Prescription of antidepressants by general practitioners: recommendations by FHSAs and health boards

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SUMMARY

Background. *In order to cut costs of prescribing by general practitioners family health service authorities (FHSAs) and health boards in the UK have been instructed to improve the quality and cost-effectiveness of prescribing by general practitioners in their area by tailoring advice to individual general practices.*

Aim. *As over 95% of patients suffering from depression are treated by their general practitioner, a study was set up to investigate the effectiveness of the advice given by FHSAs and health boards to general practitioners on treatment of depression and prescription of antidepressant drugs.*

Method. *The recommendations on prescription of antidepressants of professional advisors from all 117 FHSAs and health boards in the UK were elicited by telephone. Those who had produced written information for the general practitioners in their area regarding depression and antidepressant prescribing during the study period were asked to send a copy to the researchers.*

Results. *An excellent response rate (100%) was obtained to the telephone survey, and all of the bodies that provided their general practitioners with written information on depression and prescription of antidepressants sent in copies. Most of the documents received were informative and accurate; however, others provided information that was incorrect.*

Conclusion. *Bulletins and newsletters from FHSAs and health boards are capable of influencing the prescribing patterns of general practitioners in their area, and must contain accurate and up-to-date information if they are to improve the management of depressed patients in the community.*

Keywords: antidepressants; prescription; general practitioners.

Introduction

AT any given time, 4–5% of the general population are suffering from depression.[1] Over 95% of these patients are treated by general practitioners, the rest being referred to specialist psychiatric services.[2] Katon and Roy-Byrne have found that up to 25% of patients attending a general practitioner are depressed and account for significantly more consultations than non-depressed patients.[3]

The antidepressants available and commonly prescribed at the time this study was undertaken included the tricyclic and related antidepressants (TCAs), and the selective serotonin reuptake inhibitors (SSRIs). Other agents, such as the monoamine oxidase inhibitors, flupenthixol and L-tryptophan, are much less widely prescribed by general practitioners.[4]

With the drugs bill rising at a rate of 14% per year and prescriptions by general practitioners accounting for £3.6 billion of national health service expenses in 1992–1993, reducing the costs of expenditure on drugs has become a priority.[5] The primary health care systems in which general practitioners work — family health service authorities (FHSAs), health boards and their professional advisors — have been charged with improving the quality and cost-effectiveness of prescribing.[6] Representatives of these bodies visit general practices and tailor their advice to the general practitioners involved. Some FHSAs and health boards provide written information in the form of bulletins or newsletters which are circulated to all general practitioners in their area.

This study was set up to determine what information, if any, is provided to general practitioners regarding the prescribing of antidepressants.

Method

In late 1994, a pharmaceutical or medical prescribing advisor at each FHSA in England and Wales, and each health board in Northern Ireland or Scotland was contacted by telephone by one of the researchers (DNJ). They were asked whether any written information on the subject of depression or antidepressants, produced since January 1993, had been sent to the general practitioners in their area, and to forward copies to the researchers (a Freepost envelope was supplied for the purpose). Participants were assured that any information supplied would be made anonymous but that it was intended to publish the findings. The initial telephone call was followed up by a letter outlining the study, and if no reply was received within 14 days, a further telephone call was made.

A copy of each document received was made, and any references to FHSA/health board or any individuals were removed. Information was abstracted from the bulletins and compared with widely accepted guidelines.[7]

Results

All 117 FHSAs/health boards agreed to participate, a response rate of 100%. Each claimed to provide information on a practice-by-practice basis regarding various aspects of prescribing, including antidepressants, if the practice required it or if the prescribing advisor felt it necessary. A total of 33 (28.2%) had sent written information on the subject of depression to the general practitioners in their area between January 1993 and December 1994, a further 11 (9.4%) were in the process of preparing written guidance and 73 (62.4%) had produced no such information during the study period. Those bodies that had produced no bulletins on depression either did not provide information in this format or stated that depression was too controversial or too difficult an area on which to produce guidelines or recommenda-

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Submitted: 30 June 1996; accepted: 20 October 1995.

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tions. The researchers were supplied with a copy of the information sent out by the 33 bodies that did so. A summary of the findings is shown in Table 1.

Only two (6.1%) participants recommended the use of newer TCAs, such as lofepramine, or SSRIs as first-choice agents; 19 (57.6%) suggested that older TCAs should be the treatment of choice. Those bodies recommending TCAs as first-line agents suggested the use of SSRIs in the following patients: those who are obese (2); anyone who fails to respond to the older drugs (2); an elderly patient (2); a patient who is suicidal (6); and someone who has suffered intolerable side-effects with the older agents (11) or in whom the older drugs were contraindicated (15). Most of the FHSA/health board bulletins (see Table 1) did not remind general practitioners that an inadequate dose of an antidepressant for an inadequate treatment period may adversely affect patients' responses to treatment.

Discussion

Although it was time-consuming to contact the appropriate person in all the FHSAs and health boards, some of whom worked only part-time, the method chosen was considered acceptable as the response rate was excellent (100%).

The older TCAs were recommended as first-line agents primarily for two reasons: efficacy and familiarity. Several meta-analyses have demonstrated that TCAs and SSRIs are equally efficacious,[9–11] but tolerability (an important determinant of patient compliance) is a far more contentious issue: rates of drop out are lower for patients taking SSRIs or lofepramine (both 15%) than for those on older TCAs (21%).[12] As SSRIs and lofepramine are better tolerated than the older TCAs, these should be considered as first-line treatments for depression in primary care.

Only 25% of respondents recommended that treatment should be continued for 4–6 months after recovery. Furthermore, the bodies suggesting older TCAs as first-line treatment mentioned (and may be considered to have implied) doses that were suboptimal compared with the doses recommended in a number of consensus statements for amitriptyline, dothiepin, imipramine and lofepramine (see Table 1).[7,13–15]

Although much of the information contained in the newsletters was correct, some had shortcomings which detracted from their overall quality. If bulletins are intended to influence the prescribing pattern of at least some general practitioners, they *must* contain information that is accurate and up to date. The cost of antidepressant treatment must not be considered in isolation but together with the tolerability to the drugs prescribed and the indirect costs associated with depression.

Table 1. Information supplied in FHSA/health board bulletins on choice of antidepressant.

Number providing written information	33
DSM-III-R[8] diagnostic criteria of depression mentioned	5
Trial period of at least 4 weeks recommend before stopping treatment	9
Recommended continuation of treatment after resolution of symptoms for at least 4 months	12
Non-compliance mentioned as a common reason for treatment failure	3
Inadequate dosing mentioned as a common reason for treatment failure	5
Side-effects of SSRIs mentioned	27
Side-effects of TCAs mentioned	27
Drug interactions of SSRIs mentioned	9
Drug interactions of TCAs mentioned	1
No references cited in bulletin	17
Bulletin refers prescriber to appropriate data sheets for further information	1
Daily dose of amitriptyline recommended is inadequate (up to 100 mg day^{-1})	15
Daily dose of dothiepin recommended is inadequate (up to 100 mg day^{-1})	13
Daily dose of imipramine recommended is inadequate (up to 100 mg day^{-1})	11
Daily dose of lofepramine recommended is inadequate (70 mg day^{-1})	1

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Acknowledgements

This study was supported, in part, by an educational grant from Pfizer Ltd.

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