can be influenced by factors other than clinical symptoms (Mojtabai and Olfson, 2011). A multi-centre study across 14 countries found that the decision to prescribe antidepressants is influenced at least as much by socio-demographic factors as by clinical factors related to depression (Kisely et al., 2000; Nielsen and Gotzsche, 2011). Cruickshank et al. (2008) reported that, of the cases reviewed, 56% failed to meet criteria for a formal psychiatric diagnosis which would support long-term use. Review of antidepressant use in the USA in 2005–2008 revealed that less than a third of Americans taking one antidepressant medication had seen a mental health professional in the past year (Pratt et al., 2011). Another study reported that 21% had no documented mental health review in the previous two year period (Petty et al., 2006).

Interpretation of these findings can be difficult especially if they are based upon prescribing data and the reason for prescription is difficult to ascertain. In these cases it is not clear whether the antidepressant use is actually for another condition regularly encountered in primary care for which antidepressants are an effective treatment such as pain conditions, incontinence and irritable bowel syndrome (Mercier et al., 2013). The current study overcomes this limitation as the antidepressant use reported here is in response to questions about what participants report using to help them with their depressive symptoms.

This study aimed to examine in detail the socio-demographic, clinical factors and health service use characteristics associated with long-term antidepressant use for depressive symptoms in a primary care cohort recruited on the basis of their depressive symptom count, to extend our understanding of the factors that may be driving the increase in antidepressant use.

2. Methods

2.1. Participants

This study is based upon 789 participants from 30 randomly selected general practices in Victoria, Australia that form the *diamond* cohort, a prospective, longitudinal cohort study of people with depressive symptoms which commenced in 2005 (Gunn et al., 2008). Full details of the study design, methods and GP and patient characteristics have been reported previously (Gunn et al., 2008; Potiriadis et al., 2008). GPs were recruited from a randomly selected list of 200 GPs provided by the Health Insurance Commission (HIC) and were broadly representative of the GP population (Calcino, 1993;

Gunn et al., 2008; Potiriadis et al., 2008). 7667 patients of the selected GPs completed a screening survey. Participants were included in the cohort after informed consent was obtained if they scored 16 or more (probable depression) on the Centre for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977). These 789 participants completed a wide range of validated and study specific measures, which included demographic, socio-economic, and clinical characteristics, as well as antidepressant and health service use.

2.2. Measures

2.2.1. Categories of length of antidepressant use

The original survey data yielded six categories of length of current antidepressant use: < 1 month, 1 to < 3 months, 3 to < 6 months, 6 months to < 1 year, 1 to < 2 years and 2 years or more. These responses were only addressed if participants reported use of antidepressants in past year. We combined these with answers to a self-report question asking whether participants were currently taking antidepressants to generate a new outcome variable labelled “Length of antidepressant use” (LAU). LAU comprised three time-ordered categories: (1) “No use” which grouped participants who answered that they were not taking antidepressants and had not done so in the previous year; (2) “Short-term use” which grouped participants reporting use of antidepressants for less than 2 years; and, (3) “Long-term use” which included participants reporting use of antidepressants for 2 years or more. A cut off for long-term use at 2 years was chosen as current guidelines recommend that antidepressants are taken for 6 months following full resolution of symptoms from an episode of Major Depression and for up to 2 years for those at risk of relapse (National Institute for Health and Clinical Excellence, 2009).

2.2.2. Depression diagnosis

The Composite International Diagnostic Interview (CIDI) (World Health Organization, 1997) assessed whether participants satisfied criteria for major depressive disorder (MDD) in the past year. Participants were categorised as either with no depression, single episode, or recurrent depression.

2.2.3. Depression severity

The Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001; Spitzer et al., 1999) is a widely used self-report measure of depression that is brief, easy to administer and well validated (Arroll et al., 2010). It consists of nine criteria, assessed over the last two weeks, on which the diagnosis of *DSM-IV* depressive disorder is based. In this study depression severity, measured by the PHQ-9 (Kroenke and Spitzer, 2002) scores (range: 0–27), was used as a control variable (covariate) in the analysis.

2.2.4. Demographic, socio-economic, clinical and health service use characteristics

Patient, clinical and health service use characteristics reported to be associated with antidepressant use in the published literature were measured using study specific items and validated scales selected based upon the suitability for use in postal surveys of a primary care population. The selected tools included: Social Participation Index (Baum et al., 2000; Densley et al., 2013); the psychosis screening questionnaire (Bebbington and Nayani, 1995); Standardised Assessment of Personality – Abbreviated Scale (SAPAS) (Moran et al., 2003); The FAST Alcohol Screening Test (Hodgson et al., 2002); General Practice assessment survey (GPAS-2) (Roland, 2002); PRIME MD (Anxiety) (Spitzer et al., 1999) and Trust in Physician scale (Anderson and Dedrick, 1990). Self-rated health status was assessed using the general health question of the Short-Form 12 Health Questionnaire. (Ware et al., 1996) GP consultation length was measured using study item: “On

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