Depression and the Medicalization of Sadness: Has Treatment Come to Mean Drugs?

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At Green Shield Canada (GSC), we pay more claims in volume for antidepressants than any other class of medication. It’s clear that plan sponsors are investing a lot of dollars in antidepressants—we reimbursed $45 million in antidepressants in 2015—but is this investment paying off in terms of impacting plan member health? Back in 2016, we spent some time trying to better understand the patterns associated with spending on antidepressants and unearthed plenty for plan sponsors to consider.

$45 Million in Antidepressants

As part of our study, we zeroed in on 35,000 plan members who had newly started an antidepressant over a three-year period to see what we could learn from the prescribing and claiming patterns. Analysis revealed that of the “new starts” over the three years, 12-15% followed typical treatment guidelines for depression. As for the rest, we saw a combination of dropouts who never started their prescription, “one and done-ers” who didn’t continue their prescription past the first fill, and folks taking extremely low doses—so low that you wouldn’t expect any clinical outcome at all.

High medication nonadherence, low dosages and usage that hints at overprescribing put us on high alert: Are some plan members needlessly taking antidepressants? Are others who could benefit from these drugs not getting the support they need? Time to turn to the world of research to see what’s going on more broadly regarding depression.

What Does the Research Show?

Over the last decade, the number of antidepressants prescribed in England has more than doubled—a trend that many countries worldwide are also experiencing. For instance, in 2011, the last year for which comparative figures are available, Canada had the third-highest level of consumption of antidepressants among the 23 countries surveyed by the Organisation for Economic Co-operation and Development (OECD). However, there have been no changes in the annual prevalence of major depressive episodes in Canada.

Like the GSC study findings, the broader scientific research suggests that many people who need some level of support—but not necessarily antidepressants—are being prescribed antidepressants. They are incurring the risks of the medication (i.e., side effects) without receiving the benefits. On the other hand, those who could benefit from an antidepressant may not be taking them. For instance, findings from a 2011 U.S. study found that “just one-third of severely depressed people who really need antidepressant medication are taking it, while more than two-thirds who are taking antidepressants are not currently depressed.”

What Are the Factors at Play?

One of the biggest issues influencing the rising incidence of antidepressant use is that—both culturally and clinically—we seem to be casting the net increasingly wide. For instance, society now labels someone experiencing mild symptoms of depression as being ill. And similarly, patients who in the past would be considered as having mild symptoms of depression are now being diagnosed as depressed and are prescribed antidepressants. Why?

Increasingly, North American society is influenced by a self-help culture focused on happiness—that happiness is the goal at all times. However, this idea can set up unrealistic and potentially unhealthy expectations. So, as we experience life’s inevitable ups and downs, people beat themselves up as they try to reach this unattainable goal.

Cultural influences also include society’s interest in reducing the stigma surrounding mental health issues and encouraging people to seek help. Over the last several years, we’ve seen an influx of mental health campaigns with the purpose of reducing stigma, raising awareness and providing education. There’s evidence that these programs are having a positive impact; howev-
er, when we consider that the rates of diagnosing depression are rising with no significant increase in the actual rates of depression, we wonder: Are there unintended consequences of these mental health awareness efforts? Are we inadvertently creating a culture in which sadness and stress are labeled as illness? As a society, although we want people to get the help they need, we need to ensure we’re not becoming focused on creating and treating illness rather than promoting healthy behaviors aimed at prevention.

These cultural influences may be resulting in overdiagnosing depression and, as a result, overprescribing. For instance, medicalization in relation to unhappiness is described as “the increasing tendency, especially in primary care, to diagnose depression (commonly major depressive disorder) in patients presenting with sadness or distress and offering them antidepressant medication.” Again, why?

In Terms of Clinical Diagnosis

It’s important to note that diagnosing depression isn’t simple. There is very little (close to nothing) in the way of objective testing to help doctors definitively diagnose depression. Even when doctors use standardized screening tools for depression, research shows that screening has minimal impact on accurate detection, management or outcome.

Adding to this situation is the diagnostic manual that most North American doctors consider the authoritative guide to diagnosing mental disorders. This manual has been criticized for its tendency to support overdiagnosis. Traditional diagnostic categories have become more inclusive, and many new categories are introduced with each succeeding iteration of the manual.

Another contributing factor is yet another challenge doctors face: In terms of mental health, they lack resources to draw on. For example, although a doctor’s first instinct may be to refer a patient to counseling, the reality is that counseling is not widely available, can take months to access and is usually expensive.

In addition, patients typically expect a quick fix from their doctors—a cure-all in pill form. With patients who are not severely depressed but are just going through temporary life problems and need support, doctors face a serious dilemma. Their choice is between not helping the patient at all versus providing them with a prescription—like a subtherapeutic dose of an antidepressant. Basically, doctors are between a rock and a hard place; they are pressured by cultural and clinical forces to effectively treat depression while not having a comprehensive tool kit to do so.

A Fresh Perspective

Not all antidepressant use is inappropriate; we’re not suggesting that at all. However, what we are strongly recommending is a fresh perspective on treating depression—mild, moderate and severe. On the one hand, we need to make sure that those with mild and moderate symptoms of depression get the help they need, which may or may not include antidepressants. And on the other hand, we must more effectively capture those who are most likely to benefit from treatment by an antidepressant.

For a plan sponsor, this means ensuring that your mental health programs support health rather than focus on identifying illness. Promote healthy behaviors that help prevent and improve mental health, including regular exercise, healthy eating, smoking cessation and moderate alcohol consumption. Also, consider increasing your plan’s annual maximum for counseling services, because approaches like cognitive behavioral therapy are well-documented in the scientific evidence as beneficial. It’s important that plan sponsors understand—and, in turn, educate plan members—that good mental health involves a lot more than just drugs.

Endnotes

6. Ibid.