

Actions against depression

Improving mental and well-being by combating the adverse health, social and economic consequences of depression



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Preface

Depression and depression-related problems are today among the most pressing public health concerns. Estimates for total disease burden quoted in this report indicate that they account for more than 7% of all estimated ill health and premature mortality in Europe, only exceeded by ischaemic heart disease (10.5%) and cancer (11.5%).

And there are other burdens caused by depression, beyond the health systems: These include the loss of quality of life for the affected and their families, a loss of productivity for firms and an increased risk of unemployment for individuals. Depression can mean that people withdraw from family life, social life and work, and far too many people with depression commit suicide.

This is why the European Commission's Directorate General for Health and Consumer Protection has taken the initiative of requesting from a group of distinguished experts a report on "Actions against depression".

This report builds on a whole range of past and current mental health-related activities under the Programme of Community action in the field of public health (2003-2008)¹. They focus on better information about the mental health of the population as well as on the promotion of good mental health and the prevention of mental disease.

The activities are based on the knowledge that mental health is an integral part of health, and the conviction that health is an important resource for the quality of life of citizens, the success of the European economy and social cohesion.

This report describes the illness of depression and highlights its economic and social consequences. It presents the evidence base and areas for effective interventions. It identifies some of the challenges in developing promotion and prevention strategies and possible solutions. Finally, it presents conclusions and suggestions for the way forward.

The present report constitutes a valuable contribution to building action against depression at the level of the European Community.

Robert Madelin
Director General for Health and Consumer Protection

¹ Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a Programme of Community action in the field of public health, in: Official Journal L 271 , 09/10/2002, P. 1 – 12

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Executive summary

This report presents an overview of current knowledge on actions already taken jointly by the European Commission and the World Health Organisation to improve mental health and well-being by combating the adverse health, social and economic consequences of the illness depression.

Chapter 1 records what has been done by the international organisations and Member States in the area of public health.

Chapter 2 contains a descriptive account of depression, the illness.

Chapter 3 details the economic and social consequences of depression.

Chapter 4 highlights the evidence base for effective actions and the importance of participation with a wide range of stakeholder interests.

Chapter 5 identifies the challenges in developing promotional and preventive strategies and presents the evidence for solutions to these challenges.

Chapter 6 proposes conclusions and the way forward for action.

The report presents existing models of good practice. The positive outcomes of these examples demonstrate that effective actions against depression and depression-related problems are possible.

Recognition of the rights of people with mental health problems and their full participation in society is a prerequisite for any successful strategic approach to successful actions.

Chapter 1

Flashback: what has been done?

The Challenge

The health of the people of Europe is under increasing challenge from a range of environmental, social, political, lifestyle and life circumstance factors. There is an increasing recognition that these do not only have an affect on our physical health but also on our mental health and well-being. Identifying and addressing these factors requires a strong public health approach across Europe, building on our collective knowledge, experience and expertise. One of the most pressing public health challenges we face in Europe is taking action to address depression.

Depression and depression-related problems directly affect about 2–10% of our European citizens. It affects the young, the old and the adult working population, impacting on quality of life, economic activity, learning, social and cultural life and people's ability to participate in their communities and to be included in everyday life. A vast number of working days a year are lost to depression affecting our economies and our social, community and family life. Depression affects quality of life more than most physical illnesses, and in some cases it even leads to suicide or suicide attempts. There are also well established links between physical illness and depression and vice versa.

But there are grounds for increasing optimism. From the evidence, we now know a lot more about what works at a population level, what works well within service systems, within workplaces, schools and communities and what helps individuals and families to prevent and treat depression and to recover. We also know that taking a public health approach and improving awareness and understanding about depression significantly helps to de-stigmatise the condition and enhance people's chances of recovery as people are more encouraged to seek help earlier.

So whilst there is undoubtedly a challenge to health across Europe, there are actions that can be taken at Member State, regional and local levels as part of wider action on mental health, public health, economic and social policy which will significantly help reduce the impact of depression across Europe. Investing in the promotion of mental health and the prevention of depression will lead to savings regarding the significant direct and indirect social costs of depression. It also means

an investment in the quality of life of the European population and in the productivity of the European economy.

Actions Taken

Public Mental Health: Action on Promotion and Prevention

The actions of the European Community within the area of public health are legally based on Article 152 (ex Article 129) of the Treaty. This article dictates that "a high level of human health protection shall be ensured in the definition and implementation of all Community actions and policies" and that "Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources to human health."

The development of mental health (which includes action on depression) as an essential component of the public health agenda in Europe, was supported by the European Union in the Community action on health promotion, information, education and training, within the framework for action in the field of public health (1996-2000). This Community action was extended until the end of 2002. A European Commission supported project *Putting Mental Health on the European Agenda* was coordinated by the Finnish Ministry of Social Affairs and Health and the National Research and Development Centre for Welfare and Health (STAKES) 1998-2000.

The outcome of this project was published under the title *Public Health Approach on Mental Health in Europe* (2000) which sets out the main broad elements of public health action on mental health. This report advocates the continuing need to shift the focus of mental health into the broader sphere of public health and to strengthen the population approach to mental health as one part of an overall approach to mental health policy that includes promotion, prevention and care and treatment of individuals and their families. The report also highlights the need to give greater attention to positive mental health as an important resource for individuals, families, communities, regions and nations. This emphasis on promotion is important in responding to the public health challenge posed by depression.

Joint Actions

In April 1999, a joint World Health Organization / European Commission meeting on 'Balancing Mental Health Promotion and Mental Health Care' was held in Brussels. This meeting reached a

consensus on the need to ensure a **balance between providing mental health care and undertaking mental health promotion activities in Europe** in the years to come.

As part of the official programme of the Finnish EU Presidency, the ‘European Conference on Promotion of Mental Health and Social Inclusion’ was held in Tampere, Finland in October 1999. The Conference marked an important step in the process to put mental health on the European Agenda. In November 1999, the Health Council of the European Union adopted a **Resolution on the Promotion of Mental Health**. The Resolution stated the need for enhancing the value and visibility of mental health and for promoting good mental health particularly amongst children, young people, old people and at work. The Resolution invites the Member States and the Commission to take **specific actions in mental health promotion**, good quality data collection, support to research, the incorporation of mental health in future programmes of public health action and **stated the need to consider a proposal for a Council Recommendation on the promotion of mental health**.

Initiatives on the promotion of mental health in the European Agenda have been preserved and continued by several Presidencies. In March 2000, a conference on ‘Health Determinants in the EU’ and later in June 2000 on ‘Violence and Promotion of Mental Health of Children and Young People’ were held in Portugal. In September 2000, a conference on ‘Prevention of Youth Suicide’ was held in France. In Sweden, February 2001, a conference was held on ‘Young People and Alcohol’. All these activities help to underline the importance of taking action on depression as one of the most common public health challenges.

In Brussels, in October 2001 during the Belgian Presidency of the EU, the Federal Ministry of Social Affairs, Public Health and Environment in Belgium, together with the European Commission and the World Health Organization, launched the WHO World Health Report *Mental Health: New Understanding, New Hope* during the opening of the conference ‘Coping with Stress and Depression-related problems in Europe’. The Commissioner gave an introductory speech on the importance of promoting mental health in Europe and tackling stress and depression-related problems in the EU and in accession countries. During this conference, the WHO European Office also emphasized the high prevalence and the magnitude of the burden of depression in the Region. The conference considered work-related stress, stress and depression in children and adolescents, prevention programmes and strategies for monitoring and evaluating action.

In November 2001, the Health Council of the European Union adopted the conclusions of the conference, which invited the Member States to give due attention to the impact of stress and depression-related problems in all age groups, giving special attention to the problems of work-related stress and depression. The conclusions invited the Commission to facilitate the collection of comparable data, to consider undertaking activities recognising best practices concerning the promotion of mental health, as well as the recognition, prevention and monitoring of stress and depression-related problems, and to consider developing strategies for their prevention.

During the Greek Presidency of the European Union in March 2003, a conference was held in Athens on ‘Mental Illness and Stigma in Europe: facing up to the challenges of social inclusion and equity’. In June 2003, the Council of Ministers of Employment, Social Policy, Health and Consumer Affairs, adopted the Conclusions of the conference. Member States were invited to give specific attention to the impact of stigma and discrimination due to mental illness in all age groups, and to give special attention to a reduction of the consequential risks of social exclusion. The Commission was invited to give attention to active collaboration in all relevant Community policies and actions, in particular those relating to employment, social protection, education and health in order to reduce discrimination in relation to mental illness. The Commission was invited to facilitate the exchange of information in the context of national policies to ensure protection for people with mental health problems and to promote their inclusion in society.

In Brussels, in September 2001, the European Commission and ‘WHO Euro’ organised a consultative meeting ‘Future Mental Health Challenges in Europe: Impact of other policies on mental health’. This meeting focused on discussing the impact of environmental policies, social welfare policies and education policies on mental health and addressed the importance of the need for future work on the social and economic burden of illness in the mental health field.

In Luxembourg, in December 2002, the European Commission and ‘WHO Euro’ organised a seminar ‘Future Mental Health Challenges in Europe: Strengthening co-operation between EU and WHO’. This seminar put emphasis on the issues of premature mortality and suicide prevention, experiences of mental health promotion actions and prevention strategies during the life cycle and the crucial transitions in life, and enhancing implementation of coping and prevention strategies of stress and depression-related problems at European Member State, regional and local levels.

During the period 2001–2003, the European Commission supported a large-scale collaborative project on “Mental Health Promotion and Prevention Strategies for Coping with Depression,

Anxiety and Stress-related Disorders in Europe”. The focus of the project was on three stages of the lifespan, childhood and adolescence, working life and old age. Depression in childhood and adolescence is a highly recurrent condition and is identified as a major public health problem. Likewise, depression and depression-related problems are commonplace in working life, accounting for the frequency of short-term sickness absence from work and a significant loss of workforce productivity. Depressive illness is the most frequent mental disorder among older people. The report of the project carries ten key recommendations on promotion and prevention activities in mental health on common mental health problems such as anxiety, depression and stress-related disorders which themselves contribute to the challenges posed by stigmatizing people with mental health problems.

The evidence emerging from seven years’ experience of the work of the Community action programme in the field of public health, and the work of the WHO mental health programme, supports the need to take action against depression as a key public health challenge for the 21st century.

TABLE 1: Summary of selected EC events relating to mental health between 1999 and 2003

MONTH/ YEAR	TITLE OF THE EVENT	LEVEL	COUNCIL RESOLUTIONS/ CONCLUSIONS
04/1999	Balancing Mental Health Promotion and Mental Health Care	Joint EU/WHO meeting	
10/1999	European Conference on Promotion of Mental Health and Social Inclusion	EU Presidency	Council Resolution on the promotion of mental health
03/2000	Health Determinants in the EU	EU Presidency	Council Resolution on action on health determinants
06/2000	Violence and Promotion of Mental Health of Children and Young People	EU Presidency	
09/2000	Prevention of Youth Suicide	EU Presidency	
01/2001	Young People and Alcohol	WHO Ministerial Conference/ EU Presidency	Council conclusions on a Community strategy to reduce alcohol-related harm
09/2001	Future Mental Health Challenges in Europe: Impact of Other Policies on Mental Health	Joint EU/WHO meeting	
10/2001	Coping with Stress and Depression-Related Problems in Europe	Joint EU Presidency and WHO	Council conclusions on combating stress and depression-related problems
12/2002	Future Mental Health Challenges in Europe: Strengthening Co-operation between EU and WHO	Joint EU/WHO seminar	
03/2003	Mental Illness and Stigma in Europe: Facing up to the Challenges of Social Inclusion and Equity	Joint EU Presidency, WHO and Council of Europe	Council conclusions on combating stigma and discrimination in relation to mental health
10/2003	Mental Health in Europe: New Challenges, New Opportunities	EC-funded conference/co-sponsored by WHO	

Chapter 2

Depression: what is it?

Depression: the illness

Depression may range from a “feeling of gloom” to a severe and life-threatening illness.

- At any given point of time, 2-10% of the European population will suffer from a depressive illness.
- Depression poses a heavy burden to individuals, families and societies.
- Depression impairs quality of life more than physical illness.
- Inability to feel pleasure, tiredness, worthlessness, helplessness, hopelessness and feelings of guilt are common signs of depression-related problems.
- Those suffering from depression may see everything as dark and empty, cannot concentrate, have clearly lowered functional capacity.
- Depressive illness is not self-inflicted, nor a sign of weak or low morale.
- Effective methods of prevention and treatment of depression and depression-related problems are available.
- The majority of people with depression can and do recover.

Description

"Depression not only affects your emotions, but can also change the way you think, how you behave, and how you function physically" [1]. A common everyday language expression to describe the condition could be that of "falling into a black hole".

Depression is a word which refers to an ambiguous concept and which can mean different things. According to common misunderstandings, the word “depression” conveys a normal everyday emotional reaction and expresses itself as feelings of unhappiness, sadness and frustration. This report, however, deals with depression as an illness entity, which can be most severe and even life-threatening. In severe cases it can lead to suicide. Depressive illness affects not only the individual but also those around - in the family and in the workplace.

The main features of depression are a lowered state of mood, and the inability to experience joy and pleasure. A depressive mood is the basic reaction of a human-being to psychic pain and emotional

ill-being. In itself, depression is a normal emotion which has an important adaptive meaning and is familiar to everybody.

Prevalence, Severity and Global Burden

Depressive disorders are by far the most frequent psychiatric disorders in the population and, using diagnostic criteria set out in the ICD-10 and DSM-IV, the point-prevalence of depressive disorders is estimated to be between 2 and 10%. To illustrate the magnitude of the disorder, it is estimated that in any given year, some 33.4 million people in the WHO European Region suffer from major depression [2]. The WHO *World Health Report* for 2001 ranks clinical depression as number 2 in the list of top ranking international health burdens by the year 2020, as measured by its impact as a cause of death, disability, incapacity to work and the use of medical resources.

Depression can be a severe and, sometimes, a life-threatening condition, which can impair quality of life in a more fundamental way than chronic physical conditions such as cardiovascular diseases, diabetes mellitus, or musculoskeletal problems. Furthermore, depression is associated with a high risk of suicide and suicide attempts. About 15% of patients with severe depression commit suicide, whilst 56% attempt suicide [3] and the majority have suicidal ideas during depressive episodes. Most suicides (30-88%) in Europe can be attributed to affective disorders [4]. In most of these countries older men are at highest risk of committing suicide whilst young men in some European countries are at an increasing risk of suicide. For women, the highest risk of committing suicide is in middle age groups from 35–55 years, whilst younger women have increased rates of self-harm.

The WHO publication *Global Burden of Disease* [5] provides a methodology for determining the total morbidity and mortality associated with different health problems. It has been calculated worldwide and may be used by decision-makers to help identify potential priorities for health promotion and health care (assuming effective interventions are available). The principle measure used is the ‘Disability Adjusted Life Year’ (DALY), which estimates the shortfall in average life expectancy, and weighs this further to take account of the severity of disability associated with a condition. A second measure used is ‘Years Lived with Disability’ (YLD), which again uses disability adjusted weights, reflecting the chronic nature of many health conditions.

In the 2001 World Health Report (*Mental health: New understanding, new hope*) it was estimated that unipolar depression alone accounted for more than 6.1% of total DALYs in the European region (4.5% worldwide). It is also identified as the leading cause of years lived with disability,

accounting for 11.9% of YLDs. Differences are reported by gender; for males the figure is 9.7% of all YLDs, while for women the contribution is 14.0%. These figures are even higher when looking at people between the ages of 15-44 years, accounting for 16.4% of all YLDs. Furthermore, by 2020, unipolar depression is expected to be the leading cause of death and disability in the developed countries.

Signs and Symptoms

One of the most commonly used international classifications of disease, ICD-10 [6], divides depression into three categories: mild, moderate, and severe.

During a typical depressive episode, the individual may suffer from lowered mood, loss of interest and enjoyment, and from increased tiredness. This episode may be characterized by reduced energy and diminished activity.

General symptoms include:

- ideas of guilt and unworthiness (even in a mild type of episode);
- bleak and pessimistic views of the future;
- ideas of suicide;
- acts of self-harm;
- reduced self-esteem and self-confidence;
- reduced concentration and attention;
- indecisiveness;
- disturbed sleep;
- diminished appetite; and
- reduced libido.

In addition to these symptoms, depression may be frequently presented together with severe symptoms of anxiety.

As a mental disorder, depression can have several clinical manifestations and courses. The following list presents some examples of this variety:

- some depressions occur rather suddenly and have a clear connection to adverse life events while others appear more slowly and without any evident reason.

- some persons suffer from repeated episodes of depressive symptomatology, others may have only one severe episode during their whole lifetime.
- some persons may suffer from a lifelong ailment which does not interfere very much with their functional capacity, whilst others may be so severe that the person is totally incapacitated.
- some persons suffer from a fluctuating mood disorder where depressive episodes vary with episodes of elated mood.

Causes and Risk Factors

Depression and depression-related problems are not caused by a single factor. The aetiology of depression is clearly **multifactorial** in nature, covering **biological**, **psychological** and **social** factors. The onset of depression is influenced by adverse life events, and other factors may increase a person's susceptibility to depression or may precipitate the condition.

Depression has a familial occurrence indicating that genetic susceptibility plays a role. Twin studies have shown the role of heredity: the concordance for depression in identical twins was 54% whereas in non-identical twins it was only 19%. The hereditary pattern, however, is neither simple nor clear-cut and, of course, other explanations than genetic may also account for this familial occurrence. Adoption studies have confirmed that both heredity and environment have a role as risk factors.

Neurochemical research of depression has grown rapidly since the 1950s when the first anti-depressive drugs were launched. It has been discovered that several neurotransmitters of the brain have a role in the development of depression, the most important being noradrenaline, serotonin and dopamine systems. Most of the anti-depressive drugs increase the amount of these neurotransmitters in the brain, especially that of noradrenaline and/or serotonin. Other biological disturbances in depression occur in the hormonal systems.

There are several **psychological theories of depression**. Some personality factors are connected with the propensity to depression. In psychodynamic theory, depression is seen as a reaction to the experience of bereavement where the person has not had the opportunity for a normal mourning process. As a result of this, aggression felt toward the lost object is turned toward oneself. Cognitive theory stresses the negative change of the thought processes and its central role in the

interpretation of the surrounding world. The central feature is an inclination to automatic negative thinking. This tendency makes the person especially vulnerable to negative life events and problems in intimate interpersonal relationships.

Several **social factors** are associated with the existence of depression. Studies have also shown a relationship between low socio-economic status and the occurrence of depression. Unemployment, especially long-term unemployment, is also an apparent risk factor. On the other hand, undetected depression with lowered working capacity may lead to exclusion from the labour market. Current alcohol and substance abuse may be a consequence of depression and also a risk factor. Loneliness and lack of social support are risk factors as well, whereas adequate social support may be a protective factor.

Several studies have demonstrated that people suffering from depression experience a significant excess of life events in the six months prior to the onset of the disorder. Loss and separations, for example death of a spouse or divorce, are particularly common and, in children, separation can be caused by parents' divorce or by hospitalisation due to a severe illness. The strongest relationship is demonstrated between threatening or undesirable events and the onset of depression; the relative risk in these cases may be sixfold. On the other hand, a significant number of people experiencing depression fail to report any adverse life events prior to onset of the illness.

Gender differences concerning the prevalence of depression, with higher morbidity for females, are a common finding. Discussions around possible explanations have focused on differences in the willingness to report about depressive symptoms in surveys, biological differences, e.g. concerning hormonal stability, or factors associated with gender differences concerning social roles.

Chapter 3

Depression: what are the social and economic consequences?

Depression has many social and economic consequences:

- The tragic loss of human life.
- An increased risk of physical health problems.
- An overall economic cost of at least 1% of GDP across countries.
- 60%–80% of total costs are due to lost work productivity.
- Financial hardship for people with depression and their families.
- It is a leading cause of long-term disability and early retirement.

Overall Socio-economic Costs of Depression¹

The socio-economic costs of depression for society as a whole, not just to the health system are considerable, approximately equivalent to 1% of Gross Domestic Product (GDP). The principal economic costs of depression are incurred outside the health care system [7]. In many international studies, lost employment, absenteeism and sick leave, reduced performance at work, lost leisure opportunities and premature mortality account for between 60% and 80% of all costs of depression. For example, one study of the economic burden of depression in Portugal estimated costs of approximately €102 million (€50 million 1992 prices) of which 80% were due to lost productivity at work. This total economic loss was equivalent to 50% of the Portuguese National Health budget [8].

In the United Kingdom (U.K.), total costs of adult depression were estimated to be €15.46 billion (GBP 9 billion, 2000 prices) of which only €636 million (GBP 370 million, 2000 prices) was for direct treatment [9]. In the United States, total annual costs associated with depression have been estimated at €100 billion (\$83 billion in 2000), 69% of which is for lost employment and premature mortality [10]. Hospitalisation is the most important contributor to health system costs, accounting for 50% of these costs in U.S. and U.K. studies, and 70% in Italian studies [11].

¹ All costs are reported in 2002 Euros. Currencies converted at interbank rates 28/02/02.

Costs of childhood and adolescent depression

There have been few socio-economic studies of childhood or adolescent depression or mood disorders. One recent U.K. study reported that depression in childhood or adolescence often has long-term poor health consequences continuing into adulthood and generating the need for additional specialist services and support [12]. Another study that looked at the relationship between childhood mental health problems and various agency costs in adulthood, found that for behavioural disorders (many sufferers of whom also have a depressive disorder) children with a diagnosis of “conduct problems” at age 10 were likely to incur an additional €29,000 (£16,000 1998 prices) in costs between the ages of 10 and 27 years, while children with a diagnosis of ‘conduct disorder’ (more severe than conduct problems) incurred over €109,000 (£60,000, 1998 prices) additional costs between these ages. For both the conduct problem and conduct disorder groups, the largest proportion of additional costs were for criminal justice services, followed by extra educational provision, foster and residential care and state benefits; health care costs were smaller [13] (see also further discussion in Chapter 4). On top of these reported costs, there may also be costs associated with lost life opportunities (for example, the opportunity to go to higher education, impact of increased risk of teenage pregnancies etc).



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Absenteeism from work and reduced work performance

There is much evidence of the substantial costs to employers of depression and depression-related disorders in the workplace. (It should be noted though that a formal diagnosis of depression is not always obtained for fear of being "labelled" as having a mental health problem. Therefore, most depression-related problems tend to be referred to as "stress"). Depression is associated with longer time off work compared to other occupational health problems [14,15] and also generates higher levels of disability/sickness benefit claims. Almost 20% of all claims in a two-year period for such benefits were reported in one study, with 2.5% of the workforce having at least one episode of short term depression. There is some limited evidence that workplace costs are significantly higher for women [16], who are more likely to take time off for depression, although their average period of sick leave is typically shorter than those of men [17].

In Germany, it has been estimated that during 2002, 18 million working days were lost because of depression, which was estimated to have cost employers some €1.59 billion, while the U.K. Health and Safety Executive has estimated that between 5 and 6 million days are lost because of depression. Another study in the U.K. estimated the cost of working life lost due to depression, reporting that 109.7 million working days were lost and 2,615 deaths caused by depression in 2000. Across Europe, mental health problems have been identified as a leading cause of taking early retirement or a disability pension [18].

Most cost estimates reported are likely to be conservative because they do not take into account the additional costs of reduced performance at work by people with untreated depression. One study has estimated that for all mental health problems, reduced performance on work days may be five times the number of days lost through absenteeism [19]. Another recent study estimated that 81% of all lost productive work time was a function of reduced performance at work [20]. There may be additional work-related costs for individuals, including the loss of pension rights and missed career opportunities.

Costs of depression for older people

Depression is the major cause of suicide in older people. In more than 90% of all countries, the suicide rate is highest in the older age groups (over 75 years), and the health care costs of older people with depression may be 50% higher than for non-depressed, older people. Nursing home admission frequently occurs earlier and costly professional help is required more often [21,22].

Non-remunerated roles

Although not yet quantified in studies, it should also be remembered that there are also substantial costs associated with lost productivity in ‘non-remunerated’ roles. There are significant costs if those with family responsibilities cannot perform these functions well. For example, the health, education and social functioning of children of parents with depressive disorders may be at risk, having important long-term developmental consequences.

Costs to family caregivers

Depressive disorders can also cause great distress for individuals and their families. Spouses of patients with persistent depression have marked difficulties in maintaining employment, social and leisure activities, complain about a decrease in total family income and may have considerable strains placed on their marital relationships [23,24].

Additional mortality/morbidity costs

In addition to the above costs associated with depression, there are other substantial costs which can sometimes be overlooked or are difficult to include in economic analysis. There are higher rates of non-mental health-related co-morbidity and premature mortality, for example, the risk of developing cardiovascular disease may be four times greater for people with depression compared with the general population [25,26,27]. Personal relationships may suffer, people may become unemployed, they may be at higher risk of becoming homeless, have to face stigma and discrimination within society, and come into contact with the criminal justice system [28].

Costs of suicide

No cost of depression can be greater than the loss of human life and its profound impact not only on the individual and their family, but there are also economic costs of this public health tragedy. It has been estimated that suicide constitutes around 7% of the total cost of depression. The total cost of suicide from all mental health conditions was estimated in the U.K. during 1997 to be some GBP 2.5 billion, or just under 10% of the total cost of mental illness [29]. In Switzerland, the cost of suicides and attempted suicides was €1.7 billion (2.5 billion Swiss Francs 2003) [30].

Chapter 4

Actions: what can be done?

- Effective and cost effective interventions are available.
- Different actions are required for different groups: general public, health and other sector professionals, employers, schools, service users and families.
- Combinations of interventions are most successful.
- Early intervention especially for children and in the workplace is highly cost effective.
- Community based intervention programmes can reduce suicidality significantly.

The first three chapters of this report have outlined the work undertaken on mental health within the first EC Public Health Programme, defined and described depression and depression-related problems and highlighted their social and economic impact. Whilst it is important to understand this tremendous social and economic impact, progress is only possible if effective interventions are available. Resources need to be directed towards interventions shown to be effective in preventing and treating depression. In a world of scarce resources, policy-makers increasingly need to consider the cost effectiveness of interventions vis-à-vis other possible health interventions, but this should never be the only consideration.

In this chapter, evidence associated with strategies that can be used to intervene in tackling depression and depression-related problems is identified. Where available, some indication of the cost effectiveness of these strategies is also provided. It should be clear that the focus here is on positive mental health promotion and the prevention of the secondary consequences of depression rather than on treatment, in line with the European Union Treaty. The chapter includes an examination of interventions to improve training for health and other care professionals and workplace interventions. Treatments are not discussed, though clearly a combination of interventions such as pharmacotherapy, interpersonal and cognitive therapy and other approaches play an important role in the management and treatment of depression and depression-related disorders [31].

Strategies

Strategies to promote positive mental health and reduce the potential impact of depression can be implemented at four different levels:

- The General Public - the population level
- Health Care Services
- Other Services and Settings
- Individuals and Families

The General Public

Improving public awareness and understanding of mental health problems including depression is a key component of any strategy. Those with mental health problems have been shown to be much less likely to come into contact with formal health care services even where financial barriers do not exist [32,33,34]. This is in part due to the stigma and discrimination associated with mental health problems and a fear of being labelled and can be compounded by a lack of awareness of the availability and accessibility of services. Employers may discriminate against individuals with depression, fearing that they may not be able to work effectively. One study, for example, reported overt discrimination when comparing attitudes of potential employers towards people with a physical illness compared to equally well qualified candidates with depression [35].

Awareness campaigns have been the primary mechanism used with the general public. However, evidence on the effectiveness of information campaigns alone influencing public attitudes around mental health problems is generally very limited unless supported by a range of actions at local level and sustained over time [36].

Health Care Services

Most evaluations of interventions within health care services have concentrated on pharmaceuticals, but a body of evidence supporting a range of health promotion and primary care interventions has steadily built up. One way of trying to synthesise some of these data is through systematic reviews and meta-analysis. These techniques can be used to combine the results of a number of studies to determine whether an intervention systematically appears to be effective compared with a comparator. Using these techniques can help to reduce the likelihood that specific factors associated

with the conduct of any one study may lead to conclusions that are not easily generalised across a range of settings.

A major, systematic review of studies on the detection and management of depression has been conducted by the National Health Service Centre for Reviews and Dissemination (NHS CRD) at the University of York, U.K. [37, 38]. This review examined the impact of questionnaires completed in a primary care setting (either specific depression or health-related quality of life questionnaires with a mental health well-being dimension), on the recognition of depression, cross-referral to other services and depression outcomes. The questionnaires alone did not have significantly different results in the analysis in respect of recognition, cross-referral between services and outcomes. When those individuals who were identified at high risk from the questionnaires were randomised between intervention and control groups, recognition of depression did improve significantly, although final health outcomes did not improve.

Building on a review of 34 studies examining educational and organisational interventions, it was shown that multiple interventions are required to influence change and that a reliance on passive dissemination methods (simply publishing information) or the use of guidelines alone will be insufficient to lead to change. The results of the review were consistent with earlier findings indicating that professional practice is changed through a combination of interventions, including educational outreach visits, reminders, interactive meetings and interventions that combined two or more of either audit and feedback, reminders and local consensus processes [39].

Effective approaches identified by the NHS CRD review consisted of a combination of both patient and professional education, liaison between primary care physicians and other health professionals, and the provision of counselling and support services. Nurse case management and nurse telephone counselling and support were also both found to be effective. Guideline implementation strategies were found to be effective only when combined with other interventions. The review also concluded that primary care educational and training strategies alone did not have an impact on outcomes.

Evidence was also provided that some of these interventions led to reduced overall costs, as more complex patient management was accompanied by improved treatment outcomes and thus reduced costs. This of course may be a conservative estimate, as it does not include the additional reduction in non-health sector costs for the individual and society as a whole, for example time lost from work.

Other Services and Settings

It is vital that, in developing complex intervention approaches to tackling depression and promoting positive mental health, the education, information, advocacy, training and support interventions that have been discussed in relation to health care sector providers are also made available to other service providers and local community stakeholders. These can include such groups as social and community development workers, housing officers, teachers, the clergy, law enforcement and criminal justice professionals. The media also play a vital role in reinforcing public attitudes towards mental health. Training and interaction to improve the press-coverage of events such as suicide and failed suicide attempts could be provided, although the effectiveness of such interventions is unknown.

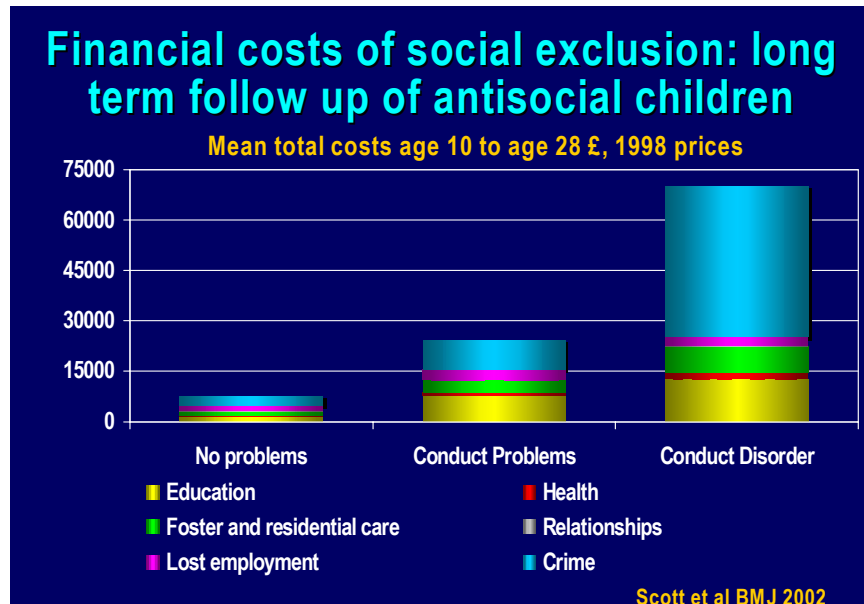
Early intervention for childhood depressive disorders

There is some evidence of the socio-economic benefits of early effective intervention across multiple sectors to help prevent some of the adverse consequences of childhood mental health problems including depression. If no intervention is made, these consequences can be particularly profound; suicide is the principal cause of death for female teenagers. Some very long-term studies have looked at the impact of childhood mental health problems on adulthood. Children in London, U.K., diagnosed as having both major depressive disorders and co-morbid conduct disorder followed up into adulthood were found to have much higher health and social care costs than those without depression. Furthermore, this group was also reported to have substantially higher criminal justice system costs [12]. Less is known about the long-term social and economic impact of depression in children alone. In many cases, however, depression will be co-morbid with other mental health problems and more studies are required. Early intervention to tackle problems associated with conduct disorder, which although a different problem is often seen alongside depression, can help avoid significant social and economic costs in later life.

One study of this type is described to illustrate the potential economic benefits of early intervention. A group of children in London with and without conduct disorder, were followed up from age 10 until age 28. Total costs associated with those with either diagnosed conduct disorder, or those recognised to have conduct problems (but not meeting full diagnostic criteria), were much higher than for those children with no mental health problems (See Figure 1). While the costs to the health care system did not differ greatly, costs were much higher to the criminal justice and education systems. Given the high costs of not intervening, low cost interventions such as parent training programmes were likely to be cost effective [13]. The costs for children with co-morbid disorders

are likely to be higher for children also having depressive disorders. Other school-based studies have also reported that provision of specialist social workers and psychologists within the school setting can also be cost effective [40]. Effective, low-cost school-based suicide prevention programmes have also been developed [41].

Figure 1: Potential costs avoided through early intervention in childhood.



Interventions at work

The socio-economic consequences of time lost from work or an inability to maintain employment have a profound impact not only on the individual, but also their employer (who, for example, may have to invest resources in recruiting and training a new employee) and society as a whole through lost productivity. One recent Swedish study indicated that employees who had to take time off from work because of a serious physical illness (e.g. cardiovascular disease), were much less likely to return to work if they had been suffering from depression [42]. Similarly, another study in the U.K. looking at community interventions to help people with mental health problems return to work, also reported that those with depression were more likely to remain employed [43], but may have lower rates of productivity [15].

There is evidence that effective workplace health and mental health promotion interventions are available to help reduce the risks of stress² and depressive disorders at work. Such interventions can ameliorate the adverse consequences and improve productivity. [44] There is strong evidence that systematic, organisation wide approaches are of greatest effect in reducing work-related stress, and have been recommended to include staff support, communication structures, enhanced job control, increased staff involvement and improved working environment [45, 46].

In the United States, Employee Assistance Programmes (EAP), which involve the provision of counselling services for employees and their families for a range of issues, including stress and depression, are well-known. A study of the EAP programme run by the McDonnell-Douglas company was found to have reduced work-loss days by 25% and reduced turnover by 8% of people with mental health problems [47]. The productivity gains from such programmes, and other measures which help people with depression and depression-related disorders return to the workplace, can, if implemented effectively, far outweigh the costs of such interventions, although more evaluation is required [48].

However, it is essential that a good partnership is established between employers, employees' associations and stakeholders in other sectors in order to promote effective implementation of interventions. Employees may be reluctant to take part in programmes which might identify them as having mental health problems, as they may fear that this might affect their employment status. Employers may also be reluctant to participate if there is a possibility of adverse publicity or a breakdown in relationships with employees associated with interventions [17].



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A European Commission review of workplace interventions has identified a number of best practice interventions underway in enterprises across a number of European countries [21], a number of which emphasise partnership working (see Example 2, page 32). Although contexts will vary, essential elements of these interventions might be replicated in other situations.

While the focus here has been on helping people retain employment, there is also evidence that group cognitive behavioural therapy can be

² It should be noted that many workplace studies do not discuss terms such as 'depression' but rather use the more everyday expression 'stress'.

effective in improving mental health and employment outcomes in unemployed adults, and in reducing the risk of depression. In particular interventions with a strong focus on job search self-efficacy, social and emotional coping skills and building social support are effective [49].

Interventions for older people

Major risk factors for depression in older people are disturbances and diseases leading to a reduced capacity to perform activities of daily living and the weakening of social networks. Many of these risk factors can be prevented and/or targeted by special interventions. Actions include improving access TO effective psychological therapies, the promotion of well-being in old age through preventing/reducing physical morbidity and impairment, and the provision of help and support programmes for those in crisis situations (e.g. bereavement) [21].

Individuals and Families

Many potential service users do not in fact come into contact with services, thus developing self-help skills is also important. Such self-help may include seeking out family support, taking up hobbies and other enjoyable activities, hence improving self-esteem and developing life-coping skills. Access to family support, for example, has been shown to be effective for people with mild forms of depression [50]. However, in general, there is as yet little strong evidence of the effectiveness and cost effectiveness of strategies to improve general awareness of self-help techniques. Support for families can help reduce some of their costs, such as having to give up work to care for a family member.

Case Studies

Four examples of approaches to promoting mental health and tackling depression are presented below:

Example 1: From the Nuremberg Alliance to the European Alliance against Depression Project

Early, community-based educational programmes, notably one Swedish study for general practitioners, demonstrated a limited positive impact on suicide rates and economic costs [51].

Community programmes increasingly adopt a multi-faceted approach to tackling depression, as a recent study in Germany demonstrates. This study aimed to assess the effectiveness of a programme for improving the care of depressed patients in Nuremberg, a city with a population of 480,000. An intensive evaluation was undertaken to compare two-year outcomes both with baseline data and with a control region, the city of Wuerzburg with a population of 270,000.



The project had four levels of intervention:

1. Primary care doctors

Training on the diagnosis and management of depression, a series of workshops, a video with information, and access to a specialist telephone advice line were provided.

2. Community facilitators

A number of educational workshops and materials were provided for teachers, counselling centres, the clergy, telephone support line personnel, psychotherapists, the police, carers of older people, and pharmacists.

3. Depressed patients and their families

Two videos were provided and self-help groups were set up. An emergency card was handed out to patients after suicide attempts, aimed at guaranteeing rapid access to specialist help in the event of a suicidal crisis.

4. General public

A professional PR-campaign was run in order to promote information about depression, symptoms and treatment. This included, for example, presentations by politicians, distribution of 25,000 brochures and 100,000 leaflets, poster and cinema advertising. A 10 point media guide was prepared in order to influence media coverage of suicides and reduce the chances of people copying suicide attempts.

The evaluation of the project impact indicates that suicidality (suicides + suicide attempts) dropped significantly (by about 26%) in Nuremberg at the end of the two years of the campaign, compared with the control region Wuerzburg. A formal cost effectiveness analysis of the programme has yet to be undertaken.

The programme is presently being expanded to many other regions in Germany as well as in other European countries. This can be done quickly and with low costs because the material and the concept are available and can be easily adopted. Since April 2004, *The European Alliance Against Depression Project* (EAAD), funded by the European Commission, is now working in 16 countries (including some new Member States) to develop similar local action programmes. These local experiences will be used eventually to establish nationwide actions.

Example 2: Mental health promotion in the workplace

The programme is provided for managers within a major retail company with stores throughout the U.K. The primary aims of the scheme are to :

- Improve psycho-social health and remove stigma associated with mental health problems in the workplace.
- Improve skills, well-being and behaviour of line managers.
- Provide a mechanism for early detection and intervention of mental health issues.
- Create a more positive attitude in the stores.
- Increase the quality of the customer experience and the level of discretionary effort.
- Increase staff attendance levels.

A number of different interventions are used by the programme including:

- Help given by the trainer to aid understanding of participants' detailed personal profiles.
- Teaching cognitive behavioural skills to provide participants with a toolkit of resources.
- Building support among the group.
- Providing an opportunity to meet the trainer outside of work for counselling.

In addition to this scheme, the company has long recognised the problems associated with stress and depression, and a long-term strategy seeking to provide a good working environment and a clearly defined job is in place. Professional on-site counselling is also available and the company may modify working hours during the period of rehabilitation if someone who has had to give up work gradually returns to full work. Financial support is also provided through the company's sick pay scheme, thereby reducing any anxiety during time of reduced income.

Example 3: A national programme

'Doing Well by People with Depression' is a national programme running across seven health areas in Scotland. It was launched in 2003. The programme takes a collaborative approach to

service improvement, in partnership with a range of local organisations including the voluntary sector. It is supported until March 2006 by funding of about €2.3 million (£1.5 million) per annum from the Scottish Executive's Centre for Change and Innovation. The programme is co-ordinated nationally and works with local health systems to redesign services for people with depression to improve their mental health and well-being and improve access to a range of local community- and primary-based interventions which have a good evidence base.

The programme will also help build support and capacity for self-help work to help meet the needs of people with depression. It will also build capacity for psychological interventions in primary care to help reduce pressures on secondary care services and improve the assessment of symptoms and associated problems. This helps with developing a shared understanding of people's needs and the sequence of treatments and / or support that people require. Access to a range of community-based services and support will also be improved.

The programme has established a national development network that will support the seven areas which have received funding, as well as informing all the remaining nine health areas in Scotland. The network meets three times a year and focuses on and shares the experiences and developments that are taking place. The programme is also being independently evaluated. The evaluation is being undertaken by a consortium of universities in Scotland and the Scottish Development Centre for Mental Health. The evaluation will report in March 2006.

Further information on the programme is available on the Centre for Change and Innovation website www.cci.scot.nhs.uk

Example 4: Tackling depression in primary care - "The Slovene Gotland study"

The main objective of this, presently ongoing, study was to show that an intensive educational programme on depression and suicide prevention, as organised for primary care doctors, can lead to:

- (1) a significant improvement in detection of depression, which would result in an associated increase in prescriptions of antidepressants; and
- (2) a significant improvement in detection of suicidal risk, which would in turn result in an associated reduction in suicide rates.

Two neighbouring regions with similar health indicators, and which are also the most affected Slovenian regions regarding suicide, *Celje* and *Koroška*, were selected as testing regions and *Maribor* as a control region. The great majority of primary care doctors in the testing region were invited to attend the intensive educational programme on depression (two short lectures, followed by a longer workshop).

The successfulness of the educational programme was supposed to be tested by two means: (1) by comparing the way antidepressants and anxiolytics are prescribed (between the two groups and between the four-month period following the education and the same four-month period a year before); and (2) by comparing the regional suicide rates (between the regions and between the two periods). Doctors who underwent the training increased the number of antidepressant prescriptions significantly more than their counterparts (change in cases between the two periods: 90 more; controls 23 more; $t = 3,2$; $p = 0,002$; 95% CI 25 - 108).

The 2003/2002 ratio was also significantly higher in cases: 2,5; controls 1,5; $t = 2,4$; $p = 0,017$; 95% CI 0,2 - 1,9.

Cases also increased the number of anxiolytics significantly more than controls, but the 2003/2002 ratio was not significantly different between the two groups as the obtained change in anxiolytics represented a much lower share of all anxiolytics usually prescribed. Accordingly, a significant difference in the improvement of the anti-depressants per anxiolytics ratio was obtained between the two groups: cases 1,8; controls 1,4; $t = 2,2$; $p = 0,027$; 95% CI 0,5 - 0,7.

For the period studied, regional suicide rates have not as yet been obtained. As this is still an ongoing study, no major conclusions can be made. However, the obtained significant increase in prescriptions of antidepressants is promising and it does speak in favour of depression being diagnosed and treated more effectively than before, which can in turn lead to a decline in suicide rates in the two regions.

Chapter 5

Implementation: what are the challenges and possible solutions?

- Tackling depression needs to be an integral part of a positive mental health strategy.
- Awareness and understanding of depression and the importance of positive mental well-being in society may be low.
- Stigma and ignorance may reduce willingness to invest in mental health strategies.
- Recognition of depression and the risk of depression by frontline employers, teachers, social workers, general practitioners and other related professionals can improve.
- Dialogue and partnership with all stakeholders is helpful for the development of national/regional mental health promotion policy.
- Key local 'champions' can help in the implementation of policies.
- Actions across different sectors and parts of the life-cycle need to be co-ordinated.
- Europeans should share their knowledge of effective actions and best practice.

Despite the existence of effective interventions (as in Chapter 4), the implementation of strategies to combat the adverse health, social, and economic consequences of depression remains a challenge. Perhaps the most obvious evidence of this is the high level of unmet needs in individuals with depressive disorders. Solutions proposed often involve controversies around increasing the provision of mental health care services arguing with some justification that they are under resourced.

While this is undoubtedly true, and health care services have an important role to play in the primary/secondary prevention of depression, it is also vital to invest in holistic strategies that reach the whole community and promote positive mental well-being. These strategies need to pay special attention to particular life states and transition periods (e.g. school, workplace and retirement), where the risk of depression and other mental health problems may be greatest.

One challenge is that public health/health promotion interventions may be inadequately resourced given that their benefits take more time to be realised. A second challenge is to ensure that there is recognition of the need to include mental health within public health/health promotion strategies. There is also a need to improve public understanding of the value of positive mental health and well-being, to become better informed on how to maintain good mental health, as well as to improve recognition of early signs and symptoms of depression and other mental health problems.

Improving awareness would also help tackle major problems of stigma and discrimination which, among other things, may make individuals reluctant to seek help for fear of being labelled, and may also act against public support for funding any interventions to improve mental health. One further challenge is to address the issue of adverse and distorted portrayals of people with mental health problems - an all too common practice in the media.

An effective support network is also required for people with mental health problems and their families to help avoid the adverse consequences of mental health problems. Employers need to be persuaded of the benefits of introducing workplace health promotion programmes and providing flexible working arrangements, while the education system needs to be persuaded of the benefits of school-based systems for early identification of childhood problems. Self-help guides for people at risk of mental health problems can also help as part of a co-ordinated suicide prevention strategy.

Co-ordination is crucial between different professional and non-governmental sector agencies responsible for providing a wide range of care and support. The development of effective partnerships between different groups is not without difficulties, particularly if there is no previous history of joint working. As well as the challenges of achieving good communication and collaborative working towards common objectives, differences in funding arrangements may also be problematic.

While emphasising the importance of investing in strategies to promote and maintain positive mental health, it is vital, when mental health problems such as depression occur, that they are recognised as early as possible. One solution is to ensure that primary care practitioners and other frontline health and related sector professionals, such as social workers, are able to recognise the signs and symptoms of depression. Without recognition of these problems, individuals may not receive appropriate treatment or the necessary support. Local estimates are that between 30% and 87% of all suicides occur in people with depression whose needs have not been recognised.

Ensuring the implementation of these strategies will mean tackling factors contributing to the gaps in the provision of strategies for holistic mental health promotion and positive well-being. Such strategies will also generate greater awareness and understanding of people with mental health problems, not only by health and social care professionals but also by all stakeholders working towards their greater social inclusion.

Factors contributing to current gaps

Some of the factors that need to be addressed for different target groups in different settings and at different points in the life-cycle are highlighted below:

Awareness and understanding of the general public

- The stigma associated with depression may mean that individuals suffering from depression are unwilling to come into contact with health and social care services, or to seek help within the school or workplace. Such stigma may be reinforced by negative stories in the media.
- Stigma can also mean that it is politically more difficult to achieve the investment of more resources towards the promotion of positive mental health.
- Lack of knowledge about how to maintain good mental health and well-being, limited knowledge and awareness about depression, its signs and symptoms, and the potential severity of their adverse consequences.
- Fear of coming into contact with support services because of the stigma of having a mental health problem. Fears and ignorance about treatment.
- Lack of support and information for families of an individual with depression.

At School

- The limited provision of programmes and strategies within schools to promote good mental health and well-being to aid the recognition and provision of early intervention for children with mental health problems.
- The lack of provision of help and support for issues such as bullying, and actions to counteract children developing negative body image.

Workplace

- Employers may be unaware of the relationship between stress and depression and productivity, or of the availability of cost effective strategies to promote positive workplace health and to help employees cope with stress and depression.

- Employers may be reluctant to set up such schemes, fearing that they may generate negative publicity about the mental health of employees and cause difficulties with trade unions and employees.
- Employees may also be reluctant to participate in health promotion and screening schemes, which they fear may label them as having a mental health problem.

Resources and co-ordination between - and access to - different agencies in health, social care and related sectors

- In some parts of Europe, funding for mental health promotion, treatment and rehabilitation services has been neglected in comparison to other health and social welfare services, again reflecting a perception that mental health problems are a low health care priority.
- There may be poor co-ordination and co-operation between the many different agencies and stakeholders involved in the prevention and treatment of depression, such as health and social care systems, education, workplace, criminal justice system, etc.
- Limited understanding of, and challenges in, implementing mental health promotion-related services.
- Lack of incentive for budget-holders to work together, particularly when financial gains (through reduction in depression-related problems) may benefit other sectors.

Primary care

- There may be limitations in the ability of primary care physicians to recognise and manage depression. This may include a lack of knowledge about the availability and effectiveness of different treatments (including non pharmaceutical therapies).
- Individuals visiting their doctor may focus on physical complaints making diagnosis difficult.
- Depression may be an unpleasant diagnosis for many general practitioners to consider, given that it can be both time-consuming for GPs as well as emotionally difficult, for example when suicidality becomes an issue.
- There may be a reluctance to “label” an individual as having a mental health problem.

Overcoming these deficits

Actions against depression require intervention at different levels, both within the health and social care sector and also more broadly in society. The goal of tackling depression should not be seen in isolation, but as a key element of a strategy to promote positive well-being. At a European level, this is in line with the social and economic benefits envisaged in the Lisbon agenda, enhancing both quality of life and reducing other adverse socio-economic consequences. It is also important to recognize that there is a broad range of determinants of mental health status: economic status, poverty, development of civil society institutions, attitudes towards immigration, environmental factors, access to social welfare systems, are just a few.

Taking action against depression will help to prevent and identify other mental health problems (and health problems in general). While the focus here is on promotion and prevention, a comprehensive strategy at national and local level will also need to address issues such as early intervention, treatment and rehabilitation.

Although there are effective interventions available to tackle depression in the community, in the workplace, at school and at home, and which also have positive economic benefits, persuading policy-makers of the need to invest in strategies to prevent depression remains a major challenge. Developing an implementation strategy is crucial firstly to help raise awareness of the health, social and economic problems caused by depression at both a national and community level, and secondly to translate effective actions into everyday practice.

A Framework for European, national, regional and local action

Key stakeholders at the European, national/regional and local levels that can help implement a plan need to be identified. These will include **professionals, individuals using the services and their families, employers, the media personnel and the general public**. A subsequent step is then to convey tailored messages to these different groups. This will mean developing and maintaining dialogue between stakeholders, providing the opportunity to take on board different views relevant to the local context. This can increase a sense of local ownership over possible actions and increase willingness to change and improve local policies and practices. Some potential key objectives are set out below:

Key objectives: Awareness and policy setting

- *Raising awareness* of the challenges and the health, social and economic benefits of preventing depression and promoting mental well-being across all groups.
- Implementing community-wide initiatives to *reduce the stigma* associated with mental health problems.
- *Incorporation of mental health promotion into European, national and local policies*, followed by the development of local evidence-based *strategies and implementation plans to tackle depression* that take into account issues of cost effectiveness, equity, individual values and ethics.
- *Acceptance by professionals and those with experience of using the services* of recommended strategies and the need for improved co-ordinated action.
- *Recognition by employers* of the advantages of providing a flexible and appropriate working environment to maintain and return individuals to employment, reduce absenteeism, unemployment and early retirement or use of disability pensions.

Key objectives: Achieving impact “on the ground”

- Strengthening *legislation* to reduce discrimination and promote social inclusion in all settings, including the workplace, at home, school and in leisure.
- *Empowering individuals* who have potential problems with information to help maintain positive mental health and also to obtain information and receive appropriate support.
- Facilitate *locally developed mental health promotion plans* (including suicide prevention strategies) to meet national/regional objectives.
- Encourage the *development of partnerships* between stakeholders in different sectors
- *Improving the ability of general practitioners and other ‘frontline’ professionals* to identify depression and depression-related problems.
- *Improving links between primary care and other relevant support services*, such as guidance and social welfare support to increase referrals between sectors. Perhaps by locating all facilities under the same roof.

- Establishment of a *monitoring system* to help measure the success of strategies in reducing depression and improving positive mental health.
- Introducing *mechanisms to share information and evidence* both within and across countries on potential strategies, their impact and cost effectiveness.

Incorporating the promotion of mental health and well-being into national and regional policies

A crucial step at national and/or regional level is to incorporate the promotion of mental health and well-being into general health and mental health policies. This can help ensure that the emphasis of strategies to reduce the consequences of depression do not just focus on treating people who are already ill. Effective mental health policy requires a commitment to health improvement, prevention and indeed to wider goals and principles within society, such as social justice. Official support for these wider objectives can also help in developing programmes and strategies to improve the co-ordination between agencies and also in raising the profile and priority of mental health promotion. By its very title the ‘*National Programme for Improving the Mental Health and Well-being of the Scottish Population*’, is an example of a strategic approach to public mental health and one that gives emphasis to the importance of achieving and maintaining positive mental health and well-being [52].

Co-ordinating action across different public sectors

National policies and programmes can develop strategies working across different public sectors and different points in the lifecycle (e.g. through health, social care, education, employment and housing). In New Zealand, ‘*Building on Strengths*’, a comprehensive national mental health promotion policy, sets out the vision, values, principles, goals, priority actions and outcomes to be achieved across many different sectors, not just health [53].

Appointing a specific national or regional co-ordinator with responsibility for developing and implementing a mental health promotion strategy can help in getting different agencies and sectors to work together. The co-ordinator might also act as an advocate at governmental level to ensure that sufficient resources are available to implement actions. For example, in the U.K., the National Director of Mental Health is responsible for ensuring the implementation of a national strategic

framework for mental health which includes a focus on evidence based strategies and mental health promotion, as well as developing national standards for action in services.

Targeted and appropriate dissemination

Information on mental health promotion and depression needs to reach many different groups. For policy-makers the emphasis should be on brief, **one page** summaries of key actions required and their justification, rather than reliance on long technical reports which may be read by very few people. Good practice is to produce a one page summary, a three to four page policy brief, and a maximum twenty-five page full report, which could provide references to more detailed background documents as required. Different short briefs may be required for different audiences. Guidelines are more effective if they specify who is responsible, what should be done, where this should happen and how [54]. Receiving information from peers can improve uptake of recommended actions. The ‘Ambassador programme’ of SBU, the Swedish Council on Technology Assessment in Health Care, employs more than 30 health care professionals to travel around the country circulating information on guidance and best practice. At a public level, the incorporation of story lines on depression and depression-related problems into popular television and radio programmes, such as soaps, can also help. Advice and contact information could follow at the end of these programmes.

Working to alleviate stigma

A key challenge remains in tackling the stigma and discrimination that may limit willingness to invest in effective mental health programmes. Identifying ‘*local champions*’, key stakeholders or role models with a particular interest in depression (perhaps because of personal experience), can help raise awareness and interest. For example, the public admission of the Norwegian Premier that he had taken time off from work because of depression, helped raise awareness and reduce stigma at the national level, as well as providing the impetus for the development of a new national mental health strategy [55]. Engaging constructively with the media so as to try and reduce sensationalist and incorrect headlines about mental health problems can be important, as there is evidence that media portrayals do impact negatively on both public and political attitudes [56].

Legislation

Legislation also has an important role to play in helping to reduce discrimination across all areas of society associated with depression and other mental health problems. Effective implementation of legislation in the workplace can reduce discrimination and encourage employees and trade unions to be more open about dealing with potential mental health problems without fears over losing jobs.

Targets, monitoring and evaluation

Mental health related targets can help improve performance and emphasise the importance of tackling identified goals and priorities [57]. Some countries have introduced health targets broadly related to mental health promotion, such as targets for reducing the suicide rate, but appropriate indicators for positive mental health and well-being are required urgently. A health monitoring project recently supported by the European Commission compiled a comprehensive set of mental health indicators, placing a special emphasis on mental health promotion. [58].

The chances of long-term sustainability of health promotion actions against depression will be strengthened when the evidence of impact emerges in meeting targets, improving health outcomes and when reliable socio-economic costs can be estimated. The introduction of monitoring and data collection systems will also allow for future evaluation to be carried out more extensively. As many actions, particularly those to tackle stigma and promote well-being, may take a significant time period to make a difference, it will become more necessary to evaluate those actions over time. When any benefits are more easily seen in a short period of time, such as in the workplace, short-term evaluation may be possible to associate the strategy with successful outcomes.

Linking mental health promotion research findings to policy and practice

Information from research must help inform the mental health policy-making process. Translating research knowledge into policy and practice may be enhanced by employing the use of “knowledge brokers”, individuals with some skills in both research and policy, who can identify key messages for policy-making emerging from research. Such dialogue can help ensure that research is relevant to policy, and that policy-driven research questions are in fact possible to answer.

A system at international and national level for the exchange of data on the effectiveness and resource consequences of different actions will also be helpful. There is no need to reinvent the wheel to optimise what may be limited evaluation and research capacity within and across

countries. This can be used to help transfer and adapt successful actions from one setting to other settings and countries and to evaluate their social and economic impact on an international basis.



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Chapter 6

Conclusions

‘The cost of not taking action on depression is too great. Doing nothing is not an option’

The various actions led by the European Commission in collaboration with WHO and Member States support the commitment to take action on depression within the recently established EC public health programme. This recognises that action against depression is a public health issue.

As a public health issue, actions are required across populations, service systems and in support of interventions and supports for families and individuals. These require an emphasis on both positive mental health and well-being and actions to improve the quality of life of people who suffer from depression in order to support their recovery.

“Depression” is a term commonly used in everyday language to describe feelings of sadness, unhappiness, lack of hope, low aspiration and self-esteem. These are seen as normal reactions and feelings of mood to everyday events, stresses and strains. However, for some people, the continuing persistence of these feelings and symptoms over time, together with impaired concentration and an inability to carry out and perform everyday tasks, leads to the clinical manifestation of an identifiable and diagnosable mental illness.

The illness “depression” is multi-factorial in nature encompassing neurological, psychological, biological and social elements, causes and influences.

Depression is now one of the most serious health problems in Europe. The illness depression can be severe and often life threatening.

Depression brings a significant cost to society. It impacts on economic wealth and productivity, employment and working life, brings increased costs to health, social care and welfare systems and impacts not just on those suffering from depression but also on their families and care givers.

Effective interventions are available to promote mental health and tackle depression in the community, workplaces and within primary and secondary care settings.

This gives grounds for increasing optimism. From the evidence, we now know a lot more about what works for the general public, what works well within service systems, within workplaces, schools and communities and what helps individuals and families to prevent and treat depression and recover.

Within the parameters of the policies of the European Union Treaty, interventions need to focus on increasing public awareness and understanding, promoting positive mental health, addressing stigma and taking actions to prevent, and reduce the impact of depression by focusing on the causes and the consequences of the illness depression. This is the public health challenge on depression.

In tandem, within Member States, continuing efforts need to be made to provide a combination of self help, interpersonal and cognitive therapy and pharmacotherapy in the clinical management and treatment of depression. In addition, efforts are required to improve the capacity of a range of professionals and other workers in being able to identify, assess and respond to depression.

Whilst the evidence base is growing, more attention needs to be given to systematic, long-term and detailed evaluations of both clinical interventions and population-based strategies, including the economic dimensions. Examples of such evaluations have already emerged. Action-oriented and community-based projects like the *European Alliance Against Depression* (EAAD) have been implemented to demonstrate that the process and quality of evaluation can be significantly enhanced through greater international collaboration and through the sharing and transfer of best practices.

Challenging society to recognise depression as a treatable and recoverable illness involves greater efforts in public information and awareness.

The goal of tackling depression should not be seen in isolation, however, but as one key element of a strategy to promote positive well-being and prevent and alleviate mental ill health. Taking a life cycle and settings approach to this public health agenda will give emphasis to the co-ordination and communication required between sectors and agencies.

There are also challenges to improving the recognition of depression as an illness and the accessibility and acceptability of services and supports provided. These will require an increased capacity and ability to respond effectively by those working in primary care settings.

Tackling the scourge of stigma and discrimination remains a key challenge to help facilitate the implementation of actions against depression.

Rising to the challenge of the European goal of improving public health and enshrining the ideal of achieving a high level of human health protection in all community actions and policies which complement Member States actions, sets the agenda for actions against depression across Europe.

Recommendations

Article 152 of the Treaty provides that Community Action is to complement national policies and be directed towards improving public health, preventing human illness and diseases and obviating sources of danger to human health. Such actions shall cover the fight against the major health scourges by promoting research into their causes, their transmission and their prevention, as well as health information and education. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.

Depression is a major public health concern throughout Europe, including all Member States. There is a need to see the further development of programmes in community health that combat the adverse health, social and economic consequences of depression. Developments and actions are now required that complement Member States' responsibilities for the organisation and delivery of health services.

Based on the Report, "Actions Against Depression", recommendations for the **Member States** include:-

National Policy Action

1. Take actions against depression as one part of a comprehensive public (mental) health approach at a population level. This approach should be based on the following principles:
 - Interventions at population and individual level should be based on saving lives and adding quality to life, improving health and enhancing population and individual well-being.
 - Account should be taken of specific needs of communities and people who may be at a higher risk of depression for particular reasons (for example: social, environmental, occupational, lifestyle, life circumstances, gender, ethnicity, sexuality, genetics).
2. Implement actions throughout the life cycle from early years, through childhood, early adulthood, during working age and into older age.
3. Take a multi-level and multi-sector approach with the following key elements:
 - early identification and detection of depression;
 - work at primary care level to improve recognition, assessment, treatment and referral;
 - public education, awareness raising and anti-stigma programmes in schools, workplaces, communities and through the media;
 - development of self help programmes; and
 - training programmes and continuing professional development for a range of workers in health and related services.
4. Introduce mental health promotion to increase understanding and awareness of depression, as well as to reduce stigma and discrimination against people with depressive illness.

5. Support the collection and dissemination of evidence and further research into combating depression.
6. Collect national data and information on incidence and trends in depressive illness. Monitor the impact of national policies and programmes against depression.
7. Report to the Commission on these recommendations within three years of the adoption of the recommendations.

Based on the Report, “Actions Against Depression” recommendations for the **Commission** include:-

Public Health Programme

1. Actions against depression should be introduced through the Programme for Community action in the field of public health.
2. Introduce a methodology for the collection of Europe wide data on the incidence of depression and the emerging trends across Member States.
3. Ensure the systematic collection of the evidence base relating to effective population-based and individually focused interventions to prevent and treat depression.
4. Ensure the development of economic-based, cost benefit and cost efficiency indicators and tools for measuring the impact of population-based and individually focused interventions to prevent and treat depression.
5. Support the exchange of policies and practice across and between Member States to ensure the exchange of best practice and learning to add value to Member States' own national efforts.

Implementation Report and Follow Up

A report to the Commission on these recommendations will be made within three years of the adoption of the recommendations.



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This report was commissioned by Unit C2 of the Health and Consumer Protection Directorate-General of the European Commission. The report intends to provide a timely and up-to-date outline of actions against depression in order to highlight the earlier work that has been done in this area and to pave the way for future actions.

To carry out this work, a "drafting group" was set up. The members of the group were selected on the basis of expertise on various aspects of the phenomenon in question. A balance between representatives of the academic world and those working on an administrative level was maintained.

The members of the group were:

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The Members of the EC Mental Health Working Party, an informal group established in connection with the Programme of Community action in the field of public health (2003–2008), were invited to comment on the manuscript.

During the progress of the work, the main responsibility for writing the report fell on a "core group" consisting of the authors *Dr. J. Henderson, Mr. G. Henderson, Dr. J. Lavikainen and Mr. D. McDaid*. The editing of the report into its final form has also been a joint effort of this group.

The core group has met several times with officials of the Commission to review progress and to agree the direction and final drafting of the report. The contribution of this group was especially significant at the concluding stages of the production of the report.

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