Depression is a common and significant health problem associated with impairment in a patient's ability to function in their role (e.g. student, worker, homemaker), and may have a fatal outcome in the case of suicide. Recently there has been progress in developing new antidepressant medications, such as the selective serotonin reuptake inhibitors (SSRIs). These agents, while no more effective than the tricyclic antidepressant (TCA) drugs, are generally better tolerated than traditional medications used to treat depression. Further, because of their adverse effect profiles, they are generally better tolerated, and safer in overdose, than the TCAs.

In response to concerns about aggregate healthcare costs, formularies are being employed to control the direct costs of prescription drugs. When direct drug costs alone are considered, the TCAs are initially less expensive than the SSRIs. However, compared with those taking SSRIs, patients taking TCAs withdraw from treatment more frequently, have more accidents, experience more adverse effects that require treatment, and are more likely to die from an overdose (if it...
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occurs). Furthermore, unsuccessful treatment may be due to noncompliance, which is frequently related to adverse effects.

Medications have effects on indirect costs. For example, adverse effects may impair productivity and lead to accidents in the home and at work. There are increased hospital and indirect costs of drugs used in overdose. Medication noncompliance may lead to failure to recover from depression, which results in ongoing expense to the state in the form of disability benefit payments. The largest cost savings are often associated with indirect costs, such as reduced benefit payments and improved productivity and earnings when treatment is successful. Taking all these considerations together, it does not appear that TCAs, taken over time, are any less expensive than the newer antidepressant medications.

Clinical practice in all areas of medicine has reached a watershed. Major changes are occurring, due principally to 2 factors: greater attention to the costs of care; and developments in the pharmaceutical armamentarium of clinical medicine. Clinicians, accustomed to considering quality-of-life issues, now find that their focus has expanded to pharmacoeconomic evaluations of resource utilisation and its impact on quality of life.

Pharmacoeconomics has, therefore, taken on added significance with the realisation that controlling expenditures on drug therapy is a component of efforts to contain healthcare costs. New terms have entered the clinician’s vocabulary to reflect these changes. Clinicians have begun to consider issues of direct and indirect cost, cost-benefit analysis, cost-effectiveness analysis and cost-utility analysis, along with practice guidelines for economic and clinical evaluation of new treatments.[1,2]

This new way of thinking has resulted in changes in clinical practice. For example, there is increasing awareness in clinical psychiatry that, by preventing relapse and recurrence of depression, cost savings can be made by avoiding consultations, inpatient admissions and expensive inpatient procedures such as electroconvulsive therapy.

1. The Nature of Depressive Illness

Depression is a common condition.[3] Among the noninstitutionalised elderly, the prevalence of clinically significant depression is about 15%.[4] With a lifetime prevalence of 6%, and associated risks such as suicide, major depression is a significant public health concern in the US.[5] For example, in 1979 and 1989, suicide was the fourth leading cause of death for White Americans.[6]

Depression is a chronic disease. Most patients who recover from an initial episode of depression will experience a recurrence.[7-9] Depressive disorder is recognised as having a high risk of recurrence, and additional episodes carry increased risks of chronicity, psychosocial impairment and suicide.[8,10] More precisely, approximately 50% of the patients who recover from an initial episode of depression will have at least 1 subsequent episode during the following 2 years.[9]

The factors associated with a heightened probability of relapse include increased severity of the initial episode, the high number of prior episodes, a poor response to prior treatment, and a history of chronic depression.[8] Other significant factors include comorbid conditions such as chronic medical disorders and the degree of psychosocial perturbation. Because recurrence is so common, early and aggressive treatment has been recommended.[11] Lee and Murray[12] noted that while severe forms of depression (including those with psychotic features) often respond better to treatment than neurotic depression, they have a much poorer long term prognosis when social, economic and physical well-being are tracked as variables. These patients require long term treatment.

Major depression produces an impairment in functioning which exceeds that of many general medical conditions.[13] The risk of disability (impaired function) in patients with major depression