Background paper:

Helping People with Depression in Europe

Background analysis in support of the recommendations by the Expert Platform on Mental Health – Focus on Depression to support the implementation of the European Pact for Mental Health and Well-being
# Table of Contents

**Foreword** ................................................................................................................................. 3

## I Introduction ............................................................................................................................ 5

1.1 Depression – A key public health challenge in Europe........................................................... 5

1.2 The contribution of the EU Mental Health Pact to the depression debate ......................... 6

1.3 A multi-stakeholder approach to depression: The Expert Platform on Mental Health – Focus on Depression .............................................................................................................. 7

1.4 Addressing key challenges in the field of depression and providing recommendations for action............................................................................................................................................... 7

## 2 Selected clinical and epidemiological features ........................................................................ 9

## 3 Promoting early identification and appropriate intervention .............................................. 12

3.1 Early identification .................................................................................................................. 12

3.1.1 Clinical staging model........................................................................................................... 12

3.1.2 Providing adequate training for healthcare professionals.................................................. 16

3.1.3 Early identification of depression in at-risk groups ......................................................... 17

3.1.4 Detecting depression at home............................................................................................. 18

3.2 Adequate interventions ........................................................................................................ 19

3.2.1 Age groups.......................................................................................................................... 21

3.2.2 Depressed people with physical illness ........................................................................... 21

3.2.3 Depressed people with psychiatric conditions................................................................. 22

3.2.4 Maintenance treatment....................................................................................................... 23

3.2.5 Conclusions ....................................................................................................................... 24

## 4 The economic burden of depression ..................................................................................... 28

4.1 The cost of depression in Europe............................................................................................ 28

4.1.1 Quantifying the overall cost................................................................................................ 28

4.1.2 Variations across EU Member States.................................................................................. 29

4.1.3 The cost of mild and moderate depression ..................................................................... 30

4.1.4 The cost of suicide............................................................................................................. 30

4.1.5 The cost of depression in women...................................................................................... 31

4.1.6 The cost of depression in older people............................................................................ 31

4.1.7 The cost of depression in children and young people...................................................... 32
4.1.8 Cost impact of physical/mental comorbidities ........................................... 32
4.2 European public investment in depression ..................................................... 33
4.3 Impact in the workplace .................................................................................. 34
4.4 The role of business in addressing depression .................................................. 36
4.5 Making an economic case for action ............................................................... 37
4.5.1 Early identification of depression and early intervention ........................ 38
4.5.2 Adequate treatment ..................................................................................... 40
4.6 The way ahead ................................................................................................. 42

5 The state of mental health services for depression in the EU 27 Member States ................................................................. 45
5.1 Background ....................................................................................................... 45
5.2 Key findings ...................................................................................................... 46
5.3 Recommendations ......................................................................................... 50

6 The way forward: the commitment of the Expert Platform on Mental Health – Focus on Depression ......................................................... 53

7 Annexes ........................................................................................................... 54
7.1 Composition of the Expert Platform on Mental Health – Focus on Depression ................................................................................. 54
7.1.1 ORGANISATIONS PARTICIPATING IN THE EXPERT PLATFORM ........................................................................ 54
7.1.2 EXPERTS PARTICIPATING IN THE EXPERT PLATFORM IN THEIR INDIVIDUAL CAPACITY .................................. 55
7.1.3 REPRESENTATIVES OF THE EUROPEAN INSTITUTIONS PARTICIPATING IN THE EXPERT PLATFORM MEETINGS AS OBSERVERS ........................................................................ 55
7.1.4 PROJECT ADVISOR .................................................................................. 55
7.2 Bibliography and relevant sources of information ............................................. 56
Foreword

Depression can cause much suffering for the people experiencing it, and to those around them. It also imposes a high strain on health and social welfare systems and is a cause of major productivity losses for the EU economy.

This is why the European Pact for Mental Health and Well-being launched in 2008 addresses depression as a key theme. The Pact aims to provide an EU-level framework for exchange and cooperation between Member States and non-governmental stakeholders on the best ways to address the challenges caused by mental disorders and the opportunities that lie in promoting mental well-being.

The implementation of the Pact has met with great interest among Member States, professional organisations and civil society. It has helped to raise awareness about the need to better enable health systems in Member States to cope with depression and other mental disorders, and to disseminate good practices.

In this context, the Commission organised, in cooperation with the Ministry of Health of Hungary, a meeting on depression in Budapest in December 2009. Two important issues were highlighted: the need to improve the capacity of health professionals to detect and treat depression, and to develop partnerships with other sectors, such as education, social affairs and workplaces.

The present document on Helping people with depression in Europe is a solid contribution to support the implementation of the European Pact for Mental Health and Well-being. I am confident that it will be regarded as a source of inspiration for all those of you trying to alleviate the pain and suffering caused by depression.

John Dalli
European Commissioner for Health and Consumers
Members of the Expert Platform on Mental Health - Focus on Depression include:

Dr André Joubert, Director, Lundbeck Institute/Lundbeck International Neuroscience Foundation (LINF); Prof Charles Pull, Centre de Recherche Public-Santé/Centre Hospitalier de Luxembourg; Prof Cyril Höschl, Board Member, European Brain Council; Prof David Nutt, Professor of Psychopharmacology, Imperial College; Dolores Gauci, President, Global Alliance of Mental Illness Advocacy Networks-Europe (GAMIAN-Europe); Prof Franz Caspar, President, International Federation for Psychotherapy (IFP); Dr Gabriel Ivbijaro, WONCA Working Party on Mental Health; Dr Iman Barilero, Vice-President, H. Lundbeck A/S; Mr Jacques Van der Vliet, Rapporteur on Mental Health, Standing Committee of European Doctors (CPME); Prof Karl Kuhn, Chairman, European Network for Workplace Health Promotion (ENWHP); Mr Kevin Jones, Secretary General, European Federation of Associations of Families of People with Mental Illness (EUFAMI); Prof Martin Knapp, Professor of Social Policy, London School of Economics; Mrs Mary G. Baker, President, European Brain Council (EBC); Prof Norman Sartorius, Professor of Psychiatry, University of Geneva; Mr Roland van de Sande, General Secretary, European Psychiatric Nurses/Horatio; Prof Vincenzo Costigliola, President, European Depression Association (EDA); Prof Wolfgang Gaebel, Professor of Psychiatry, University of Dusseldorf; Prof Zoltan Rihmer, Professor of Psychiatry, Semmelweis University.

Additional contributing authors to this document include:

Prof Graham Thornicroft, Professor of Community Psychiatry Health Service and Population, King’s College London; Teresa Poole, Independent Consultant; Waldemar Greil, Professor of Psychiatry, University of Munich.

Jürgen Scheftlein from the European Commission’s Directorate-General Health and Consumers and Patrizia Tosetti from the European Commission’s Directorate-General for Research and Innovation participate as observers in the meetings of the Expert Platform.
1 Introduction

1.1 Depression – A key public health challenge in Europe

Depression affects 13% of EU citizens at some point in their life.\(^1\) According to World Health Organisation (WHO) projections, it will be the single most important cause of burden of illness in the EU and worldwide by 2030.\(^2\) Depression is an illness that is experienced by many people; it is much more than being unhappy, sad or disappointed, and it is not merely a response to stress.

Despite its documented burden, the complexity of depression is not fully understood, leading to mis-diagnosis and inadequate care for people living with the disease. Inadequate care, in turn, has huge cost implications for Europe’s healthcare and social security systems. Although EU governments are making increasing efforts to devise and establish strategies for the prevention and treatment of depression, a large proportion of people living with depressive disorders do not receive optimal care. This causes unnecessary suffering for affected people and their families, and represents a major economic burden for individuals and communities due to disability linked to untreated depression.

In a recent European report, depression was identified as the most important contributor to the burden of mental disorders and other disorders of the brain.\(^3,4\) In addition to constituting an important social and emotional burden for the individual, the consequences of the disease commonly affect people’s education and their professional and private life – representing a major cause of productivity loss and generating massive economic costs compared with other illnesses.\(^5\)
1.2 The contribution of the EU Mental Health Pact to the depression debate

Policy initiatives undertaken at EU level can support Member States in combating the burden of depression, in particular by raising awareness on the issue, and by bringing stakeholders together to share knowledge and best practices and agree on actions to improve the situation.

By initiating the European Pact on Mental Health and Well-being (the EU Mental Health Pact), the European Commission has put in place an EU-level policy framework for exchange and cooperation to address the burden of depression in the EU. By including Prevention of Depression and Suicide as one of the five priority themes of the Pact, the European Commission has recognised the importance of tackling the problem and bringing together all the relevant stakeholders to address unmet needs in depression. Furthermore, the European Commission has supported several additional initiatives to combat depression at EU level, such as financing the creation of the European Alliance Against Depression (via the Executive Agency for Health and Consumers – EAHC).\(^a\)\(^b\)

\(^a\) Other projects include the OSPI Europe project aimed at optimising suicide prevention programmes and their implementation in Europe, or the forthcoming Preventing Depression and Improving Awareness through Networking in the EU (PREDI-NU) project focusing on the use of e-health for action on depression.

\(^b\) The Standing Committee of European Doctors (CPME) has published two statements in support of the EU Mental Health Pact: Mental Health in workplace settings – ‘Fit and healthy at work’ (2009) and Mental Health in older people (2010), and adopted a third statement on mental health, combating stigma and social exclusion in November 2011.
1.3 A multi-stakeholder approach to depression: The Expert Platform on Mental Health – Focus on Depression

In response to the European Parliament’s call to support the implementation of the EU Mental Health Pact, the Expert Platform on Mental Health – Focus on Depression was established in September 2009 as a multi-stakeholder initiative gathering mental health experts, representatives of major organisations concerned with mental health in Europe and representatives of the European institutions as observers. Its goals are to raise awareness of depression at the EU and national levels, and put forward recommendations to promote the effective management of depression in support of the implementation of the EU Mental Health Pact and the five European Commission thematic conferences.

The Expert Platform contributed regularly to the preparation of the thematic conferences organised by the European Commission in the framework of the EU Mental Health Pact between September 2009 and March 2011.

1.4 Addressing key challenges in the field of depression and providing recommendations for action

The Expert Platform and its member organisations fully endorse the important recommendations that have come out of the five thematic conferences convened under the EU Mental Health Pact, including the need to fight the stigmatisation of depression, support mental health prevention and promotion and raise awareness of depression as an issue that affects all segments of society and therefore calls for a coordinated societal response.

Looking at the key outcomes of the five thematic conferences, the Expert Platform identified two issues that merit further analysis and assessment: early diagnosis and appropriate treatment of depression and the economic impact of depression. In the context of the implementation of the EU Mental Health Pact, and building on the momentum generated by the Hungarian Presidency’s Council Conclusions on Mental Health adopted in June 2011 and the invitation of a Joint Action
on Mental Health and Well-being between Commission and Member States, this paper seeks to analyse current challenges, gaps and opportunities with regard to these issues, and make recommendations concerning future action to European and national policymakers, health professionals, businesses, families and carers and people living with depression.

The paper analyses current challenges in the early diagnosis and appropriate treatment of depression and provides recommendations on how to address them. In particular, that part of the paper seeks to highlight critical issues in the management of depression, including the reduction or control of risk factors for depression (such as measures to reduce workplace stressors), as well as the need for early identification and adequate treatment of depressive disorders.

With regard to the economic burden of depression, the analysis provides evidence about the economic impact of the disease, including its direct and indirect costs, with particular emphasis on the economic burden of depression in the workplace. This part of the paper also describes the cost-effectiveness of interventions that could lead to improved prevention, early diagnosis and adequate treatment.

Finally, the paper provides an overview of the key findings and recommendations of a survey carried out by the Expert Platform to assess the state of mental health services for depression in the EU Member States. The aim of the survey, undertaken in collaboration with experts and Ministries of Health in the Member States, was to:

- understand how the needs of mental health services for depression are being met across the EU
- identify similarities and differences between EU countries in terms of access to appropriate mental healthcare services for depression
- make recommendations on what could be done to ensure better coordinated and more effective mental health services for people with depression.
2 Selected clinical and epidemiological features

Depression is the most common mood disorder,\(^4\) ranking in the top five morbidities for both men and women worldwide and with a social and economic impact that is estimated to be in the billions of Euros. Although mild depression – usually the precursor to later major depressive episodes – is often episodic, most people experience multiple episodes and residual distress. In some cases, depression can last for years.

WHO defines depression as “a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration”.\(^8\) These problems can become chronic or recurrent and lead to substantial impairments in a person’s ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of approximately 850,000 lives worldwide every year.\(^9\)

---

\(^4\) There is an on-going debate over whether the definition of mental illness should be as a ‘disorder’ or a ‘disease’; in this chapter, the term disorder is used.
Depression is associated with the loss of productivity at work, the risk of social isolation and impaired self-esteem, and should not be confused with brief reactive feelings of sadness and despair associated with a sudden loss or traumatic experience.

Depression has no single cause; people develop the disorder for different reasons.

Depression falls into two main categories. **Unipolar depression** is a chronic disabling condition that involves depression only. **Bipolar disorders** involve episodes of elevated or irritable mood (mania or hypomania) alternating with even more frequent depressive episodes over the life course. Both unipolar and bipolar disorders recur at high rates and are often chronic and associated with increased risks for subsequent episodes. Moreover, both are typically associated with a number of other comorbid psychiatric or medical conditions that often complicate the picture and worsen treatment outcomes.

In many cases, a major depressive episode can be one of a series of recurring episodes. In these cases, risk factors (like those listed in Box 2) can bring back symptoms. Approximately two-thirds of people in one study suffered at least one recurrence and the risk of relapse progressively increased with each successive episode. Causality is not proven, but every phase of depression increases a person’s risk of experiencing

---

**Box 2: Facts and figures (a, b, c)**

- At some point in their life, around one in five women and one in 10 men will suffer from a major depressive episode. At any given time, 3-5% of the adult population suffers from depressive disorders. The incidence of depression is high in both young people and the elderly.
- Each year, three in every 10 employees will be affected by mental health problems, of which depression is the most prevalent condition. It is associated with high rates of sick-leave, accidents, staff turnover and presenteeism (reduced work performance).
- WHO expects the incidence of depression to increase, especially in high- and upper middle-income countries, reaching 8.5% and 6.0%, respectively, of the total burden of disease in 2030.
- Two thirds of people with depression report severe interference with normal function – a considerably higher proportion than people with physical chronic conditions.
- Worldwide estimates indicate that approximately 80% of people who took their own life had recently suffered from (mostly untreated) depressive episodes. Therefore, early recognition of depression and early intervention can save many lives.

---

further phases of depression in the future. People with such relapses or recurrences are therefore particularly vulnerable and need to be considered when developing adequate management plans for depression.

While the well-being of people suffering from depression can be improved through better integrated, cross-sectoral care management, defining and improving sustainable healthcare systems that meet the needs of people with depression remains a significant social challenge. Related challenges range from a lack of financial resources and funding to a lack of cooperation between the many different stakeholders required for prevention and intervention initiatives. This includes countries that are federally administered, where many responsibilities rest with the autonomous regions, making cooperation difficult.\textsuperscript{12}

The burden imposed by depression is likely to increase in the future, impacting further on already stretched national healthcare services and reducing economic productivity. The total annual tangible cost of depression in Europe was an estimated €118 billion in 2004,\textsuperscript{d} corresponding to €253 per capita.\textsuperscript{13} In light of this economic burden, there is a strong case to be made for adequate assessment, diagnosis and treatment planning for those who are affected by severe mood disorders in order to ensure that these people receive the care and treatment that best corresponds to their specific needs, enabling them to have better lives, function better and to contribute fully to society.

\textsuperscript{d} This study included 28 countries (EU-25 plus Iceland, Norway and Switzerland) with a combined population of 466 million.
3  Promoting early identification and appropriate intervention

3.1 Early identification

Only one in two people with depression who visit a primary care professional is recognised as having a depressive episode and will go on to receive adequate interventions.\textsuperscript{14,15} Similarly, the fear of stigma is a frequent reason for people to postpone seeking help, thus delaying adequate diagnosis and treatment.\textsuperscript{16} At the same time, there is a risk of depression being misdiagnosed, with some people receiving treatment that is not suited to their particular condition. As a result, those people experience the debilitating effects of their disease, reducing their possibilities to interact with friends and family, function at work and contribute to society.

The goal of early detection should be to identify early symptoms of depression and provide interventions that are best suited to a person’s particular needs, bearing in mind his or her overall mental and physical health. At the same time, early identification of depression should aim to empower those affected to gain knowledge about their condition and seek the help they require. Early and correct diagnosis of depression will lead to better intervention outcomes for people living with depression and reduced costs for Europe’s healthcare systems in the long term.

3.1.1 Clinical staging model

Early identification is key to successful secondary prevention, effective interventions for depression and improved outcomes for people living with the disease. Clinical staging, which has been defined as a more refined form of diagnosis, has been introduced to facilitate identification, promote effective management and improve outcomes. Clinical staging differs from conventional diagnostic practice in so far that it tries to describe the extent of a person’s depression at a particular point in time. It defines the progression of a disease over time and identifies the patient’s position along the continuum of the course of illness, placing strong emphasis on a detailed description of where a person suffering from depression lies along that continuum.\textsuperscript{17}
A variety of physical diseases, particularly cancers, have used the concept of clinical staging models, and it has been proposed for the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-V). An example of a staging model that may be of interest is given below.


<table>
<thead>
<tr>
<th>Clinical stage</th>
<th>Definition</th>
<th>Target populations</th>
<th>Potential interventions</th>
<th>Indicative biological and endophenotypic markers</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Increased risk of anxiety or depressive disorder; no symptoms currently</td>
<td>First-degree teenage relatives of probands</td>
<td>Improved mental health literacy, psychoeducation for young person and family, including resiliency training</td>
<td>Trait marker candidates; SHTT short form and endophenotypes</td>
</tr>
<tr>
<td>1a</td>
<td>Mild or nonspecific symptoms of anxiety or depression, including neurocognitive deficits of severe mood disorder; mild functional change or decline</td>
<td>Screening of teenage populations; referral by primary care physicians, school counsellors</td>
<td>Formal mental health literacy, psychoeducation for young person and family, lifestyle interventions, simple CBT skills training</td>
<td>Trait and state candidates where feasible according to sample size, e.g. shortened REM latency</td>
</tr>
<tr>
<td>1b</td>
<td>Ultra-high risk: moderate but subthreshold symptoms of anxiety or depression, with moderate neurocognitive changes and functional decline to caseness (GAF &lt;70)</td>
<td>Referral by educational agencies, primary care physicians, emergency departments, welfare agencies</td>
<td>Psychoeducation for young person and family, lifestyle interventions, CBT skills training including problem solving</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>First episode of major depressive disorder; full-threshold disorder with moderate to severe symptoms, neurocognitive deficits and functional decline (GAF 30–50)</td>
<td>Referral by primary care physicians, emergency departments, welfare agencies, specialist care agencies, drug and alcohol services</td>
<td>Formal CBT as first-line treatment, including psychoeducation for young persons and family, lifestyle interventions concurrently; antidepressant agents for treatment of non-response or severe depression</td>
<td>Continue with markers of illness state, trait and progression</td>
</tr>
<tr>
<td>Clinical stage</td>
<td>Definition</td>
<td>Target populations</td>
<td>Potential interventions</td>
<td>Indicative biological and endophenotypic markers</td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
<td>--------------------</td>
<td>-------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>3a</td>
<td>Incomplete remission from first episode of care; could be linked or fast-tracked to stage 4</td>
<td>Primary and specialist care Services</td>
<td>As for ‘2’ with additional emphasis on medical and psychosocial strategies to achieve full remission</td>
<td>Continue with markers of illness state, trait and progression</td>
</tr>
<tr>
<td>3b</td>
<td>Recurrence or relapse of depressive disorder which stabilizes with treatment at a level of GAF, residual symptoms, or neurocognition below the best level achieved following remission from first episode</td>
<td>Primary and specialist care Services</td>
<td>As for ‘3a’ with additional emphasis on relapse prevention and ‘early warning signs’ strategies</td>
<td>Continue with markers of disease state, trait and progression</td>
</tr>
<tr>
<td>3c</td>
<td>Multiple relapses, provided worsening in clinical extent and impact of illness is objectively present</td>
<td>Specialist care services</td>
<td>As for ‘3b’ with emphasis on long-term stabilisation</td>
<td>Continue with markers of disease state, trait and progression, e.g. less external provocation to trigger even and increasingly negative information processing model</td>
</tr>
<tr>
<td>4</td>
<td>Severe, persistent OR unremitting illness as judged on symptoms, neurocognition and disability criteria; NB: could fast track to this stage at first presentation through specific clinical and functional criteria (from stage 2) or alternatively by failure to respond to treatment (from stage 3a)</td>
<td>Specialized care services</td>
<td>As for ‘3c’ but with emphasis on medication</td>
<td>Continue with markers of disease state, trait and progression</td>
</tr>
</tbody>
</table>

The clinical staging model provides greater utility for testing efficacy, cost-effectiveness, risk-benefit ratios and feasibility of available interventions. Clinicopathological correlates and predictors of illness stages can also be introduced within a neurodevelopmental framework. GAF = Global Assessment of Functioning; CBT = cognitive behavioural therapy

By using the clinical staging model approach, a variety of neurobiological, social and personal risk factors are integrated, enabling a clinical decision framework for individually tailored early interventions.20 The arguments for the promotion and incorporation of clinical staging models include the following:

- Traditional diagnostic systems, such as DSM-IV and the latest WHO International Classification of Diseases (ICD-10), are more appropriate to
people in the later stages of an illness and do not distinguish clinical changes that occur early in an illness from those that occur later.

- Once identified, clinicians can select treatments that are more relevant to earlier stages. For example, self-help strategies and psychoeducation can be utilized at earlier stages. These may take place across community and primary care settings.
- There are potential benefits in research, by helping to find biological changes that underlie mental disorders at different stages.

Representatives of people with depression should be consulted when developing these guidelines and devising training programmes.

One reason for the major contribution of depressive disorders to the burden of disease in Europe is that they start earlier than most physical disorders, commonly during childhood or adolescence. Modified staging models for use in children and adolescents do exist and their use should be promoted. By the same token, clinical staging models should be adapted for use in other risk groups, such as people in later life, men and women.

At the same time, some of the limitations of clinical staging models ought to be highlighted:

- In clinical practice, no staging model is routinely used and they have not (as yet) lived up to the promise of preventing transition to later stages.
- With various staging models, there remain unresolved important conceptual differences.
- There is no unified approach that can be applied across a broad range of mental disorders.
3.1.2 Providing adequate training for healthcare professionals

Another challenge in providing adequate interventions for people living with depression relates to insufficient awareness among the primary care physicians in some countries who treat people with depression.22

- Family doctors do not always receive relevant education to treat people with depression.
- Physicians have great difficulty providing treatment for people with depression and mostly use tranquilizers.
- Psychological and psychiatric issues are not very prominent in training provided for the physicians, yet they are expected to provide services for people with depression.

The above examples highlight the importance of adequate training for all mental health professionals and the need for greater collaboration between professionals. This is critical in light of the close links between mental and physical health, whereby people suffering from depression and other mental disorders are more likely to have physical health problems, and vice versa. Depression occurs in more than half of people who have experienced a stroke23 and in 10-25% of cancer patients.24 In people with chronic physical illness (including heart disease, musculoskeletal disorders, respiratory disorders and diabetes) depression is two to three times more prevalent than in healthy people.

One report assessed the effectiveness of inter-professional education interventions. One of these examined and evaluated the effects on improving the competence of mental health professionals (psychiatrists, nurses, therapists, case managers, residential staff, mental health workers, administrative support) working in community mental healthcare provider organisations. Interventions over a one-year period included presentations, discussions, small groups and role-playing techniques, as well as three or four full-day detailing site visits – plus an additional 16 hours spent with staff at the sites. Other interventions included team restructuring, tools such as posters, cue cards and questionnaires, measurement and feedback, and consumer-directed interventions. Mental health professionals in the intervention group, in comparison to those in the
control group, reported significantly higher scores overall and in relation to a number of competencies: teamwork, holistic approaches, education about care, rehabilitation methods. The study contained multi-faceted interventions, of which inter-professional education was only one component.²⁵

3.1.3 Early identification of depression in at-risk groups

Preventing mood disorders by intervening in the pre-symptomatic phase of depression has been acknowledged for decades. The Personal Assistance and Crisis Evaluation (PACE) clinic was established to access and intervene in vulnerable people who are possibly at imminent risk of mood disorders. Here, a ‘close in’ strategy focuses on individuals who have already developed some low-grade psychopathology. The authors reported that a clinic like this could contribute to the development of preventive measures.²⁶

Furthermore, the frequent contacts that pregnant women and mothers and their infants have with health services provide an opportunity for early intervention in the perinatal period for women who are at risk of developing depression in the postnatal period. No predictive tool used in the antenatal period has demonstrated adequate sensitivity, specificity or positive predictive value when applied to the task of predicting postnatal depression. However, individual supportive interventions in symptomatic or clinically depressed women, whether antenatal or postnatal, have proved to be of benefit. It has been concluded that whichever the psychosocial assessment and interventions chosen, these need to be well-validated, acceptable to staff and affected individuals, accessible and cost-effective.²⁷ This gives credence to the notion that health professional associations should provide training for gynaecologists, midwives and other healthcare professionals caring for pregnant women and new mothers in order to help them to identify women who are at risk or have developed pregnancy-related depression — enabling these professionals to encourage such women to seek adequate support.

Finally, given that physical health challenges may trigger depression, targeted early identification efforts are important among people suffering from physical illness, such as cancer or cardiovascular disease. One study examined the links between depression and coronary heart disease. It recommended: including routine screening for
depression in cardiac patients and, where positive screening results are found, further evaluation; monitoring cardiac patients who are under treatment for depression for drug efficacy, safety and interactions and treatment adherence; and coordination of care between respective healthcare providers.  

3.1.4 Detecting depression at home

Families and carers occupy a unique position in the provision of care for people living with depression. Family members and carers are often the first point of contact for depression sufferers and hence play an important role in detecting depression, often without specific training and knowledge on what constitutes effective care. Accordingly, psychosocial interventions should be promoted to provide them with education on the causes and treatment of mental illness, as well as coping strategies and community resources to promote early identification of depression.

Participation in such interventions has been found to increase the knowledge and coping ability of families, which in turn should help to alleviate to some extent the burden of depression that affects family carers themselves.  

Carers should be provided with additional adequate support mechanisms in order to enable them to care for people suffering with depression who are dependent on their support. Measures can take the form of social interaction through relatives' support groups or multifamily problem-solving groups. In addition, businesses have an important responsibility to provide families and carers of people living with depression with flexible and inclusive workplace policies that enable them to take time off work to care for their relative.

Finally, recognising the crucial role that family members and carers play in the detection process, it is logical that both EU and national policymakers should consult with these groups when developing policies and supporting services in order to ensure optimal care.
3.2 Adequate interventions

Studies into the treatment of mental health disorders, such as depression, have indicated that people suffering from these disorders are often undertreated. For depression specifically, it has been estimated that globally 56.3% of people remain untreated.\(^{30}\)

Conversely, studies have also suggested that some people, who did not have a diagnosable mental illness, received treatment nevertheless.\(^{31}\) These findings suggest that many healthcare providers have no effective treatment triage for separating individuals who are well from individuals suffering from moderate or severe mental health disorders and are in need of medical attention. Even in countries with the best healthcare resources available, problems of under treatment of mental health disorders such as depression can persist. For example, it has been estimated that 74% of Europeans with mental health disorders do not receive the treatment they require.\(^{35}\)

Depression is a complex mood disorder with many contributing factors. Therefore, it is understandable that a single treatment will not be effective for everyone. Various combinations of interventions may be needed to address different individual needs. Only one in two people with depression receives appropriate healthcare for his or her condition and/or does not respond adequately to specific interventions. All stakeholders should therefore promote the adoption of a person-centred approach to depression to ensure that these people receive the care and treatment that best corresponds to their specific needs. This approach is vital to ensure that people suffering from depression can have better lives and function better in society.

Depression has been a focus for the development of various approaches to psychotherapy with proven effectiveness and practical usefulness. These include cognitive behavioural therapy (CBT) and interpersonal psychotherapy. A substantial part of the outcome depends not only on the right approach, but also the qualities of the therapist and the therapeutic relationship. Therefore, therapist training and selection - as well as on-going quality assurance (for example, using patient questionnaires) - are important issues. Considering its effectiveness and side effects, psychotherapy can be considered a treatment choice for light and moderate
depression when qualified psychotherapists are available, but personal preferences also should be given weight.  

Despite the large number of available anti-depression medications, there is a need for new innovative treatments that are tailored to the specific needs of a person suffering from depression. In particular, many people do not respond well to depression medication, which leads to serious long-term consequences for their well-being and participation in society. Some people receiving medical treatment for depression continue to experience residual symptoms of the disease, in particular an impairment of cognitive functions (ability to process information, attention, learning and memory). These people suffer from prolonged absences from work, are not able to function fully in their job, are at increased risk of committing suicide, etc. New treatment interventions are therefore needed to help these people to cope with their condition and enable them to lead an improved life and contribute fully to society.

Some studies have shown improvements in the long-term effects of psychotherapy alone or a combined therapy using CBT and anti-depressants. Other studies highlight the effectiveness of a combination of CBT and pharmacological therapy in lowering the number of relapses (evaluated after 4.5 years) and demonstrate the improved long-term effects of a pharmacological therapy when used an additional psychotherapeutic intervention.

Another important element in providing adequate interventions for people living with depression is the need for affected people themselves to become equal partners in the management of their condition. People living with depression need to be empowered to seek the help they need and participate in choosing the most suitable treatment. In this context, decision-makers and other stakeholders need to recognise the importance of self-help groups in supporting people with depression to manage their condition and should support actively people living with depression in establishing such groups. In a similar vein, and with a view to promoting patient empowerment, decision-makers should consider establishing a sick fund in order to finance the provision of psycho-education for people living with depression and their family members and carers.
3.2.1 Age groups

Young people are especially likely to have their depression go unrecognised and ultimately untreated.\textsuperscript{41} One study looked at the efficacy and safety of a selective serotonin reuptake inhibitor (the standard first-line treatment in Europe for depression) compared with placebo in the treatment of children and adolescents living with major depression. It found that the drug treatment reduced depressive symptoms in the young people generally, and was an effective intervention in children.\textsuperscript{42}

A review of the psychological treatment of depression in children found that the most promising psychological interventions were individual rather than family therapies. Although not conclusively demonstrated, CBT was effective for depressive symptoms and mild depressive disorders.\textsuperscript{43}

Age-specific therapy groups focusing on topics such as mastering the loss of loved ones, increasing potentials, including experience time available for personal use, have been reported on. In particular, group therapy that also promotes social interaction was deemed to be an effective and cost-effective form of treatment.\textsuperscript{44} However, further evidence is needed to corroborate these findings.

The findings do suggest that both medication and psychotherapy should be specific to the age of the person undergoing treatment for his or her depression and should take account of each individual’s particular needs.

3.2.2 Depressed people with physical illness

According to one study, non-pharmacological treatment for people with depression and chronic physical illness is most effective when an intervention is aimed at solely reducing depression. While the efficacy of non-pharmacological interventions was similar to that in people with depression without chronic physical illness, further research is needed to validate this evidence.

The efficacy of a selective serotonin reuptake inhibitor for people with diabetes suffering from depression was evaluated in another study. On one rating scale for depression, there was a 14% reduction in depression symptoms in people receiving the medication, compared with 8.8% in people taking a placebo; on another, there was a
10.7% reduction in depression symptoms in people receiving the medication, compared with 5.2% in people on placebo. Also, the percentage of people who were receiving had achieved a significant improvement in depression was higher.45

On the other hand, a review looked at medication or psychological interventions in the prevention of depression in people with stroke across multiple trials. That study found that neither medication nor psychotherapy had an effect on the prevention of depressive illness, disability or other outcomes. A small but significant improvement in mood was evident for psychotherapy; however, this treatment effect was from a single trial. The conclusion was that more evidence is required before any recommendations can be made for the routine use of such treatments to improve recovery after a stroke.46

Conclusively, it can be said that in people with physical illness, both medication and psychotherapy should be considered depending on the person’s particular circumstances.

3.2.3 Depressed people with psychiatric conditions
A systematic review and meta-analysis was conducted to quantify the efficacy of antidepressant medications to treat combined depression and substance use disorders. It was found that antidepressant medication provided a modest beneficial effect for people with combined depressive and substance use disorders. Also, concurrent therapy directly targeting addiction provided a treatment benefit. However, there were variations in the strength of the effect and further research is needed.47

An example of an intervention using psychological treatment in depressed people with a psychiatric condition was the evaluation of a therapist- versus computer-delivered psychological treatment for people with comorbid depression and alcohol/cannabis use problems. The results showed that depression responded better to intensive motivational interviewing and CBT compared with a brief intervention alone, with ‘live’ treatment demonstrating a strong short-term beneficial effect that was matched by computer-based treatment at 12-month follow-up.48
Adequate training for all mental health professionals should be developed so that suitable interventions for comorbid mental health conditions – for instance, whether one medication and/or psychotherapy would be sufficient for both conditions – can be recognized.

3.2.4 Maintenance treatment

Maintenance treatment is generally recommended where relapses have occurred in the past. In every case of less-than-complete remission, maintenance treatment is recommended. Often, different healthcare professionals use only one form of treatment. A psychotherapist, for example, may only use a psychodynamic approach; a medical doctor may only use benzodiazepines.

Motivating a person for long-term maintenance treatment is also an important factor; side effects (time needed and costs for psychotherapy, the physical side effects of medication – such as sexual dysfunction and weight gain) are important obstacles. An analysis of different treatment studies with a 12-month follow-up window found that 60% of patients fell back into depression following acute therapy with antidepressants, while only 29.5% fell back into depression following CBT. The analysis therefore suggests that antidepressants are not always effective in treating depression, and that there is a need for new treatments in this context.

Another review of maintenance treatments for depressive conditions explored the optimal duration of treatment to prevent relapse. It was found that antidepressants reduce the risk of relapse in acute depressive disorders and continued treatment with antidepressants would benefit many people with recurrent depressive disorder. For each person, the treatment benefit will depend on his or her absolute risk of relapse, with greater benefits for those at higher risk.

The role of long-term medication and psychotherapy in the prevention of relapse and recurrence in depression was explored in another study. This stated that the body of data supports continuation medication for the prevention of depressive relapse and recurrence in people who are at high risk of relapse or recurrence. Those depressed people who are at high risk of recurrence need longer maintenance treatment, perhaps indefinitely. As outlined earlier, psychotherapy – alone or combined with medication –
has been shown to be effective in preventing further episodes of depression, and plays an important role in preventing chronicity and the development of resistance to treatments. People who lack treatment adherence may need to be monitored by outreaching professionals, such as community mental health nurses, to prevent severe depressive or manic episodes.

In light of the above, the benefits of both medication and psychotherapy maintenance treatment should be highlighted in the prevention of relapse and recurrence in depression.

Successful intervention strategies to manage depression require a holistic approach – combining the use of medication and psychotherapy. In particular, there is a need for new innovative treatments to curb the burden of depression in people who do not respond to available treatments. Particular attention should be paid to people who display residual symptoms of depression, in particular impaired cognition (lack of attention, reduced ability to process information), which severely impacts their functionality and hence prevents them from contributing fully to society.

3.2.5 Conclusions

It should come as no surprise that not everyone with depression receives adequate management for their disorder. Delays in accurate diagnosis and untreated depression can have adverse consequences, including comorbid alcohol/substance abuse, domestic conflicts and suicidal behaviour. Therefore, early recognition and successful treatment, as well as long-term monitoring, are important to reduce the risk of adverse complications, including suicide. The adoption of a consensus paper also should be considered on how to improve cooperation among the different disciplines involved in the diagnosis and management of depression in order to provide healthcare that is tailored to the needs of people living with the disease.

Some of the challenges that exist in the early diagnosis and treatment of depression across Europe are linked to low awareness and deficient health literacy, stigma related to depression, deficient capacity (expertise to diagnose, staffing levels) and a lack of interventions to help family carers to cope with their relative’s depression or prevent a depressive episode in themselves. It is therefore necessary to ensure that mental
health professionals who treat people with depression have received the relevant education, in order to avoid difficulties in providing treatment for people with depression and the overuse tranquillizers. Similarly psychological and psychiatric issues should become more prominent in the education of the general practitioners and nurses to enable them to provide effective services for people with depression.
Early diagnosis and treatment of depression are key aspects in the management of this disorder.

- Early diagnosis is the responsibility of the cross-sectoral team – physicians, nurses, midwives, therapists, etc. – and could be supported by the use of identified clinical staging models for different groups. In this context, health professional associations should promote the development and implementation of primary care guidelines for the diagnosis and treatment of depression, including training for primary care professionals to deliver healthcare according to those guidelines. Representatives of people with depression should be consulted when developing these guidelines and devising training programmes.

- National policymakers should fund initiatives to raise awareness among people who work outside the healthcare system with vulnerable groups (including adolescents, older people, carers of people with mental diseases, those subject to social care) and to establish reporting channels to promote case-finding and ensure adequate management.

- Any intervention, whether medication or psychotherapy, needs to be tailored to a specific individual and delivered at the right time. The combined use of medication and psychotherapy has been shown to be more effective in preventing relapse than any single therapy alone. Healthcare professionals therefore should promote this intervention further.

- In particular, there is a need for innovative treatments to manage depression in people who resist prevailing treatments and display residual symptoms of depression that prevent them from functioning fully. Such innovative treatments will enable those affected to have better lives and contribute fully to society. In particular, national-health budget holders should assess possibilities for the reimbursement of new depression medicines that address unmet medical needs in people with depression – including those who experience residual symptoms of the disease. Equally, dedicated funding should be made available for transnational research projects exploring the use of innovative options in the management of people with depression, such as access to internet-based therapy or telephone case management.

- People living with depression should be empowered to participate in choosing the treatment that is best suited to their needs. National stakeholders should
therefore consult with representatives of people with depression when taking decisions about the reimbursement of drugs and therapies since these representatives are an important source of information regarding therapy and medication adherence and are in a position to identify inefficiencies.

- With regard to carers and families of people living with depression, EU and national policymakers should promote social services and support programmes, such as training schemes, that are aimed at integrating family members and carers into society and into the labour market specifically. Businesses should be called on to devise flexible employment conditions that would allow family members and carers to provide appropriate care to their relatives.
4 The economic burden of depression

4.1 The cost of depression in Europe

4.1.1 Quantifying the overall cost
For governments and policymakers, the wide prevalence of depression and its disabling symptoms represent not only a huge public health challenge but also a substantial – and potentially growing – economic cost for society.

The total annual tangible cost of depression in Europe was an estimated €118 billion in 2004, corresponding to €253 per capita. Depression has been identified as the most costly brain disorder in Europe, accounting for 33% of the total cost of brain disorders. The cost of depression is equal to 1% of the total economy of Europe (GDP).

Indirect productivity costs due to morbidity (sick leave and early retirement) and premature death

Box 3: The economic burden of depression
The economic burden of depression manifests itself in a various ways:

- **Direct costs** – healthcare (including primary care, outpatient, inpatient and pharmaceutical costs); non-medical costs (including social care services and transport); and additional private costs carried by people living with depression and families.

- **Indirect costs** – morbidity and mortality costs, including productivity losses due to absence from the workplace (sick leave), long-term unemployment, early retirement and premature mortality, and reduced productivity at the workplace through presenteeism (poor performance while at work); lower tax revenues; higher benefits payments; other public expenditure costs; and additional private costs. Depression also can impair the employment and income of family members who have to spend time supporting their loved ones.

- **Intangible costs** – a monetary value can be assigned to the negative impact of depression on quality of life, including the pain and suffering associated with the disease (for the person with depression and his or her family and friends), the restrictions on social functioning and the impact of suicide.


* This study included 28 countries (EU-25 plus Iceland, Norway and Switzerland) with a population of 466 million.
accounted for almost two-thirds of the total cost. As a consequence, the majority of the costs were in the working population (89%) – far higher than for older people (11%). This analysis did not include the cost of presenteeism (poor performance while at work), which would have further increased the proportion of costs arising in the workplace.

Direct costs accounted for just over one-third of total costs, with outpatient care the biggest element; drug costs accounted for less than 8% of the overall total cost. The profile of the cost burden associated with depression contrasts sharply with that of conditions like diabetes and cardiovascular disease, where direct costs represent the majority of the overall cost. The level of lost productivity estimated in this depression model, for instance, is more than twice that estimated for cardiovascular disease in the EU (€35 billion).

4.1.2 Variations across EU Member States

Data on individual European countries are often incomplete or inconsistent, making it challenging to draw comparisons, but the overall cost of depression is estimated to vary considerably across Europe (Figure 1).

Figure 1: Cost in Euros per patient with depression in Europe (€ Purchasing Power Parity 2004)
According to this analysis, the total average costs across the different countries ranged from €1,175 to €8,006 per patient. Generally, estimates have shown that the total cost of depression was highest in countries with high national income and high healthcare expenditure per capita.55

4.1.3 The cost of mild and moderate depression

The overall economic costs to society associated with mild and moderate depression are considerable and approach those of severe depression due to their high prevalence.

A study in the Netherlands found that the 2003 annual costs of mild and moderate depression were $2,141 per person, compared with $3,313 for major depression, for adults aged 18 to 65.56 However, due to the higher prevalence of minor depression, the overall costs of mild and moderate depression per 1 million population were $160 million per year, not far behind the $192 million for major depression.

The study concluded that mild and moderate depression represented an important public health challenge and that “large-scale treatment of minor depression will probably result in increased medical costs, but may be cost-effective from a societal perspective”.57

4.1.4 The cost of suicide

Suicide is a major cause of premature deaths in Europe, with a standardised suicide death rate of 10 per 100,000 population in 2008 across 27 EU Member States (EU-27).58 In fact, around 60% of suicides are associated with mood disorders, principally major depression and bipolar disorder.59

The overall economic impact of suicide is profound. It is estimated that the average cost per completed suicide for a person of working age in England is £1.67 million (at 2009 prices), and £1.45 million for all suicides.60,61 This includes intangible costs (loss of
life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

There are also costs to the public purse from recurrent non-fatal suicide attempts; these are more difficult to estimate, and vary by means of suicide attempt.\textsuperscript{62} One study indicates that only 14\% of costs are associated with accident and emergency attendance and medical or surgical care; more than 70\% of costs are incurred through follow-up psychiatric inpatient and outpatient care.\textsuperscript{63} This is in part because a proportion of individuals who survive suicide attempts are likely to make further attempts, in some cases fatal.

### 4.1.5 The cost of depression in women

The early onset of depression in women was associated with a 12-18\% reduction in future earnings, compared with women who suffered depression after age 21 or never in one study. It was suggested this was due to the role of early depression in reducing the likelihood of affected women proceeding to higher education.\textsuperscript{64}

An analysis of employees at a Fortune 100 company concluded that, on average, a female employee with depression cost the company $9,265 compared to $8,502 for a male employee.\textsuperscript{65} The women had lower medical costs than comparable men, but generated significantly greater costs associated with absence from work.

Depression associated with childbirth is a particular aspect of female depression.\textsuperscript{66} The economic costs of post-natal depression are conservatively estimated at £45 million for England and Wales.\textsuperscript{67} This includes additional health- and social care costs, but does not include indirect costs to society, such as lost productivity due to a mother’s reduced ability to return to work or work at full capacity.

### 4.1.6 The cost of depression in older people

Because older people have usually left the workforce, the costs of depression in older people stem from an increased utilisation of healthcare, rather than the productivity losses associated with depression in younger adults. Studies suggest that the healthcare costs for older adults with depressive symptoms are around 50\% higher than for those
The association between depression and total costs remains significant after adjusting for age, sex and severity of chronic medical illness.

Further concerted action is required to address the prevalence of depression among older people, which too often goes unrecognised and entails not insignificant economic costs.

4.1.7 The cost of depression in children and young people
Relatively little is known about the long-term economic impact of childhood depression. General and psychiatric inpatient services are thought to account for the biggest costs, although criminal justice-related costs have been found to be much higher for those with a comorbid conduct disorder, compared with depression alone. There are also significant further costs arising from lost employment and the economic burden associated with the high levels of suicide and suicide attempts among individuals who had been diagnosed with depression in childhood. The workplace performance of parents whose children suffer with depression also may be a cost factor.

4.1.8 Cost impact of physical/mental comorbidities
Comorbid depression and physical illness may delay recovery from both the mental and physical disorders and worsen health outcomes – with a consequent impact on direct and indirect costs and quality of life. Research suggests that the negative impact of depression on physical health leads to higher healthcare utilisation and spending, most of which is not the result of depression treatment costs.

The two-way interaction between depression and physical ill health has significant cost implications. While evidence on the incremental costs of comorbid physical illness is limited, one study found healthcare costs to be 70% higher in people with comorbid depression than in people without depression. The majority of the increase in healthcare costs associated with comorbid depression may be accounted for by an increased number of medical visits for medically unexplained, minor somatic symptoms, such as headache, abdominal pain and fatigue.

People with a primary physical illness diagnosis of diabetes who also have depression may have costs that are between 1.7 and 4.5 times greater than those generated by
people who have diabetes alone. Evidence shows that comorbid depression exacerbates the complications and adverse consequences of diabetes, in part because depressed people may manage their diabetes poorly, which increases the risk of disability and premature mortality. There are also substantial indirect economic consequences from lower productivity due to reduced work performance, increased absenteeism and withdrawal from the labour force.

The presence of a physical illness can complicate the assessment of depression, and some symptoms, such as fatigue, are common to both mental and physical disorders. At the same time, awareness of the extra costs associated with comorbid depression and physical disease potentially can lead to appropriate interventions being undertaken and a reduction in long-term healthcare costs.

4.2 European public investment in depression

There are marked variations across Europe in the percentage of the health budget spent on mental healthcare, and considerable differences in how the boundaries are drawn around mental health in the health system accounts of different countries. In some European countries, only one-third of those with depression and anxiety disorders access mental health services, regardless of the need for out-of-pocket payments. As outlined in the previous chapter, while the perceived stigma around mental health problems partly explains why some people do not seek help for depression, the availability of appropriate services also can be a reason. Of those people with mood disorders who have been in contact with the health services, only approximately half receive adequate treatment.

A greater awareness of the impact of depression on quality of life and the associated economic burden has encouraged an increase in the implementation of prevention programmes. In the Netherlands, the prevention of depression was one of five priority areas in the national public health policy for the period 2007-2010. A Depression Prevention Partnership was established, and access to evidence-based interventions aiming to prevent depression is a specific priority within its framework. Raising awareness of mental health problems and developing e-health solutions, such as
web-based depression prevention courses, are among the measures to improve access to mental-illness prevention.\textsuperscript{83}

In the UK, the Government has committed itself to investing around £400 million over four years to ensure that adults with depression or anxiety in all parts of England have access to a choice of psychological therapies. The investment will enable also the expansion of psychological therapies in services for children and adolescents.\textsuperscript{84}

4.3 Impact in the workplace

Lost productivity is the principal factor in the economic burden of depression. The economic costs include increased absenteeism, presenteeism, long-term unemployment, early retirement, premature retirement as a result of caring for a family member with mental illness, and premature mortality among working-age people with depression.

For businesses across Europe, depression is a significant cause of lost productivity in the workplace. Poor mental health can impact also on the employment and income of family members who have to spend time supporting their loved ones.\textsuperscript{85} For all these reasons, productivity losses have increasingly been the focus of research and policy attention in recent years.

In Europe, people with major depression report more than seven times as many working days lost as people without any mental disorder, and they lose more working days than people with heart diseases or diabetes.\textsuperscript{86} People with major depression report, on average, about 25\% of lost working days, while sufferers of heart diseases or diabetes report 18\% and 12\%, respectively.\textsuperscript{87} Two-thirds of people with depression report severe interference with normal functioning – a considerably higher proportion than people with physical chronic conditions.\textsuperscript{88}

In Finland, for example, over 200,000 people suffer from depression each year, which led in 2007 to about 2.5 million lost working days.\textsuperscript{89} Since the mid-1990s the number of depression-related disability pensions in Finland has almost doubled, generating a cost
of around €519 million in 2009.\textsuperscript{90} In the UK, a survey suggested that 11.4 million working days were lost in the period 2008-2009 due to work-related stress, depression and/or anxiety; this equates to 27.3 days lost per affected worker.\textsuperscript{91} The average annual cost from lost employment due to depression is estimated at £7,226 (2005/06 prices) in England.\textsuperscript{92}

Studies of the number of additional sickness days accounted for by depression demonstrate part of the economic burden of the illness. However, they underestimate the total cost if they do not also take into account lost productivity due to presenteeism. Research suggests that the productivity costs of employees not functioning effectively while at work may be two to six times the costs of absenteeism.\textsuperscript{93,94,95,96}

Depression also appears to be a key determinant of whether a person who has suffered a physical illness will return to work. For instance, in the 20\% of people who have a stroke who are under 65, “the presence of depression one month after the stroke more than halves the likelihood that the person will return to work, regardless of the level of physical impairment. After a heart attack, virtually all the factors influencing whether the person becomes work disabled occur above the neck.”\textsuperscript{97}

Last but not least, the economic burden of depression on families and carers of people living with the disease must not be overlooked. Many family members need to take

---

**Box 4: Case study – Electricité de France and Gaz de France**

In France, Electricité de France and Gaz de France implemented the APRAND programme (Action de Prévention des Rechutes des troubles Anxieux et Dépressifs) for their 140,000 employees. The aim was the early identification of anxiety and depressive disorders by company occupational health physicians, as well as by primary care doctors and social workers. Results indicate that of those workers on long-term sick leave identified as having anxiety or depressive disorders, the cohort that subsequently participated in additional preventative activities had a 10-20\% higher probability of recovery or remission at 12 months, compared with those who received usual care alone. (e)

time off work to care for their sick relative, and often face problems of integration in the workplace and lack of participation in society.

As the above evidence suggests, lost productivity is a key contributor to the costs associated with depression. This being the case, it is logical to conclude that further concerted efforts are needed to ensure that this indirect impact is not overlooked. One way to do this would be to include an evaluation of the indirect costs of depression in health technology assessments.

4.4 The role of business in addressing depression

Over the past decade, companies increasingly have recognised that they have much to gain from improved mental health in the workplace, and that there can be a financial benefit from investing in programmes that support the early diagnosis and treatment of depression.

Some risk factors for depression are outside the control of an employer but others are directly connected with the workplace. A poor psychosocial working environment - including unrealistic high demands on staff, low opportunity to contribute to decision making, poor promotion prospects, poor management, inequality, insecurity and the threat of harassment or even violence – increases the risk of poor mental health, particularly depression and anxiety.98

On the other hand, as concluded by the Organisation for Economic Co-operation and Development (OECD), good-quality jobs, good working conditions and, in particular, good management can play a crucial role in successfully addressing mental health illnesses like depression.99

To help workers suffering from depression deal with working conditions, employers may also consider organizing training sessions on coping behaviour, developing skills in order to be able to handle stress factors in the work. At the same time it is important to train the management level on aspects of detecting employees with mental health complaints enabling them to show interest and offer support where necessary.
Mental health might be just one part of an employer’s broader well-being strategy. Such programmes offer the potential for a range of commercial benefits. Not only can improved levels of psychological and physical well-being be associated with improvements in workplace performance, they also can help to improve the level of staff retention, enhance employee-employer dialogue, encourage greater levels of creativity and innovation and improve the reputation of the workplace.\textsuperscript{100}

Measures to prevent depression can either focus on the entire employee population or target high-risk groups. For the former, the employer “could examine company culture and its impact on employee work-life balance and determine if changes could be made that could positively impact the entire employee population.”\textsuperscript{101}

Employers should consider also the specific role of families and carers and put in place adequate support systems to provide them with the flexibility they need to care for their relatives with depression.

An important question for Member State governments is whether health and social security systems should invest more resources in collaboration with business and employees to improve workplace mental health promotion.\textsuperscript{102} Such initiatives do not only have a place in the private sector; public sector organisations are major employers and have much to gain from reducing lost productivity through depression. Whether a public or private enterprise, it is vital that organisations recognise their critical role in screening for and treating depression.

4.5 Making an economic case for action

In assessing depression interventions, it is important to consider the effectiveness of the intervention (and for whom and in what circumstances) and the cost of any investment – the cost of trying to diagnose and treat the depression, for example.\textsuperscript{103} For the government or organisation making the investment, this raises the question of whether the intervention is likely to produce savings in the future (for example, to business or the public purse) that can be offset against the cost of the intervention. At best, savings (or any reduction in future costs) could mean that the intervention ‘pays
for itself over time, or is net cost-saving. The timescale over which any savings are likely to be realised is an important consideration in such an assessment.

Through this type of cost-offset analysis, it may be possible to mount a business case that extra investment today can lead to reduced costs in the future.

Whether or not a healthcare intervention improves outcomes or quality of life at a price that society is willing to pay is a more sophisticated question. This allows different interventions for the same condition to be compared with each other and against interventions for different illnesses. Evidence of this type of comparative cost-effectiveness is needed to ensure that scarce resources are deployed most effectively. Cost-effectiveness studies commonly report the cost-effectiveness of a new intervention in terms of the cost of an additional quality-adjusted life year (QALY) relative to usual care.

Given the substantial economic burden that depression presents to society, evidence that depression interventions are cost-saving or more cost-effective than current interventions may encourage greater public investment in the diagnosis and treatment of the disease. Similarly, with the costs of depression falling disproportionately on employers, businesses may be persuaded to invest in depression interventions if they believe that workplace initiatives can be cost-saving or cost-effective from a business perspective.

As shown below, evidence from existing research suggests that the overall economic burden of depression potentially can be lowered through effective early diagnosis and adequate treatment, especially if the intervention reduces the negative impact of depression on workforce participation.

4.5.1 Early identification of depression and early intervention
One of the factors behind delayed diagnosis of depression is the stigma around mental illness that inhibits people from coming forward to seek help. The opportunities for early diagnosis and early intervention would be improved if these perceptions could be changed. It has been estimated that if an anti-stigma campaign increased the number of
people with depression accessing services, the net economic benefits from people staying in or returning to work would amount to £421 per person with depression.\textsuperscript{104}

**Box 5: Screening of post-natal depression**

In England, the National Institute for Health and Clinical Excellence (NICE) recommends the screening of post-natal depression as part of routine care. However, in practice a significant proportion of women with post-natal depression are missed in primary care (f,g). In this context, health visitors (community health professionals) are well placed to provide screening for postnatal depression, with early interventions for those suffering from, or at risk of developing, depression (h). A range of UK trials with interventions provided by health visitors have been positive: women were more likely to recover fully after three months (i); targeted antenatal intervention with high-risk groups was shown to reduce the average time mothers spent in a depressed state (j); and a combination of screening and psychologically informed sessions with health visitors was clinically effective at six and 12 months after childbirth (k). This latter type of intervention – either universal or targeted at high-risk groups – was modelled by the London School of Economics (l), with the highest costs arising from training and the additional time spent by health visitors with mothers. Over one year, there were no cost savings when considering solely the impact on mothers of reduced postnatal depression (and not including the wider impact on fathers and infants); when quality of life benefits to women were incorporated, the intervention provided a positive net benefit at around £4,500 per QALY.


In addition, people living with depression need to be empowered to take ownership of their condition and overcome self-stigmatisation.

A more direct approach is through screening programmes for the early detection of depression, followed by appropriate early access to specialist advice and support, and there is some evidence that this can be cost-saving and/or cost-effective. In several of
the studies, it appears that staff with depression can be helped to stay at work by being offered some form of psychological therapy.

In the workplace, a strong case can be made to employers that initiatives aimed at early diagnosis and intervention can be significantly cost-saving in the short term. One modelling exercise assessed a workplace-based screening and enhanced depression care programme in the UK. The intervention consisted of completion by all employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. It was assumed that those identified were offered a course of CBT paid for by their employer. Over a two-year period, the return to the employer approached £5 for every £1 spent. This intervention has been shown in a number of studies to be effective in tackling depression and reducing productivity losses in various workplaces.

While the evidence is incomplete and often nuanced, workplace and primary care-based screening and early intervention programmes appear to offer the potential for short-term cost-savings. More research is needed to confirm this correlation.

4.5.2 Adequate treatment

Historically, the majority of studies into the cost-effectiveness of anti-depressants only consider direct healthcare costs, but there is nevertheless evidence that pharmacological treatments reduce absenteeism and reduce productivity losses. It has been estimated that if anti-depressant medication were given to people suffering from moderate or severe depression who are in contact with services but not receiving active treatment, the costs of treatment would be exceeded more than nine times by the economic gains of extra employment.

As anti-depressants come off patent, and therefore become cheaper, the cost-offset and cost-effectiveness properties of pharmacological interventions become more favourable.

Psychological treatments include interventions such as CBT, cognitive behavioural analysis system of psychotherapy, interpersonal psychotherapy, counselling, psychotherapy and couples therapy. There is limited evidence of the cost-saving
potential and cost-effectiveness of psychological therapies, particularly when compared directly to pharmacotherapies.\textsuperscript{109}

CBT may be more effective but also more costly than usual care, requiring an examination of the willingness to pay for an improvement in effectiveness\textsuperscript{110} – although studies that include the wider impact on indirect costs indicate the potential for overall cost savings.\textsuperscript{111} The relapse rate for CBT has also been found to be lower than for anti-depressants in follow-ups of individual trials.\textsuperscript{112} Psychotherapy has been proven to be cost-effective for some groups of service users.\textsuperscript{113} When compared to anti-depressants, the evidence is mixed as to which is the most cost-effective strategy.

CBT can be provided face to face, by telephone or via computer, with reduced costs if the intervention can be delivered on a self-help basis. Computerised CBT is effective and cost-effective in addressing depression among workers.\textsuperscript{114,115} An appraisal by NICE in England of low-intensity psychosocial interventions for depression found that a computerised package, Beating the Blues, demonstrated an incremental cost per QALY over usual treatment of £1,801 – well below normal cost-effectiveness thresholds.\textsuperscript{116} NICE commented that, as the licence fee for Beating the Blues comprised 73% of the total intervention cost, greater cost-effectiveness would be achievable from a similarly effective computerised package with a lower licence fee.

Psychological therapies can be used instead of anti-depressants, or in conjunction. The demand for both is increasing. For instance, in England from 2006 to 2010, the number of prescriptions for selective serotonin reuptake inhibitors, the most commonly prescribed group of anti-depressants, rose by 43% to nearly 23 million per year.\textsuperscript{117} This increase occurred despite improved access to ‘talking therapies’; in the last year alone, referrals for talking therapies rose four-fold to nearly 600,000.

The provision of enhanced depression care in a primary care setting has been shown to have productivity benefits. Among employed people, it led to a higher chance of being in employment after one year (92% compared with 82%) and fewer workplace conflicts, and was considered to produce economic benefits through reduced staff turnover, increased tax revenues and reduced welfare payments.\textsuperscript{118} The enhanced intervention included an initial meeting with a nurse care manager to discuss treatment
options and address identified treatment barriers. Regular telephone or face-to-face contact was maintained for five to seven weeks, followed by telephone contact over 12 months.

Collaborative care (with a care manager) also appears effective in treating older people affected by depression. Collaborative care entails physicians and other providers using complementary skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each other’s skills and knowledge. One case study suggested that 45% of people in collaborative care aged over 60 had a 50% or greater reduction in depressive symptoms, compared with 19% of participants in usual care. The cost of the intervention was about US$553 per patient over 12 months, described as “relatively modest” given the potential savings from avoiding the increased healthcare costs associated with older people with depression.

There is very limited evidence regarding the cost impact specifically of depression treatments for children and adolescents.

Overall, the evidence base for the economic impact of depression interventions remains sparse and any conclusions depend on the choice of indirect costs included in analyses. For this reason, while effective treatment of depression appears cost-effective compared with other healthcare interventions, the evidence on whether the costs of treating depression are offset by reductions in healthcare costs and/or productivity losses remains equivocal. This points to the need for further research in this area.

4.6 The way ahead

There is considerable evidence to suggest that the economic burden of depression in Europe is substantial and likely to grow over coming decades. In many countries in Europe, depression and its costs remain under-researched, and the condition and its impacts are under-recognised by key decision-makers. Further work is needed on the costs of depression in sub-populations, including women, children and adolescents, and people with comorbid mental health conditions.
The economic evidence base for depression interventions is limited. Moreover, from a European perspective it is an additional challenge that a majority of the existing studies relate to the US, and results from economic evaluations do not easily transfer from one country to another “because of differences in system structure and financing, leading to differences in relative costs”. Caution must be exercised, therefore, in generalising the results of US-based studies “and there is an urgent need to undertake more European assessments” and explore the potential to adapt US studies to differing European contexts. There are additional caveats when over-viewing the evidence: many studies are based on small samples of patients; and many of the cost/savings evaluations come from simulation models rather than direct observations.

Nevertheless, the evidence is growing that a business case can be made for greater investment in depression interventions, particularly when the economic analysis includes indirect costs from lost productivity. Although reducing the economic burden should not be the primary focus of depression policy, evidence that interventions potentially can save money may serve to promote investment in depression at a time of tight budgets. One challenge for policymakers is that the costs and savings often accrue to different parts of the economy. For instance, additional net healthcare costs may be offset by reduced productivity losses for employers.

Cost-effectiveness studies also demonstrate that improvements in quality of life often can be achieved for people with depression at a price that represents good value for money compared with other healthcare interventions.

Given that a large proportion of the overall cost of depression falls on business, and that there is evidence that interventions at the workplace can be cost-saving for organisations even in the short term, there appears to be an important role for employers in helping to tackle depression. Public sector organisations in many countries are major employers, of course, and should explore opportunities to invest in the mental health of their workforce. In the private sector, many of the established examples of mental health initiatives are in large companies, and policymakers may wish to consider providing financial incentives to encourage small and medium-sized enterprises – which otherwise might not have sufficient resources to invest in effective workplace mental health interventions. At the same time, it is imperative that
population groups not in the workforce or not seeking employment are not neglected, even though the (narrow) economic case for action might be harder to make.

Based on the above, the following recommendations can be made:

- Existing research on the economic and social costs of depression should be compiled by the European Commission, in cooperation with Member States, in a centralised information resource to serve as a reference base for interventions and further targeted research.
- National decision-makers should ensure that the indirect economic impact of depression in terms of lost productivity is not overlooked, by including indirect costs in health technology assessments.
- As highlighted above, the potential impact of addressing depression in the workplace is great. Decision-makers, particularly at European level, therefore, should take the initiative to ensure that benefits that can be won in the workplace setting are fully exploited. The European Commission, for instance, might consider facilitating roundtable discussions between representatives active in mental healthcare, sick funds and employer associations (both large business and small and medium-sized enterprises) to further the development of screening programmes at the workplace combined with the availability of adequate support management.
- EU and national policymakers should consult with patients and carers to assess the economic burden of depression on those affected and their family members.
5 The state of mental health services for depression in the EU 27 Member States

5.1 Background

In the summer of 2009, the Expert Platform decided to carry out a survey providing an overview of mental health services for depression in the EU Member States, in order to understand better the way in which the needs of mental health services for depression are being met across the Community. The Lundbeck International Neuroscience Foundation agreed to support this study, which was carried out by the consultancy Hill+Knowlton Strategies on behalf of the Expert Platform.

The data that this report draws upon were collected using a 25-item questionnaire. The items were developed by the Expert Platform in collaboration with the Commission’s Directorate-General for Health and Consumer Affairs (DG SANCO). It was decided to focus the questionnaire around six key priority areas: health systems, infrastructure, other available structures, self-help facilities, information and quality of care.

The survey started in July 2009 and ended in February 2011. The data collection was undertaken in four steps:

- As a first step, the survey questionnaire was sent to previously identified national medical experts in each EU Member State.
- Secondly, where possible, the answers provided by these experts were complemented by the input of the national Ministries of Health.
- Thirdly, where applicable, the collective responses of the national medical experts and the Ministries of Health were, again, cross-checked with the 2008 WHO data factsheet report on policies and practices for mental health in Europe.
• For the final analysis of the responses, the Expert Platform enlisted the expertise of its members.

Before publication, the results were made available to the government of each Member State. This has allowed government officials in Member States to comment on the findings obtained for their country – to check the accuracy of the results and to correct them if necessary; and compare the practices and services available in their country with those that are available elsewhere. In addition, the Expert Platform member organisations provided their comments on the outcomes of the survey, highlighting some of the gaps or missing elements in the policy recommendations.

This document presents the final findings of the survey,\(^1\) which serve to:

- provide an overview of the state of play of mental health services across the 27 Member States by analysing and comparing the responses of key opinion leaders and Ministries of Health to a set of 25 questions
- draw conclusions and make recommendations to highlight opportunities for improving mental health services for people with depression in Europe.

5.2 Key findings

The results of the survey highlight the availability of different mental health services for depression in each Member State (please refer to Table 1).

- Table 1: Overall results of the survey on the state of mental health services for depression across the EU Member States

\(^1\) The full data set of this survey is available upon request.
## I. Health system

<table>
<thead>
<tr>
<th>Questions</th>
<th>Austria</th>
<th>Belgium</th>
<th>Bulgaria</th>
<th>Cyprus</th>
<th>Czech Republic</th>
<th>Denmark</th>
<th>Estonia</th>
<th>Finland</th>
<th>France</th>
<th>Germany</th>
<th>Greece</th>
<th>Hungary</th>
<th>Ireland</th>
<th>Italy</th>
<th>Latvia</th>
<th>Lithuania</th>
<th>Luxembourg</th>
<th>Malta</th>
<th>Netherlands</th>
<th>Poland</th>
<th>Portugal</th>
<th>Romania</th>
<th>Slovakia</th>
<th>Slovenia</th>
<th>Spain</th>
<th>Sweden</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1 – Is psychotropic medication fully reimbursed?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Question 2 – Is outpatient visit to GP and/or Psychiatrist fully reimbursed?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Question 3 – Is Psychotherapy fully reimbursed?</td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Question 5 – Does the patient need a referral to visit a psychiatrist?</td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Question 6 – Does the patient need a referral to see a psychotherapist?</td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Question 7 – Are physicians reimbursed for providing psychoeducation to patients?</td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Questions</td>
<td>Austria</td>
<td>Belgium</td>
<td>Bulgaria</td>
<td>Cyprus</td>
<td>Czech Republic</td>
<td>Denmark</td>
<td>Estonia</td>
<td>Finland</td>
<td>France</td>
<td>Germany</td>
<td>Greece</td>
<td>Hungary</td>
<td>Ireland</td>
<td>Italy</td>
<td>Latvia</td>
<td>Lithuania</td>
<td>Luxembourg</td>
<td>Malta</td>
<td>Netherlands</td>
<td>Poland</td>
<td>Portugal</td>
<td>Romania</td>
<td>Slovakia</td>
<td>Slovenia</td>
<td>Spain</td>
<td>Sweden</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>----------</td>
<td>--------</td>
<td>----------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>--------</td>
<td>---------</td>
<td>--------</td>
<td>---------</td>
<td>---------</td>
<td>-------</td>
<td>--------</td>
<td>------------</td>
<td>------------</td>
<td>-------</td>
<td>-------------</td>
<td>--------</td>
<td>----------</td>
<td>----------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Question 8 – Can GPs prescribe all antidepressants?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Question 9 – Can GPs prescribe benzodiazepines?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**II. Infrastructure**

| Question 14 – Is telephone case management available country-wide?       | ✓       | ✓       | ✓         | ✓      | ✓              | ✓       | ✓       | ✓       | ✓      | ✓       | ✓      | ✓       | ✓       | ✓     | ✓      | ✓          | ✓          | ✓     | ✓            | ✓      | ✓        | ✓        | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       |
| Question 15 – Is Internet-based psychotherapy available country-wide?    | ✓       | ✓       | ✓         | ✓      | ✓              | ✓       | ✓       | ✓       | ✓      | ✓       | ✓      | ✓       | ✓       | ✓     | ✓      | ✓          | ✓          | ✓     | ✓            | ✓      | ✓        | ✓        | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       |
| Question 17 – Are crisis hotlines available country-wide?                | ✓       | ✓       | ✓         | ✓      | ✓              | ✓       | ✓       | ✓       | ✓      | ✓       | ✓      | ✓       | ✓       | ✓     | ✓      | ✓          | ✓          | ✓     | ✓            | ✓      | ✓        | ✓        | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       |
| Question 18 – Are self-help groups available country-wide?              | ✓       | ✓       | ✓         | ✓      | ✓              | ✓       | ✓       | ✓       | ✓      | ✓       | ✓      | ✓       | ✓       | ✓     | ✓      | ✓          | ✓          | ✓     | ✓            | ✓      | ✓        | ✓        | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       | ✓       |
The results of the survey highlight practices that are common to all or most Member States in terms of reimbursement and financial assistance for people living with depression:

- Outpatient visits to a family doctor, a psychiatrist or other medical doctor for depression are fully reimbursed in the majority of Member States and at least partially in the remaining Member States.
- Antidepressants for depression are fully or partially reimbursed for people living with depression in all Member States, whether prescribed by a psychiatrist, a family doctor or other medical doctor.
- Psychotherapy for depression is fully or partially reimbursed in all Member States, but may be limited in time or/and be conditional to the qualification of the psychotherapist (whether he or she is a psychiatrist or a psychologist, for example) and/or to referral by a family doctor or other medical doctor.
- Finally, people living with depression who are unfit to work are entitled to sick leave and financial compensation in all Member States, allowing those affected to seek treatment while reducing the socio-economic impact of their illness on themselves and their families. There are, however, considerable variations in the length of sick leave between countries, varying from four to 24 months and even to an unlimited duration in a few Member States.

Major innovative practices and services are not available in many European Member States and ought to be further implemented:

- Psychoeducation is provided and paid for by social security in only a few Member States, although empirical studies have shown that psychoeducation about depression plays a major role in the prevention of new depressive episodes in people suffering from a recurrent depressive disorder.
- Self-help groups for depression are available in just over the half of Member States.
- While hotlines for people living with depression are available in all Member States, some other innovative telecommunications approaches, such as case management by telephone and/or Internet-based psychotherapy (both for case
management and as a medium for treatment), which allow people to access appropriate care from their home, are available in only a few Member States.

Taking into consideration the key findings, it appears that the majority of Member States provide most components of appropriate care, namely:

- access to a mental health specialist
- access to psychotropic medication and psychotherapy
- hotlines for people living with depression
- case management by telephone and/or Internet-based psychotherapy
- psychoeducation for people living with depression and carers
- access to a self-help group.

However, at least one component of appropriate mental healthcare is missing currently in quite a few Member States. Therefore, there is room for improvement in several Member States to implement some of the missing services with the aim of fulfilling all criteria of appropriate care.

5.3 Recommendations

The survey has identified the following challenges in the provision of mental healthcare across Europe and puts forward possible solutions to address them efficiently. The implementation of these recommendations will contribute ultimately to harmonised and integrated provision of mental healthcare to people living with depression across Europe.

- **Challenge 1**
  Lack of equitable access to mental healthcare services for depression within Member States
• **Recommendation 1**
  a) Member States that already provide all the elements of appropriate healthcare mentioned above but provide some of these services only in certain regions should explore ways to expand these services at country level, ensuring harmonised provision of healthcare nationally.
  b) In addition, Member States should be encouraged to make use of new technologies, such as Internet-based psychotherapy, telephone case management and depression hotlines, to improve remote access to healthcare services for people living with depression; and to promote greater coordination among healthcare professionals in the management of depression.
  c) Promote reimbursement of psychotherapy and psychoeducation in the Member States, as appropriate.

• **Challenge 2**
  Disparities in the delivery of appropriate mental healthcare for people living with depression across the EU Member States

• **Recommendation 2**
  Mutual learning and exchange of best practices in the provision of mental healthcare and use of innovative technologies to improve remote access to mental healthcare services for people suffering from depression ought to be promoted across Member States. One suggestion in this context would be to add these best practices to the EU-Compass for Action on Mental Health and Well-being. This resource tool, launched in conjunction with the European Mental Health Pact in 2008, plays an essential role in facilitating the exchange of good practice and policies across the EU, allowing the dissemination of relevant documents, and encouraging the expression of commitment by key stakeholders to future action on mental health.

• **Challenge 3**
  Lack of information on the availability and compatibility of mental health services for depression across the EU Member States
• **Recommendation 3**
  a) To ensure a better understanding of mental healthcare services across Europe, it would be beneficial to collect the information on all mental healthcare services available in each country in a dedicated database. Ideally, this could lead to the creation of a European Depression Services Map, whereby each Member State could develop a mental healthcare services card to inform people living with depression of the nature and scope of mental healthcare services available to them in their country of residence.
  b) In addition, the Expert Platform would recommend developing a European dictionary on available practices and healthcare professions in the field of depression in order to highlight the different terminologies used with regard to depression.
The way forward: the commitment of the Expert Platform on Mental Health – Focus on Depression

The above recommendations are meant to serve as a basis to add value to the policy debate by complementing existing European and national policy initiatives on depression management and related issues.

As outlined at the outset of this paper, the Expert Platform fully supports the recommendations that have already come out of the five Thematic Conferences convened under the umbrella of the European Pact for Mental Health and Well-being. In addition, the Expert Platform is committed to supporting the implementation of these recommendations, and to this end will invite interested stakeholders to join specific task forces. These task forces will be asked to develop specific action plans with concrete goals and timelines. The Expert Platform will monitor the progress achieved on an on-going basis.
7 Annexes

7.1 Composition of the Expert Platform on Mental Health – Focus on Depression

7.1.1 ORGANISATIONS PARTICIPATING IN THE EXPERT PLATFORM

- **Global Alliance of Mental Illness Advocacy Networks-Europe (GAMIAN-Europe)** (represented by Ms Dolores Gauci, President)
- **European Brain Council (EBC)** (represented by Ms Mary G Baker MBE, President; and Prof Cyril Höschl, Board Member)
- **European Depression Association (EDA)** (represented by Prof Vincenzo Costigliola, President)
- **European Network for Workplace Health Promotion (ENWHP)** (represented by Prof Karl Kuhn, Chair)
- **European Federation of Associations of Families of People with Mental Illness (EUFAMI)** (represented by Mr Kevin Jones, Secretary-General)
- **European Psychiatric Nurses (Horatio)** (represented by Mr Roland van de Sande, Secretary-General)
- **International Federation for Psychotherapy (IFP)** (represented by Prof Franz Caspar, President)
- **Lundbeck Institute/Lundbeck International Neuroscience Foundation (LINF)** (represented by Dr André Joubert, Director)
- **Standing Committee of European Doctors (CPME)** (represented by Dr Jacques van der Vliet, Rapporteur on Mental Health)
- **World Organisation of Family Doctors (WONCA-Europe)** (represented by Dr Gabriel Ivbijaro, Chair of the Working Group on Mental Health)
7.1.2 EXPERTS PARTICIPATING IN THE EXPERT PLATFORM IN THEIR INDIVIDUAL CAPACITY

- **Prof Wolfgang Gaebel**, Professor of Psychiatry, Head of Department of Psychiatry and Psychotherapy, Heinrich-Heine-University, Düsseldorf
- **Prof Martin Knapp**, Professor of Social Policy, Director, London School of Economics, Personal Social Services Research Unit (PSSRU)
- **Prof David Nutt**, Professor and Head of Department of Neuropsychopharmacology, Imperial College London
- **Prof Charles Pull**, Centre de Recherche Public-Santé and Centre Hospitalier de Luxembourg
- **Prof Zoltán Rihmer**, Professor of Psychiatry, Semmelweis University, Faculty of Medicine, Budapest
- **Prof Norman Sartorius**, Professor of Psychiatry, Geneva

7.1.3 REPRESENTATIVES OF THE EUROPEAN INSTITUTIONS PARTICIPATING IN THE EXPERT PLATFORM MEETINGS AS OBSERVERS

- **Mr Jürgen Scheftlein**, Policy Officer, DG SANCO (Health Determinants Unit), European Commission
- **Ms Patrizia Tosetti**, Scientific Officer for Medical and Public Health Research, Directorate General for Research, European Commission
- **Ms Nessa Childers**, Member of the European Parliament

7.1.4 PROJECT ADVISOR

- **Dr Iman Barilero**, Vice-President, H. Lundbeck A/S
7.2 Bibliography and relevant sources of information

All web addresses were accessed on 30 November 2011 except where stated otherwise.


