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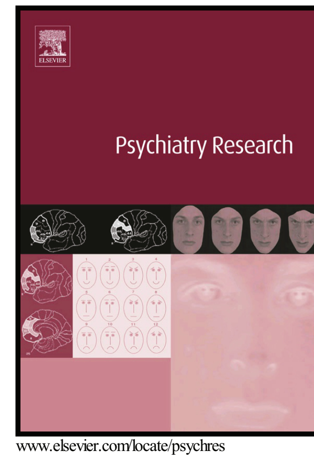

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John Read, Kerry Gibson, Claire Cartwright

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Do GPs and psychiatrists recommend alternatives when prescribing anti-depressants?

John Read[a*], Kerry Gibson[b], Claire Cartwright[b]

[a]School of Psychology, University of East London, UK

[b]School of Psychology, University of Auckland, New Zealand

[*]Corresponding author: Professor John Read, +44 (0)208 223 4943 john@uel.ac.uk

Abstract

This study explores whether a partial explanation for high antidepressant prescription rates is the failure of prescribers to recommend alternatives. 1,829 New Zealand adults were asked which of six non-pharmacological treatment approaches were recommended when prescribed anti-depressants. The majority (82%) received at least one recommendation and 32% received three or more, most commonly 'Counsellor/Psychologist/Psychotherapist' (74%) and Exercise Schedule (43%). It cannot, therefore, be concluded that failing to consider non-pharmacological treatments is a major cause of high prescribing rates. Being younger and more severely depressed were both positively related to number of recommendations. Psychiatrists made significantly more recommendations than GPs.

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Keywords: Depression, antidepressants, psychotherapy

1. Introduction

Prescription rates for antidepressants (ADs), internationally, are high and continue to increase (Ilyas and Moncrieff, 2012; Read et al., 2015). In New Zealand, between 2007 and 2012, the number of adults receiving ADs each year increased by 35% from 304,530 to

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412,631 (PHARMAC, personal communication 2012), in a population of 4.4 million, of whom 3.7 million are aged 16 or older. Thus one in nine adults (11.2%), and (because women are prescribed ADs at approximately twice the rate as men) about one in six women are prescribed ADs every year.

These increases occur despite evidence that their efficacy has been overestimated (Kirsch et al., 2008; Pigott et al., 2010), and their adverse effects minimized. For example, eight adverse effects were reported by more than 50% of the large sample of AD recipients in the current study, including sexual difficulties, emotional numbing, drowsiness, and withdrawal effects (Read et al., 2014a).

This study examines whether high rates of AD prescription can be partly attributed to doctors' failure to recommend non-pharmacological treatments, as alternatives or adjuncts, when prescribing ADs.

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2. Method

Following ethics approval from the University of Auckland, an online questionnaire about antidepressants was completed by 1,829 New Zealand adults prescribed antidepressants in the preceding five years (Read et al., 2014a). This total excluded 295 people who stopped before the end of question 19 (of 47); and the 45 who cited medications other than ADs. Females constituted 76.6% of the sample. The modal age group was 36-45 (24.2%). The majority, 92.1%, identified as 'New Zealand/European'. In terms of education, 49.6% had a university degree; 26.1% gained a diploma or certificate after high school, 17.2% completed high school, and 7.1% did not complete high school. The questionnaire and sample characteristics have been reported in greater detail elsewhere (Read et al. 2014a, 2014b).

The majority (82.8%) replied yes to the question 'Did your antidepressants reduce your depression?'. Participants reported the following levels of depression in the year before

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taking ADs: ‘severe’- 42.7%, ‘moderate’ - 37.8%, ‘mild’ - 11.8%, and ‘not at all’ - 7.6%. In 83.6% of cases the prescriber was a GP, and in 16.4% a psychiatrist.

This paper reports the percentages of the 1829 respondents that answered yes to each of six options following the question: ‘*Which, if any, of the following alternative treatments were offered to you at the time you were prescribed anti-depressants’*. The options were: ‘*Counsellor/psychologist/psychotherapist’, ‘Relationship counselling/family therapy’, Support group’, Exercise schedule’, Social activities’ and ‘Nutritional advice’.*

Respondents were also asked to respond to the questions ‘How would you describe your relationship with the doctor?’ and ‘How well do you think your doctor understood your problem(s)?’ on five point likert scales from ‘very good’ to ‘not at all good’, and from ’a lot’ to ‘not at all’, respectively.

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3. Results

The majority (81.3%) received at least one recommendation; with 28.7% receiving only one recommendation, 20.5% receiving two and 32.4% three or more. The mean number of recommendations received was 1.88 (sd = 1.47).

Approximately one in every five patients (18.7%) received none of the six types of recommendation. Even when invited to tick an ‘other’ recommendation box the proportion of people who received no advice other than to take the medication was 17.5%.
By far the most common recommendation was Counsellor/Psychologist/Psychotherapist (74%), followed by Exercise Schedule (43%) (see Table 1). The least frequently recommended were Relationship Counselling/Family Therapy (14%) and Support Group (13%).

3.1 *Demographics*

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Younger age was positively correlated with number of recommendations ($r = 0.09$, $p < 0.0001$). For example, the mean number of recommendations for 18-25 year olds was 2.09, compared to 1.68 for 56-65 year-olds and 1.45 for 66-75 year olds. Furthermore, 22.4% of 66-75 year olds and 25.0% of 56-65 year olds received none of the six recommendations, compared to 13.5% of 18-25 year olds. Three of the six recommendations were significantly more likely to be made to younger people. A recommendation of Counsellor/Psychologist/Psychotherapist was significantly related to younger age ($\chi^2 = 33.85$, $p < 0.0001$). This was recommended to 81% of 18-25 year olds and 80% of 26-35 year olds, but only 64% of 56-65 year olds and 62% of 66-75 year olds. Similarly, recommendations of Social Activities ($\chi^2 = 23.18$, $p = 0.002$) and Nutritional Advice ($\chi^2 = 23.50$, $p = 0.001$) were significantly related to younger age.

Level of education was positively correlated with number of recommendations ($r = 0.07$, $p = 0.004$), but the only specific recommendation significantly related was Exercise Schedule ($\chi^2 = 18.0$, $p = 0.001$).

Level of income was not correlated with number of recommendations or any of the six specific recommendations. There were no significant gender or ethnicity differences, either in terms of total number of recommendations or any of the six specific recommendations.

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3.2 Severity of depression

Severity of depression at the time of the prescription was positively related to the number of recommendations ($r = 0.15$, $p < 0.0001$). Specifically, depression severity was significantly related to Counsellor/Psychologist/Psychotherapist ($\chi^2 = 39.48$, $p < 0.0001$), Exercise ($\chi^2 = 16.43$, $p < 0.001$), and Relationship Counselling/Family Therapy ($\chi^2 = 14.18$, $p < 0.01$), but unrelated to the other three recommendations.

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3.3 Interaction with prescriber

Both the perceived quality of the relationship ($r = .13$, $p < 0.0001$) and how well the patients felt the prescriber understood their problems ($r = .17$, $p < 0.0001$) were significantly related to the number of recommendations. Both were significantly related to Exercise Schedule, Counsellor/Psychologist/Psychotherapist, Social Activities and Nutritional Advice (all at the $p < .002$ level or beyond). Similarly, the amount of time spent with the prescriber was related to number of recommendation (r - = 0.26, $p < 0.0001$), and to all six specific recommendations (all at $p < 0.0001$). (The frequencies at the two anchor points in the six point scale were; 'about 5 minutes' - 5.4% and 'more than 60 minutes' - 4.3%; with a modal response of 'about15 minutes'- 36.1%).

A greater number of recommendations were also made by prescribers who informed patients about adverse effects, about how long they should stay on the medication, about how the ADs work, and what benefits they might expect (all at the $p < 0.0001$) level).

Psychiatrists made significantly more recommendations (mean = 2.19) than GPs (1.82), ($t = 3.91$, $p < 0.0001$). Specifically, psychiatrists were significantly more likely to recommend Counsellor/Psychologist/Psychotherapist, Relationship Counselling/Family Therapy and Support Group (all at the $p < .0001$ level).

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4. Discussion

The findings do not support the hypothesis that high rates of AD prescription are due to prescribers failing to discuss alternative/adjunct treatments with patients, at least in New Zealand. Over 80% were recommended at least one treatment approach other than medication.

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Furthermore, prescribers were not basing their recommendations on generalised assumptions that certain groups (e.g. better educated, females, the less severely depressed) are more likely to benefit from psychotherapy. It is of some concern, however, that older people received fewer recommendations in general, and particularly for psychotherapy. This finding is consistent with findings that older people are prescribed ADs more readily than younger people (Aarts et al., 2014; Verhoeven et al., 2014). In the current sample participants aged over 55 were prescribed antidepressants with significantly fewer symptoms and were significantly less likely to meet DSM criteria for depression (Read et al., 2016). It is conceivable that the relative lack of alternative recommendations given to older people in the current study may be a partial cause of their being significantly more likely to have used the drugs for three years and still be using them at the time of the study (Read et al., 2016).

4.1 Implications

Recommendations by doctors for non-pharmacological approaches to depression might be more frequent if they were more accessible. Studies of GPs in the UK (Rout and Rout, 1996) and New Zealand (Wilson and Read, 2001) suggest that their low referral rates for psychotherapy/counselling are not because they have an overly biologically approach to understanding or treating depression but because of poor accessibility and affordability of non-pharmacological treatment approaches.

The reasons for increasing prescribing rates most frequently endorsed by the current sample included: ‘Other types of treatment are not funded or are too expensive’ and ‘Drug companies have successfully marketed their drugs’. The least endorsed explanation was ‘Anti-depressants are the best treatment’ (Read et al., 2014b).

Furthermore, the public, internationally, clearly favours psycho-social rather than bio-

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medical explanations, and treatments, for mental health problems (Read et al., 2016), including depression (Angermeyer and Dietrich, 2006; Schomerus et al., 2012). This is not reflected in what is discussed with patients or with what is available and affordable.

4.2 Limitations

In this convenience, online, sample, Maori, Pacific Islanders, men, older people, and poorer and less educated people were underrepresented. Such a sample may be more likely, both because of their own behaviour or that of the prescribers, to be offered non-pharmacological treatments.

The reports of what was recommended, and other variables, are subject to inaccuracy due to being entirely dependent on retrospective recall.

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Table 1. Other treatments recommended at the time anti-depressants were prescribed

	%	Younger Age	Greater Severity of Depression	Psychiatrist > GP	Good Relationship with Prescriber
Counsellor/Psychologist/ Psychotherapist	73.8%	***	***	***	**
Exercise Schedule	43.4%		**		***
Social Activities	23.6%	*			*
Nutritional Advice	20.6%	**			*
Relationship Counselling/ Family Therapy	13.6%		*	***	
Support Group	13.2%			***	

* < 0.01; ** < 0.001; *** < 0.0001

Highlights

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- 1,829 recipients of antidepressants completed an online survey
- 82% received at least one recommendation for an alternative treatment
- Psychiatrists made significantly more recommendations than GPs.

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