Original Research

The Utilization of Antidepressants and Benzodiazepines Among People With Major Depression in Canada

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Objective: Although clinical guidelines recommend monotherapy with antidepressants (ADs) for major depression, polypharmacy with benzodiazepines (BDZs) remains an issue. Risks associated with such treatments include tolerance and dependence, among others. We assessed the prevalence and determinants of AD and BDZ utilization among Canadians who experienced a major depressive episode (MDE) in the previous 12 months, and determined the association of seeing a psychiatrist on the utilization of ADs and BDZs.

Method: Data were drawn from the 2002 Canadian Community Health Survey: Health and Well-Being, a nationally representative sample of Canadians aged 15 years and older. Descriptive statistics quantified utilization, while logistic regression identified factors associated with utilization, such as sociodemographic characteristics or type of physician seen. Sampling weights and bootstrap variance estimations were used for all analysis.

Results: The overall prevalence of AD and BDZ utilization was 49.3% of respondents who experienced an MDE in the past 12 months and reported AD use. Key determinants of utilization were younger age and unemployment in the past week (OR 2.6; $P < 0.001$). Being seen by a psychiatrist increased utilization (OR 2.5; $P < 0.001$), possibly because psychiatrists were seeing patients with severe depression.

Conclusion: A large proportion of people with past-year MDEs utilized ADs and BDZs. It is unclear how much of this is appropriate given that evidence-based clinical guidelines recommend monotherapy with ADs in the treatment of major depression.

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Clinical Implications

- In Canada, the utilization of ADs and BDZs is high among people with MDEs, suggesting lack of adherence to clinical guidelines.
- High-risk people should be closely monitored for effectiveness of treatment and overall well-being.
- Reasons for the utilization should be determined to help develop strategies to promote uptake of the evidence-based guidelines.

Limitations

- We used cross-sectional self-reported data, which may be subject to reporting bias.
- Indications for medication use to know the diagnosis of the disease were not accounted for in the data.
- The survey was conducted in 2002; therefore, study findings may not reflect current clinical practice.

Key Words: *antidepressants, benzodiazepines, utilization, major depressive episodes, Canada*

Depression is one of the leading causes of disability, worldwide. It has a profound effect both on the life of the people and on the health care system, and thereby represents a major public health challenge.[1–3] The CCHS 1.2 revealed that 4.8% of Canadians experienced MDEs in the past year.[4] The pharmacological treatment of choice is therapy with ADs,[5] and this is reflected in data from the CCHS 1.2, where 40.4% of Canadians who had experienced MDEs in the past year reported using ADs.[6]

The therapeutic management of major depression becomes more complex with the presence of comorbid anxiety. A meta-analysis of RCTs on the use of ADs alone, and in conjunction with BDZs, among adults with major depression and (or) anxiety and (or) insomnia identified combination therapy as superior to ADs alone at 1 to 4 weeks of the treatment.[7] For example, combination therapy minimized dropouts from side effects, compared with ADs alone. However, the advantage of the combination therapy, compared with ADs alone, diminished between 6 to 12 weeks of the treatment and the meta-analysis failed to elucidate patient outcomes beyond 12 weeks.[7] The authors suggested physicians should carefully weigh the use of ADs in combination with BDZs to treat comorbid anxiety or insomnia in patients with major depression, such that the potential benefits offset the risks of the combination therapy for individual patients.[7]

Even in the presence of comorbid anxiety, clinical practice guidelines on pharmacotherapeutic management of major depression do not recommend the long-term use of BDZs to treat comorbid symptoms of anxiety or insomnia.[5] This is based on several findings. First, ADs have equal or greater efficacy than BDZs to treat anxiety disorders, such as panic disorder, and are the first choice in the treatment of panic disorder and agoraphobia.[8–12] In particular, ADs with anxiolytic properties are better tolerated and a more appropriate intervention to manage anxiety symptoms concurrent with major depression in the longer term.[7–13] By contrast, BDZs are not superior to a control treatment in reducing the depressive symptomatology that often accompanies panic disorder.[10] Last, the long-term use of BDZs is not recommended because of the risks associated with their use, including dependence.[14]

Abbreviations

AD	antidepressant
BDZ	benzodiazepine
CCHS 1.2	Canadian Community Health Survey: Mental Health and Well-Being
MDE	major depressive episode
RCT	randomized controlled trial
SSRI	selective serotonin reuptake inhibitor
WMH-CIDI	World Mental Health–Composite International Diagnostic Interview

Despite this, the use of BDZs in conjunction with ADs is common, with prevalence ranging from 9.8% to 62.9%.[15–25] These studies[15–25] identified potential factors that increase concurrent use of BDZs and ADs, such as 1) type of AD (SSRIs), 2) females, 3) older age, 4) presence of comorbid anxiety, and 5) seeing a psychiatrist. However, none of these studies[15–25] examined utilization of ADs and BDZs among people with past-year MDEs.

A further study[26] found that utilization of ADs and BDZs was more likely in respondents who had been depressed in the previous year, compared with those who had not. However, this study did not report in detail on factors associated with such coprescribing in major depression.[26] One explanation is that physicians sometimes prescribe BDZs while initiating the treatment for depression to mitigate early symptoms but then fail to withdraw BDZ therapy following treatment response.[27] Such widespread use of BDZs to treat comorbid anxiety in depressed people is of significant concern, given the potential risks of combination therapy, compared with therapeutic benefits.[7] These potential risks include tolerance, dependence, and the higher risk of falls, especially among seniors.[7]

There is also evidence of variation between countries. A comparison between Nova Scotia and Australia found double the use of BDZs to ADs in Nova Scotia.[28] However, findings from Nova Scotia may not generalize to the entire country. The study was also restricted to people aged 65 years and older.[28]

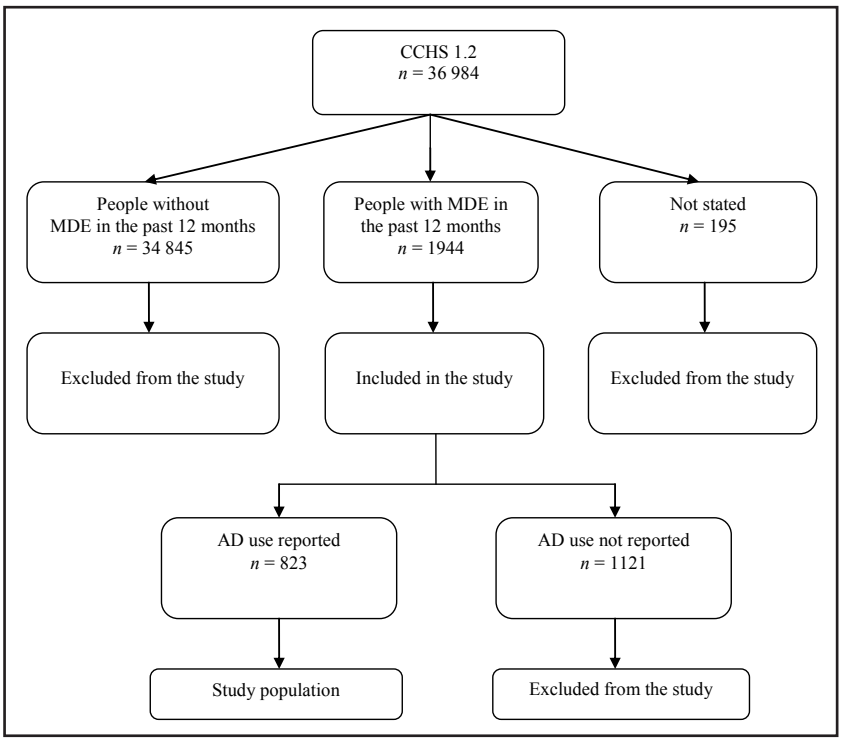
We employed a nationwide community survey to determine the prevalence and determinants of ADs and BDZs utilization in Canadians aged 15 years and older who have experienced MDEs in the past 12 months. We also determined the association of seeing a psychiatrist (compared with a family doctor or other health profession) on the utilization of ADs and BDZs. We compared the observed use of ADs and BDZs with the Canadian Network for Mood and Anxiety Treatments (commonly referred to as CANMAT) clinical practice guidelines published in 2001, as the survey (CCHS 1.2) was conducted in 2002.[5,29]

Method

Survey

We analyzed data from the CCHS 1.2,[29] a cross-sectional survey of a nationally representative sample of people aged 15 years and older, conducted by Statistics Canada between May and December of 2002. The survey collected information on the prevalence of mental disorders, such as major depression, mania, panic disorder, agoraphobia, and social phobia, as well as health service use related to these disorders. The survey achieved a 77% (n = 36 984) response rate. Most of the interviews were conducted face to face, and about 14% of the survey was conducted over the phone.[29] We selected people who experienced an MDE in the past 12 months before the interview and had used ADs in the past 12 months (Figure 1). Our study sample comprised 823 people who met the inclusion criteria.

Figure 1 Schematic representation of study population



Measures

Mental Illness. Questions on mental disorders were determined using a Canadian modified version of the CIDI developed for the WMH 2000 Survey, the WMH-CIDI. The WMH-CIDI generates both lifetime and past 12-month mental health profiles based on the definitions of the International Classification of Diseases, 10th Revision, and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.[29]

Medication Use. Participants were asked about their psychotropic medication use in the 12 months before the interview. Indications for medication use were not recorded in the CCHS 1.2 data; hence medications were assumed to be used for the conditions in which they were prescribed. AD use was based on the question, "In the past 12 months, that is, from date 1 year ago to yesterday, did you take antidepressants (such as Prozac, Paxil, or Effexor)?"[30] Similarly, BDZ use was based on the question, "In the past 12 months, that is, from date 1 year ago to yesterday, did you take any medication to reduce anxiety or nervousness (such as Ativan, Valium, or Serax)?"[30] Responses included dichotomous measures: yes and no.[30]

Physician Speciality. The key determinant in the study measured the association of physician speciality on utilization of ADs and BDZs. Physician specialty was derived from the question "Who prescribed the medication?" Responses include "psychiatrist," "family doctor or general practitioner," "other medical doctor (for example, cardiologist, gynaecologist, and urologist)," and "other health professional."[30] This variable was recoded to a dichotomy to compare psychiatrists with other health professionals ("family doctor or general practitioner" and "other" combined).

Determinants. Potential determinants of AD and BDZ utilization included were: age (recoded to aged 15 to 35 years, aged 36 to 50 years, aged 51 to 65 years, or aged 66 years and older); gender (coded either male or female); marital status (coded as married, living common-law, widowed, separated, divorced, and single, or never married); education (coded as less than secondary school, secondary school graduation, post-secondary, or post-secondary graduation); self-perceived generally physical health (coded as excellent, very good, good, fair, or poor); household income (coded into quintiles as lowest income quintile, lower middle income quintile, middle income quintile, upper middle income quintile, or highest income quintile); employment status in the last week (coded as yes or no); urban or rural residence (coded as urban or rural); regional or provincial residence (coded as Atlantic [Newfoundland and Labrador, Prince Edward Island, Nova Scotia, and New Brunswick], Prairies [Manitoba and Saskatchewan], Western [Alberta and British Columbia], Quebec, and Ontario); and health insurance coverage (coded as a dichotomous measures: yes or no).[30]

Statistical Analysis

Secondary data analysis was performed in 3 stages to examine the association between the determinants and the dependent variable. In the first stage, the prevalence of AD and BDZ utilization in the study population was

Table 1 Frequency and prevalence of AD and BDZ utilization by people who had experienced MDEs in the past 12 months

Characteristic	Unweighted *n* = 423	Weighted %	Bootstrap 95% CI
Sex			
Male	140	51.0	42.3–59.7
Female	283	48.4	42.4–54.5
Age, years			
15–35	146	48.8	41.4–56.3
36–50	158	49.7	41.2–58.3
51–65	100	52.8	42.4–63.2
≥66	19	31.4[a]	14.7–48.1
Marital status			
Married	107	49.0	40.5–57.5
Common law	32	47.6[a]	30.9–64.3
Widowed	26	44.6[a]	25.5–63.8
Separated	56	44.1[a]	29.2–59.0
Divorced	67	59.4	47.5–71.3
Single (never married)	135	48.3	38.5–58.1
Location			
Urban	363	50.1	44.7–55.6
Rural	60	44.0	32.5–55.5
Self-perceived health			
Excellent	16	46.8	25.7–67.9
Very good	80	43.4	32.7–54.1
Good	125	47.5	39.1–55.9
Fair	126	49.8	40.9–58.7
Poor	76	66.3	53.3–79.3
Education			
<Secondary school	96	45.0	36.0–53.9
Secondary school graduation	73	45.7	34.8–56.7
Post-secondary	40	51.2	36.3–66.1
Post-secondary graduation	212	52.2	44.7–59.8
Household income			
Lowest	71	63.9	52.8–75.0
Lower middle	66	53.2	40.0–66.5
Middle	101	53.0	43.8–62.3
Upper middle	101	44.4	34.5–54.3
Highest	58	49.1	37.7–60.6
Employment in past week			
Yes	146	37.9	30.3–45.5
No	200	57.5	50.6–64.4
Insurance coverage for medications			
Yes	333	49.5	44.0–55.0
No	89	48.5	38.3–58.7
Region or province			
Atlantic	78	55.0	44.7–65.4
Prairies	35	39.3	24.9–53.8
Western	86	41.7	32.0–51.4
Quebec	70	53.0	39.7–66.2
Ontario	154	53.8	46.4–61.2
Medication prescribed by psychiatrist			
Yes	153	65.7	57.4–73.9
No	264	42.2	36.2–48.2

[a] Low estimate precision owing to high sampling variability; interpret with caution

examined. Descriptive statistics were generated to provide an overview of utilization across population subgroups based on sociodemographic and other measures.

In the second stage, unadjusted analysis were performed to identify predictors of AD and BDZ utilization, incorporating covariates such as sex, age, marital status, location, employment in past week, insurance coverage for medications, education, household income, self-perceived health, provinces, and medication prescribed by a psychiatrist. Based on the unadjusted analysis, covariates with $P \leq 0.2$ were further analyzed adjusting for age, employment in last week, household income, self-perceived health, and provinces. In the third stage, a logistic regression model was constructed to examine the mediating effect[31,32] of having a prescription from a psychiatrist, compared with other health profession, on utilization, while adjusting for employment in past week, age, and region or province.

Multi-stage design effects of the survey were taken into account to obtain precise estimates that were representative of the target population. Sampling weights and bootstrap methods to estimate 95% confidence intervals, as provided by Statistics Canada, were employed in all analysis.[29] Statistical significance for all analysis was set to 2-sided alpha of less than 0.05. Data analysis was conducted using SAS software.[33] All the analysis were conducted at the Atlantic Research Data Centre, located at Dalhousie University, to maintain confidentiality of the data.[34] Our study was approved by The Health Sciences Human Research Ethics Board, Dalhousie University, Halifax, Nova Scotia.

Results

Table 1 summarizes the utilization of ADs and BDZs among people who experienced MDEs in the past 12 months. The data suggest 49.3% (95% CI 44.4% to 54.2%; unweighted $n = 423$) of respondents who had experienced an MDE in the past 12 months and were taking ADs were also taking BDZs; a high prevalence rate given the recommendations of the clinical practice guidelines.[5]

Table 2 presents unadjusted and adjusted results for the utilization of ADs and BDZs among Canadians who had experienced an MDE in the past 12 months. Adjusted results indicate that people without a job (OR 2.3; $P < 0.001$) and those aged 65 years and younger were significantly more likely to utilize ADs and BDZs. Table 3 adds psychiatrist to the analysis to assess changes in the odds of utilization, adjusting for other covariates. People whose medications were prescribed by a psychiatrist were significantly more likely to utilize ADs and BDZs (OR 2.5; $P < 0.001$) (Model 2).

We explored the possibility that one reason for combined therapy being prescribed by psychiatrists was that they saw patients with more serious cases of depression. We did this by examining people who screened positive for depression but did not experience an MDE in the past year; that is, people who did not meet the threshold to qualify for clinical depression. Among these people, having medications prescribed by a psychiatrist (OR 1.3; 95% CI 0.88 to 1.89; $P = 0.19$) or family physician or GP (OR 0.87; 95% CI 0.6 to 1.23; $P = 0.46$) had no effect on the likelihood of AD and BDZ utilization.

Discussion

Comparisons With Other Studies

Our research is one of the first population-based studies to assess the utilization of ADs and BDZs among people with major depression, and the first national Canadian study to do so. Results gleaned from our study indicate about 49% of respondents who reported an MDE in the past 12 months and reported AD use also reported BDZ use. These population-based findings are generally consistent with rates of between 9.8% and 62.9% in studies from mostly clinical settings.[15–25] This variation in prevalence likely arises from differences in setting (for example, community, primary care, or secondary care) and diagnostic criteria. We specifically assessed people with MDEs in the past 12 months, while other studies conducted in United States and Europe have employed varying definitions of depression.[15–25]

Factors Associated With the Utilization of ADs and BDZs

As has been found elsewhere, we were unable to demonstrate differences in the utilization of ADs and BDZs between males and females.[20,22] This seems surprising given that ADs and BDZs are generally prescribed more often to females.[6,23,24,35,36] The reasons for this discrepancy are unclear and warrant further investigation. However, we found that AD and BDZ utilization was associated with being aged 64 years and younger, which has been shown in studies in the United States where the odds of using ADs or BDZs among people treated for depression was higher among people aged 45 to 64 years than those aged 65 and older.[20,22] AD and BDZ utilization being less among people aged 65 years and older is encouraging, given that older people are particularly susceptible to the adverse effects of polypharmacy. Further, variation in AD and BDZ utilization across age groups identified in our study and the extant literature may arise from differences in patient characteristics, study designs, and access to prescription medications.

Employment status was found to be associated with the utilization of ADs and BDZs. People identifying themselves as unemployed were more likely to use ADs and BDZs, a finding similar to preceding studies.[24,35,36] We also found people who had medications prescribed by a psychiatrist were twice as likely to utilize ADs and BDZs (OR 2.5; $P < 0.001$), a finding uncovered in a national study completed in the United States.[20] One explanation for this finding is that psychiatrists treat patients with a higher severity of depression and (or) concurrent anxiety,[7,20,37] where it may be appropriate to add a short course of BDZs for up to 1 month.

Table 2 Logistic regression analysis of AD and BDZ utilization by people who had experienced MDEs in the past 12 months

	Unadjusted			Adjusted		
Independent variable	OR	95% CI[a]	*P*	OR	95% CI[a]	*P*
Sex						
Males	1.1	0.7–1.7	0.64	—	—	—
Age, years						
15–35	2.1	0.9–5.0	0.1	1.5	1.3–16.6	0.02
36–50	2.2	0.9–5.2	0.09	1.4	1.2–14.3	0.02
51–65	2.4	1.0–6.12	0.06	3.6	1.0–12.7	0.04
Marital status						
Married	1.2	0.5–2.8	0.69	—	—	—
Common law	1.2	0.4–3.1	0.82	—	—	—
Separated	1.0	0.4–2.6	0.97	—	—	—
Divorced	1.8	0.7–4.7	0.21	—	—	—
Single	1.2	0.5–2.9	0.75	—	—	—
Location						
Urban	1.3	0.7–2.2	0.36	—	—	—
Employment in past week						
No	2.3	1.5–3.5	<0.001	2.3	1.5–3.6	<0.001
Insurance coverage for medications						
Yes	1.0	0.6–1.7	0.86	—	—	—
Education						
Secondary school graduation	1.0	0.6–1.8	0.95	—	—	—
Some post-secondary	1.3	0.6–2.5	0.51	—	—	—
Post-secondary graduation	1.3	0.8–2.1	0.24	—	—	—
Household income, Can $						
Lowest	2.0	1.1–3.7	0.02	1.4	0.7–2.8	0.33
Lower middle	1.3	0.6–2.6	0.45	1.2	0.6–2.6	0.58
Middle	1.3	0.8–2.2	0.35	1.1	0.6–2.0	0.74
Upper middle	0.9	0.5–1.6	0.74	0.9	0.5–1.6	0.79
Self perceived health						
Very good	0.9	0.3–2.4	0.79	1.06	0.4–3.1	0.9
Good	1.0	0.4–2.7	0.95	1.09	0.4–3.1	0.86
Fair	1.1	0.4–3.0	0.81	1.08	0.4–3.2	0.88
Poor	2.2	0.8–6.5	0.14	2.01	0.6–6.6	0.24
Region or province						
Atlantic	1.9	0.9–4.0	0.1	1.77	0.8–3.9	0.16
Western	1.1	0.5–2.3	0.81	1.05	0.5–2.2	0.89
Quebec	1.7	0.8–3.9	0.21	1.7	0.8–3.8	0.17
Ontario	1.8	0.9–3.5	0.1	1.68	0.8–3.3	0.13
Medication prescribed by psychiatrist						
Yes	2.6	1.6–4.1	<0.001	—	—	—

[a] Bootstrap confidence intervals

— = no data

Reference groups for statistical analyses: sex = females; age = ≥66 years; marital status = widowed; location = rural; employment in past week = yes; insurance coverage for medications = no; education = less than secondary school graduation; household income = highest; self-perceived health = excellent; region or province = Prairies; medication prescribed by psychiatrist = no

Table 3 Logistic regression analysis of AD and BDZ utilization on key determinants, and access to a psychiatrist, among people who had experienced MDEs in the past 12 months (parsimonious model)

	Model 1			Model 2		
Independent variable	AOR	95% CI[a]	*P*	AOR	95% CI[a]	*P*
Age, years						
15–35	3.4	1.4–8.4	<0.01	3.4	1.3–9.1	0.01
36–50	3.6	1.5–8.6	<0.01	3.4	1.3–9.1	0.01
51–65	3.3	1.3–8.3	0.01	3.0	1.1–8.3	0.03
Employment in past week						
No	2.6	1.7–4.0	<0.001	2.3	1.5–3.6	<0.001
Region or province						
Atlantic	1.7	0.8–3.6	0.16	2.1	1.0–4.5	0.04
Western	1.0	0.5–2.0	0.94	1.2	0.6–2.3	0.58
Quebec	1.5	0.7–3.3	0.26	2.1	1.0–4.4	0.06
Ontario	1.7	0.9–3.2	0.11	1.9	1.0–3.5	0.05
Medication prescribed by psychiatrist						
Yes	—	—	—	2.5	1.5–3.9	<0.001

[a] Bootstrap confidence intervals

— = no data

Reference groups for statistical analyses: age = ≥66 years; employment in past week = yes; region or province = Prairies; medication prescribed by psychiatrist = no

Another explanation is that physicians are unaware or fail to adhere to guidelines,[5] such as those recommending ADs alone for the pharmacotherapy of MDEs. Of course, it is possible that guidelines developed for specific disorders may not reflect the realities of clinical practice where there are higher levels of comorbid anxiety. For instance, guidelines often rely on RCTs that do not include typical patients in the community, owing to stringent inclusion and exclusion criteria. Accordingly, physicians may often initiate treatment for depression (and [or] concurrent anxiety) with ADs and BDZs to allow for quick relief of symptoms.[38,39] While this treatment is often meant to be pursued for the short term, physicians may fail to withdraw BDZ therapy based on improvements in the patient's condition over time. Physicians may also accede to request by their patients for BDZ to preserve their therapeutic relationship.[27,39] There is also better compliance with AD therapy among depressed people when they have also received a BDZ.[7]

Reasons for Utilization of ADs and BDZs

There may be systemic reasons for the relatively high rates of AD and BDZ utilization. One may be due to high overall rates of SSRIs and BDZs whether or not these are used in combination.[6,19,40,41] The high rates of BDZ prescription in Canada, compared with other jurisdictions, have been attributed to the easy availability in terms of reimbursement and the wide range of BDZs listed in the Canadian provincial formularies.[41,42]

Although clinical guidelines[5] in effect at the time of the survey recommended ADs alone for the pharmacotherapy of MDEs, our study clearly suggests significant use of ADs in conjunction with BDZs by Canadians who had experienced an MDE in the past year. Our study serves as a marker for potential divergence between recommended clinical guidelines[5] and actual care received by Canadians who have experienced MDEs. The combination therapy of ADs and BDZs among high-risk people (such as seniors) makes them more vulnerable to a range of adverse events (that is, oversedation, poor concentration, and mental confusion),[7,14] which could lead to complications, such as falls among seniors.[7,43]

Findings from our study should be interpreted with caution owing to the following limitations. First, the data were self-reported and possibly subject to recall bias. However, previous research reveals good concordance between self-reported and actual medication use.[44–47] Second, the CCHS 1.2 was conducted in 2002, only 1 year after clinical guidelines that recommended monotherapy for major depression. Previous studies have reported that the uptake of evidence-based guidelines into clinical practice may take many years.[48] Third, severity of the disease has not been fully accounted for in the CCHS 1.2 data. As such, our study was unable to identify possible referrals of patients with severe cases by family physicians to psychiatrists, and the higher rate of coprescribing of ADs and BDZs by psychiatrists may be reflective of such referrals. Further support for this explanation comes from our finding that in patients with subclinical cases, there was no association between being seen by a psychiatrist and being coprescribed a BDZ. Fourth, the duration of use for both medications was not recorded in the CCHS 1.2, which may result in an overestimation of the rate of AD and

BDZ utilization. Although the CCHS 1.2 failed to provide data on the length of therapy, other work suggests that up to 60% of primary care patients prescribed BDZs receive this on a long-term basis of more than 8 weeks; 15% have at least 7 prescribing events.[49] Moreover, patients with major depression make up a large proportion of long-term BDZ users (60%).[50] Therefore, we assume short-term BDZ use (that is, 8 weeks or more) would not have contributed greatly to the prevalence rates we report. The prevalence of AD and BDZ therapy identified in our study is similar to the rates reported elsewhere for long-term use of BDZs, providing further support for this assumption.[21,22] Fifth, we were unable to establish the influence of anxiety on the study findings as the data failed to account for whether any anxiety disorders were concurrent with MDEs or if they occurred at different times within the past year. Finally, it is important to acknowledge that there is need for further research on the long-term risks and benefits of BDZs, especially as compared with ADs, and some physicians continue to prescribe BDZs for durations exceeding guidelines, especially in refractory patients.[51–55]

Conclusion

To conclude, our research is one of the first population-based studies from Canada to assess the utilization of ADs and BDZs among people with major depression. Our study suggests extensive use of ADs and BDZs by the respondents. This underscores a potential lack of concordance between medication use to treat MDEs and the recommendations of *Clinical Guidelines for the Treatment of Depressive Disorders*[5] on pharmacotherapeutic management of major depression.

Further studies are indicated to more fully understand patient- and physician-based factors associated with the combined use of ADs and BDZs. Methods could include qualitative research as well as quantitative analysis of administrative data. Initiatives to bridge the gap between research findings and medication prescribing should be explored.

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Résumé : L'utilisation d'antidépresseurs et de benzodiazépines chez les personnes souffrant de dépression majeure au Canada

Objectif : Bien que les guides cliniques recommandent une monothérapie d'antidépresseurs (AD) pour la dépression majeure, la polypharmacie avec benzodiazépines (BDZ) demeure en question. Les risques associés à ces traitements comprennent la tolérance et la dépendance, entre autres. Nous avons évalué la prévalence et les déterminants de l'utilisation d'AD et de BDZ chez les Canadiens qui ont subi un épisode de dépression majeure (EDM) dans les 12 derniers mois, et déterminé l'association entre la consultation d'un psychiatre et l'utilisation d'AD et de BDZ.

Méthode : Les données ont été tirées de l'Enquête sur la santé dans les collectivités canadiennes, Santé mentale et bien-être de 2002, un échantillon représentatif à l'échelle nationale des Canadiens de 15 ans et plus. Les statistiques descriptives quantifiaient l'utilisation, tandis que la régression logistique identifiait les facteurs associés à l'utilisation, comme les caractéristiques sociodémographiques ou le type de médecin consulté. Les poids d'échantillonnage et les estimations de variance par la méthode *bootstrap* ont été utilisés pour toutes les analyses.

Résultats : La prévalence globale de l'utilisation des AD et des BDZ était de 49,3 % des répondants qui ont eu un EDM dans les 12 mois précédents et qui ont déclaré utiliser des AD. Les principaux déterminants de l'utilisation étaient le jeune âge et le chômage dans la semaine précédente (RC 2,6; $P < 0,001$). Consulter un psychiatre augmentait l'utilisation (RC 2,5; $P < 0,001$), possiblement parce que les psychiatres voyaient des patients souffrant de dépression grave.

Conclusion : Une grande proportion des personnes ayant souffert d'EDM l'année précédente utilisaient des AD et des BDZ. La mesure dans laquelle cela est approprié n'est pas claire, étant donné que les guides cliniques fondés sur des données probantes recommandent une monothérapie d'antidépresseurs pour le traitement de la dépression majeure.