The

INSIDE STORY®

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DEPRESSION AND THE MEDICALIZATION OF SADNESS

HAS 'TREATMENT' COME TO MEAN 'DRUGS'?

Despite all the articles you read from us on biologics, biosimilars, specialty drugs… claims for antidepressant medications represent the largest spend for GSC's block of business. We pay more claims for antidepressants—both in terms of number of claims and cost—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 having an equal downstream impact on plan member health?

Our loyal readers know we like to ask these hard questions, so we're taking a closer look at the patterns associated with spending on antidepressants. However, as you also know, we don't always have all the answers, but we make it our mission to keep digging. As a health benefits specialist, we do our best to determine whether concrete health outcomes result from our plan sponsors' investment. So far, we've unearthed a lot for plan sponsors to consider…

$45 million in antidepressants

As you may recall from the June 2016 edition of *The Inside Story* when we reported on the GSC 2015 health study, a goal of all our studies is to identify costs driving up spending in your health plan. Specifically, as part of the 2015 analysis, we zeroed-in on 35,000 plan members who were "new starts" on 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 the typical treatment guidelines for depression. With the remaining 80-85%, over three years, we saw a combination of dropouts who never started their prescription, "one and done'rs" who didn't continue their prescription past the first fill, and those taking extremely low doses—so low that you wouldn't expect any clinical outcome at all.

High medication non-adherence, low dosages, and usage that hints at overprescribing put our antennae on high alert: are some plan members needlessly taking antidepressants while others—those that could benefit most from antidepressants—aren't necessarily getting all the support they need? Disturbing to say the least. As always, time to turn to the world of research to see if the GSC data is representative of what's going on out there regarding depression.

What does the research show?

Over the last decade, the number of antidepressants prescribed in England has more than doubled[1]—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 OECD.[2] However, there have been no changes in the annual prevalence of major depressive episodes in Canada.[3]

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So on the one hand, if rates of depression haven't significantly changed, why is there so much diagnosing of depression and prescribing of antidepressants? And on the other hand, with such high prescribing of antidepressants, why aren't the rates of depression going down?

Like the GSC study findings, the broader scientific research (see sidebar) 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. Whereas those that could benefit from an antidepressant may not be taking them. For instance, findings from a 2011 American 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."[4] To figure out why this is happening—and how to improve the situation—we tried to determine all the contributing factors.

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 widely.

For instance, society now labels someone experiencing mild symptoms of depression as having a disease; they are "ill." And similarly, in the doctor's office, patients who in the past would be considered as having mild symptoms of depression are now being diagnosed as depressed and are prescribed antidepressants. But to use our favourite word, why?

Must read!

Snapshot of

RESEARCH RESULTS

What constitutes depression continues to evolve

This critical review of the diagnosis of major depressive disorder found that a broad diagnostic label has resulted in over-diagnosis and over-treatment. It suggests that the approach to diagnosis and management of depression should change to reduce stigmatizing "the sad" and provide better help for those who most need medical treatment and comprehensive monitoring. (*Medicalising Unhappiness: New classification of depression risks more patients being put on drug treatment from which they will not benefit*[5])

Antidepressants minimally effective (if at all) for mild depression

This study found that there is no substantive evidence that people suffering a loss (uncomplicated bereavement) benefit from antidepressants and that many conditions currently diagnosed as major depressive disorder, especially those related to other forms of loss, should not include care that assumes drug treatment. (*Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-Analysis*[6])

Many who screen positive for depression do not receive treatment

The findings include that most American adults who screened positive for depression did not receive treatment for depression. By contrast, most who were treated did not screen positive. This suggests that it is important to more effectively align depression care with each patient's clinical needs. (*Treatment of Adult Depression in the United States*[7])

Serious side-effects of antidepressants often under reported

A review of clinical-study reports showed that essential information on patient outcomes was often missing in the published articles. For example, in some cases, major harms were missing from journal articles and in summary trial reports. (*Suicidality and aggression during antidepressant treatment: systematic review and meta analyses based on clinical study reports*[8])

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In terms of culture…

Increasingly North American society is influenced by a self-help culture that is focused on happiness, or as some caution, one that is happiness obsessed. However, many feel this idea—that at all times happiness is the goal—sets up unrealistic and potentially unhealthy expectations. As we experience life's inevitable ups and downs, some people beat themselves up as they try to reach the unattainable goal of happiness at all times.[9]

Cultural influences also include society's interest in reducing stigma surrounding mental health issues and encouraging people to seek help. For instance, over the last several years, we have seen an influx of mental health campaigns with the purpose of reducing stigma, raising awareness, and providing education. There is evidence that these programs are a having positive impact. For example, organizations that promote mental health awareness are seeing decreasing durations of absences due to mental health issues.

That is good.

However, when we consider that the rates of diagnosing depression are rising with no significant increase in the actual rates of depression, it makes you think—what are the unintended consequences of society's mental health awareness efforts? Are we casting the net so wide that we are inadvertently creating a culture where sadness and stress are labelled as "illness"? As one expert explains, "The line between the beneficial destigmatization of illness and the epidemic spread of an illness attribution is a thin one."[10] As a society, although we want to ensure that the right people get the help they need, at the same time, we need to ensure that we are not creating a culture that focuses on creating and treating "illness" rather than promoting healthy behaviours aimed at preventing illness.

These cultural influences may be resulting in the over-diagnosis of 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."[11] But (here we go again), why?

In terms of clinical diagnosis…

First, it's important to note that diagnosing depression is no simple task. As we've learned while taking our deep dive into behaviour change and all things neurological, it's clear that the brain is complex. And in fact, up until fairly recently, vast aspects of the brain were considered unchartered territory.

Although technology continues to make it possible for scientists to learn more than ever, 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 of depression.[12]

Adding to this situation is the diagnostic manual that most North American doctors consider the authoritative guide to diagnosing mental disorders. This manual, which has gone through multiple iterations over the years, has been criticized for its tendency to support over-diagnosis. Traditional diagnostic categories have become even more inclusive and many new categories of diagnosis are introduced with each succeeding iteration of the manual. "It seemed that every kind of psychological problem, even those intrinsic to the human condition, could be described by a psychiatric diagnosis."[13]

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Another contributing factor is yet another challenge that doctors face—and it's a biggie. In terms of mental health, doctors lack resources to draw on; essentially they don't have a mental health toolkit at the ready. As a result, for example, although a doctor's first instinct may be to refer a patient to counselling, the reality is that counselling is not widely available, can take months to access, and is usually high cost.

In addition, we are still very much a "pill-popping" society; patients typically expect a quick fix from their doctors—a cure-all in pill form. Accordingly, with patients who are not severely depressed but 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 sub-therapeutic dose of an antidepressant. Basically, doctors are between a rock and a hard place; they are being pressured by cultural and clinical forces to effectively treat depression while not having a comprehensive toolkit to do so.

What are the consequences of overprescribing?

Labeling mild symptoms of depression as an illness and prescribing antidepressants—even at sub-therapeutic doses—can have extremely negative implications for patients. For instance, labeling plan members with a psychiatric diagnosis can lead some to believe and behave as if they are ill. This in turn (for a whole number of other issues) can tend to limit ownership of their health issues and deter self-care efforts.

And in the bigger picture, a culture that is too quick to turn to medicalization of unhappiness and quick prescribing of antidepressants can result in draining scarce resources and diverting resources away from those who can truly benefit from them. For example, we spoke with a senior psychologist in Toronto who described many people with mild symptoms sitting on waiting lists to see him when they could be better managed in the community. This makes it difficult for him to provide treatment to those who are severely depressed.

A fresh perspective

As you can see from what we've learned so far, "depression" has come to mean even mild symptoms, and "treatment" for depression has come to largely mean drugs. From this we have come to a major conclusion: it's time to take a fresh perspective on treating depression.

Peter Gove, GSC's health innovation leader sums it up this way, "Not all antidepressant use is inappropriate, we're not suggesting that at all. However, what we are strongly recommending is that we take 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 the more severely ill that are most likely to benefit from treatment by an antidepressant."

As a plan sponsor, this means recognizing that casting the widest net possible and assuming a medicalized approach for all may have very limited value regarding overall plan member health. Accordingly, ensure that your mental health programs promote *health* rather than focus on identifying *illness*.

What does this mean? It's important that plan sponsors understand—and in turn, educate plan members—that good mental health involves a lot more than just drugs. Promote healthy behaviours that are shown in the research to help prevent and improve mental health like regular exercise, healthy eating, smoking cessation, and moderate alcohol consumption. Also, consider increasing your plan's annual maximum for counselling services because approaches like cognitive behavioural therapy are well documented in the scientific evidence as beneficial.

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...And now for the big newsflash...

To address the accessibility and affordability of other approaches beyond drugs, GSC will be piloting some new ideas in 2017 to help provide doctors (and plan members) with a different set of tools that are not entirely medication based. Now that really is a fresh perspective!

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What's UP...

NEW CANADIAN DRUGS AND SUBSTANCES STRATEGY

As you may recall from the November 2016 edition of *The Inside Story*, where we covered the growing opioid crisis in Canada, the federal government has been working collaboratively with various stakeholders. All levels of government as well as non-government groups, addictions experts, the medical community, first responders, indigenous groups, and communities including individuals directly affected by drug use have all come together to try to combat drug use.

An outcome of this collaboration is a new evidence-based strategy that ensures a health focus while also strengthening law enforcement. The new *Canadian Drugs and Substances Strategy* replaces the existing National Anti-Drug Strategy. In addition to prevention, treatment, and enforcement, the new strategy emphasizes harm reduction as an essential component.

The new strategy is being supported by the proposed Bill C-37, which includes proposed legislative changes to amend the *Controlled Drugs and Substances Act*, the *Customs Act*, and the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act*. To enhance harm reduction, Bill C-37 proposes the following:

- → Simplify the application procedure for new supervised injection sites, as well as the renewal process for existing ones.
- → Stop unregistered importing of certain devices like pill presses that may be used in the illicit manufacturing of narcotics.
- → Give border guards the authority to search international packages weighing less than 30 grams arriving via mail or courier; currently they cannot open these packages without the consent of the recipient.

There are a variety of other proposed amendments like making it a crime to possess or transport anything intended to help produce controlled substances, allowing temporary authority over any potentially dangerous substance pending its review, and working toward faster and safer disposal of seized chemicals and other dangerous substances. The proposed amendments support Health Canada's Opioid Action Plan (June 2016), as well as updates to the action plan signed at the Opioid Summit (November 2016).

For more information, visit the government of Canada at http://news.gc.ca/web/article-en.do?mthd=index&crtr.page=4&nid=1168519

ONTARIO PHARMACISTS NOW ABLE TO GIVE ADDITIONAL VACCINES

Now in participating pharmacies in Ontario, pharmacists can give people (five years of age and older) vaccines—many of which are travel vaccines—that help protect against the following 13 preventable diseases:

- → Bacille Calmette-Guérin (tuberculosis)
- → Haemophilus influenzae type B—known as Hib (severe bacterial infection)
- → Hepatitis A
- → Hepatitis B

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- → Herpes zoster (shingles)
- → Human papillomavirus (HPV)
- → Japanese encephalitis
- → Meningococcal disease (severe illnesses like infections of the lining of the brain and spinal cord, as well as bloodstream infections caused by a certain bacteria)
- → Pneumococcal disease (range of infections from ear and sinus to pneumonia and bloodstream)
- → Rabies
- → Typhoid
- → Varicella (chicken pox)
- → Yellow fever

How does this affect your plan? Some of the vaccines require a prescription from a primary care provider like a family doctor, pediatrician, or nurse practitioner. Others, like the flu shot, don't require a prescription and are free when given by a pharmacist or primary care provider. If the vaccine is part of Ontario's publicly funded immunization program, it is free when given by a primary care provider. However, if given by a pharmacist, there is a charge and most plans don't cover the cost of the actual injection—accordingly, this would be an out-of-pocket expense for your Ontario plan members. In addition, even in cases where a pharmacy doesn't require a prescription to dispense the vaccine, if covered under your plan, GSC requires a prescription for it to be an eligible expense.

For more information, visit the Ontario government at https://news.ontario.ca/mohltc/en/2016/12/ontario-making-it-easier-to-get-your-travel-vaccines.html

RAISING AWARENESS THROUGH CHRONIC CONDITIONS INFOGRAPHICS

Canada-wide infographics

The Chronic Disease Prevention Alliance of Canada (CDPAC)—which is a network of national organizations that have come together to help prevent chronic conditions—has been developing educational infographics. The series of infographics explain chronic conditions including common risk factors, provide evidence about the degree of chronic conditions in Canada, depict how much money could be saved by even small reductions in risk factors, and illustrate ways to promote healthy living and preventing chronic conditions. To download the infographics, visit the CDPAC at www.cdpac.ca/content.php?doc=330.

Ontario-specific infographics

A coalition of more than 20 health-related organizations called the Ontario Chronic Disease Prevention Alliance (OCDPA), has launched an initiative, which includes raising awareness of chronic disease by way of free and easy to download infographics for each of the risk factors. The broader initiative is the development of a framework that involves gathering existing data about the main risk factors related to chronic disease—unhealthy diet, physical inactivity, tobacco use, high-risk alcohol use, and mental illness—and then compiling the data into a single resource. It represents the first comprehensive Ontario-specific framework that collects and compares chronic disease risk factors across Ontario and provides a baseline for future measurement. The idea is that the government, as well as organizations, researchers, and individuals will use the framework as a planning tool in their efforts to prevent chronic disease and monitor short, medium, and long-term changes to identify challenges to be addressed. To download the infographics or the report about the framework, visit the OCDPA at www.ocdpa.ca.

COMMUNITY GIVING PROGRAM

HERE'S HOW WE **ADD** TO THE **GREATER GOOD**…

Paving the way for a brighter future

Take a look at how our grant recipients are making a difference

Frontline care—like dental services, vision care, prescription drugs, disease management, and mental health supports—can act as a catalyst for change. That's why the GSC Community Giving Program is focused on supporting organizations and initiatives that provide frontline care for underinsured or uninsured populations. And all grant recipients include a navigator component—this means ongoing positive change as clients are referred to any additional services they may need.

GSC frontline care™

Frontline care in action

YWCA of Yellowknife – Moving On Up program

Since 1996, the YWCA of Yellowknife has worked with women and families—many who are homeless, working poor, and on social assistance—to help them reach their full potential. As the North's largest and longest-serving women's organization, it has grown from one small house providing housing for single working women to a comprehensive organization that provides a wide range of services: two women's shelters, two transitional housing apartment buildings for families, violence prevention programs, affordable after-school child care, and youth empowerment programs. Housing and shelter continue to be key components of its mandate as seen in the Moving On Up program.

From poverty to possibility

Moving On Up is a transitional housing program accessed mainly by single mothers and couples who are experiencing housing problems such as homelessness, eviction, overcrowding, and safety concerns, as well as issues related to the breakdown of family relationships. Clients are typically the working poor or are receiving income assistance. In addition to providing transitional housing, to help move vulnerable people from poverty to possibility, the program creates an individualized agreement with each client and family.

The agreement outlines specific issues associated with homelessness that the individual client or family is facing and indicates ways to transition to a stable situation that includes independent living. Central to the program is having a staff member work with each client or family to assess their unique situation, needs, and goals to create the agreement and a plan to address underlying issues. Decisions are then in the client's hands so they see the agreement as empowering. The strength of the program is the staff; however, existing staff members are stretched too thinly, making a new navigator role essential to the program's continued success.

Navigator – the heart of the program

Moving On Up is having an impact; for example, regarding transitional housing, 97% of current and previous clients said their lives are better because of the program. Fortunately, the program is now well-positioned for continued success thanks to GSC funding that made it possible to hire a navigator so staff members no longer need to juggle several roles. The navigator performs key functions like making referrals and ensuring clients receive the support they need, as well as following up with individuals and families who have transitioned out of the program. To learn more, visit www.ywcanwt.ca

January Haiku

Tough questions abound
Too many caught in the net
While others left out

WINNER OF THE DRAW FOR A FITBIT

Congratulations to **KATHRYN JUNG**, of **Toronto, ON**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

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