DEPRESSION: *A Global Crisis*

World Mental Health Day, October 10 2012

World Federation for Mental Health

20th Anniversary of World Mental Health Day
October 10 2012

FOREWORD: *Deborah Wan*

After World Mental Health Day was initiated by the World Federation for Mental Health in 1992 many countries adopted it as a means of promoting mental health.

Every year a theme is chosen and educational materials are produced by WFMH for distribution. This year, the 20th anniversary, we have chosen DEPRESSION as the main theme. Depression can affect anyone and it is one of the most widespread illnesses, often co-existing with other serious illnesses. According to the World Health Organization, unipolar depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and will move into the first place by 2030.

The 2012 Depression package is intended to provide information about depression as a treatable illness, and to spread the message that recovery is possible and achievable. The information will be useful both in developed countries and in middle- to low-income countries that need basic information for their national and local publicity campaigns. Among the developed countries, the current economic downturn has resulted in increased unemployment, increased debts and increased insecurity resulting also in an increasing incidence of depression among the population. For middle- to low-income countries, public education on mental health is often inadequate due to limited resources. We hope this material will be useful for mental health promotion in these countries.

World Mental Health Day 2012 aims to encourage governments and civil society around the world to address depression as a widespread illness that affects individuals, their families and their peers, and to recognize that it is a treatable condition. People should be alert to the early signs of depressive disorder—it can affect anyone, from young people to seniors. It is now estimated that 350 million people globally are affected by depression, and this alarming figure is a wakeup call for us to address this global non-communicable disease.

World Mental Health Day is the signature project of the World Federation for Mental Health and its yearly information package is used in many different ways. The text can be translated for use by local organizations.

As President of the World Federation of Mental Health, I appeal to all of you to see that depression is included in your own country's health agenda. I also express my appreciation to all those involved in preparing and supporting the 2012 World Mental Health Day and applaud their energetic efforts in supporting the global agenda on depression.

Deborah Wan

President

A SALUTE *to Richard Hunter* *(1914-2004)*

On this 20th Anniversary of World Mental Health Day we salute the founder of the event, Richard Hunter. He would have been very proud to see how wide the reach of the Day is now. He was a man with a dream that mental health concerns would be recognized as an integral part of overall health, and who felt that the mission of WFMH was to seek parity for mental health alongside physical health. He brought passion to the crusade to improve the care of people with mental illnesses, and each year without knowing it the organizers of national and local World Mental Health Day activities carry forward his vision.

Dick trained as a lawyer in the state of Minnesota, USA. His career changed direction when he registered for alternative service as a conscientious objector during World War II, having declined to serve in the armed forces. He was assigned to work as an attendant in a psychiatric hospital and spent three years at institutions in North Carolina and New Jersey. Those years forged his deep commitment to the need to improve standards of care. He was also moved by the writings of Clifford Beers (1876-1943), who experienced severe mental illness and in recovery led a movement in the United States to reform the conditions he had experienced in mental hospitals.

After the war Dick Hunter joined the staff of the National Mental Health Foundation and later became a senior staff member of the National Mental Health Association (now Mental Health America). On his retirement, Dick was recruited as the Deputy Secretary General of the WFMH, serving in that capacity as a volunteer from 1983 until 2002, a central figure in the Federation's worldwide network. He continued to work at his office as an advisor to the Federation until a few weeks before his death in 2004.

It was Dick who promoted the idea in 1992 that mental health deserved an annual "Day," like similar observances for other causes. He saw that an international World Mental Health Day could be, in his own words, "a focal point around which global mental health advocacy could gain maximum public attention." When the suggestion came up that the World Federation for Mental Health should sponsor an international telecast, he saw a valuable opportunity. A broadcast received in many countries could become a central feature of a wider celebration linking activities not only for advocacy but for much needed public education.

He selected October 10 as the annual observance day and developed the concept of an annual theme, with the Federation assembling a packet of information that could be sent to participating organizations to allow them to follow the theme in their own way, holding local events within their own budgets. It was a practical way to spread mental health advocacy, drawing attention to the needs of people with mental illnesses and to the importance of mental health. Almost immediately some national authorities joined in, organizing large countrywide campaigns for public education. At every level the idea of participating in an international activity had resonance among those who believed that care and concern for those with mental disorders should have higher priority.

Over the years the United Nations, the World Health Organization, the Pan American Health Organization and the International Labour Organization have recognized World Mental Health Day. Events have been held in numerous cities and countries around the globe.

The World Federation for Mental Health honors Richard Hunter on this 20th Anniversary of World Mental Health Day for his conviction that advocacy would be strengthened if concerns were shared internationally, bringing people together to continue to work for improvements in care and recognition of the importance of mental health.

L. Patt Franciosi, PhD
Chair, World Mental Health Day. WFMH President 2003-2005

WORLD MENTAL HEALTH DAY

20 years on

World Mental Health Day was established in 1992 thanks to the work of Richard (Dick) Hunter, the Deputy Secretary General of the World Federation for Mental Health. After a period of planning the Federation proclaimed 10 October as World Mental Health Day and Dick looked for ways to build support for it. He saw the value of working with a television producer, Richard Leighton, to make a global telecast the central feature of world-wide activities. The World Health Organization agreed to become a co-sponsor, and the project was also supported by the Carter Center when former U.S. First Lady Rosalynn Carter agreed to become honorary chair of the event.

The immediate goal of the project was to draw attention to mental health as a cause common to all people across national, cultural, political and socioeconomic boundaries. The longer term goal was to establish parity for mental health with physical health in national health priorities and services. The first Day was a great success. A two-hour telecast was broadcast to 127 countries by the U.S. Information Agency WorldNet satellite network. A number of Federation officers and mental health leaders assembled in a television studio in Tallahassee, Florida in the United States for the program. Similar groups gathered in studios in other locations around the world to watch and, from some sites, to participate directly in the telecast. This was before the Internet era, and at the time it was a cutting edge use of telecommunications technology

I was the President of the World Federation for Mental Health at the time, and as co-chair of that first World Mental Health Day participated in the telecast from a television studio in Auckland, New Zealand. We were one of the sites that fed in commentary and I remain grateful to colleagues who joined me during the very early hours of that morning. In New Zealand our Minister of Health made a formal announcement in recognition of the Day and local Federation members accompanied Joan Bolger, the wife of the Prime Minister, on a visit to community mental health facilities. Local Mental Health Associations and other NGOs organised events in other parts of the country.

The Federation's Secretariat received reports from about 40 countries that first year describing a wide range of activities to promote mental health causes. It was pleasing to see that the Day had clearly focused official and public attention in so many parts of the world, including countries where mental health was very low on political agendas and poorly resourced.

Global telecasts were also a feature of the 1993 and 1994 World Mental Health Days, but they were very expensive enterprises and there was insufficient funding to sustain them after 1994. In subsequent years emphasis was placed on the preparation and distribution of planning kits, with background information focusing on each Day's particular theme, and resources to assist with local activities. Translations from English to other languages expanded. Over time Internet distribution and the production of DVDs augmented and then largely replaced the physical distribution of the printed planning kits through the post.

Federation staff, Board members and members (international and national NGOs, affiliate

organisations and individuals) all played vital roles in enlarging the reach of the program. In some countries World Mental Health Day soon expanded into a Mental Health Week or Month, with significant government and NGO engagement. The Day's growing importance in advocacy and public education was further recognized when the Secretary General of the United Nations began to release an annual message for 10 October on the year's theme.

Event organizers were encouraged from the start to send reports about their activities to the WFMH Secretariat. In addition to narrative descriptions, photographs and examples of local materials were submitted. There were many reports from the industrialized world, but staff was amazed to receive photos of marches in Kathmandu, billboard messages in Ulaan Baator, meetings in Sudan, elephants and camels carrying banners in India.... As the use of the Internet grew so did reporting about World Mental Health Day events around the world. Last year there was a lot of traffic on Facebook and Twitter.

Looking back over general trends in the field in the past two decades it is clear that there have been substantial changes in the place of mental health at global, national and local levels. High quality epidemiological research has helped quantify the extent and impact of mental health disorders on individuals, families and societies. They are now ranked at or near the top of public health challenges and priorities by the World Health Organization and an increasing number of its member states. There have been advances in human rights, reduction of stigma, and empowerment of service users. To a growing extent the large asylums and mental hospitals of past ages are being replaced by community mental health and support services. Increasingly, mental health services are becoming stronger and better integrated into primary health settings. Treatments are becoming more effective and readily available.

This said, there are vast differences in standards of available services between and, often, within countries. Appalling ignorance, neglect and abuse run alongside enlightened understanding and supportive treatment and care. Some countries have not made basic steps forward. Advances in other places have been reversed or are under challenge as economies struggle or shrink and governments seek to reduce public expenditure.

World Mental Health Day remains an important vehicle to advance mental health objectives worldwide and press for continued improvements in care. It illustrates the ways in which the World Federation for Mental Health works to promote advocacy at a global level and facilitate engagement with governments as well as with local communities by way of its NGO network and outreach. It provides a time for mental health advocates to reflect on what has been accomplished and celebrate, a time to take stock of what still needs to be done and to develop plans and strategies, and a time to feel part of an international family with common concerns and ambitions.

Prof Max Abbott
WFMH President 1991-1993
Pro Vice-Chancellor and Dean
Faculty of Health & Environmental Sciences
AUT University (North Shore), New Zealand

DEPRESSION

A Global Public Health Concern

Developed by Marina Marcus, M. Taghi Yasamy, Mark van Ommeren, and Dan Chisholm, Shekhar Saxena
WHO Department of Mental Health and Substance Abuse

Depression is a significant contributor to the global burden of disease and affects people in all communities across the world. Today, depression is estimated to affect 350 million people. The World Mental Health Survey conducted in 17 countries found that on average about 1 in 20 people reported having an episode of depression in the previous year. Depressive disorders often start at a young age; they reduce people's functioning and often are recurring. For these reasons, depression is the leading cause of disability worldwide in terms of total years lost due to disability. The demand for curbing depression and other mental health conditions is on the rise globally. A recent World Health Assembly called on the World Health Organization and its member states to take action in this direction (WHO, 2012).

What is depression?

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life (WHO, 2012).

There are multiple variations of depression that a person can suffer from, with the most general distinction being depression in people who have or do not have a history of manic episodes.

- *Depressive episode* involves symptoms such as depressed mood, loss of interest and enjoyment, and increased fatigability. Depending on the number and severity of symptoms, a depressive episode can be categorized as mild, moderate, or severe. An individual with a mild depressive episode will have some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely. During a severe depressive episode, on the other hand, it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent.
- *Bipolar affective disorder* typically consists of both manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated mood and increased energy, resulting in over-activity, pressure of speech and decreased need for sleep.

While depression is the leading cause of disability for both males and females, the burden of depression is 50% higher for females than males (WHO, 2008). In fact, depression is the leading cause of disease burden for women in both high-income and low- and middle-income countries (WHO, 2008). Research in developing countries suggests that maternal depression may be a risk factor for poor growth in young children (Rahman et al, 2008). This risk factor could mean that maternal mental health in low-income countries may have a substantial influence on growth during childhood, with the effects of depression affecting not only this generation but also the next.

Managing depression

Depression is a disorder that can be reliably diagnosed and treated in primary care. As outlined in

the WHO mhGAP Intervention Guide, preferable treatment options consist of basic psychosocial support combined with antidepressant medication or psychotherapy, such as cognitive behavior therapy, interpersonal psychotherapy or problem-solving treatment. Antidepressant medications and brief, structured forms of psychotherapy are effective. Antidepressants can be a very effective form of treatment for moderate-severe depression but are not the first line of treatment for cases of mild or sub-threshold depression. As an adjunct to care by specialists or in primary health care, self-help is an important approach to help people with depression. Innovative approaches involving self-help books or internet-based self-help programs have been shown to help reduce or treat depression in numerous studies in Western countries (Andrews et al, 2011).

Treatment effectiveness in resource-constrained settings

Over the past decade, a number of clinical trials have shown the effectiveness of treatment for depression across a range of resource settings.

- *Uganda:* A trial carried out in rural Uganda, for example, showed that group interpersonal psychotherapy substantially reduced the symptoms and prevalence of depression among 341 men and women meeting criteria for major or subsyndromal depression (Bolton et al, 2003).
- *Chile:* A trial was conducted with 240 low-income women suffering from major depression to examine the effectiveness of a multi-component intervention that included psycho-educational group intervention, structured and systematic follow-up, and drug treatment for those with severe depression. The trial found that there was a substantial difference in favor of the collaborative care program as compared to standard care in primary care. A depression test administered at the 6-month follow up point showed that 70% of the stepped-care group had recovered, as compared with 30% of the usual-care group (Araya et al, 2006).
- *India:* A trial was conducted to test the effectiveness of an intervention led by lay health counselors in primary care settings to improve outcomes for people with depression and anxiety disorders. The intervention consisted of case management and psychosocial interventions led by a trained lay health counselor, as well as supervision by a mental health specialist and medication from a primary care physician. The trial found that patients in the intervention group were more likely to have recovered at 6 months than patients in the control group, and therefore that an intervention by a trained lay counselor can lead to an improvement in recovery from depression (Patel et al, 2010).

Despite the known effectiveness of treatment for depression, the majority of people in need do not receive it. Where data is available, this is globally fewer than 50%, but fewer than 30% for most regions and even less than 10% in some countries. Barriers to effective care include the lack of resources, lack of trained providers, and the social stigma associated with mental disorders.

Reducing the burden of depression

While the global burden of depression poses a substantial public health challenge, both at the social and economic levels as well as the clinical level, there are a number of well-defined and evidence-based strategies that can effectively address or combat this burden. For common mental disorders such as depression being managed in primary care settings, the key interventions are treatment with generic antidepressant drugs and brief psychotherapy. Economic analysis has indicated that treating depression in primary care is feasible, affordable and cost-effective.

The prevention of depression is an area that deserves attention. Many prevention programs implemented across the lifespan have provided evidence on the reduction of elevated levels of depressive symptoms. Effective community approaches to prevent depression focus on several actions surrounding the strengthening of protective factors and the reduction of risk factors. Examples of strengthening protective factors include school-based programs targeting cognitive, problem-solving and social skills of chil-

dren and adolescents as well as exercise programs for the elderly. Interventions for parents of children with conduct problems aimed at improving parental psychosocial well-being by information provision and by training in behavioral childrearing strategies may reduce parental depressive symptoms, with improvements in children's outcomes.

Conclusion

Depression is a mental disorder that is pervasive in the world and affects us all. Unlike many large-scale international problems, a solution for depression is at hand. Efficacious and cost-effective treatments are available to improve the health and the lives of the millions of people around the world suffering from depression. On an individual, community, and national level, it is time to educate ourselves about depression and support those who are suffering from this mental disorder.

References

Andrews G, Cuijpers P, Craske MG, McEvoy P, Titov N. Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis. PLoS One. 2010 Oct 13;5(10):e13196.

Araya R, Flynn T, Rojas G, Fritsch R, Simon G. Cost-effectiveness of a primary care treatment program for depression in low-income women in Santiago, Chile. Am J Psychiatry. 2006;163:1379–87.

Bolton P, Bass J, Neugebauer R, et al. Group interpersonal psychotherapy for depression in rural Uganda randomized controlled trial. JAMA. 2003;289(23):3117-3124.

Patel V., Weiss H.A., Chowdhary N., Naik S., Pednekar S., Chatterjee S., De Silva M.J., (...), Kirkwood B.R. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial (2010) The Lancet, 376 (9758), pp. 2086-2095.

Rahman A, Patel V, Maselko J, Kirkwood B. The neglected 'm' in MCH programmes–why mental health of mothers is important for child nutrition. Trop Med Int Health 2008; 13: 579-83

World Health Organization 2008, The Global Burden of Disease 2004 update. http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf Accessed 16.6.2012

World Health Organization, World suicide prevention day 2012. http://www.who.int/mediacentre/events/annual/world_suicide_prevention_day/en/ Accessed 16.6.2012

World Health Organization, Sixty-fifth world health assembly 2012. http://www.who.int/mediacentre/events/2012/wha65/journal/en/index4.html Accessed 16.6.20120

World Health Organization. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings 2010. http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf Accessed 16.6.2012

"A SOLUTION FOR DEPRESSION IS AT HAND... EFFICACIOUS AND COST-EFFECTIVE TREATMENTS ARE AVAILABLE TO IMPROVE THE HEALTH AND THE LIVES OF MILLIONS OF PEOPLE AROUND THE WORLD..."

FACT SHEET

Depression around the World

Who gets depression varies considerably across the populations of the world. Lifetime prevalence rates range from approximately 3 percent in Japan to 16.9 percent in the United States, with most countries falling somewhere between 8 to 12 percent. (1) The lack of standard diagnostic screening criteria makes it difficult to compare depression rates cross-nationally. In addition, cultural differences and different risk factors affect the expression of the disorder. (2) We do know that the symptoms of depression can be identified in all cultures. (3) Worldwide, there are certain risk factors that make some more likely to get depression than others.

- Gender. Depression is two to three times more common in women, although a few studies, particularly from Africa have not shown this. (4)
- Economic disadvantages, that is, poverty. (5)
- Social disadvantages, such as low education. (6)
- Genetics. If you have someone in your immediate family with the disorder, you are two to three times more likely to develop depression at some point in your life. (7)
- Exposure to violence. (8)
- Being separated or divorced, in most countries,especially for men. (9)
- Other chronic illness.

Getting Help, Worldwide

There are many possible treatments for depression; and equally, if not more, barriers to getting treatment. Fewer than 25 percent of people across the world have access to treatments for depression. (10) The World Health Organization recently studied what it calls the "treatment gaps" in mental health care and found that worldwide, the median rate for untreated depression is approximately 50 percent. (11) In some countries, fewer than 10 percent of people with depression receive any treatment. (12) When people do get treatment, it is often inadequate.

A few snapshots from around the world:

- A 2007 international household survey of 84,850 respondents in 17 countries found that unmet needs for mental health treatment are pervasive and especially deserving of concern in less-developed countries. (13)
- An international study looking at six locations (Spain, Israel, Australia, Brazil, Russia and the United States) found it unlikely that a person would receive treatment for depression even after seeing a primary care health practitioner and being diagnosed with depression. This study found the probability of receiving treatment for depression was more influenced by the existing health care systems and financial barriers than by the clinical characteristics of individual patients. (14)
- In a recent literature review, researchers reported that only 14 percent of people in Belgium seek treatment within a year of onset of depression. (15)
- A recent study of several Latin American countries found a significant treatment gap for depression in the elderly. This study, in Peru, Mexico and Venezuela, found that most participants with symptoms had never received treatment. (16)
- There are only 26 psychiatrists for approximately 80 million inhabitants of Ethiopia, according to a recent survey. (17) Some countries have only a single psychiatrist. In many countries around the world there are a limited number of health professionals available or trained to provide effective treatments.

If you or someone you know is depressed, finding appropriate treatment can be difficult, depending upon where you live and the resources available to you. While many treatments can be provided and monitored in primary care, (18) barriers to effective care include the lack of resources and lack of trained providers. Even some of the symptoms of depression can be a barrier to treatment. A person may feel too tired or too overwhelmed to get help.

The first step to finding help is to begin in your community, with resources familiar to you. Try to talk with a healthcare practitioner. If there is no healthcare provider in your community, talk with a representative from non-governmental organizations (NGOs). An estimated 93 percent of African countries and 80 percent of Southeast Asian countries have NGOs in the mental health sector. (19)

These organizations provide diverse services—including counseling, advocacy, informal support, suicide prevention, substance abuse/misuse counseling, and research. In some communities, the NGOs provide the only programs available; in others, they complement existing programs.

If there is a university nearby, its departments of psychiatry or psychology may be able to help. Or consider a telephone directory or community resource book, and look under "mental health," "social services," "suicide prevention," "crisis intervention," "hotlines," "hospitals," "health clinics," "physicians," or "health." Another source of treatment and support could be a traditional healer, common in many countries and cultures.

Depression may be unfamiliar to people who are trying to help you. Talk to them about the information you have learned in this document. If you cannot find the help you need, you may need to seek treatment farther away. Utilizing the Internet to find information could be very helpful. If you don't have access, go to a local library or NGO with the resource list at the end of this publication.

Living with Depression

Living with depression, especially if it is chronic or recurring, can make you feel exhausted, overwhelmed and helpless. These feelings can often make you want to give up. Recognizing that these negative thoughts are part of your depression is one step toward recovery. It is important to take good care of yourself throughout your treatment. This can be hardest in the beginning, especially before your treatment begins to work.

Taking Care of Yourself

Depression is real. It is an illness of the brain that usually requires some form of treatment. It is important for you to recognize this, to take the illness seriously, and to take good care of yourself.

Depression can make even the simplest parts of daily living very difficult. If possible, there are some things you can do to make yourself feel better, even if only slightly. Your health care practitioner may make some of these suggestions as well.

- Consider some form of exercise daily. Exercise is good for both physical and mental health. Establishing a regular exercise routine will help maintain a healthy weight and reduce stress
- levels, important for someone with depression.
- Try to eat a healthy balanced diet every day. A healthy diet, which includes whole grains, fresh fruits and vegetables, protein, and is low in fat, will help keep your body healthy.
- There are many relaxation techniques to lower your stress, including meditation and deep breathing, which can help with depression. These techniques, widely used around the world, are a low-cost way to lower stress.
- Maintain healthy sleep habits, as much as possible. Set up a regular routine for bedtime and morning to be sure you are getting enough sleep, but not too much sleep.
- Avoid and reduce stress. Stress, both at work and home, can increase your feelings of depression. It is important to avoid stress in your daily life.
- Keep your working hours predictable and manageable. Openly communicate with family mem-

bers and loved ones about what is going on in your life to foster better relationships and elicit their support.
- Limit or curtail alcohol or substance use or abuse. Use of these substances may worsen your symptoms of depression or interfere with your prescribed medications.
- Create a daily routine. Organizing and planning your day will help to manage the many daily life tasks that you have to do. Create and maintain a monthly calendar.
- Be patient with yourself. For someone with depression, even the smallest tasks can seem impossible.

If you can't find the energy to go for a walk today, then just stand outside for a little while and get some fresh air. If you can't make a healthy meal for yourself, try to eat a piece of fruit. If you are finding yourself unable to sleep, consider learning meditation or other relaxation techniques. If you are sleeping all of the time, consider ways to spend less time in bed. These things will not make your depression go away, but they may make your day feel a little bit easier.

Seeking Support
A network of family and friends can make all the difference for someone with depression. Seek out friends and family, as well as local organizations, for help in taking care of you.

Friends and Family
Family members and close friends can be a significant source of support for you in coping with your depression.

- They can make you feel like you are not alone.
- They can listen to you.
- They can help you to find resources and learn all you can about depression.
- They can help you maintain a healthy lifestyle every day.
- They can help you stick to your treatment plan.

Seek out friends who will stick by you and help you through tough times. Ask them for specific help with daily routines, such as getting to therapy, exercising with you and encouraging you to take good care of yourself.

You may need to educate your friends about your depression. They may not understand that depression is an illness and requires treatment. They may expect that you can just pull it together and get better. They may think they can cheer you up. Consider sharing this World Mental Health Day information with them.

Peer Support Groups
Peer support groups, or group meetings with other people with depression, can be helpful for some people. These groups, especially when well run and organized, provide insight into day-to-day coping with the disorder.

Research has shown these groups to be helpful in particular areas, such as providing support, helping participants cope with problems and crises, and enabling participants to stick to treatment plans. (20) However, a recent systematic review found that more research is needed to fully understand and evaluate what conditions make these groups effective. Currently most existing peer-to-peer communities have been evaluated only in conjunction with additional interventions and interactions with healthcare professionals that coincide with participation in support groups. (21)

To locate a peer support group in your community, consult referral hotlines of professional organizations, including your state, regional or provincial mental health association. Another possibility is a peer support group on the Internet. Currently, there are multiple organizations running these groups, reaching across the world. There is limited amount of research on the quality of these support groups and their impact on the symptoms of depression. (22)

Nonetheless, depending upon where you live, it may be worthwhile investigating whether an online support group could be helpful for you. As with

any online service, please exercise caution when considering it and spend some time researching the organization and the kind of support group they are running. This could include corresponding with the organization and asking them how they determine who can participate in the group and how they monitor the group. Or talk to your healthcare provider or another depression organization to see if they have heard about this group. Finally, another possibility is to ask to talk with or correspond with someone who has participated in the support group. Although peer support groups are not for everyone, participation may make you feel less isolated and alone, and provide you with an opportunity to see how others with the disorder are successfully managing their lives. They also offer structured activities to cope with your illness.

Mental Health Organizations
Many local community organizations, together with national organizations, can help by providing information and resources on many issues, from finding mental health service providers to resolving insurance matters or employment issues. See the Resources section at the end of this document for local organizations.

Recovery
In many places around the world, mostly developed nations, there has been increasing emphasis on recovery and active illness management for people with mental disorders, including depression. Born out of substance abuse and addiction programs, the recovery model emphasizes the following:

- Finding hope;
- Personal empowerment in your own treatment and wellness;
- Expanding your knowledge about your illness and its treatments;
- Establishing support networks and seeking inclusion;
- Developing and refining coping strategies;
- Creating a secure home base;
- Defining a sense of meaning for your life.

Some have pointed to two different models of recovery, one developed by practitioners, the other by patients/mental health consumers. Both, however, involve these three points: (1) Each person's path to recovery is unique; (2) recovery is a process, not an end point; and (3) recovery is an active process, in which the individual takes responsibility for the outcome, with success depending primarily on collaboration with helpful friends, family, the community and professional supports. (23)

Recovery, as a movement, also has its roots in what is seen as a disconnect between health practitioners seeing success in treatment and patients still not feeling well. Many patients with depression report residual depression symptoms despite apparently successful treatment. These same patients felt that successful treatment and recovery should involve psychological well-being. (24) This angle has lead to efforts by some to better link treatment success measures with patient well-being. For example, a group in Scotland has developed what they call the Scottish Recovery Indicator, which is a complicated tool to help mental health services ensure that their activities are focused on supporting the recovery of the people who use their services. (See www.scottishrecoveryindicator.net/).

There are hundreds of recovery-based resources across the world. In the United States, one such program is the Wellness Recovery Action Plan, which recommends five actions for recovery:

1) Believe in yourself and your recovery.
2) Take personal responsibility.
3) Educate yourself.
4) Stand up for yourself.
5) Learn how to both receive and give support. (25)

"BELIEVE IN YOURSELF AND YOUR RECOVERY"

Summary

Living with depression can be difficult. You will need a lot of support to maintain a healthy lifestyle and stick to your treatment. Family members and close friends can play critical roles in your treatment plan. Peer support groups and mental health organizations may also be sources of support for coping with depression. There is a growing emphasis on a recovery model across the world that involves empowering people with mental illness to take charge of their own illness, their treatment and their lives.

"THERE IS GROWING EMPHASIS ON A RECOVERY MODEL ACROSS THE WORLD THAT INVOLVES EMPOWERING PEOPLE WITH MENTAL ILLNESS TO TAKE CHARGE OF THEIR OWN ILLNESS, THEIR TREATMENT AND THEIR LIVES."

References:

1. Andrade L, Caraveo-Anduaga JJ, et al.The epidemiology of major depressive episodes: results from the International Consortium of Psychiatric Epidemiology (ICPE) Surveys. Int J Methods Psychiatr Res 2003;12(1):3-21.
2. Weissman MM, Bland RC, et al. Cross-national epidemiology of major depression and bipolar disorder. JAMA 1996;276(4):293-9.
3. Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
4. Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
5. Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
6. Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
7. Klerman GL, Weissman MM. Increasing rates of depression. JAMA 1989;261(15): 2229-35.
8. Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
9. Klerman GL, Weissman MM. Increasing rates of depression. JAMA 1989;261(15): 2229-35.
10. World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
11. Kohn R, Saxena S, et al. The treatment gap in mental health care. Bull World Health Organ 2004 Nov;82(11):858-66. Epub 2004 Dec 14.
12. World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
13. Wang PS, Aguilar-Gaxiola S, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. Lancet 2007 Sep 8;370(9590):841-50.
14. Simon GE, Fleck M, et al.Prevalence and predictors of depression treatment in an international primary care study. Am J Psychiatry. 2004 Sep;161(9):1626-34.
15. Bruffaerts R, Bonnewyn A, Demyttenaere K. The epidemiology of depression in Belgium. A review and some reflections for the future [Article in Dutch]. Tijdschr Psychiatr 2008;50(10):655-65.
16. Guerra M, Ferri CP, et al. Late-life depression in Peru, Mexico and Venezuela: the 10/66 population-based study. Bri J Psychiatry (2009) 195: 510-515.
17. Shibre T, Spångéus A, et al. Traditional treatment of mental disorders in rural Ethiopia. Ethiop Med J 2008 Jan;46(1):87-91.
18. World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
19. Hyman S, Chisholm D, et al. Mental Disorders. 2006. Disease Control Priorities in Developing Countries (2nd Edition), New York: Oxford University Press, 2006: 5/Chpt-31.
20. Depression and Bipolar Alliance Support Groups: An important step on the road to recovery, 2008. Downloaded on 18 Dec 2009 from http://www.dbsalliance.org/site/DocServer/DBSASupportGrps_0708_FINAL.pdf?docID=2381.
21. Eysenbach G, Powell J, et al. Health related virtual communities and electronic support groups: systematic review of the effects of online peer to peer interactions. BMJ 2004 May 15;328(7449):1166.
22. Griffiths KM, Calear AL, et al. Systematic Review on Internet Support Groups (ISGs) and Depression (1): Do ISGs Reduce Depressive Symptoms? J Med Internet Res 2009;11(3):e40. Available online, http://www.jmir.org/2009/3/e40/
23. Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. A report of the Standing Senate Committee on Social Affairs, Science and Technology, May 2006. http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/rep02may06-e.htm
24. Fava GA, Ruini C, Belaise C. The concept of recovery in major depression. PsycholMed 2007 Mar;37(3):307-17.
25. Retrieved from www.mentalhealthrecovery.com.

Depression as a consequence of the ECONOMIC CRISIS

Prof. George N. Christodoulou, Professor of Psychiatry, University of Athens, President-elect, World Federation for Mental Health, Honorary Fellow, World Psychiatric Association. gchristodoulou@ath.forthnet.gr

Introduction

Although population-level research between economic crises and specific mental disorders is considered scarce (Lee et al 2010), yet there is some evidence arising from previous economic crises in the USA, Asia and the former Soviet Union as well as some evidence arising from the present economic crisis associating such crises with psychopathology (Araya et al 2003b)—especially depression (Butterworth et al 2009) and suicide (Lee et al 2010).

Normal sadness and depression

It is important to differentiate between normal sadness and depression. Under adverse conditions like death of a relative, personal humiliation (especially in certain cultures), disappointment, loss of social status, even financial loss, a psychological response is expected and is, of course, normal. Under these circumstances, it is lack of response that would be abnormal, as is the case with the absence of response (apathy) often encountered in patients with schizophrenia and some patients with personality disorders (Christodoulou et al 2000).

It is, therefore, important to differentiate between sadness and depression, i.e. between an "adaptive" and a "dysfunctional" response to an adverse life event, even though this distinction is sometimes difficult (Maj, 2011).

Both sadness and depression are expected during periods of economic crises. In the former case active labor market programs, family support, solidarity and psychological support are needed. In the latter case, in addition to the above, treatment for depression is also required.

Prevalence of depression

One out of ten people suffer from major depression and almost one out of five persons has suffered from this disorder during his (or her) lifetime (one-year prevalence is 10% and lifetime prevalence 17%) (Kessler et al 1994). By 2020, depression will be the second leading cause of world disability (WHO, 2001) and by 2030; it is expected to be the largest contributor to disease burden (WHO, 2008).

These figures show the public health importance of depression, but behind the numbers there are human beings who suffer and this is certainly more important. The degree of psychic pain of a person with depression can be understood if one considers that many patients prefer death to their suffering. In view of the fact that the overwhelming majority of people who commit suicide are persons with mental illness and especially depression, the need for screening for and early detection of depression in primary care services is unarguable (Patel et al 2010, Araya et al 2003a).

Atypical clinical expression of depression

Depression is notorious for the different ways it can be expressed and its changeable nature. It can hide behind a variety of conditions ranging from accident proneness to sexual dysfunction, it can co-occur (co-morbidity) with a great number of conditions like anxiety, panic attacks, alcoholism and with somatic illnesses like cancer, diabetes and chronic pain. In some cases depression can be expressed with a variety of symptoms other than its cardinal symptom (masked depression, "depression without depression") and even with antithetical symptoms ("smiling depression") (Christodoulou, 2000). Due to the many ways depression can be expressed, its diagnosis requires clinical skills and experience on the part of the clinician.

It appears that a great proportion of suicides occurring during economic crises are committed by people who suffer from either typical or atypical depression. In these cases, the economic crisis (and especially unemployment) acts as a precipitant. It is therefore especially important to screen for depression during these periods of economic hardship.

Economic crises and mental health

The present world economic crisis that started in 2008 was preceded by the economic crises in the United States of North America in 1929, by the severe crisis in the former Soviet Union in the early 1990s and by that of Asia in the late 1990s. On the basis of these experiences we know that economic crises are accompanied by reduced income, unemployment and uncertainty, and also by cuts in the funding of public services (including those of the mental health sector).

In her Foreword to the WHO booklet "Impact of economic crises on mental health" (2011) the WHO regional director for Europe, Zsuzsanna Jakab, notes that the present economic crisis has led to significant declines in economic activity, a rise in unemployment, depressed housing markets and increased number of people living in poverty. Severe cuts in public spending have resulted from this and many countries are facing an era of austerity in health and welfare services.

Under these circumstances low-income people and especially people living near the poverty line are under great psychosocial stress (WHO 2009). Through its influence on parents, a financial crisis affects the mental health of children (Solantaus et al 2004, Anagnostopoulos & Soumaki 2012) and this may result in deficits in cognitive, emotional and physical development of the children (Marmot 2009).

People's health can be influenced by socioeconomic degradation due to loss of jobs and limitations in income (Wilkinson & Marmot 2003) and social inequality in health can become more pronounced (Kondo et al 2008).

Unemployment, impoverishment and family disruptions are likely to produce or precipitate a variety of mental health problems. Depression, suicide and alcoholism are among them (Dooley et al 1994, Clark & Oswald 1994, Dorling 2009, Lewis & Sloggett 1998, Agerbo 2005). Unemployment is very strongly associated with suicide (Stuckler et al 2009, Economou et al 2008). Every 1% increase in unemployment is associated with a 0.79% rise in suicides at ages younger than 65 years (Stuckler et al 2009). Men are particularly vulnerable to death due to suicide (Berk et al 2006).

Debt seems to be a crucial factor for the development of mental health problems (Jenkins et al 2008, Skapinakis et al 2006, Brown et al 2005). The same holds for housing payment problems and financial problems in general but it seems that debt especially is a situation with heavy psychological loading, as for some sensitive people and people predisposed to depressive reactions it may precipitate or increase pre-existing guilt feelings. The more debt people have the more likely they are to suffer from mental disorders (Jenkins et al 2008).

The association of psychopathology with poverty (a condition that may result from an economic crisis, especially in people living at the borderline of economic collapse) has been repeatedly demonstrated (e.g. Patel et al 2003). Evidence from Japan, Hong Kong, Korea and other Asiatic countries (Chang et al 2009) indicates that severe financial losses due to the economic crisis in Asia and especially unemployment have resulted in increases in suicide. The same holds for China as a result of the social change that has led to a variety of losses, including severe financial losses, which have produced or precipitated depression and suicide (Philips et al 1999). The mass suicides of farmers in India following the agricultural reform in the middle of the 90s that resulted in a sharp economic decline are in line with the above (Sundar 1999).

Giotakos et al (2011) studied the relationship between two economic indicators, (unemployment and

average income) with mental health variables. The unemployment rate was positively associated with the number of homicides and, most importantly, average income was negatively correlated with suicide rates. In other words poverty and suicide go hand in hand.

Kentikelenis et al (2011) have reported that due to the economic crisis in Greece the budget of public hospitals was cut by 40% in 2011, admissions to public hospitals increased and the proportion of citizens who reported that their health condition was bad or very bad rose. Furthermore, homicides and thefts almost doubled between 2007 and 2009, suicides increased dramatically, heroin use increased and there was a 10-fold increase in infections among heroin users between 2009 and 2010. There was, however, a positive side effect of the economic crisis and this was reduction in the number of drunk drivers coupled with reduction in the consumption of alcohol.

A telephone survey carried out in Greece (Economou et al 2011) revealed a 36% increase in the reported number of attempted suicides between 2009 and 2011. These findings are in line with those of Stuckler et al (2011).

A pronounced increase in telephone calls with direct or indirect reference to the economic crisis during 2010 and onwards was reported by Economou et al (2012). The callers exhibited depressive symptoms and were predominantly unemployed.

The reported association of the current economic crisis in Greece with suicide has been challenged by Fountoulakis et al (2012) on the basis of the relevant WHO and Greek statistics reports which do not indicate substantial changes during the economic crisis period. The authors recommend caution in the interpretation of the existing data.

Measures to prevent psychopathology during periods of economic crisis

The association of unemployment with psychopathology and especially depression and suicide calls for programs to help people regain employment. It is interesting to note that in Finland and Sweden, during a period of economic recession, suicide rates were not influenced negatively, probably because of the efficiency of social services and the provision of social benefits. (Ostamo and Lönnqvist 2001, Hintikka et al 1999). Seen from a different angle the same conclusion can be reached. Reductions in state welfare spending in USA were accompanied by increased suicide rates (Zimmerman, 2002).

The above conclusion is further reinforced by the following data :

A comparison in suicide rates between Sweden and Spain from 1980 to 2005 revealed that while the severe bank crisis in Sweden in the early 1990s that produced a rapid rise in unemployment did not increase suicide rates, the reverse was observed in Spain following multiple banking crises in the 1970s and 1980s (Stuckler et al 2009). Although certainly there are many socio-cultural differences between Sweden and Spain, yet a major differentiating factor was probably the extent to which resources were used for social protection (WHO, 2011).

Data from Greece (Giotakos et al 2012) are in line with the above findings as it has been shown that suicide rates were reversely associated with the number of primary health care and mental health service providers as well as with the number of mental health infrastructures in Greece.

Active labor market programs can counteract the detrimental mental health effects of unemployment to a certain extent (Stuckler et al 2009). These programs include resilience-building mental health promotion programs for unemployed people and they have been found to be cost – effective (Vuori et al 2002, Vinocur et al 1991).

Family support programs are important during periods of economic crises. The problem is that the funding of such programs and also the salaries of professionals working in them are curtailed because of the crisis and some of these programs are

abandoned altogether. Yet, there is evidence that in EU countries, each US $100 per person spent on such programs reduces the effect of unemployment on the suicide rate by 0.2 percentage points (Stuckler et al 2009). Clearly, mental health professionals and advocates should highlight the cost-effectiveness of these programs more clearly.

Among the issues tackled and recommendations made by the WHO report (2011) the following are included:

- Control of alcohol prices and availability in view of the association of increases in unemployment with a rise in deaths from alcohol use in many EU countries (Stuckler, 2009) and increases in alcohol-related deaths following the crises of 1991 and 1998 in Russia (Zaridze et al 2009).
- Early recognition of mental health problems, suicidal ideas and heavy drinking.
- Development of community-based mental health services, since this has been associated with reduction of suicide (Pirkola et al 2009).
- Promoting problem-solving skills that may protect against depression and suicidal behavior (WHO Report, 2009).
- Debt relief programs.
- Countering stigma (general population campaigns have shown modest effects and targeted approaches are indicated).
- Demonstrating that investing in mental health has economic benefits.
- Continuing mental health reform (especially deinstitutionalization and delivery of mental health services in primary health care), but linking funding to accreditation systems and assessment of provider performance.

Conclusion

Depression, especially in its self-destructive clinical expression is one of the major psychopathological conditions that are linked with economic crises. Screening for depression and suicidal tendencies during periods of economic crises as a routine psychiatric prevention strategy is recommended. In view of the association of suicidal potential with unemployment, active labor market and support programs are necessary.

Highlighting the above and advocating for the establishment of cost-effective active labor market, rehabilitation and family support programs are recommended.

References

Agerbo E. (2005). Effect of psychiatric illness and labor market status on suicide: a healthy worker effect? Journal of Epidemiology and Community Health 59, 598-602

Anagnostopoulos D., Soumaki E. (2012). The impact of socio-economic crisis on mental health of children and adolescents. Editorial. Psychiatriki 23: 15-16

Araya R., Lewis G., Rojas G., Fritsch R. (2003b). Education and Income: which is more important for Mental Health? J. Epidem. Commun. Health 57, 501-555

Araya R., Rojas G., Fritsch R. et al (2003a). Treating depression in primary care in low-income women in Santiago, Chile: a randomized controlled trial. Lancet 361, 995-1000

Berk M., Dodd S., Henry M. (2006). The effect of macro-economic variables on suicide. Psychological Medicine 36, 181-189

Brown S., Taylor K., Price SW. (2005). Debt and distress: evaluating the psychological cost of credit. Journal of Economic Psychology 26, 642-663

Butterworth P., Rodgers B., Windsor TD. (2009). Financial hardship, socio-economic position and depression: results from the PATH through the Life Survey. Soc Sci Med 69: 229-237

Chang SS., Gunnell D., Sterne JAC et al (2009). Was the economic crisis 1997-1998 responsible for rising suicide rates in east/southeast Asia? A time-trend analysis for Japan, Hong-Kong, South Korea, Taiwan, Singapore and Thailand. Soc. Sci Med. 69, 1322-1331

Christodoulou GN and collaborators (2000). Psychiatriki, Beta, Athens

Clark A., Oswald AJ. (1994). Unhappiness and unemployment. Economic Journal 104, 648-659

Dooley D., Catalano R., Wilson G. (1994). Depression and unemployment: panel findings from the Epidemiologic Catchment Area Study. American Journal of Community Psychology 22, 745-765

Dorling D. (2009). Unemployment and health. British Medical Journal 338, b829

Economou M., Madianos M., Theleritis CP., Peppou L., Stefanis C. (2011). Increased suicidality and economic crisis in Greece. Lancet 378, 1459

Economou A., Nikolaou A., Theodossiou I. (2008). Are recessions harmful to health after all? Evidence from the European Union. Journal of Economic Studies 35, 368-384

Economou M., Peppou LE., Louki E., Komporozos A., Mellou A., Stefanis C. (2012). Depression telephone helpline: Help seeking during the financial crisis. Psychiatriki 23: 17-28

Fountoulakis K., Grammatikopoulos I., Koupidis S., Siamouli M., Theodorakis P (2012). Letter to the Editor, Lancet 379,

1001
Giotakos O., Karabelas D., Kafkas A. (2011). Financial crisis and mental health in Greece: Findings from the association between financial and mental health factors. Psychiatriki 22, 109-119
Giotakos O., Tsouvelas G., Kontaxakis V. (2012). Suicide rates and mental health services in Greece, Psychiatriki 23: 29-38
Hintikka J., Saarinen PI., Viiramäki H. (1999). Suicide mortality in Finland during an economic cycle, 1985-1995. Scandinavian Journal of Public Health, 27: 85-88
Jenkins R., Bhugra D., Bebbington P. et al (2008). Debt, income and mental disorder in the general population. Psychological Medicine 38, 1485-1493
Kentikelenis A., Karanikolos M., Papanikolas I., Basu S., Mc Kee M., Stuckler D. (2011). Health effects of financial crisis: omens of a Greek tragedy. Lancet 378, 1457-1458
Kessler RC., McGonagle KA., Zhao S. et al (1994). Lifetime and 12month prevalence of DSM-III-R psychiatric disorders in the US : Results from the National Comorbidity Survey. Arch. Gen. Psychiatry 51, 8-19
Kondo N. et al (2008). Economic recession and health inequalities in Japan: analysis with a national sample, 1986-2001. Journal of Epidemiology and Community Health 62, 869-875
Lee Sing, Guo Wan-Jun, Tsang Adley, Mak Arthur DP, Wu Justin, Ng King Lam, Kwok Kathleen (2010). Evidence for the 2008 economic crisis exacerbating depression in Hong Kong 126, 125-133
Lewis G., Sloggett A. (1998). Suicide, deprivation and unemployment: record linkage study. British Medical Journal 317, 1283-1286
Maj M. (2011). Clinical Depression VS Understandable Sadness. Is the difference clear and is it relevant to treatment decisions? Festschrift volume for Prof. George Christodoulou, Beta Publishers, Athens pp. 174-178 (www.paeeb.com – editions)
Marmot MG., Bell R. (2009). How will the financial crisis affect health? British Medical Journal 338, b1314
Ostamo A., Lönnqvist J. (2001). Attempted suicide rates and trends during a period of severe economic recession in Helsinki, 1989-1997. Social Psychiatry and Psychiatric Epidemiology 36: 354-360
Patel V., Gwanzura F., Simunyu E., Mann A., Lloyd K. (1995). The explanatory models and phenomenology of common mental disorder in Harare, Zimbabwe, Psychol. Med 25, 1191-1199
Patel V., Weiss HA., Chowdhary N. et al (2010). Effectiveness of an intervention led by lay health counselors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomized controlled trial. Lancet 376, 2086-2095
Philips MR., Liu H., Zhang Y. (1999). Suicide and social change in China. Cult Med Psychiatry 23, 25-50
Pirkola S. et al (2009). Community mental-health services and suicide rate in Finland: a nationwide small-area analysis. Lancet, 373: 147-153
Skapinakis P. et al (2006). Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK, British Journal of Psychiatry 189, 109-117
Solantaus T., Leinonen J., Punamäki RL. (2004). Children's mental health in times of economic recession: replication and extension of the family economic stress model in Finland. Development. Psychology 40, 412-429
Stuckler D., Basu S., Suhroke M., Coutts A., Mc Kee M. (2009). The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis, Lancet 374, 315-323
Stuckler D., Basu S., Suhrcka M., Coutts A., Mc Kee M. (2011). Effects of the 2008 recession on health: a first look at European data. Lancet 378, 124-125
Sundar M. (1999). Suicide in farmers in India. Br J Psychiatry 175, 585-586
Vinokur AD., van Ryn M., Gramlich EM., Price RH. (1991). Long – term follow-up and benefit-cost analysis of the jobs program: a preventive intervention for the unemployed. Journal of Applied Psychology 76: 213-219
Vuori J. et al (2002). The Työhön Job. Search Program in Finland: benefits for the unemployed with risk of depression or discouragement. Journal of Occupational and Organizational Psychology 78: 43-52
WHO Global Burden of Disease (2008): 2004 update. Geneva: World Health Organization. http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf (accessed Feb. 5, 2012)
Wilkinson R., Marmot M. (eds) (2003). Social determinants of health: the solid facts, 2nd ed. Copenhagen, Regional office for Europe
World Health Organization (2001). The World Health Report 2001. Mental Health. New Understanding. New Hope. Geneva WHO
World Health Organization (2009). Financial crisis and global health: report of a high-level consultation. Geneva, World Health Organization
World Health Organization (2011). Impact of Economic crises on mental health, Regional Office for Europe, Copenhagen
Zaridze D. et al (2009). Alcohol and cause – specific mortality in Russia: a retrospective case-control study of 48.557 adult deaths. Lancet 373: 2201-2214
Zimmerman SL. (2002). State's spending for public welfare and their suicide rates, 1960 to 1995: what is the problem? Journal of Nervous and Mental Disorders, 190: 349-360

SYSTEM STRENGTHENING

Across the Healthcare Sector to Promote Resilience in a Time of Economic Hardship

Dr Gabriel Ivbijaro MBE, MBBS, FRCGP, FWACPsych, MMedSci, MA, Vice President WFMH (Europe)
Chair Waltham Forest Clinical Commissioning Group, London, UK. gabriel.ivbijaro@gmail.com

On this, the twentieth anniversary of World Mental Health Day, we are focusing on depression as a global crisis.

Whether we live in high-, medium- or low- income countries, the current global economic crisis is affecting us all and this contributes to the burden of disease resulting from depression. We need to build global resilience so that individuals and states can limit its impact on our societies. Nobody is protected from the consequences of the global economic crisis, so we need to strengthen our health services to respond to depression and the many factors that cause it—including socioeconomic factors(1)—in a holistic way. This means that we must include health promotion, social interventions, early diagnosis, appropriate treatments and above all give service users, their families and friends hope by tackling stigma and improving access. This year's World Mental Health Day provides us with an opportunity to think about the practical things that we can do. Doing nothing is not an option.

The Impact of Depression on Health

Since 1978, The Alma-Ata Declaration(2) has been instrumental in primary care development worldwide. It called for primary care to address health problems in the community, providing preventive, promotive, curative and rehabilitative services reflecting the economic situation and the social values of the country and its communities. Primary care was noted to be especially important for low-income countries as the essential elements were the promotion of proper nutrition and an adequate supply of safe water, basic sanitation, maternal and child care including family planning and immunization, control of endemic disease, health education and appropriate treatment for common diseases and injuries (Ivbijaro et al 2008)(3). The contribution of depression to the burden of disease is very significant and primary care capability needs to be improved to support the population's resilience to depression.

Depression and other common mental health problems that present in primary care, no matter how mild, contribute significantly to the burden of disability and lower the quality of life people enjoy. Common mental health problems have been associated with substantial impairment in health-related quality of life, even in those with sub-threshold illness (Spitzer et al 1995)(4). This suggests that primary care should address even the mildest forms of illness through improved access and early diagnosis.

Debt can act as a predisposing, precipitating or maintaining factor in depression and people should be provided with access to good quality advice on managing resources and debt counseling so that they can maintain hope in the face of financial hardship. Even before the current global economic crisis, the World Health Organization estimated that depression would occupy a growing share in the global burden of disease, rising from third place in 2004 with 4.3% of the total to first place by 2030 with 6.2% of the total (followed by ischaemic heart disease, road traffic accidents, cerebrovascular disease and chronic obstructive pulmonary disease). WHO found that depression was already the leading cause of lost years of healthy life for women in the 15-44 age groups.(5) We should act to address the upward trend of this widespread illness.

Depression has significant socioeconomic costs. European studies have shown that early retirement accounted for 47% of the cost of depression, and sick leave a further 32%, compared with just 3% for the cost of drugs to treat the illness (Sobocki et al, 2007, European Psychiatry). Underperformance at work is also a significant factor (Centre for Mental Health, Mental Health at Work: Developing the business case, 2007) because depressive symptoms such as lack of attention, memory loss, and difficulties with planning and taking decisions are often overlooked, although they affect up to 94% of all patients, and make a huge impact on the ability to work (Conradi HJ, Ormel J, de Jonge P. Psychol Med. 2010 Oct 8:1-10).

It is important to remember that a depressive disorder is not a sign of personal weakness. Without intervention symptoms can last for weeks, months, or years. Depression is a mental health disorder that prevents people from conducting a normal life, including the ability to hold down a job, attend school and to perform other normal functions. Depression affects all ages and those people who are employed, unemployed and retired. It is the most predominant and costly mental health challenge among working-age patients for instance 11% (European Pact for Mental Health and Well-being, 2008) of EU citizens suffer from depression at some point in their life.

System Strengthening

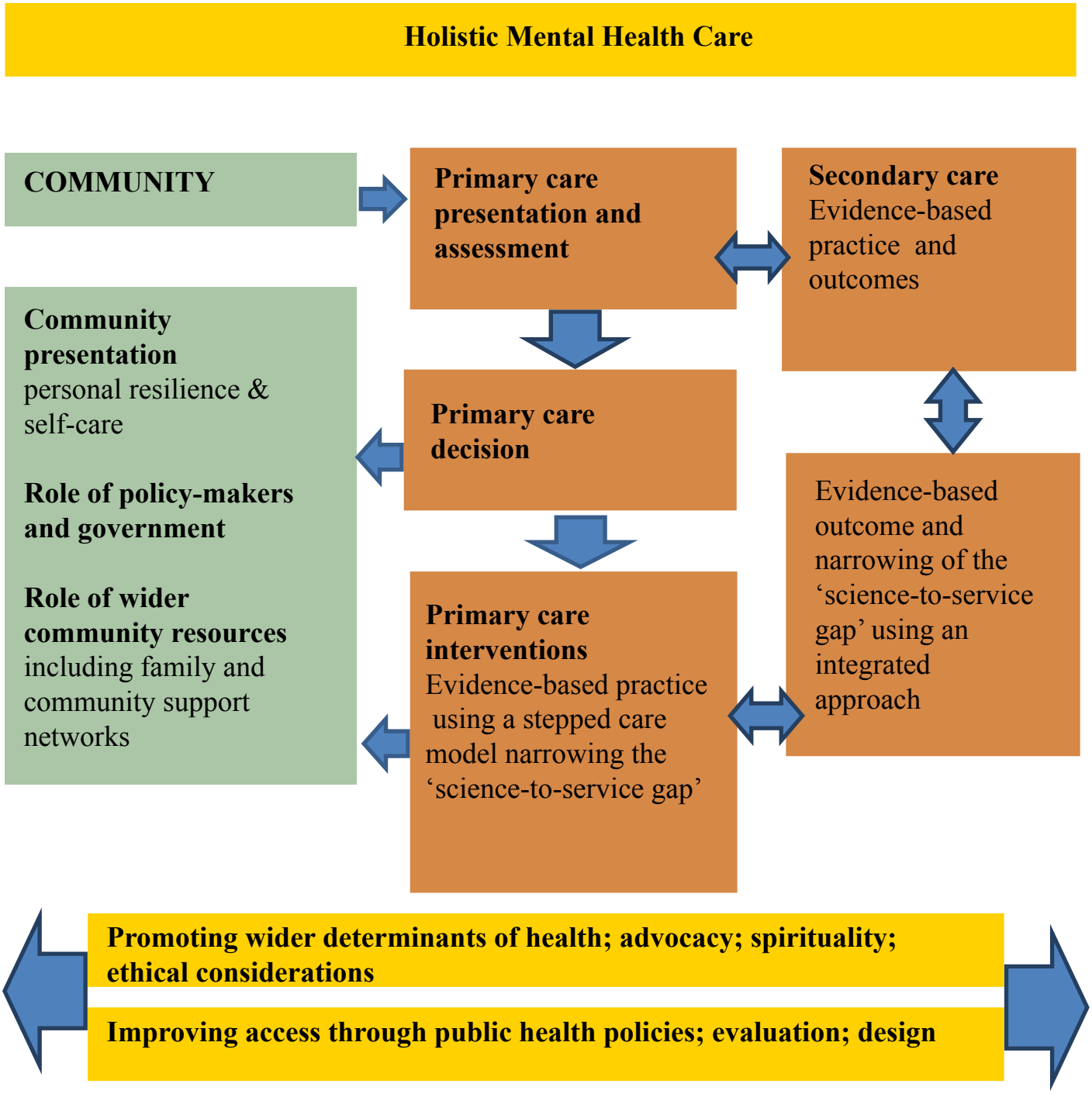
With the increasing gravity of the financial crisis and increasing prevalence of illness, the resources that we have need to be better managed. In 2008 the World Organization of Family Doctors (Wonca) and the World Health Organization (WHO) published "Integrating Mental Health into Primary Care: A Global Perspective"(6) which highlighted patient preference for receiving mental health care in primary care.

Although there are a lot of primary care services that deliver mental health interventions globally, this is still not a reality in many places. Often patients suffering a mental health crisis in low-, middle- and some high- income countries do not readily have access to comprehensive free or affordable mental health care. We therefore need to develop an integrated approach to care that will harness the social determinants of health in order to build populations that are more resilient to mental health problems. The complex networks of factors that contribute to building a health care system to deliver a resilient population are described in Figure 1 below (Ivbijaro 2012).(7) The aim is to develop resilience at the individual and community level by delivering an evidence-based approach in partnership with policy makers and government. The pathways can be adapted to suit low-, medium- and high-income countries, and emphasis can be placed on strengthening those elements that already exist in the community and integrating them through a comprehensive primary care network to the secondary care workforce.

Financing

To obtain the best value and quality for our communities and the individuals that are part of those communities, health needs to be appropriately financed. The World Health Organization has stated that everyone should be able to access health services and not be subject to financial hardship while doing so (WHO 2010),(8) but acknowledged that we are currently a long way from this ideal.

There is a need to focus on domestic health financing systems in order to improve coverage.(9) To achieve universal coverage, pooled funds need to be increased to include those individuals who currently have no coverage. The treatment of depression, especially in primary care, should be included in health service systems. This would help to ensure that financial barriers do not prevent people from accessing a range of interventions for health promotion, debt counseling and depression treatment. The current global crisis has provided an additional drive for us to review the funding of services for the prevention and treatment of depression so that we can build resilience to all the pressures we face as individuals and societies (Jenkins et al 2011) (10),(11),(12),(13)



Conclusion

The current global financial crisis has added to the societal burden that we face across the globe and has resulted in an increased number of people developing depression. Whether mild, moderate or severe, depression contributes significantly to the burden of disability and affects the quality of life people enjoy. We need to strengthen our services to increase the numbers of people who have access to health services. There is a need for donor organizations and states to work together in a more coordinated way so that the resources we have can be better managed while we work towards universal health coverage. The theme of this year's 2012 World Mental Health Day, *Depression: A Global Crisis*, provides us the opportunity to focus on how we can best work together using the resources at our disposal to build increased resilience in individuals and society in order to reduce the burden of disease and individual suffering resulting from depression.

World Mental Health Day 2012 provides an opportunity for all Colleges and Academies that train health care workers to revisit the idea of working together as they did in 1992 in the Defeat Depression Campaign, which made a significant impact on access to care by increasing community and professional awareness of this common condition while reducing the stigma associated with it.(14),(15)

Averting this global crisis will require continued collaboration between governments, donors, non-governmental organizations, pharmaceutical companies and civil society to pool our resources and strengthen the resilience of individuals and the structures that support them.

Acknowledgements
I wish to thank Professor Chris Dowrick, Dr Patt Franciosi, Professor Michael Kidd, Dr Lucja Kolkiewicz, Professor Rachel Jenkins and Dr Filippo Zizzo for their reviews. I also wish to thank the members of London Health Programmes and Waltham Forest Clinical Commissioning Consortium for their support.

References

Miech RA, Caspi A, Moffitt TE, Wright BE, Silva PA (1998). Low Socioeconomic Status and Mental Disorders: A Longitudinal Study of Selection and Causation during Young Adulthood. Working Paper No. 98-05, Center for Demography and Ecology, Madison, WI

Declaration of Alma-Ata: international conference on primary health care, Alma-Ata, USSR, Sept 6-12, 1978. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed 18.03.2012)

Ivbijaro G, Kolkiewicz L, Lionis C, Svab I, Cohen A, Sartorius N (2008) Primary care mental health and Alma-Ata: from evidence to action. Mental Health in Family Medicine. 5: 67-9

Spitzer RL, Kroenke K, Linzer KM, Hahn SR, Williams JBW, deGruy FV, Brody D, Davies M (1995) Health-related quality of life in primary care patients with mental disorders. Results from the PRIME-MD 1000 Study. Journal of the American Medical Academy. 274 (19): 1511-1517

World Health Organization (2008). Global Burden of Disease: 2004 update 46, 51.

WHO/Wonca (2008). Integrating mental health into primary care: A global perspective. Geneva: WHO

Ivbijaro GO (ed) (2012). Companion to Primary Care Mental Health. Radcliffe/Wonca

World Health Organization (2010). The World Health Report. Health Systems Financing. The Path to Universal Coverage. Geneva: WHO

Evans DB, Etienne C (2010). Health systems financing and the path to universal coverage. Bulletin World Health Organization 88: 402

Jenkins R, Baingana F, Ahmad R, McDaid D, Atun R. (2011) Mental health and the global agenda: core conceptual issues. Mental Health in Family Medicine 8:69-8

Jenkins R, Baingana F, Ahmad R, McDaid D, Atun R. (2011) Social, economic, human rights and political challenges to global mental health. Mental Health in Family Medicine 8:87-96

Jenkins R, Baingana F, Ahmad R, McDaid D, Atun R. (2011) International and national policy challenges in mental health. Mental Health in Family Medicine 8:101-114

Jenkins R, Baingana F, Ahmad R, McDaid D, Atun R. (2011) Health system challenges and solutions to improving mental health outcomes. Mental Health in Family Medicine 8:119-127

Paykel ES, Tylee A, Wright A, Priest RG, Rix S, Hart D (1997) The Defeat Depression Campaign: psychiatry in the public arena. American Journal of Psychiatry 154 (festschrift supplement): 59-65

Rix S, Paykel ES, Lelliot P, Tylee A, Freeling P, Gask L, Hart D (1999) Impact of a national campaign on GP education: an evaluation of the Defeat Depression Campaign British Journal of General Practice 49: 99-10

Sobocki P, LekanderI, BorgströM, Ström O, Bo R (2007) The economic burden of depression in Sweden from 1997 to 2005. European Psychiatry 22(3): 146-152

Sainsbury Centre for Mental Health (2007) Policy Paper 8. Mental Health at Work: Developing the Business Case. Sainsbury Centre for Mental Health London UK (Accessed 15.07.2012 http://www.centreformentalhealth.org.uk/pdfs/mental_health_at_work.pdf)

Conradi HJ, Ormel J, de Jonge P (2011) Presence of individual (residual) symptoms during depressive episodes and periods of remission: a 3 year prospective study. Psychological Medicine 44: 1165-1174

European Pact for Mental Health and Well-Being EU High Level Conference Brussels, Belgium 12-13th June 2008. (Accessed 15.07.2012 http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf)

THE ECONOMIC IMPACT
of Depression

R. Jenkins, WHO Collaborating Centre, Institute of Psychiatry, Kings College London. Rachel@olan.org
D. McDaid, London School of Economics and Political Science. d.mcdaid@lse.ac.uk

Depression is a common problem. Broadly defined to include both pure depression and mixed anxiety-depression, it affects around 5-10% of adolescents and 10-15% of adults. It can be triggered by many different personal, social and economic factors, including major macro-economic shocks (1). Across the globe it imposes a significant economic burden, not just on individuals with the disorder, but also on their families, communities, employers, health care systems and general government budgets. At a time of economic crisis across much of the globe it is therefore an issue that societies ignore at their peril: a lack of attention given to the prevention and treatment of depression in the population, and a consequent loss of capacity in the workforce, may only serve to make it more difficult for countries to emerge from economic austerity.

There is abundant research on the economic burden attributable to mental disorders in high-income countries (2-4) and a more limited but growing evidence base on the economic consequences in low- and middle-income countries (5, 6). Estimates of these costs are likely to be conservative; few take account of the way in which families may mobilize and redirect resources in ways that have long term repercussions for the family, and risk aggravating and perpetuating socioeconomic inequalities. When aggregated across economies, these household costs have an important impact on the size and productivity of the labor force and on national incomes in general. Estimates of cost also do not usually take account of the increased risks of poor physical health that have been associated with depression.

Depression also perpetuates the cycle of poverty by interfering with the capacity to function in either a job or other activities that families engage in, leading to decreased social as well as economic productivity. Thus, people with chronic depression are often in poverty because neither they nor their carers may be able to work. In countries without universal access to health care, individuals may spend much of their savings or have to borrow money to buy conventional and/or traditional medicines. Breaking the chain of poverty and debt around people with depression is therefore vital to addressing the millennium goal of eradicating poverty and hunger (MDG1). This is not, however, just an issue for low-income countries. Greater levels of unmanageable debt and poverty can be seen in countries in Europe and elsewhere that have been experiencing the worst impacts of the economic downturn.

Another compelling reason for addressing depression is that there is ample evidence from longitudinal studies in a number of high-income countries that, if untreated, depression in childhood and youth can have profound longstanding social and economic consequences in adulthood. These include poorer levels of educational attainment, increased contact with the criminal justice system, reduced levels of employment and often lower salaries when employed, and personal relationship difficulties (7-10). In addition, depression in parents can also have adverse impacts on the health, development and education of their children (11). In some countries children may have to give up schooling during health crises to provide informal care, or it may be that the parent is simply too sick to ensure that the child goes to school. Again, at a time of economic crisis it is important to invest in the health and well-being of children who represent the future wealth of any nation.

The costs of depression are substantial but what do we know about the case for investing in the prevention and treatment of depression? While careful decisions must be made about how to invest in all aspects of health care, in even the poorest regions of the world cost effective actions to tackle depression can be identified (12). There is also an evidence base, albeit from high-income country contexts only, indicating that there are some cost-effective approaches for the prevention of depression across the life course (13).

In summary, although the effects of poor health on poverty are by no means unique to depression, the longer duration of a proportion of depressive illnesses makes their negative impacts greater than for most acute physical conditions. These various impacts increase the risk that households will fall into severe economic hardship, with major consequences for the national economy. Such risks are likely to increase during times of economic crisis, making it even more important not to neglect mental health.

References:

1. Anderson P, McDaid D, Basu S, Stuckler D. Impact of economic crises on mental health. . Copenhagen: World Health Organization Regional Office for Europe; 2011.
2. Foresight Mental Capital and Wellbeing Project. Final Project Report. London: The Government Office for Science; 2008. http://www.foresight.gov.uk/.
3. McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S. Paying the price: the cost of mental health care in England to 2026. London: King's Fund; 2008.
4. Gustavsson A, Svensson M, Jacobi F, Allgulander C, Alonso J, Beghi E, et al. Cost of disorders of the brain in Europe 2010. European neuropsychopharmacology : the journal of the European College of Neuropsychopharmacology. 2011;21(10):718-79. Epub 2011/09/20.
5. Shah A, Jenkins R. Mental health economic studies from developing countries reviewed in the context of those from developed countries. Acta Psychiatr Scand. 2000;101:87-103.
6. McDaid D, Knapp M, Raja S. Barriers in the mind: promoting an economic case for mental health in low and middle income countries. World Psychiatry. 2008;7(2):79-86.
7. Scott S, Knapp M, Henderson J, Maughan B. Financial cost of social exclusion: follow up study of antisocial children into adulthood. British Medical Journal. 2001;323(7306):191.
8. Fergusson DM, John Horwood L, Ridder EM. Show me the child at seven II: childhood intelligence and later outcomes in adolescence and young adulthood. Journal of Child Psychology and Psychiatry. 2005;46(8):850-8.
9. McCrone P, Knapp M, Fombonne E. The Maudsley long-term follow-up of child and adolescent depression: predicting costs in adulthood. European Child and Adolescent Psychiatry. 2005;14:407-13.
10. Chen H, Cohen P, Kasen S, Johnson JG, Berenson K, Gordon K. Impact of Adolescent Mental Disorders and Physical Illnesses on Quality of Life 17 Years Later. Arch Pediatr Adolesc Med. 2006;160(1):93-9.
11. Rutter M, Quinton D. Parental psychiatric disorder: efffects on children. Psychological Medicine. 1984;14:853-80.
12. Chisholm D, Sanderson K, Ayuso-Mateos JL, Saxena S. Reducing the global burden of depression: population-level analysis of intervention cost-effectiveness in 14 world regions. The British journal of psychiatry : the journal of mental science. 2004;184:393-403. Epub 2004/05/05.
13. McDaid D, Park AL. Investing in mental health and well-being: findings from the DataPrev project. Health promotion international. 2011;26 Suppl 1:i108-39. Epub 2011/12/07.

Depression and
DANGER TO OTHERS

Jeffrey Geller, MD, MPH, Professor of Psychiatry, University of Massachusetts Medical School
jeffrey.geller@umassmed.edu

Today the belief that individuals with mental illness are dangerous is one of the most common misconceptions amongst the general public. While it contributes to stigma and social distance for some types of mental illness, that is not the case for depression. Where depression is concerned, the causes of stigma and social distance are grounded in other, not yet clear factors. Depression is not generally associated with dangerousness to others.

A hallmark of depression is dangerousness to self—that is, suicide. Depression is a risk factor for suicidal thinking (there are many more attempts at suicide than there are completed acts). Good mental health care can reduce the risk, and suicide prevention programs and hotlines can provide support. However the focus on suicide and its prevention draws attention away from the fact that in "worst case" situations depression and resultant suicidal thinking/suicide attempts/suicide can be dangerous to others.

The clearest examples of situations where a depressed person is a danger to others are in those instances where a depressed individual kills someone, sometimes followed by suicide. Homicide-suicide is a worldwide problem, although the percentage of homicides accounted for by homicide-suicide varies widely amongst countries. There are several situations where depression precipitates murder, and then sometimes suicide:

- Infanticide and postpartum depression: The murder of a child under one year old by his mother. Fifty percent of infant homicides occur within the first four months, with a prominent form being "altruistic" or murder out of love, i.e., the suicidal parent does not want to leave the child "alone" and acts in what she thinks is the best interest of the child.
- Filicide: The killing of a child by a parent, which accounts for 60% of all child homicides. Depressed women who committed filicide report thinking about their own death and the death of their child(ren) for days or weeks before the event.
- Adolescent parricide, whereby a shamed and humiliated son (usually) kills a parent based on a belief this will result in a "relief of dysphoric feeling."
- Domestic homicide and homicide-suicide perpetrated by members of an older (over 65 years-old) couple include depression as one of the more frequent psychiatric disorders, a global finding.
- Mass murder followed by suicide is the all-too-common example of extra-familial killing followed by suicide. Depression is the leading diagnosis found in these cases.

There are other ways a parent's suicide is dangerous or damaging to children. Thoughts of harming their infant occurred in 41% of depressed mothers (six times the rate compared to non-depressed mothers) and these thoughts led mothers to withdraw from their infants. Children of women with postpartum depression experience poor physical developmental outcomes.

Children bereaved by parental suicide have more depressive symptoms, disproportionate rates of

suicidality and hospitalizations for suicide attempts; more psychiatric referrals, PTSD-like symptoms with guilt and self blame, higher rates of personality disorders, increased rates of convictions for violent crimes, and a substantially greater risk of suicide themselves.

Depression can be a contributing factor in a number of other situations where a suicide causes harm to others. "Suicide epidemics" have been a quagmire since long before organized psychiatry began to try to untangle its nuances. Such epidemics are known to occur sporadically, but repeatedly, in certain populations such as American Indians and in certain sites such as psychiatric inpatient units.

Suicide by car crash is an effective way to disguise a suicide: Driver suicide was ranked in the year 2000 by the WHO/Euro Multicentre Study on Parasuicide as the twelfth most common method of attempted suicide, but there is currently wide variance amongst countries in reported driver suicide. Suicide by motor vehicle is dangerous to others because the driver has no control of the actual outcome.

Some people who are intent on killing themselves set up a scenario to use another person as the lethal agent, and that other person is often a policeman/policewoman, thus "suicide by cop." In such cases, there may well be bullets flying in all directions.

Depression can be a contributing factor to pathological fire setting, and any fire setting is dangerous to the proximate population. Fire setting is frequently used in filicide. Patients with pyromania have a higher number of previous depressive episodes as compared to patients with other impulsive control disorders.

Death by self-immolation in western and developed countries is an uncommon event, and is usually a suicide in a depressed person. In eastern and developing countries, setting oneself on fire is multifactorial, but here tradition often masks suicide rooted in depression. In self-immolation, the fire setter is the sole target, but once the fire is set, the individual who set the fire has no control over the fire's course or its destruction.

Suicidality, secondary to depression, can be a danger to others. People who commit such acts predominantly suffer from mood disorders, and the most prevalent mood disorder is major depression.

FACT SHEET

Helping Someone You Know With Depression

Friends and family can be a lifeline for someone with depression. You can be a critical factor in their recovery. The information in fact sheet will provide you with some guidelines for providing the best care possible, while taking care of yourself as well.

What You Can Do to Help
Depending on the severity of the depression, there are many things you can do to help. One of the most important is talking with and listening to your loved one. Ask how they are feeling but don't force them to talk if they aren't interested. Allowing these conversations to be easy and open can show them that you are there to help. It is also good to ask them what is most helpful for them when they are feeling depressed. Listen to what they have to say. Tell them that you are there to listen when they need to talk.

Understanding Depression
It is also important for you to understand depression, its symptoms, possible course and treatments. This will help you understand your loved one and how he or she is feeling. It will also help you know if your loved one is getting better. The information provided in this packet can help you get a better understanding of the complexity of this disorder. There are also many resources online and around the world with additional information.

Supporting Their Treatment
One critical area of support for someone with depression is working with them to maintain their treatment plan, including taking their medications as prescribed, seeing healthcare practitioners as recommended, and seeking additional support as necessary. You may need to be the person to remind your loved one to take their medication every day. You may also help by setting up and/or taking them to their healthcare appointments. If they are not getting better, you may also need to encourage them to seek additional or alternative support.

Recognizing Warning Signs for Suicide
It is important to know that people with depression are more likely to attempt or commit suicide. Take seriously any comments about suicide or wanting to die. Even if you do not believe they really want to hurt themselves, the person is clearly in distress.

Help with Day-to-Day Living
Often, people with depression have difficulty with some of the basics of day-today living. If severe enough, depression can leave you feeling immobilized, unmotivated and unable to do many of life's simplest tasks. During these times, a person with depression will need support in ordinary activities —you may need to encourage them to shower, to eat, or to get some fresh air. And sometimes people might need help going to the grocery store, cleaning the house and paying bills.

Supporting Regular Activities
Try to encourage your loved one to maintain the activities they do when they are not depressed. If they play tennis regularly, offer to take them to their matches. If they volunteer at a local clinic, help them get there. If the two of you always went to a weekly movie, still go. You can also support their return to work. Don't force them to do things if they aren't ready, but do try to help them stay involved in their lives.

CALL TO ACTION

World Mental Health Day 2012

One of the annual goals of World Mental Health Day is to encourage and promote informed advocacy and action for the improvement of services to those with mental and behavioral disorders, to promote mental health and wellbeing, and to prevent mental disorders.

Recommendations are stated here as a reminder of the unfinished work of mental health advocates worldwide. WFMH encourages mental health associations, professional associations, consumer and family organizations, and individual citizen advocates to consider how they can incorporate these recommendations into their annual advocacy and policy agendas.

- **Provide Treatment in Primary Care:** The management and treatment of mental disorders in primary care is a fundamental step that would enable the largest number of people to get easier and faster access to services. Many are already seeking help at this level. In order for this model to be successful, however, general health personnel need to be trained in the essential skills of mental health care. Mental health should be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services.

- **Make Psychotropic Medications Available:** Essential psychotropic medications should be provided and made constantly available at all levels of health care. Such medicines often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable.

- **Give Care in the Community:** Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.

- **Educate the Public:** Public education and awareness campaigns on mental health should be launched in all countries. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental health and physical health care closer to each other.

- **Involve Communities, Families and Consumers:** Communities, families and consumers should be included in the development and decision-making of policies, programs and services. Interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.

- **Establish National Policies, Programs and Legislation:** Mental health policy, programs and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights considerations. Mental health reforms should be part of the larger health system reforms and health insurance schemes should not discriminate against persons with mental disorders, in order to give wider access to treatment and to reduce burdens of care.

- **Develop Human Resources:** Most developing countries need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programs. Most developing countries lack an adequate number of such specialists to staff mental health services. Once trained, these professionals should be encouraged to remain in their country in positions that make the best use of their skills.

- **Link with Other Sectors:** Sectors other than health, such as education, labor, welfare, and law, and nongovernmental organizations should be involved in improving the mental health of communities. Nongovernmental organizations should be much more proactive, with better-defined roles, and should be encouraged to give greater support to local initiatives.

- **Monitor Community Mental Health:** The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programs, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary.

- **Support More Research:** More research into biological and psychological aspects of mental health is needed in order to increase the understanding of mental disorders and to develop more effective interventions. Such research should be carried out on a wide international basis to understand variations across communities and to learn more about factors that influence the cause, course, and outcome of mental disorders. Building research capacity in developing countries is an urgent need.

"On an individual, community, and national level, it is time to educate ourselves about depression and support those who are suffering from this mental disorder."

"This year's World Mental Health Day provides us with an opportunity to think about the practical things that we can do. Doing nothing is not an option."
Dr Gabriel Ivbijaro

World Federation for Mental Health
PO Box 807
Occoquan, VA 22125, USA
info@wfmh.com
www.wfmh.org

This document was made possible by a grant from:

Lundbeck

And additional support by an educational grant from Lilly USA, LLC

Lilly

For further information
concerning Lilly grant fundin
visit www.lillygrantoffice.con

And additional support from

Otsuka

Otsuka-people creating new products for better health worldwide


WORLD FEDERATION FOR MENTAL HEALTH
FEDERATION MONDIALE POUR LA SANTE MENTALE