

Antidepressant prescribing in five European countries: application of common definitions to assess the prevalence, clinical observations, and methodological implications

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Received: 13 September 2013 / Accepted: 30 March 2014
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Abstract

Purpose Drug utilization studies have applied different methods to various data types to describe medication use, which hampers comparisons across populations. The aim of

this study was to describe the time trends in antidepressant prescribing in the last decade and the variation in the prevalence, calculated in a uniform manner, in seven European electronic healthcare databases.

Electronic supplementary material The online version of this article (doi:10.1007/s00228-014-1676-z) contains supplementary material, which is available to authorized users

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Methods Annual prevalence per 10,000 person-years (PYs) was calculated for 2001–2009 in databases from Spain, Germany, Denmark, the United Kingdom (UK), and the Netherlands. Prevalence data were stratified according to age, sex, antidepressant type (selective serotonin re-uptake inhibitors [SSRIs] or tricyclic antidepressants [TCAs]) and major indications.

Results The age- and sex-standardized prevalence was lowest in the two Dutch (391 and 429 users per 10,000 PYs) and highest in the two UK (913 and 936 users per 10,000 PYs) populations in 2008. The prevalence in the Danish, German, and Spanish populations was 637, 618, and 644 users per 10,000 PY respectively. Antidepressants were prescribed most often in 20- to 60-year-olds in the two UK populations compared with the others. SSRIs were prescribed more often than TCAs in all except the German population. In the majority of countries we observed an increasing trend of antidepressant prescribing over time. Two different methods identifying recorded indications yielded different ranges of proportions of patients recorded with the specific indication (15–57 % and 39–69 % for depression respectively).

Conclusion Despite applying uniform methods, variations in the prevalence of antidepressant prescribing were obvious in the different populations. Database characteristics and clinical factors may both explain these variations.

Keywords Antidepressants · Selective serotonin reuptake inhibitors · Tricyclic antidepressants · Prevalence · Electronic healthcare databases · Standardization

Introduction

The objectives of drug utilization research have broadened over the years to include economic and quality aspects of medication prescribing and use [1]. Drug utilization studies, published in the 1980s and 1990s, are most often cross-sectional surveys or consist of aggregate country data on drug expenditure or sales volume. The increasing availability of electronic healthcare databases has provided the opportunity for more detailed, longitudinal assessments of drug consumption at a patient level and across healthcare settings, regions, and countries.

Antidepressants are one of the most widely used drug classes, prescribed for a wide range of indications [2] with a

reported increasing trend in use [3–14]. Comparison of results of these studies is difficult owing to differences in the methods applied, data sources used, and population groups selected. Cross-country comparisons are few and are made mainly in populations with specific indications or ages [15–19]. The aim of this study was to describe the time trends and the variation in the prevalence of antidepressant prescribing across different European settings applying a uniform method for utilization assessment.

Materials and methods

Study setting and population

For this study, information was obtained from seven European electronic healthcare databases: the Spanish BIFAP Project: Database for Pharmacoepidemiological Research in Primary Care—Base de datos para la Investigación Farmacoepidemiológica en Atención Primaria (www.bifap.org); the German database of the National Association of Statutory Health Insurance Physicians of Bavaria—Kassenärztliche Vereinigung Bayerns (www.kvb.de); the Danish Register of Medicinal Products Statistics, National Institute for Health Data and Disease Control referred to as the Danish national registry in our study (www.ssi.dk); two databases from the United Kingdom: the Clinical Practice Research Datalink (www.cprd.com), and The Health Improvement Network (www.thin-uk.com); and finally, two databases from the Dutch Mondriaan project (www.projectmondriaan.nl): Netherlands Primary Care Research Database (Mondriaan-NPCRD) (www.nivel.nl) and the Almere Health Care group (Mondriaan-AHC).

Most of the databases provide primary care prescribing data. Dispensing data are present in the Danish national registry, the German Bavarian claims, and the Mondriaan AHC (for the latter in addition to prescribing data). Some of the databases include/provide links to secondary care data and registries. The characteristics of these databases have been described in detail elsewhere [20].

Data were obtained for the period between 1 January 2001 and 31 December 2009. The Bavarian claims database was able to provide valid patient information only from 2004 to 2008, while Mondriaan-AHC provided data from 2001 to 2008. Each patient in the databases was considered from the start of the study period or patient's enrolment into a practice/database, or the moment the practice became up to research standard (where applicable), whichever was the latest. Patients were considered in the study population until they left the practice/database or until the end of the study period, whichever came first.

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Antidepressant prescribing and data analysis

Antidepressant prescribing was defined as patients having a prescription (dispensed in the case of the Danish national registry and claimed in the case of the Bavarian claims database) for a selective serotonin re-uptake inhibitor (SSRI) and/or a tricyclic antidepressant (TCA). Annual period prevalence of antidepressant prescribing was calculated by dividing the number of patients having at least one prescription for an antidepressant in a calendar year by the total number of person-years (PYs) of follow-up in that calendar year in a database during the study period. Because of the dynamic nature of the source population, the denominator was expressed as PYs of follow-up in the given calendar year rather than as persons. Prevalence and 95 % confidence intervals (95 % CI) of overall antidepressants, as well as of SSRIs or TCAs were calculated separately. Prevalence was further stratified by age (10-year bands) and sex. Direct standardization of the overall prevalence with regard to age and sex was performed using the distribution of the Eurostat (<http://appsso.eurostat.ec.europa.eu>) population in 2008 with 27 countries.

Data for the year 2008 (the latest calendar year available in all databases) were stratified according to the number of prescriptions 1, 2–4, 5–9, and ≥ 10 prescriptions) and recorded indications (on the first prescription) classified into four groups: depression (with or without anxiety/sleep disorders); anxiety disorders (without depression, with or without sleep disorder); and sleeping disorders (without anxiety and depression). Different coding systems were used in the databases (ICPC for BIFAP and Mondriaan-NCPRD and AHC; ICD-9 in the Bavarian claims and Danish registries and Read codes in CPRD and THIN; protocol published at www.encepp.eu). In the case of missing information, a search was performed within the 3 months before and after the first prescription. An additional analysis was performed by looking for indications recorded any time before (until 1 January 2001) the first prescription.

Results

The age- and sex-standardized prevalence of antidepressant prescribing showed a slightly increasing trend between 2001 and 2009 (Fig. 1). The prevalence varied between 359 (Mondriaan-AHC) and 836 (CPRD) patients per 10,000 PYs in 2001 and between 389 (Mondriaan-AHC) and 930 (THIN) patients per 10,000 PYs in 2008. In both UK databases the overall antidepressant use was higher compared with the other databases. The two Dutch Mondriaan databases had lower prevalence in 2008 (376 and 382 patients per 10,000 PYs for Mondriaan-NCPRD and Mondriaan-AHC respectively) compared with the others (Table 1). The two UK databases showed the highest prevalence (917 and 913 users per 10,000

PYs for THIN and CPRD respectively) in 2008 among all (Table 1).

Stratification by sex and age for the year 2008 (Fig. 2) showed (almost two times) higher antidepressant prescribing among female subjects than male subjects in all populations. In general, there was an increase in prevalence with increasing age. The Danish national registry showed a marked increase in prevalence, almost doubling, in age groups from 60–69 years to 80+ years, in both male and female subjects (from 615 to 1,403 and from 1,013 to 2,094 per 10,000 PYs in male and female subjects respectively). Both UK databases showed higher antidepressant prescribing among age groups from 20 through 60 years (more pronounced among female than male subjects) compared with the same age groups in the other databases.

The prevalence of SSRI prescribing showed a slightly increasing trend between 2001 and 2009 in all except the two Dutch databases, where it remained stable (Fig. 3). The two Dutch and the Bavarian claims databases showed lower prescribing of SSRIs compared with the other databases. Prevalence of TCA prescribing was stable throughout the study period in all databases, but was lower than that of SSRI except in the Bavarian claims database (where TCA prescribing was two times higher than SSRI) (Fig. 3). The Bavarian claims database showed an increasing SSRI and a decreasing TCA trend (237 to 310 and 450 to 391 per 10,000 PYs for SSRI and TCA from 2004 to 2008 respectively). Both UK databases showed higher TCA prescribing in general compared with other databases, except for the Bavarian claims.

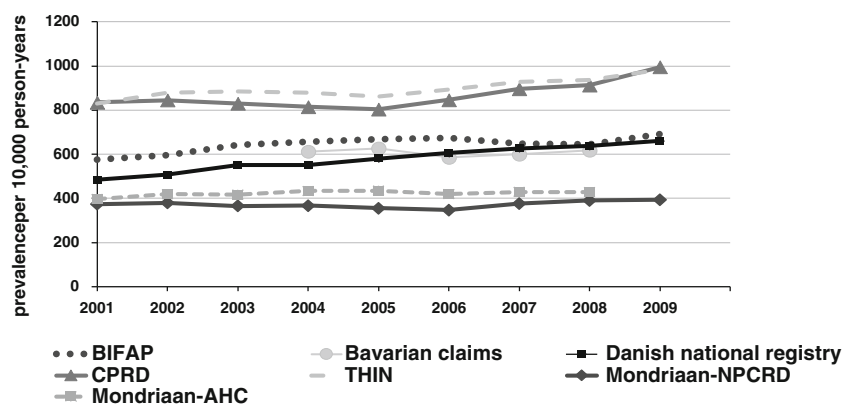
The average number of prescriptions per patient (Table 1) in 2008 varied between 2.3 and 6.4 in SSRI users and between 2.3 and 6.9 in TCA users, with the lowest number of prescriptions per patient in the Bavarian claims database. There were fewer patients with only one SSRI prescription compared with those having only one TCA prescription in 2008 in all databases except in the Danish national registry.

Depression was the most frequently recorded indication in all databases amounting to up to 57 % of the patients, as shown in Fig. 4. In CPRD, Mondriaan-AHC and THIN databases depression was recorded for only 23 %, 15 %, and 12 % of patients respectively. In our additional analysis, higher proportions of patients with depression as the registered indication were obtained, ranging from 39 to 69 % of patients.

Discussion

This study provides a recent and a distinctive overview of antidepressant prescribing in seven different databases from five European countries assessed according to uniform

Fig. 1 Age- and sex-standardized 1-year period prevalence of antidepressant prescribing by calendar year in seven European databases from 2001 to 2009



methods. In the majority of the countries we observed an increasing trend of antidepressant prescribing over time. In particular, there were between-country variations in the prevalence, even after standardization for age and sex. Having

applied a uniform method to calculate the prevalence, variations in the results may be evaluated and explained in the light of differences in the database characteristics and/or clinical aspects related to antidepressant use.

Table 1 Antidepressant prescribing in 2008 in seven European healthcare databases

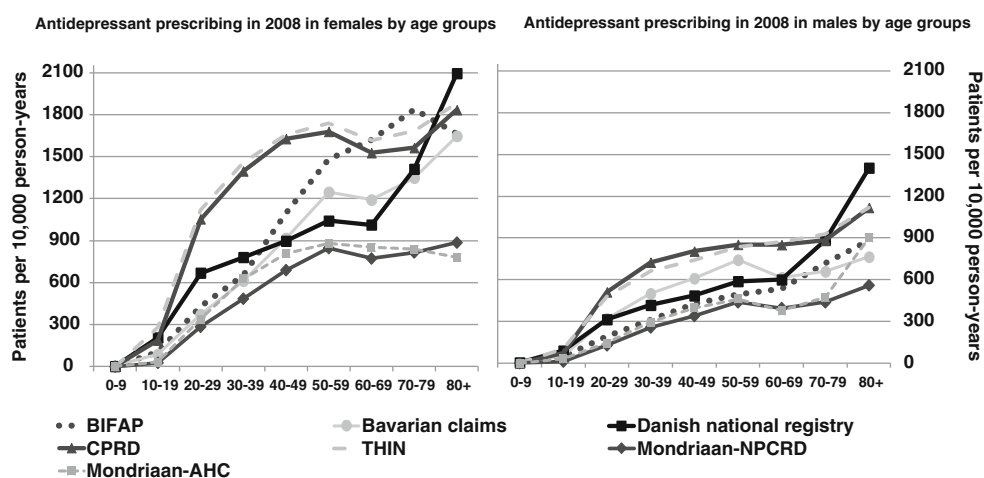
Database/source	BIFAP	Bavarian claims	Danish national registry	CPRD	THIN	Mondriaan-NPCRD	Mondriaan-AHC
Antidepressants							
Patients (<i>n</i>)	94,234	594,745	321,811	397,034	340,798	12,412	5,449
PY in 2008	1,424,572	8,558,315	5,222,891	4,348,431	3,860,850	330,477	142,819
Crude prevalence / 10,000 PY ($\pm 95\%$ CI)	662 (657–666)	695 (693–697)	616 (614–618)	913 (910–916)	883 (880–886)	376 (369–382)	382 (372–391)
Standardized ^b prevalence /10,000 PY	644	618	637	913	936	429	391
Selective serotonin reuptake inhibitors							
Patients ^a (<i>n</i>)	81,020	283,355	280,184	284,922	232,678	8,671	4,101
Prescriptions (<i>n</i>)	512,408	661,607	1,417,063	1,805,959	1,434,894	41,911	26,051
Crude prevalence / 10,000 PY ($\pm 95\%$ CI)	569 (565–573)	331 (330–332)	536 (535–538)	655 (653–658)	603 (600–605)	262 (257–268)	287 (278–296)
Standardized ^b prevalence /10,000 PY	553	302	556	657	639	271	311
Prescriptions/user (average)	6.3	2.3	5.1	6.3	6.2	4.8	6.4
Users with one prescription (%)	18	37	27	18	22	15	13
Tricyclic antidepressants							
Patients ^a (<i>n</i>)	16,566	372,656	50,803	133,965	128,696	3,979	1,488
Prescriptions (<i>n</i>)	114,664	843,303	259,209	738,003	734,231	16,381	7,942
Crude prevalence per 10,000 PY ($\pm 95\%$ CI)	116 (115–118)	435 (434–437)	97 (96–98)	308 (306–310)	333 (332–335)	120 (117–124)	104 (99–109)
Standardized ^b prevalence /10,000 PY	115	382	99	306	354	128	128
Prescriptions/user (average)	6.9	2.3	5.1	5.5	5.7	4.1	5.3
Users with one prescription (%)	27	45	16	33	34	28	25

PY person-years

^a Patients having one or more prescriptions of SSRI/TCA

^b Standardization according to the Eurostat population of 2008

Fig. 2 Period prevalence of antidepressant prescribing in 2008 by sex and age in seven European databases



Comparability of major findings

Owing to differences in the reported medication class, selected population, utilization measure, and data type in previous studies [10, 16–19, 21–27] no direct comparison with our results can be made. As such, a 40 % increase in antidepressant consumption measured in defined daily doses (DDDs) per 1,000 inhabitants from 2000 to 2004 reported in a Spanish study [28] may reflect changes in duration or dose of treatment rather than an increase in the prevalence of use. The increase in prevalence in the Spanish BIFAP database between 2001 and 2004 was only 14 % in our study.

Our results show that the highest prevalence of antidepressant prescribing was in the UK and the lowest in the Netherlands, with Spain, Denmark, and Germany in between. The standardized (for age and sex) prevalence numbers were not essentially different from the non-standardized ones. Characterization of the denominator of the prevalence ratio in databases with dynamic populations and different protocols for recording patient information can be challenging. An example of such a challenge was present in the German Bavarian claims database, where claims are recorded only on a quarterly

basis. In the absence of exact dates of prescriptions and amount of patient-time contributed per patient per year, the denominator of the prevalence ratio could not be optimally defined. Consequently, in calculating PYs of follow-up in the denominator, 1 year of follow-up was assumed for each patient in this database for a given year, instead of the exact amount of time contributed by each patient. This tends to inflate the denominator and underestimate the prevalence. Therefore, such database differences can influence utilization measures, even though application of uniform definitions is attempted. To test the stability of the denominator in the calculated prevalence, we also computed the prevalence with the denominator as the population number at 1 June of every calendar year in all the databases (data not shown). Results based on this definition of the prevalence ratio were not essentially different from those presented in our study.

Sex and age stratification

A distinctive feature in our results was the higher prevalence of prescribing in women compared with men. Moreover, there was a steady increase in the prevalence with increasing age.

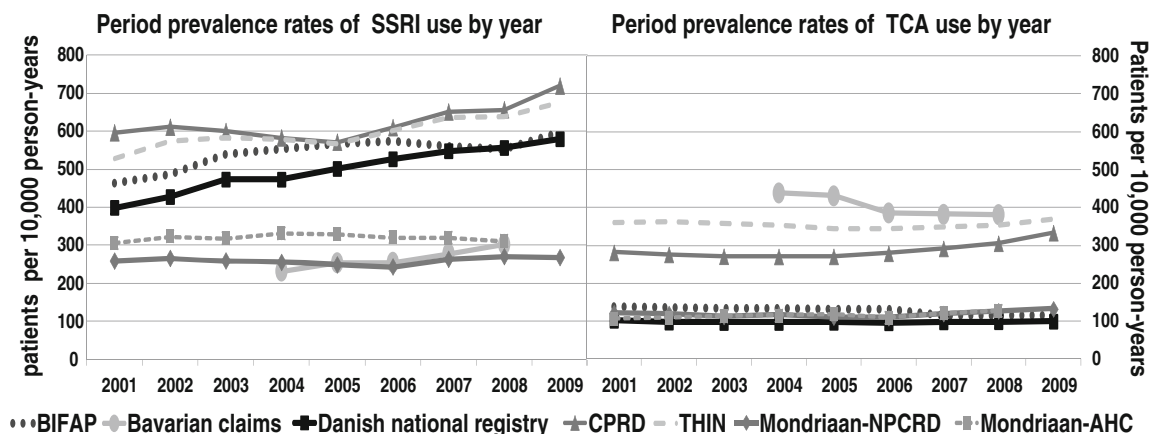


Fig. 3 Age- and sex-standardized prevalence of SSRI and TCA prescribing in seven European healthcare databases from 2001 to 2009

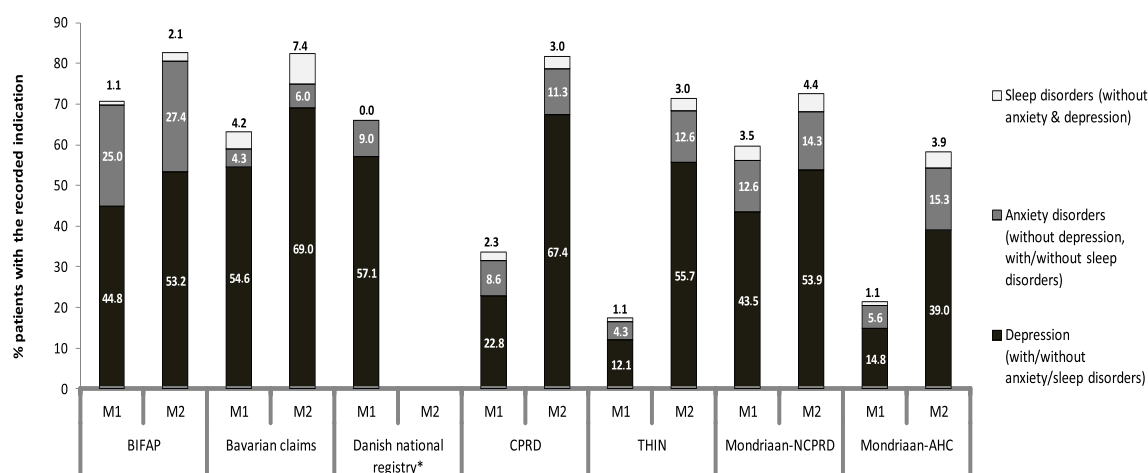


Fig. 4 Distribution of the recorded indications for antidepressants assessed using two different methods in seven European healthcare databases in 2008. M1=indication assessed in the period 3 months before/after the first antidepressant prescription in 2008. M2=indication

assessed in the period from the first antidepressant prescription in 2008 going backwards until 1 January 2001 (1 January 2004 in the Bavarian claims) *Asterisk* Assessment of the M2 method in the Danish national registry was not possible

The characteristic increase in the prevalence in patients aged 70+ years in Denmark has also been reported elsewhere [3, 29, 30]. Older patients in Denmark seem to have higher antidepressant use compared with other European countries, possibly indicating a feature that needs further investigation, as noted previously [30].

An increasing use of antidepressants among adolescents and children under the age of 18 years was reported in two studies in CPRD [31, 32] for the period 1992–2001. In our study we observed a relatively stable trend in the prevalence (94 and 81 users per 10,000 PYs in 2001 and 2009 respectively). A more recent study [33] in THIN (study period 2002–2009) reported a significant drop in SSRI use in 2005; around the time of the advice of the Committee on Safety of Medicines (CSM) on antidepressant prescribing to children and adolescents. We also confirmed this drop in SSRI prescribing in our study (92, 75, and 86 users per 10,000 PYs) in 2001, 2005, and 2009, respectively.

A distinctive feature in our results for the UK databases, which has not been reported before, was the remarkable difference (higher) in antidepressant prescribing in the age groups 20 throughout 60 years (especially in female subjects) compared with the same age groups in the other databases. This finding calls for more in-depth investigation of indications for use in this large adult age group in the UK.

SSRI versus TCA use

The trend toward a slight increase in SSRI prescribing during the period from 2001 to 2009 reported in our study adds to the knowledge of the widespread use of SSRIs in contrast to the decreasing use of TCAs [34, 35]. The use of SSRIs outweighing that of TCAs has been reported in previous studies [3, 16, 29, 36] and is in line with our findings. The

higher use of TCAs compared with SSRIs in Germany found in our study has also been reported in other studies [37, 38]. In a recent study [39], using German statutory claims data for the year 2009, Hoffmann et al. reported that among children and adolescents (aged 12 to 18 years) with a diagnosis of depression, the use of SSRIs was higher than TCA use (55.6 % vs 17.9 %). In our study, we observed a gradual increase (from 30.8 to 42.6 per 10,000 users) and a decrease (from 38.8 to 33.5 per 10,000 users) in the prevalence of SSRI and TCA from 2004 to 2008 respectively in the age group 10–19 years in the Bavarian claims database. Our results suggest the appearance of an increasing trend in SSRI and a decreasing trend in TCA use in Germany, similar to that in other European countries. However, this trend does not confirm the large differences between SSRI and TCA use in the same age groups, defined without restrictions according to indication (depression), as reported by Hoffmann et al. [39]. Moreover, inclusion of data from specialists, which is the case in the Bavarian claims database, may introduce differences in the prevalence. As shown in a French study [40], TCAs (e.g., amitriptyline or clomipramine) were more frequently prescribed by specialists than by general practitioners. Further analyses are needed to disentangle differences in the prevalence due to prescriber differences, especially because of the somewhat conflicting results reported by a recent Norwegian study on the more frequent prescribing of SSRI as initiation therapy by specialists [41].

Number of prescriptions

The proportion of users with only one prescription in a year is an indicator of a patient subgroup in which treatment is not sustained. This is true unless this single prescription is issued at the end of the calendar year and the patient continues his

treatment in the following year. Information on the treatment duration is important for proper comparison of drug use. The definition of a user as a patient with at least one prescription in a year contributes to the measure of the prevalence, while this group does not consist of regular users. Proportions of patients with one prescription reported in our study for Denmark (27 % and 16 % for SSRI and TCA users in 2008 respectively) differ from those reported in another study [3] (22 % and 33 % for SSRI and TCA users in 1995 respectively). This may indicate possible changes in the length of treatment (switching or discontinuation) and not necessarily changes in the prevalence of use.

Similarly high proportions of patients with a single prescription, especially of TCA, (in addition to the lowest number of prescriptions in general) in Germany have been reported in another study using a different claims database [38]. Prescribing large packages of antidepressants in Germany (usually for 90 days) and the high percentage of patients stopping or switching their treatment after a single prescription may explain our results. Such differences in prescribing policies should be taken into account when performing country comparisons.

Indications

The main clinical indication for antidepressant treatment is depression, which has been reported to be the most frequently reported indication for antidepressant use [2, 36]. Our sensitivity analyses (see Fig. 4) yielded larger proportions (two to fourfold) of patients with recorded indications demonstrating the importance of extensive search criteria. We could not associate the increase in the identified indications with the type of database in our study. Many conditions, such as sleeping and anxiety disorders, are also known to be comorbidities with depression [42, 43]; hence, a cross-sectional selection of subgroups based on the indication recorded on one prescription may result in misclassification [44]. The variation in the recording of indications in our study points out that the selection of a population group based on indications may not produce comparable groups in terms of drug use, and therefore hinder direct comparison of utilization patterns.

To our knowledge, this is the first study comparing the prevalence of antidepressant prescribing calculated in a uniform manner across different European databases, covering a broad age range, both sexes, major antidepressant groups, and without selection criteria on certain indications. Moreover, the databases are population-based reflecting patient-specific information in contrast to aggregate sales data calculated per inhabitants of a specific region. Owing to the application of common methods for calculating such simple measures, our results reflect the actual features of utilization or changes in

treatment course or intensity of prescribing, rather than differences in the methods of calculating the prevalence.

A limitation of our study is the inability to reach complete harmonization definitions, which was due to differences in database designs and the heterogeneity of the level of information. Also, no comparisons based on prescribed doses and indications could be performed. Inherent differences in the coding systems used in the databases may also have created differences in capturing indications. Furthermore, no prescriber characteristics analyses were performed. As we mainly had data on prescribing, we were unable to distinguish patients who did not collect their prescriptions. This has been shown to amount to 4 % in the Dutch databases [45]. In addition, some of the differences between countries we observed may be influenced by the availability of individual drugs per country and national prescribing guidelines. A separate study on these specific topics would be informative.

Conclusion

In conclusion, our study illustrates that harmonizing methods to describe the prevalence of antidepressant prescribing in electronic healthcare databases may contribute to direct cross-country comparisons. Prescribing differences, after the application of a harmonized method, may primarily reflect differences in clinical guidelines among the countries. Direct comparison of results of drug utilization studies may provide a better insight into prescribing practices and hence contribute to better drug safety systems and assessment of future research needs.

Acknowledgements The research leading to these results was conducted as part of the PROTECT consortium (Pharmacoepidemiological Research on Outcomes of Therapeutics by a European Consortium, www.imi-protect.eu), which is a public–private partnership coordinated by the European Medicines Agency. Roman Gerlach and Martin Tauscher from the KVB (National Association of Statutory Health Insurance Physicians of Bavaria, Munich, Germany) are acknowledged for their support in data acquisition.

Funding The PROTECT project has received support from the Innovative Medicine Initiative (IMI) Joint Undertaking (www.imi.europa.eu) under Grant Agreement no. 115004, the resources of which are composed of financial contributions from the European Union's Seventh Framework Programme (FP7/2007–2013) and the kind contribution of the EFPIA companies. In the context of the IMI Joint Undertaking (IMI JU), the Department of Pharmacoepidemiology, Utrecht University, also received a direct financial contribution from Pfizer. The views expressed are those of the authors only and not of their respective institutions or companies.

The Division of Pharmacoepidemiology and Clinical Pharmacology has received unrestricted funding from the Netherlands Organisation for Health Research and Development (ZonMW), the Dutch Health Care Insurance Board (CVZ), the Royal Dutch Pharmacists Association (KNMP), the privately/publically funded Top Institute Pharma (www.tipharma.nl), includes co-funding from universities, government, and industry), the EU Innovative Medicines Initiative (IMI), the EU 7th Framework Program (FP7), the Dutch Ministry of Health, and industry (including GlaxoSmithKline, Pfizer, and others).

References

1. Strom B (2005) *Pharmacoepidemiology*, 4th edn. Wiley, London
2. Gardarsdottir H, Heerdink ER, van Dijk L, Egberts AC (2007) Indications for antidepressant drug prescribing in general practice in the Netherlands. *J Affect Disord* 98(1–2):109–115
3. Rosholm JU, Andersen M, Gram LF (2001) Are there differences in the use of selective serotonin reuptake inhibitors and tricyclic antidepressants? A prescription database study. *Eur J Clin Pharmacol* 56(12):923–929
4. Development of Drug Utilization Indicators: A feasibility study using existing aggregated administrative databases 2002. Accessed December 2012. Available from: http://www.cihi.ca/CIHI-ext-portal/pdf/internet/PDF_INDI_DRUG_FINAL_REPORT_EN
5. Exeter D, Robinson E, Wheeler A (2009) Antidepressant dispensing trends in New Zealand between 2004 and 2007. *Aust N Z J Psychiatry* 43(12):1131–1140
6. Aguglia E, Ravasio R, Simonetti M, Pecchioli S, Mazzoleni F (2012) Use and treatment modalities for SSRI and SNRI antidepressants in Italy during the period 2003–2009. *Curr Med Res Opin* 28(9):1475–1484
7. Smith AJ, Tett SE (2009) How do different age groups use benzodiazepines and antidepressants? Analysis of an Australian administrative database, 2003–6. *Drugs Aging* 26(2):113–122
8. Patten SB, Wang JL, Williams JV, Lavorato DH, Beck CA, Bulloch AG (2010) Frequency of antidepressant use in relation to recent and past major depressive episodes. *Can J Psychiatry* 55(8):532–535
9. Sundell KA, Gissler M, Petzold M, Waern M (2011) Antidepressant utilization patterns and mortality in Swedish men and women aged 20–34 years. *Eur J Clin Pharmacol* 67(2):169–178
10. Volkens AC, Heerdink ER, van Dijk L (2007) Antidepressant use and off-label prescribing in children and adolescents in Dutch general practice (2001–2005). *Pharmacoepidemiol Drug Saf* 16(9):1054–1062
11. Athanasopoulos C, Pitychoutis PM, Messari I, Lionis C, Papadopoulou-Daifoti Z (2012) Is Drug Utilization in Greece Sex dependent? A Population-based Study. *Basic Clin Pharmacol Toxicol* 112(1):55–62
12. Parabiaghi A, Franchi C, Tettamanti M, Barbato A, D'Avanzo B, Fortino I et al (2011) Antidepressants utilization among elderly in Lombardy from 2000 to 2007: dispensing trends and appropriateness. *Eur J Clin Pharmacol* 67(10):1077–1083
13. Moore M, Yuen HM, Dunn N, Mullee MA, Maskell J, Kendrick T (2009) Explaining the rise in antidepressant prescribing: a descriptive study using the general practice research database. *BMJ* 339:b3999
14. Alonso MP, de Abajo FJ, Martinez JJ, Montero D, Martin-Serrano G, Madurga M (1997) [Evolution of antidepressive drug consumption in Spain. The impact of selective serotonin re-uptake inhibitors]. *Med Clin (Barc)* 108(5):161–166
15. Lidell E, Luepker R, Baigi A, Lagiou A, Hildingh C (2008) Medication usage among young adult women: a comparison between Sweden, the USA, and Greece. *Nurs Health Sci* 10(1):4–10
16. Bauer M, Monz BU, Montejó AL, Quail D, Dantchev N, Demyttenaere K et al (2008) Prescribing patterns of antidepressants in Europe: results from the Factors Influencing Depression Endpoints Research (FINDER) study. *Eur Psychiatry* 23(1):66–73
17. Zito JM, Tobin H, de Jong-van den Berg LT, Fegert JM, Safer DJ, Janhsen K et al (2006) Antidepressant prevalence for youths: a multinational comparison. *Pharmacoepidemiol Drug Saf* 15(11):793–798
18. Bowers L, Callaghan P, Clark N, Evers C (2004) Comparisons of psychotropic drug prescribing patterns in acute psychiatric wards across Europe. *Eur J Clin Pharmacol* 60(1):29–35
19. Alonso J, Angermeyer MC, Bernert S, Bruffaerts R, Brugha TS, Bryson H et al (2004) Psychotropic drug utilization in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatr Scand Suppl* 420:55–64
20. Abbing-Karahagopian V, Kurz X, de Vries F, van Staa TP, Alvarez Y, Hesse U et al (2014) Bridging differences in findings from observational pharmacoepidemiological studies: PROTECT project. *Curr Clin Pharmacol* 9(2):130–138
21. Ohayon MM, Caulet M, Priest RG, Guilleminault C (1998) Psychotropic medication consumption patterns in the UK general population. *J Clin Epidemiol* 51(3):273–283
22. Pagura J, Katz LY, Mojtabai R, Druss BG, Cox B, Sareen J (2011) Antidepressant use in the absence of common mental disorders in the general population. *J Clin Psychiatry* 72(4):494–501
23. Paulose-Ram R, Safran MA, Jonas BS, Gu Q, Orwig D (2007) Trends in psychotropic medication use among U.S. adults. *Pharmacoepidemiol Drug Saf* 16(5):560–570
24. Raymond CB, Morgan SG, Caetano PA (2007) Antidepressant utilization in British Columbia from 1996 to 2004: increasing prevalence but not incidence. *Psychiatr Serv* 58(1):79–84
25. Sanyal C, Asbridge M, Kisely S, Sketris I, Andreou P (2011) The utilization of antidepressants and benzodiazepines among people with major depression in Canada. *Can J Psychiatry* 56(11):667–676
26. Sihvo S, Isometsa E, Kiviruusu O, Hamalainen J, Suvisaari J, Perala J et al (2008) Antidepressant utilisation patterns and determinants of short-term and non-psychiatric use in the Finnish general adult population. *J Affect Disord* 110(1–2):94–105
27. Wittkamp LC, Smeets HM, Knol MJ, Geerlings MI, Braam AW, De Wit NJ (2010) Differences in psychotropic drug prescriptions among ethnic groups in the Netherlands. *Soc Psychiatry Psychiatr Epidemiol* 45(8):819–826
28. Ubeda A, Cardo E, Selles N, Broseta R, Trillo JL, Fernandez-Llimos F (2007) Antidepressant utilization in primary care in a Spanish region: impact of generic and reference-based pricing policy (2000–2004). *Soc Psychiatry Psychiatr Epidemiol* 42(3):181–188
29. Hansen DG, Sondergaard J, Vach W, Gram LF, Rosholm JU, Kragstrup J (2003) Antidepressant drug use in general practice: inter-practice variation and association with practice characteristics. *Eur J Clin Pharmacol* 59(2):143–149
30. Hansen DG, Rosholm JU, Gichangi A, Vach W (2007) Increased use of antidepressants at the end of life: population-based study among people aged 65 years and above. *Age Ageing* 36(4):449–454
31. Hsia Y, MacLennan K (2009) Rise in psychotropic drug prescribing in children and adolescents during 1992–2001: a population-based study in the UK. *Eur J Epidemiol* 24(4):211–216
32. Murray ML, de Vries CS, Wong IC (2004) A drug utilisation study of antidepressants in children and adolescents using the General Practice Research Database. *Arch Dis Child* 89(12):1098–1102
33. Wijlaars LP, Nazareth I, Petersen I (2012) Trends in depression and antidepressant prescribing in children and adolescents: a cohort study in The Health Improvement Network (THIN). *PLoS One* 7(3):e33181
34. Reseland S, Bray I, Gunnell D (2006) Relationship between antidepressant sales and secular trends in suicide rates in the Nordic countries. *Br J Psychiatry* 188:354–358
35. Bramness JG, Walby FA, Tverdal A (2007) The sales of antidepressants and suicide rates in Norway and its counties 1980–2004. *J Affect Disord* 102(1–3):1–9
36. Trifiro G, Barbui C, Spina E, Moretti S, Tari M, Alacqua M et al (2007) Antidepressant drugs: prevalence, incidence and indication of use in general practice of Southern Italy during the years 2003–2004. *Pharmacoepidemiol Drug Saf* 16(5):552–559
37. Fegert JM, Kolch M, Zito JM, Glaeske G, Janhsen K (2006) Antidepressant use in children and adolescents in Germany. *J Child Adolesc Psychopharmacol* 16(1–2):197–206
38. Ufer M, Meyer SA, Junge O, Selke G, Volz HP, Hedderich J et al (2007) Patterns and prevalence of antidepressant drug use in the

- German state of Baden-Wuerttemberg: a prescription-based analysis. *Pharmacoepidemiol Drug Saf* 16(10):1153–1160
39. Hoffmann F, Glaeske G, Petermann F, Bachmann CJ (2012) Outpatient treatment in German adolescents with depression: an analysis of nationwide health insurance data. *Pharmacoepidemiol Drug Saf* 21(9):972–979
40. Lapeyre-Mestre M, Desboeuf K, Aptel I, Chale JJ, Montastruc JL (1998) A comparative survey of antidepressant drug prescribing habits of general practitioners and psychiatrists. *Clin Drug Investig* 16(1):53–61
41. Kjosavik SR, Hunskaar S, Aarsland D, Ruths S (2011) Initial prescription of antipsychotics and antidepressants in general practice and specialist care in Norway. *Acta Psychiatr Scand* 123(6):459–465
42. Ballenger JC, Davidson JR, Lecrubier Y, Nutt DJ, Goldberg D, Magruder KM et al (1999) Consensus statement on the primary care management of depression from the International Consensus Group on Depression and Anxiety. *J Clin Psychiatry* 60(Suppl 7):54–61
43. Roberts RE, Shema SJ, Kaplan GA, Strawbridge WJ (2000) Sleep complaints and depression in an aging cohort: a prospective perspective. *Am J Psychiatry* 157(1):81–88
44. Gardarsdottir H, Egberts AC, van Dijk L, Sturkenboom MC, Heerdink ER (2009) An algorithm to identify antidepressant users with a diagnosis of depression from prescription data. *Pharmacoepidemiol Drug Saf* 18(1):7–15
45. Van Geffen EC, Gardarsdottir H, van Hulten R, van Dijk L, Egberts AC, Heerdink ER (2009) Initiation of antidepressant therapy: do patients follow the GP's prescription? *Br J Gen Pract* 59(559):81–87