ECONOMIST IMPACT

Depression in Europe

Building resilience through awareness, improved access, integrated care, and parity of esteem



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About this report

"Depression in Europe: building resilience through raised awareness, improved access, integrated care and parity of esteem" is a report researched and created by Economist Impact, and initiated and funded by Janssen. Economist Impact retained full editorial control, and Janssen reviewed the material for compliance with relevant regulations. The report aims to look beyond the data on depression in Europe and describes what good care could look like over the next decade.

The report focuses on eight European countries and discusses both the challenges they face and the successes they have seen. We explore four themes: awareness, access, integrated care and parity of esteem. For each theme we provide an evidence snapshot, case studies and "what if . . . ?" scenarios. The report incorporates insights from desk research, a literature review and in-depth interviews with academics, healthcare professionals, patient groups and other stakeholders.

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- **Rafael Bengoa**, co-director, Institute for Health and Strategy
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Glossary

Biomedical model	A general model that assumes "every disease process can be solely explained in terms of a deviation from normal function such as a physiological processes, infections, genes, developmental abnormalities, or injuries". Source: International Encyclopedia of the Social & Behavioral Sciences (Second Edition), 2015
Biopsychosocial model	"A general model positing that biological, psychological (which includes thoughts, emotions, and behaviours), and social (e.g., socioeconomical, socioenvironmental, and cultural) factors, all play a significant role in health and disease". Source: International Encyclopedia of the Social & Behavioral Sciences (Second Edition), 2015
Collaborative care	"Multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings". Source: World Health Organization "It involves a number of health professionals working with a patient to help them overcome their problems. Collaborative care often involves a medical doctor, a case manager (with training in depression and anxiety), and a mental health specialist such as a psychiatrist". Source: Archer et al, 2012
Depression severity	Depression severity can be measured using a self-rated nine-item questionnaire (adapted from the Patient Health Questionnaire 9) that asks the individual to rate the severity of their depression during the last seven days. Each item is ranked on a scale of 0 (not at all) to 3 (nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression, as shown in the table below.

Interpretation table for the PHQ-9

Levels of depressive symptoms severity	PHQ-9 score
None	0-4
Mild depression	5-9
Moderate depression	10-14
Moderately severe depression	15-19
Severe depression	20-27

Source: DSM-5-TR

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Dysthymia	A persistent or chronic form of mild depression; the symptoms of dysthymia are similar to depressive episode but tend to be less intense and last longer. Source: Global Burden of Disease
Engagement Also *patient and family engagement; community engagement*	"Involving people and communities in the design, planning and delivery of health services that, for example, enable them to make choices about care and treatment options or to participate in strategic decision making on how health resources be spent". Source: World Health Organization
Integrated care	"The organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money". Source: World Health Organization
Major depressive disorder Also *major depressive episode*	Involves symptoms such as depressed mood, loss of interest and enjoyment, and decreased energy; depending on the number and severity of symptoms, a depressive episode can be categorized as mild, moderate or severe. Source: Global Burden of Disease
Mental health	"A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Source: World Health Organization
Parity of esteem	Equal access to safe, effective and high-quality care; equal allocation of resources on the basis of need; equal status within healthcare education and practice; equal aspirations for service users and equal status to the measurement of health outcomes. Source: Bailey 2013 "The need to value mental health equally to physical health". Source: Royal College of Nursing
Patient-centred care Also *person-centred care*	"Care approaches and practises that see the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health". Source: World Health Organization

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Patient-centred care (cont.)	"Care planning focused on people with depression and/or anxiety disorder must be individualised, dynamic, flexible, and participatory. It must respond to the specific needs of the person, contemplating the identification of problems, the establishment of individual objectives, shared decision making, information and education, systematic feedback, and case management, and it should meet the patient's preferences and satisfaction with care and involve the family and therapeutic management in care". Source: Pinho, 2021
People with depression	"Includes people with a clinical diagnosis of depression and those who feel themselves to be experiencing depression or depressive symptoms, and recognises that people experience, describe and label their experiences of depression in very individual ways". Source: NICE
Psychosocial factors	Social, cultural, and environmental phenomena and influences that affect mental health and behavior. These influences include social situations, relationships, and pressures, such as competition for education, health care, and other social resources; rapid technological change; work deadlines; and changes in social roles and status (e.g., of women and minority groups). Source: APA Dictionary of Psychology
Talk-based therapy Also *psychotherapy*	"A way to help people with a broad variety of mental illnesses and emotional difficulties. Psychotherapy can help eliminate or control troubling symptoms so a person can function better and can increase well-being and healing". Source: American Psychiatric Association A category of depression treatments that includes cognitive behavioural therapy, guided self-help, counselling, person-centred experiential therapy and interpersonal therapy. Source: UK National Health Service

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Executive summary

Background

The burden of depression is growing, exacerbated by the stress of covid-19. In many European countries, the prevalence of depression during the pandemic doubled or even tripled from the year before. Reflected in these numbers is an alarming rise in the number of young people who are experiencing symptoms of depression.

Europe's health systems are struggling. With health budgets stretched in many countries, policymakers face the challenge of having to cope with increasing demands from both mental ill health and chronic physical conditions. There is a concern that mental health budgets may be seen as easier to cut than those for physical health.

This cannot be allowed to happen. Healthcare systems need to remain sufficiently resourced so that they can adapt to changing circumstances. They need to be able to identify groups that are vulnerable to depression, which increasingly includes young people, as well as the elderly and socially marginalised groups. The continuing rise in both incidence and burden of depression in Europe suggests that a step change is needed. Business as usual is not delivering adequate levels of care for many people.



Methods

After describing the burden of depression, we focus on four thematic areas, using the language of resilience to tie them together. Healthcare systems need to be able to *absorb* the rising demand for services, *adapt* to the changing needs of people with depression and *transform* in response to failures and the lessons they teach. The four themes, which together will help build resiliency, are:

1. **Awareness**, including patient empowerment and improved community recognition of depression as a serious condition
2. **Access to treatment and innovation**, including both nonpharmacological and pharmacological measures
3. **Integrated approach to care**, including prevention measures and a co-ordinated support system for patients' physical health, mental health and wider social needs
4. **Parity of esteem with physical health** and the need for support across the entire patient journey, including prevention, early detection, education and support at the workplace and in the community

We discuss the building blocks behind each theme and summarise their evidence base. We then provide case studies of good practice and offer a "what if . . . ?" scenario for each theme to explore what quality services could look like ten years from now (Table 1).

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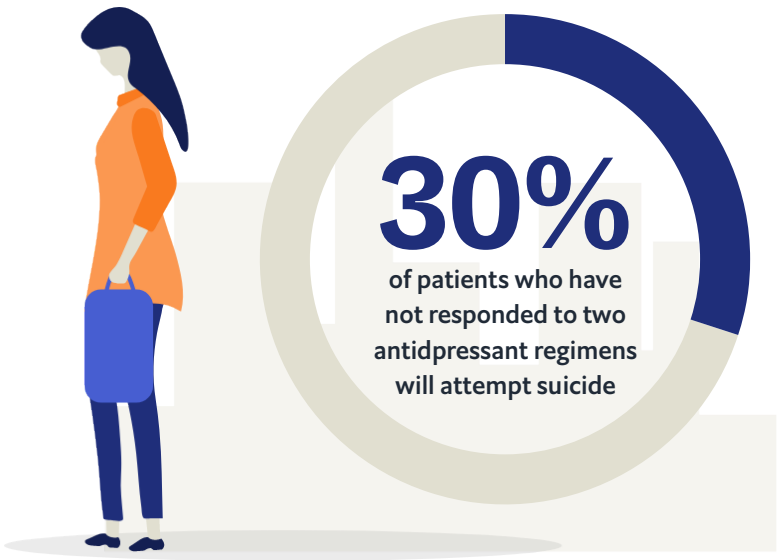
Table 1. Themes, building blocks, case studies and "what if . . . ?" scenarios

Theme	Buildilng blocks	Case studies	What if...?
Awareness	• Recognition • Attitudes • Knowledge	• First European Art Festival for Mental Health in Greece • This Is Me prevention programme in Slovenia • Suicide Prevention Action Networks (SUPRANET Community) in the Netherlands	**Egå, Denmark, 2032.** Josefine, a young mother in Denmark, has noticed signs of depression in one of her elderly neighbours...
Access to treatment and innovation	• Technology-based interventions • Community-based interventions • Talk-based interventions • Interventions for underserved groups	• Using technology to improve mental health in France, Germany, the Netherlands, and the UK • Peer support workers (médiateur de santé pair) in France • Self-help for less severe mental illness in the UK	**Frankfurt, Germany, 2032.** Hanna, a city-based banker, is suffering from anxiety and low-level depression...
Integrated approach to care	• Collaborative care • Patient-centred care • Family engagement	• Identifying comorbidities to support integrated care pathways in the UK • Using primary care as a gatekeeper in the Netherlands • Integrated, person-centred primary healthcare produces results in Slovenia	**Bristol, UK, 2032.** Jack, a first-year physics student at Bristol University, has been struggling for weeks...
Parity of esteem with physical health	• Access and utilisation • Resource allocation • Quality assurance • Education • Treatment goals and outcomes	• Policymakers enshrining a road to parity in the UK • First aid for mental health in the Netherlands	**Lyon, France, 2032.** Guillaume, an executive at an IT consulting firm, has been experiencing stress at work and grief due to the death of his father...

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Main findings

Through a literature review and series of interviews, a mixed picture emerges. First, **care remains fragmented**. In many European countries, there is little communication between primary and secondary healthcare provision, or between psychiatric healthcare providers and physicians providing care for long-term physical conditions. This lack of coordination makes it more difficult to both identify depression at an earlier stage and determine which patients need to be referred to specialist services. Related to this deficiency is the finding that **treatment of depression fails to take a holistic approach**. Even in countries where there has been a renewed focus on mental health, there is rarely holistic treatment of patients living with depression. Although families are often actively involved in care and face their own burdens as a result, they are not always integrated into treatment. In addition, specialists and policymakers are only just beginning to understand the impact of the wider environment and society on mental health in the wake of the pandemic.



For those with depression, **access to talking therapy and innovative treatment is uneven**. Although people living with depression often have access to pharmaceutical interventions—albeit most such medications date from the 1980s and 1990s—there are often long waits for "talking" therapy, if it is even available. Shortages of trained specialists and a lack of co-ordinated workforce planning mean this problem is unlikely to be easily solved. In cases where traditional anti-depressants or psychotherapy fail to have an effect, there appear to be few alternative or innovative treatments options available. Thirty percent of patients who have not responded to two or more antidepressant regimens will attempt suicide.

Parity of esteem is a term increasingly heard, but **mental health remains undervalued compared with physical health**. Mental health has long been a lower healthcare priority, especially in comparison with chronic conditions, even though depression is often a comorbidity of long-term conditions, and vice versa. Failure to understand the interaction between mental and physical health, and to give mental healthcare equal resources, makes it difficult to reduce the burden on healthcare services.

Underlying all efforts to improve the prevention and management of depression, **stigma remains a problem in many environments**. Despite attempts in many countries to improve awareness and understanding of mental health issues, stigma remains a problem in many European societies. In some cases, the persistence may result from a tendency to focus awareness campaigns on the general public, rather than concentrating on schools, universities or the workplace, where discrimination has a particularly negative impact.

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Key takeaways

Each of the thematic chapters concludes with suggestions on how resilience can be built within care systems and their wider context. We conclude with five overarching principles around which policymakers can build effective and resilient services.

Healthcare systems need to remain adaptable as rates of depression are rising in most European countries, particularly among the young. While there are many examples of good practice—particularly in attempts to integrate care settings and pathways—they are rarely scaled-up to larger populations.

Awareness needs to be targeted to remove stigma. Depression remains one of healthcare's last, and most difficult to change, objects of stigma, even as the condition itself becomes more prevalent.

More support is needed to get people treatment, whether through digital health, talking therapies or other therapeutic or diagnostic innovations. Staffing shortages remain a barrier to access, as is the lack of data infrastructure for tracking treatment and evaluation. Payment systems for digital health and other new innovations remain in their infancy, and pharmacological innovations are few. Industry, regulators, health technology assessment (HTA) organisations and payers need to work together to improve access to therapeutic or diagnostic innovations.

Healthcare systems should be integrated on all levels, leading to care delivery that is both more efficient and resilient. Primary care needs to be re-established as the home of integrated, co-ordinated, patient-centred care, with well-established referral pathways into specialist care. But apart from a few pilot programmes, delivery of care remains stubbornly fragmented.

Family and carers should be included in treatment plans. Family life can be one of the stressors that causes depression in some individuals—but with the right focus and interventions, family can also be the greatest support.

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Introduction

Depression is a hidden burden

The burden of depression has received renewed focus in the wake of more than two years of a global pandemic. Covid-19 and associated lockdowns increased isolation and aggravated existing mental health problems.[1] A May 2021 report by the Organisation for Economic Co-operation and Development (OECD) found a "significant and unprecedented" worsening of population mental health in 2020, compared with the year before the pandemic, with national estimates of the prevalence of depression doubling or tripling in many European countries.[2] Yet, the extent of depression has long varied across and within countries in Europe, with differences persisting amid the collective experience of isolation and lockdown.

Depressive disorders—which include major depressive disorder as well as dysthymia and other clinically diagnosed forms of depression—are the single largest cause of global nonfatal health loss, contributing 7.5% of all years of life lost due to disability. In Europe, this jumps to 8.1%[3] Amongst mental health disorders, depression causes the greatest burden. It accounts for 39% of years of life lost due to disability caused by mental health disorders as a whole.[4] "The obvious impacts of depression are loss of ambition, lower income, smaller social circles and less contribution to the community at large", says John Saunders, executive director of the European Federation of Associations of Families of People with Mental Illness (EUFAMI). As well as sadness and a loss of interest or pleasure, depression may also bring feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration.[5]

A variety of biological, psychological, and social factors have been associated with depression.[6] Biological factors include a person's physical health, genetic profile, their microbiome, stress levels and how their body's systems respond to stress (for example, via the hypothalamic-pituitary-adrenal axis). Psychological factors include negative self-concept, sensitivity to rejection, neuroticism and rumination. Social factors range from the environments where people are born, live, learn, work and play; their social support networks; and adverse childhood experiences. While not necessarily causes in themselves, biological, psychological and social factors all combine to raise or lower the risk of depression.

Depressive disorders are set to become the world's leading cause of disability by 2030

Depression can affect anyone, in any stratum of life. A person can be at the most successful point in their life and still suffer from depression. In fact, some argue that there seems to be something about extreme success that puts a person at higher risk for depression.[7] Depression can also occur at any age, but typically first develops during the mid-teens, twenties, or thirties.[8] "The onset of many mental health problems is around the adolescent period", says Heleen Riper, professor of eMental-Health/Clinical Psychology VU & Amsterdam University Medical Centre (VUmc), "so if we would pay more attention to that, that could prevent difficult or more painful trajectories".

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The impact of depression goes well beyond low mood. Depression and anxiety disorders are associated with excess mortality in people under age sixty.[9] In its most severe form, depression can lead to suicide, although little is known about the characteristics that increase the risk of suicide among people with depression.[10] As new studies emerge around the lifelong impacts of depression, such as increased risk of dementia, it is all the more crucial to act now to save lives and resources down the line.[11]

One of the reasons for its high burden is that depression remains difficult to treat. Only 40-60% of patients achieve remission after initial antidepressant treatment, regardless of the drug chosen. Lack of remission or response is associated with a lower quality of life, higher comorbidity, increased resource use, social and occupational disability, and worse treatment outcomes.[12]

The impacts of depression are only expected to grow, with WHO predicting that major depressive disorder will become the leading cause of disability globally by 2030.[13] This projection mirrors past trends as antidepressant consumption nearly doubled in OECD countries between 2000 and 2017.[14]

The first two sections of the report describe the epidemiological, financial and societal burden of depression. We explain not only how depression is becoming more common, but also how the burden of depression is changing shape. We then briefly profile depression in eight European countries: France, Germany, Italy, Spain, the UK, the Netherlands, Denmark and Slovenia—each faces its own challenges, as well as its own success stories.

The role of resilience

As noted, the causes of depression are many. A person's risk can be influenced by biological, genetic, environmental and psychosocial factors, and life events and personality traits play a role too.[15] However, a common theme in both the prevention and treatment of depression for decades now has been the concept of resilience. Resilience may be considered the ability to recover, learn and grow stronger from adversity.[16] The concept of psychological resilience forms a part of many talking therapies, such as some types of cognitive behavioural therapies.[17]

Covid-19 has highlighted the importance of resilience, not only among patients but also healthcare professionals.[18] But resilience is a function of systems as well as individuals.[19,20] In the same way that resilient people may be able to resist, bounce back and continue to grow, so too must healthcare systems be able to absorb and adapt to shocks while maintaining high-quality care. They must also be able to transform themselves in response to stress—the institutional equivalent of "bouncing back".

We therefore use *resilience* in this report as a way to think about how healthcare systems—and the societies in which they are embedded—can improve the awareness, prevention and treatment of depression.

Outline of the report

The first two sections of the report describe the epidemiological, financial and societal burden of depression. We explain not only how depression is becoming more common but also how the burden of depression is changing shape. We then briefly profile depression in eight European countries: France, Germany, Italy, Spain, the UK, the Netherlands, Denmark and Slovenia. Each faces its own challenges but also has its own success stories.

The second half of the report then explores depression using a thematic approach.

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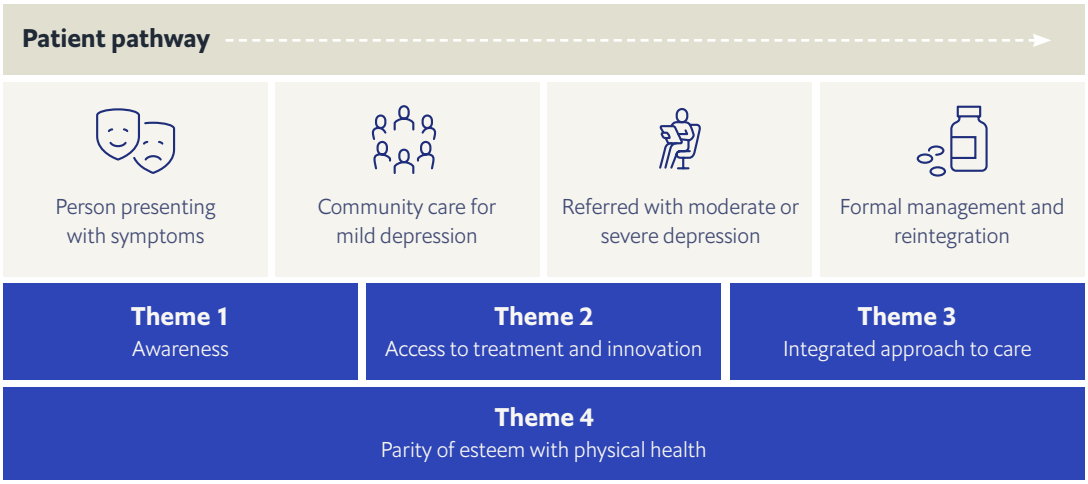
We look at how systems and societies can improve resilience in the face of depression by focussing on:

1. **Awareness**, including patient empowerment and improved community recognition of depression as a serious condition
2. **Access to treatment and innovation**, including both nonpharmacological and pharmacological measures
3. **Integrated approach to care**, including prevention measures and co-ordinated support systems for patients' physical health, mental health and wider social needs
4. **Parity of esteem with physical health** and the need for support across the entire patient journey, from prevention, early detection and education to support at the workplace and in the community

The order of the themes broadly follows the course of a simplified patient pathway (Figure 1). First is awareness because that can help prevention. For those diagnosed or at risk of depression, it is important that they be able to access care. Then an integrated approach to the management of depression is required for people being supported by the healthcare and other sectors. Last, the notion of parity of esteem stretches across all these concepts.

For each of these themes, we offer an evidence snapshot, two or three case studies and a short "what if . . . ?" scenario, set ten years from now. Our evidence snapshots illustrate the impact of each theme on the burden of depression in Europe. The case studies focus on best practices from European countries that are leading the way to improved depression care and "what if...?" scenarios show what good care could look like. The final section then offers some key policy takeaways, describing some principles around which improved care systems could be built.

FIGURE 1. A simplified patient pathway mapped against the themes covered



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Epidemiological burden

One in fourteen people in Europe reported suffering from chronic depression in 2021

Although definitions of depression—and associated estimates of burden—vary depending on the study, the picture across Europe is bleak. Just over 7% of the European Union's population reports having chronic depression, according to Eurostat figures from 2021.[21] That's about one in fourteen people and roughly 0.3% higher than in 2014.[22]

Historical data suggest that the burden of depression has been steadily increasing during the last few decades, in Europe as well as globally. The incidence of depression worldwide increased by 50% from 1990 to 2017.[13] Disability-adjusted life years attributable to depressive disorders have increased in Europe from 6,149,219 in 2000 to 6,565,500 in 2019.[23]

These are large numbers, indicating a sizeable burden on society. But they also say something about the difficulty of understanding the impact of depression on society. The Eurostat figure of 7% prevalence is based on self-reporting. It does not measure formal diagnoses. On the other hand, the 50% increase in incidence refers to the diagnosis of major depressive disorder, a clinical diagnosis made using the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).[15] Other investigators might estimate incidence or prevalence via the tracking of symptoms.[24]

Each of these methods can give quite different figures and paint different pictures; it is challenging to quote one figure representing the overall burden of depression. For example, as many as 30% of patients in primary care settings report depressive symptoms, but it is estimated that fewer than 10% will have major depression.[8] However, it is also argued that the use of multiple indicators provides a more comprehensive picture of depression than a single indicator alone, that the variety of measures used is helpful, rather than a hindrance.[25] Putting aside arguments about which is the best indicator, the common message across these various metrics allows us to say that the burden is significant and on the rise in Europe.

However, the burden of depression is not felt evenly across society. Three broad categories of risk factors for depression have been identified: psychosocial factors, socioeconomic factors and health-related factors.

- **Psychosocial factors**: Depression is more prevalent in people who are widowed, divorced or do not have a partner.[26] Other psychosocial

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factors, such as discrimination related to race, sexual orientation and immigrant status are also associated with increased depressive symptoms.[27]

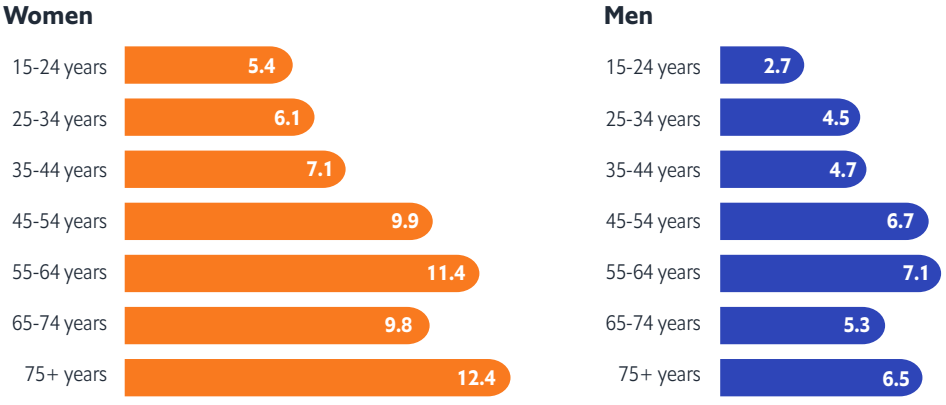
- **Socioeconomic factors**: People with lower educational attainment and/or in low-income groups are almost twice as likely to report chronic depression.[26] Unemployed people generally report higher levels of depression than those who are employed, and people with depression are more likely to be unemployed, creating a vicious cycle.[28]
- **Health-related factors**: Poor physical health—including risky behaviours like increased alcohol consumption—is associated with an increased risk of depression. Conversely, physical activity has been found to prevent and reduce depressive symptoms.[26]

Risk for depression varies geographically, by gender and socioeconomically

Risk factors for depression vary across Europe. In eastern and southern Europe, the most common predictors of depression are female gender and impairment in activities of daily living—for example, difficulties in eating, bathing and getting about. In the northern countries, poorer self-rated health and older age were more relevant. Chronic diseases are the most common contributing factor in the continental region of Europe (the area stretching from central France to the eastern edge of Poland).[29] The gender gap in depression is lowest in northern European countries, followed by western European countries, with the largest gap occurring in southern European countries.[26]

The 2014 European Health Interview Survey reported that one in twelve women had experienced chronic depression compared to one in nineteen men.[30] Across all ages (following puberty), women report a higher prevalence of depression, with a greater discrepancy later in life when women's risk of major depressive disorder is twice that of men (Figure 2).[31] This trend has been consistent for at least fifty years.[32] Risk factors for developing depression also tend to vary between men and women; for instance, men without a partner are three times more likely to develop depression than women without partners.[26]

FIGURE 2. Chronic depression in men and women across EU countries
% with chronic depression



Source: OECD, 2018[33]

These data come from the European Health Interview Survey (EHIS,) which used the Patient Health Questionnaire (PHQ-8), an eight-item depression screener.

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According to Morten Ronnenberg Møller, secretary general of DepressionsForeningen in Denmark, "overall, in the last twenty years, the prevalence of depression has gone up tremendously amongst young people between fifteen and twenty-five, and especially amongst girls and young women. That doesn't mean that it hasn't gone up for the rest of the population . . . but men act in such a manner that they self-medicate which can lead to untreated depression". Recent figures do indeed suggest that the pandemic particularly impacted females and the young.[34]

Although women have a higher risk of developing depression, there are no significant gender differences in the clinical course of the condition, with similar persistence and recurrence rates across genders.[35] Although treatment is equally effective for men and women, European men are less likely to adhere to medication and less likely than women to seek help when depressed—with this gap growing for men with lower levels of education.[36]

Up to a third of people with major depressive disorder do not respond to treatment

While estimates vary, real-world data suggest that about 10-30% of patients with major depressive disorder suffer two or more antidepressant treatment failures (which have been delivered at an adequate dose and duration).[37,38]

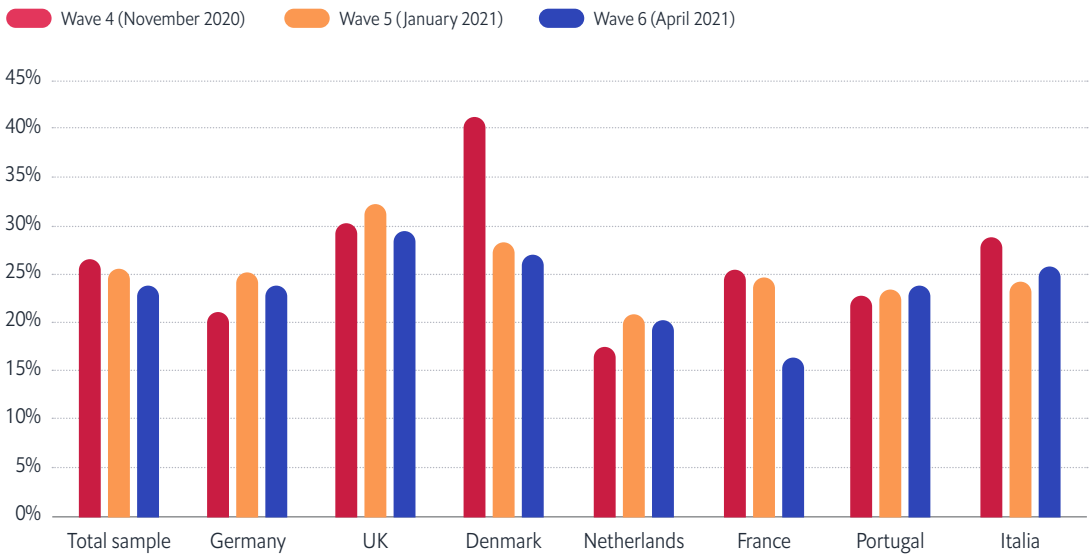
These numbers speak not only to how hard depression is to treat but also how difficult it is to identify whether a treatment has worked. When judging treatment success, responders are those who improve, typically by at least 50%, according to whichever scale is being used to measure depression.[39] Partial responders improve by 25%, while nonresponders typically show less than 25% improvement. Response is good, but remission is the ultimate goal of treatment. People in remission are generally considered to be well and virtually symptom-free, although there remains uncertainty as to how that judgement should be made.[40,41] Patients may still be considered in remission despite experiencing one or two minor symptoms.[40,42]

However, people who do not respond to treatment remain far from remission. Increasing rounds of nonresponse further reduce their quality of life,[43] function and productivity, and increases their morbidity and mortality.[38,44] Such people are also at higher risk of suicide,[45] and about half are on long-term sick leave or unemployed.[44]

There is a wide heterogeneity of treatments used for people who have not responded to two previous antidepressant regimens, highlighting a lack of consensus on the best approach to nonresponders. Moreover, despite low response rates, patients often remain on treatments that are offering them little if any benefit for substantial periods of time.[38] The likelihood of response is greatly reduced with each new attempt at treatment.[44,46] By the time a patient reaches third-line therapy, only 14% will achieve remission.[46] These data show that there remains a significant unmet treatment need for many depression patients in Europe.

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FIGURE 3. Prevalence of probable depression in select European countries throughout covid-19 waves



Source: Hajek et al, 2022[47]

Data for this graph were quantified using the validated Patient Health Questionnaire-4 (PHQ-4) with dedicated cut-off points defined to determine probable depression.

Covid-19 may have caused a global rise in incidence of depression of more than 25%

Much has been made of how the covid-19 pandemic and associated lockdowns have impacted mood and mental health. A Lancet review estimated an additional 53 million cases of major depressive disorder globally, an increase of nearly 28%, due to the covid-19 pandemic.[34] Across most of Europe, it was the earlier waves of covid-19 that were associated with the largest increase in the risk of depression (Figure 3). After an initial peak, later waves were less strongly associated with rises in depression, likely due to advancements in vaccines and improved public understanding of the pandemic.[47]

While covid-19 is an ongoing and evolving situation, current data suggests that it has had a bigger impact than previous pandemics. For example, analysis following the SARS and MERS epidemics showed the pooled incidence of depression during the outbreaks was 19.4%. In comparison, early analysis of data during the covid-19 outbreak showed a pooled incidence of 27%.[48] As data continue to be collected and analysed, this number will change, but the scale of psychological impacts will need to be addressed for years to come.

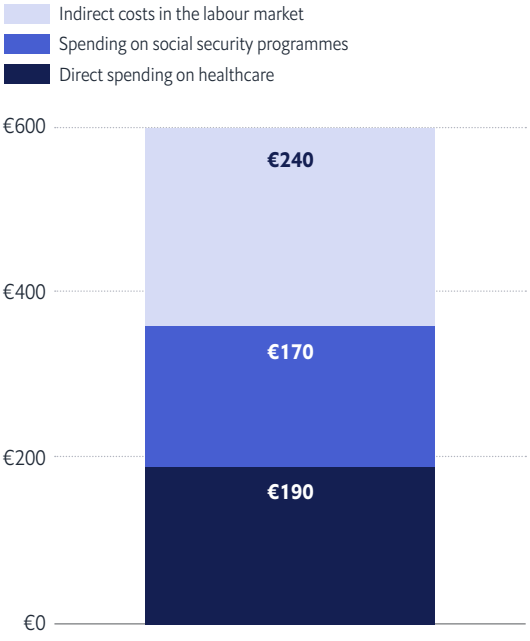
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Economic and societal burden

Depression carries a huge financial burden, including costs to the healthcare system, families and the economy as whole

The total cost of mental disorders in Europe is estimated to be more than €600 billion—equating to over 4% of GDP in 2015. This sum includes the direct costs to the healthcare system and social security programmes and the indirect costs to the labour market (Figure 4 and Table 2). Both direct and indirect costs are higher for people who do not respond to two or more antidepressant regimens.[43]

FIGURE 4. Cost of mental disorders in Europe (€ billions), 2015



Source: OECD, 2018[33]

Of the focus countries in this study, Denmark spends the most on mental health, which could be due to their higher spending on social benefits. The Netherlands, on the other hand, spends the most on indirect costs within the labour market. One portion of the indirect costs to labour markets (incorporated in the figures above), including reduced working hours and more days of absence from work, is estimated to cost about €19 billion, or an amount equivalent to 0.13% of GDP across EU countries in 2015.[33]

Depression accounts for up to 50% of chronic sick leaves in the EU.[49] However, absenteeism is not the only challenge. Even when at work, people with depression do not always function to their usual abilities and may be less productive, a phenomenon known as "presenteeism".[33] In fact, workers experiencing mental ill-health are estimated to be about 6% less productive than usual, the cost of which has been estimated to be nearly €23 billion in 2015.[33]

People with depression are also less likely to be employed compared to the general population (Figure 5). Related to this fact is the strong connection between labour-force status and self-esteem or sense of worth in society, as losing a job generally contributes to worsened mental health.[30] As Judit Simon, professor of health economics at the Medical University of Vienna noted, "most costs for depression are actually indirect costs, and not healthcare costs. Therefore, depression is really a societal issue and not just a health care issue. There are many spill-over costs, impacting, for example, work, education or informal care."

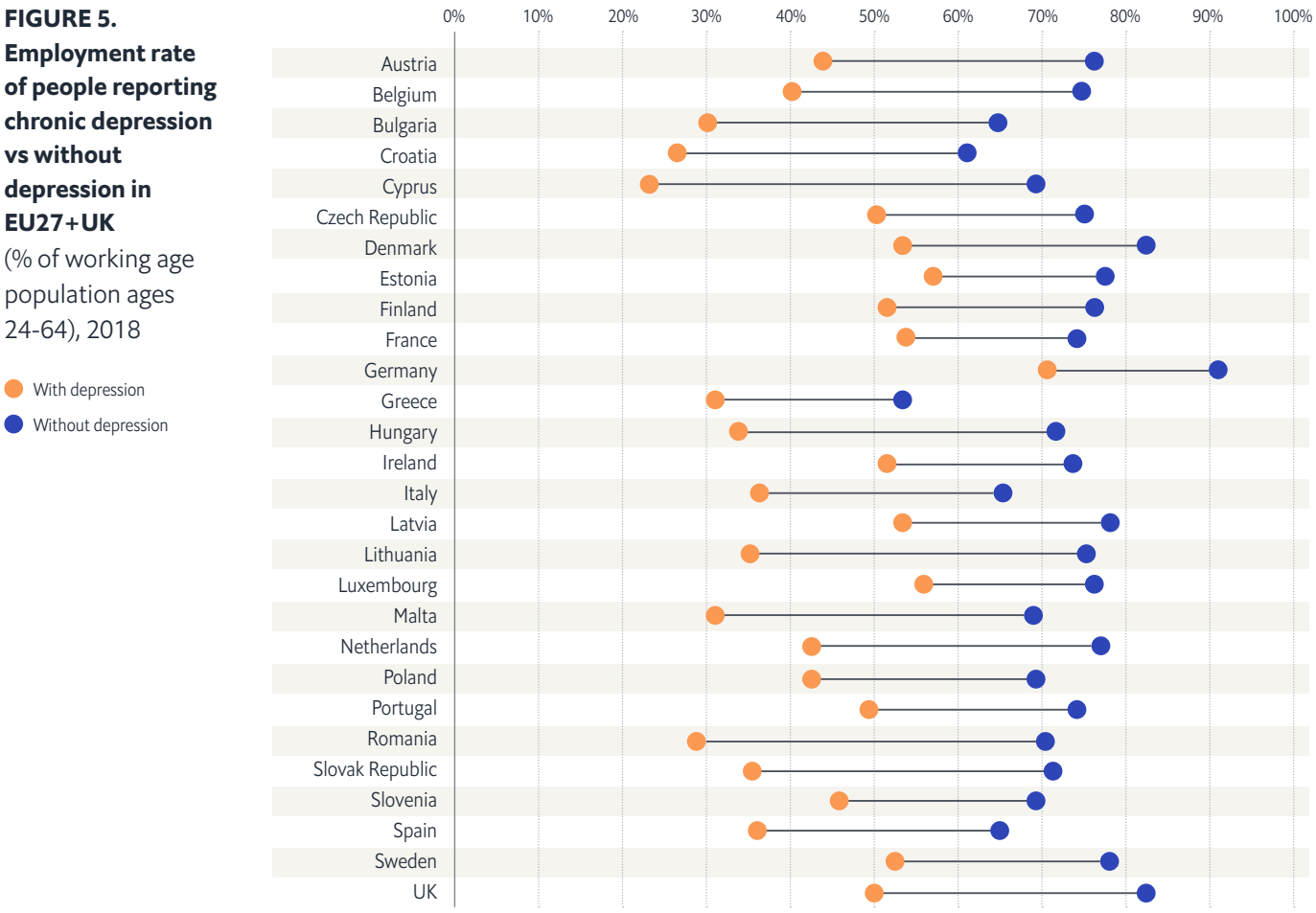
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TABLE 2. Estimates of total costs (direct and indirect) of mental health problems in select European countries, in million EUR and as a share of GDP, 2015

	Total Costs		Direct costs				Indirect costs	
			On health systems		On social benefits		On the labour market	
	In million EUR	% of GDP	In million EUR	% of GDP	In million EUR	% of GDP	In million EUR	% of GDP
EU28	607,074	4.1%	194,139	1.3%	169,939	1.2%	242,995	1.6%
Denmark	14,627	5.4%	3,431	1.3%	5,563	2.1%	5,633	2.1%
France	81,345	3.7%	29,337	1.3%	26,437	1.2%	25,570	1.2%
Germany	146,536	4.8%	43,421	1.4%	40,939	1.6%	62,177	2.0%
Italy	54,487	3.3%	20,221	1.2%	15,787	1.0%	18,478	1.1%
Netherlands	34,969	5.1%	8,534	1.6%	11,069	1.6%	15,367	2.3%
Slovenia	1,602	4.1%	507	1.3%	308	0.8%	786	2.0%
Spain	45,058	4.1%	14,415	1.3%	12,318	1.1%	18,325	1.7%
UK	106,024	4.1%	36,353	1.4%	22,704	0.9%	46,967	1.8%

Source: OECD, 2018[33]

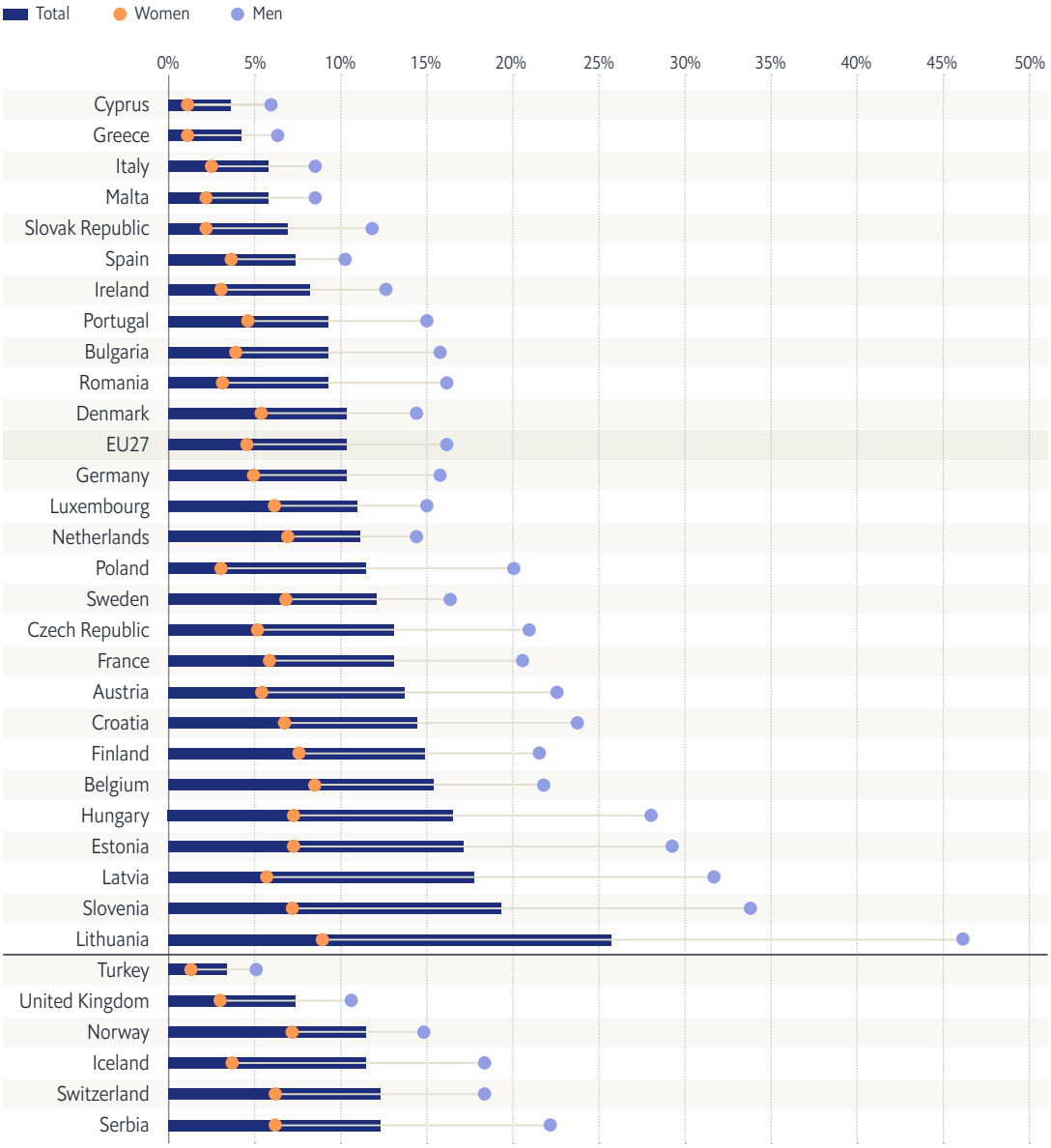
FIGURE 5. Employment rate of people reporting chronic depression vs without depression in EU27+UK (% of working age population ages 24-64), 2018



Source: OECD, 2018[50]

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FIGURE 6. Suicide rates, 2017 (or nearest year)



Source: Eurostat database[54]

Depression is also associated with homelessness, suicide and poor physical health outcomes

The social impact of depression is indeed clear. European data show that having depression is associated with a higher risk of homelessness and increased contact with the criminal justice system.[51] It is also the primary risk factor associated with suicide and suicidal ideation.[52] An estimated 120,000 people take their own lives every year in the WHO European region, equivalent to 1.3% of all deaths in 2019.[1] Suicide rates in Europe in 2017 were lowest in Cyprus, Greece, and Italy and highest in Lithuania and Slovenia (Figure 6). Many of these people would have been suffering from depression, whether diagnosed or not. About 30% of patients who do not respond to two or more antidepressant regimens will attempt suicide at least once during their lifetime.[53]

Depression is also directly associated with a number of comorbidities: low blood pressure, myocardial infarction/stroke, cardiovascular disease, cancer and diabetes.[49] Recent evidence suggests that there is a relationship between depressive symptoms in early adulthood and developing physical multi-morbidities in middle age.[55] Though more research is needed to understand the specific drivers, this alarming finding emphasises the urgent need to reduce depression across all age groups. Ms Simon

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"Stigma is really a huge barrier here, in between knowledge that people might have and then actions that they take, because there are attitudes that get influenced by stigma that really prevent them from seeking help"

Matej Vinko, head of the Public Mental Health Expert Group at the National Institute of Public Health (NIJZ)

highlighted that "when we talk about the economic burden of depression, usually it includes the main direct healthcare costs and some broader societal costs, but there are significant excess physical comorbidity costs which are currently not calculated".

There is also the burden on carers. In fact, there is an excess burden on carers for people with depression, compared with carers for other diseases.[56] Carers of adults with depression report experiencing financial impacts, scheduling difficulties and a lack of family support compared to carers of other mental or physical chronic diseases. Not only that, but carers are themselves at risk: carers of adults with depression are three times more likely to visit an emergency department and twice as likely to be hospitalized compared to noncarers.[56]

Stigma remains an issue

Underlying many of the above challenges is the issue of stigma. Individuals who feel stigmatised are more likely to conceal their condition and, in turn, delay seeking care.[57] Even when individuals do seek care, they are often reluctant to report their mental health challenges and instead tend to report more physical complaints.[58] This perceived stigma therefore leads to treatment delays and lower adherence.[58]

But stigma can be addressed. We can take cancer as an example, which was stigmatised just a few decades ago.[59] As a result of awareness and campaigns, and increased understanding of the disease, the stigma around cancer has generally receded—if not disappeared altogether. For example, in 1961, nearly 90 percent of physicians at a US hospital reported that they preferred not to tell patients they had cancer, as it could cause them harm.[60] A modern reader hearing that statistic today would find it shocking. But while the stigma around cancer has fallen, stigma about depression retains its culture of silence. As Mr Ronnenberg Møller points out, while "cancer can be spoken about at the dinner table, depression is not".

Matej Vinko, head of the Public Mental Health Expert Group at the National Institute of Public Health (NIJZ), explains how stigma can impede the step from knowledge to action. "The bigger issues are competencies to identify and approach people to provide some initial help, or to seek help for yourself and have the capabilities to really know when to look for help". Adding that "stigma is really a huge barrier here, in between knowledge that people might have and then actions that they take, because there are attitudes that get influenced by stigma that really prevent them from seeking help".

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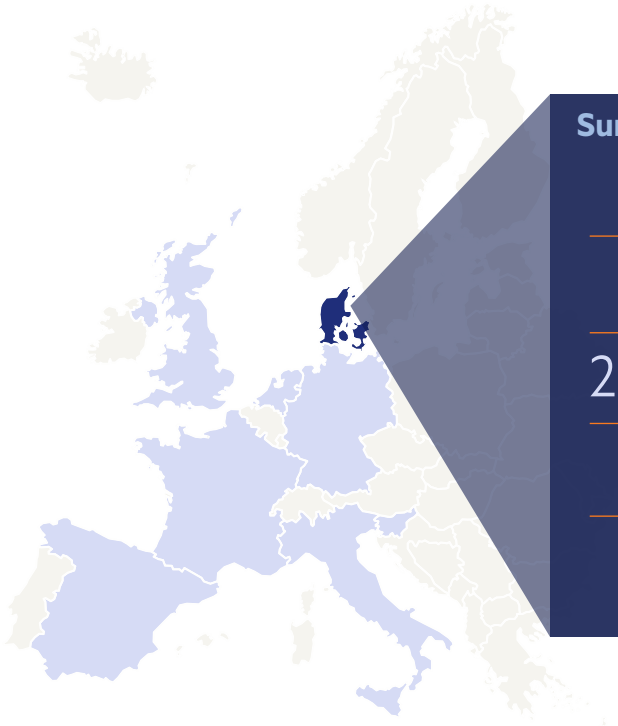
Country profiles

Denmark: often a source of best practice, but out-of-pocket costs can be steep

The Danish healthcare system is often viewed as a source of best practices for universal healthcare: its implementation led to lower spending, lower mortality rates and higher life expectancy for residents.[61] However, while Danes are able to seek free primary, secondary and tertiary medical treatment, mental health services require a copayment.[62] For this reason, Denmark's out-of-pocket costs for mental health are the highest in Europe.[62]

Costs aside, Denmark's model for approaching depression treatment has been relatively successful.[63] From 1990 to 2015, Denmark saw one of the most significant decreases in age-standardised incidence rates for depression in the world.[13] Denmark's mental health infrastructure helped the country maintain its mental health during covid-19: a recent analysis found no evidence of an increase in the prevalence of anxiety and depression symptoms during the first four months of the covid-19 outbreak.[64]

Another example of good practice is the Danish Depression Database (DDD). The database is used to monitor and improve mental health treatment throughout the country, although critics suggest that it is underutilised and leaves several areas for improvement.[63]



Summary table

7.2%	**Prevalence of depressive disorders**[55]
77.0	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
2 of 146	**World happiness ranking**[66]
10.7	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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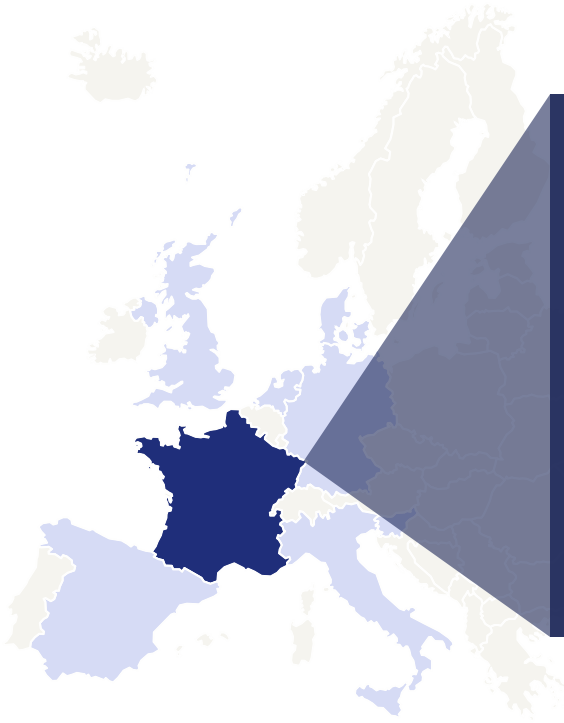
France: dedicated effort to address mental health amidst years of increasing rates of depression and suicidal thoughts

Depression in France has been on the rise for decades. A 2009 WHO mental health survey pointed to France having some of the highest rates of anxiety and mood disorders. The incidence of depression was 7.3% in 2014. This figure jumped to 10.9% in 2019 and rose again to 13.5% in 2020, when mental health was further exacerbated by the pandemic.[68] France is also known to have a high suicide rate. A recent survey by the government found that 10% of adults had suicidal thoughts in the past year,[69] with the risk of death by suicide being 10 times higher for those who are depressed.[70]

France is one of only a few European countries that do not have a stand-alone law or policy for mental health. Instead, mental health is covered in a fragmented way by multiple laws, making compliance with mental health legislation irregular or nonexistent.[71] This can, in part, be attributed to the change of treatment paradigm in the country, from a focus on psychiatry to a decentralised emphasis on mental health generally.[72]

The broader financial burden of mental health in France is significant. In a 2007 report, the cost of mental healthcare was estimated at €13 billion. Of this amount, €360 million were patients' out-of-pocket costs.[69] In terms of lost productivity, the costs amounted to €24.4 billion, with €20 billion attributable to income loss and €4.4 billion allocated to compensate for incapacity to work. Even a decade ago, more than 470,000 working years were lost because of mental illness (according to 2007 data).[69]

The increasing attention to mental health in recent years has led to greater funding for treatment. In 2021, the French government announced free therapy sessions for French citizens as part of a broader initiative to address mental health.[73]



Summary table

7.0%	**Prevalence of depressive disorders**[55]
49.8	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
24 of 156	**World happiness ranking**[66]
13.8	**Suicide rate**[67] (defined as rate per 100,000 people)
No	**Healthcare system covers psychological treatment**[62]

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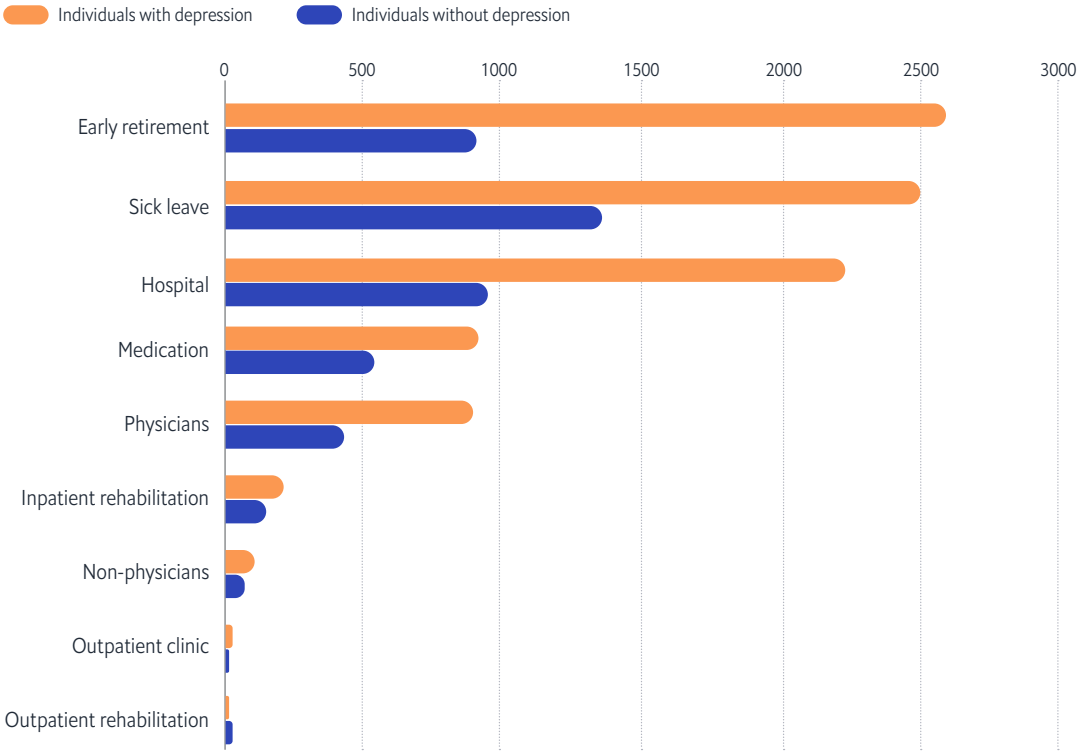
Germany: business left counting the cost of absenteeism and presenteeism

More than five million Germans suffer from depression each year.[74] In 2017, 15.7% of Germans experienced depression, up from 12.5% in 2009. Germans experiencing depression report feeling disconnected from people, withdrawing from social activities and experiencing turbulence in their personal life.[75]

Like other European countries, German women are more likely than men to experience depression. However, the gap is closing: prevalence has increased more in men than in women, up 40% in men compared with a rise of 20% in women.[75] Amongst 12- to 18-year-old adolescents, a higher incidence of depressive disorders was found in girls than in boys. However, boys with depression in primary school had a much higher relative risk for relapse of depression in later adolescence than did girls.[76]

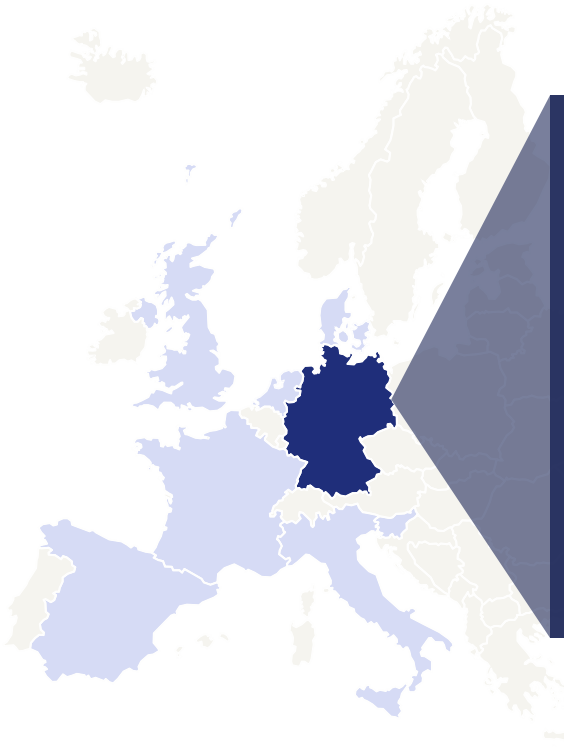
German employees are also taking more sick leave as a result of depression. Absenteeism from work rose by more than 70% from 2000 to 2013.[77] In 2020, administrative leave related to mental health was at 11.9%, an increase of 67.5% since 2008. Depression weighs heavily on those in their thirties: those aged 35-39 account for 14.1% of all lost days, followed by 30- to 34-year-olds at 14%.[78] The effects of depression are felt later in life as well: the number of people who retired early due to depressive disorders has more than doubled between 2000 and 2013.[79]

FIGURE 7. Estimated mean costs of each cost category (in euros, 2019)[80]



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The excess costs of individuals with depression versus individuals without depression are 2.0 times higher for direct and 2.2 times higher for indirect excess costs. A high share of excess costs is accounted for by early retirement. Therefore depression has severe consequences not only in terms of the number of days spent on sick leave but also in the long term in the form of permanent productivity losses. Depending on the subgroup considered, different patterns emerge (Figure 7): the excess costs of depression were highest among young people (aged 18-29 years) and decreased with increasing age.[80]



Summary table

9.2%	**Prevalence of depressive disorders**[55]
56.4	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
17 of 156	**World happiness ranking**[66]
12.3	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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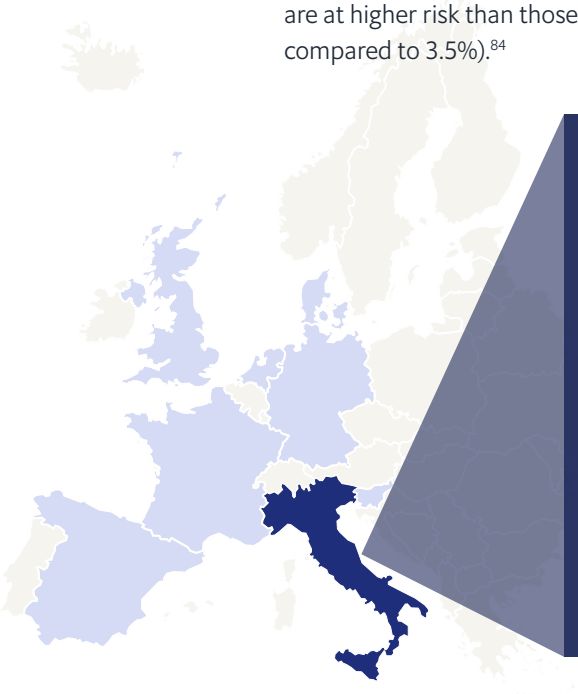
Italy: impressive history of mental health reform, but failing to build for the future

When Italy passed a law in 1978 to block all new admissions to public mental hospitals, it inadvertently forced pioneering reforms in how patients were to be treated. While the law left Italy with fewer mental health clinicians per capita,[81] it did lead to changes in how patients would be treated within community care.[82] Community mental health departments today deliver treatments for depression, anxiety and other afflictions through integrated models of care. They are in charge of the management and planning of all community-based services relating to the prevention and treatment of mental health problems.[83]

Though these reforms have served as a global model, Italy has the lowest proportion of government expenditures on mental health.[81] This relatively low spending poses a key challenge for the sustainability of the mental healthcare system, and for quality of care.[81] Italy has some of the lowest rates of depression compared to the rest of the world, but even here the rates of illness have been increasing, rising to 5.4% in 2018 from 3% in 2009.[84] As in other countries, there is a higher prevalence of depression among women (9.1%) than men (4.8%) and the jobless are at higher risk than those who work (8.9% compared to 3.5%).[84]

There has been, and continues to be, more focus on depression among the national government in recent years, with a recent parliamentary debate on the topic.[85] Five motions were approved following the session. These included the creation of a registry of suicides and suicide attempts, increasing the number of mental health professionals, reducing inequalities of access to talking therapies, strengthening the training of GPs and teachers on prevention, and launching an information and awareness campaign on mental health.[86]

Most Italians are treated for depression, particularly mild depression, through primary care, although more specialised care is available regionally through local care pathways based on collaborative care models.[83] Antidepressant consumption quadrupled from 2000 to 2011 due to a variety of factors including increases in long-term prescribing, the use of antidepressants for anxiety and the fact that general practitioners are doing more prescribing than psychiatrists.[87] This rise in antidepressant use, labelled "alarming" by the authors of the paper, suggests that a new public health agenda is needed to try to reduce the consumption of antidepressants through reductions in the prevalence of depression, not only in Italy but Europe as a whole.[54]



Summary table

3.8%	**Prevalence of depressive disorders**[55]
46.5	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
36 of 156	**World happiness ranking**[66]
6.7	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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The Netherlands: innovation has dramatically reduced rates of depression, but gaps persist at the neighbourhood level

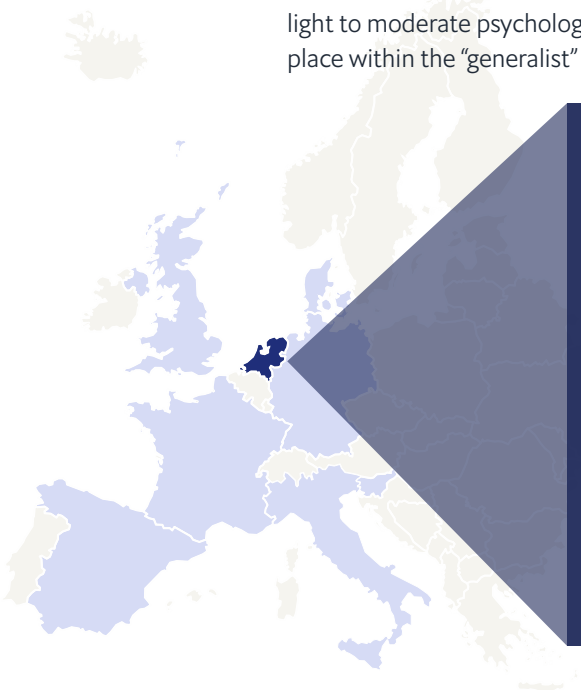
The Netherlands, which had one of the world's highest rates of depression a decade ago, has made significant strides in implementing policies for improving mental health and now ranks high on the UN World Happiness Report.[88,66] Its recent improvement in wellbeing is largely due to its innovative mental health policies.

The Dutch healthcare payment system provides incentives for general practitioners (GPs) who refer eligible patients to mental health services.[89] While both WHO and OECD have applauded this innovative practice, it has not reduced the number of beds needed for inpatient psychiatric care.[90] As GPs are the gatekeepers of mental health services, improved support for the primary care sector is needed.[91] The reforms to segment patients into one of two services have left the health system in a state of confusion in regards to quality indicators for mental healthcare.[92] The indicators have been revised numerous times, leaving such data incomparable and often unmeasurable. Therefore, as spending on mental health increases in the Dutch system, it is unclear whether quality is increasing as well.[92]

As of January 1st 2022 new funding for mental health care was introduced.[93] The treatment of light to moderate psychological problems takes place within the "generalist" mental healthcare (GB-GGZ). If there are more serious and more complex psychological problems, the treatment will take place in "specialized" mental healthcare (S-GGZ). It is too early to tell how well the new system is working.

The system in the Netherlands has implemented innovative treatment methods. An example is eMEN, a virtual mental health treatment program that aims to expand access to services.[90] Of the six countries that participated in eMEN studies, the Dutch program was the most successful, with the highest percentages of initial uptake and prolonged use.[90] Another innovative model is flexible assertive community treatment (FACT), an integrated care model based on the assertive community treatment model from the US.[94,95]

Dutch research has shown that neighbourhood socioeconomic factors (low socioeconomic status, more social security beneficiaries and more immigrants), physical factors (high levels of traffic noise) and social factors (lower social cohesion and less safety) are associated with increased prevalence of depressive and anxiety disorders. Most of these neighbourhood characteristics are also associated with increased depressive and anxiety symptoms severity.[96]



Summary table

4.4%	**Prevalence of depressive disorders**[55]
45.1	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
5 of 156	**World happiness ranking**[66]
11.8	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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Slovenia: advancements in primary care have not made up for socioeconomic inequalities and opaque mental health funding

Although Slovenia's current rate of depression is lower than the European average (6.4%), the country has been criticised in the past for its lack of primary mental health infrastructure.[55,98] As Slovenian suicide rates rose during the early 2000s, researchers identified significant gaps in primary and preventive mental health services.[98] Slovenia made some progress in this area by creating health promotion centres for primary care provision to improve health and wellbeing more broadly.[98]

The covid-19 pandemic acted as a catalyst for mental health service improvement in Slovenia.[99] Practitioners were able to use health promotion centres, which served as a source of covid-19 information, to identify a need for more robust mental health support early on.[99] Now, mental health support and services are widely available, at a local level, for Slovenian residents.[99,100] Slovenian researchers have also been involved in investigating new treatments for depressive disorder.[101]

Despite these advancements, inequality still plays a significant role in fuelling depression in the country. The effects of disparities in socioeconomic opportunities accumulate over a lifetime and largely contribute to the variation in life expectancy and mortality rates observed across Slovenia.[102] Financing for mental health in Slovenia also remains complicated and difficult to track, and therefore to plan for. Different ministries and sectors submit fragmented and out-of-date data, a major barrier to financing and coordinating mental healthcare for the future.[102]



Summary table

5.5%	**Prevalence of depressive disorders**[55]
56.8	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
29 of 146	**World happiness ranking**[66]
19.8	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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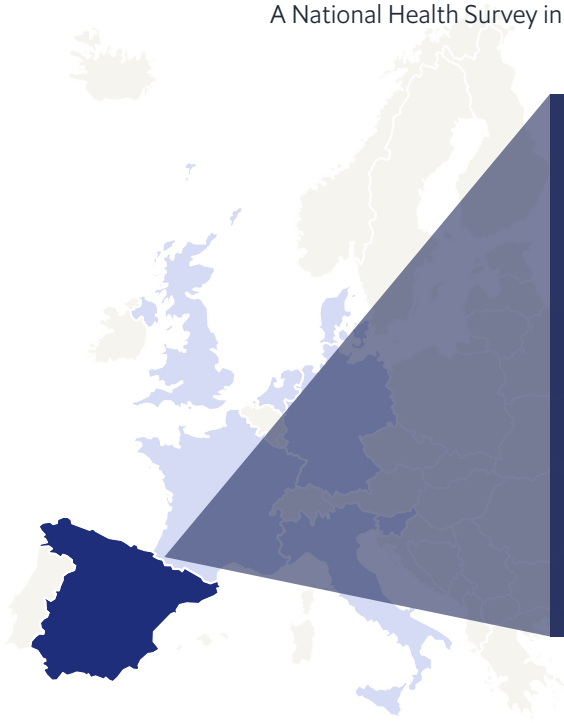
Spain: a complex delivery system and insufficient staffing are fuelling a widening gender gap

After the financial crisis in 2008, Spain recorded a very significant increase in major depression and anxiety. Diagnoses of major depression increased by 19.4% between 2006 and 2010, and anxiety increased by 8.4% during the same period.[103] One-third of those with a higher risk of major depression could have been influenced by the risk of unemployment and associated financial difficulties.[104]

A complex delivery system exists within the mental healthcare landscape in Spain. Numerous government entities (at the regional, provincial, county and local levels) have a role to play in delivering mental healthcare, yet shared information systems rarely exist.[105] There is not a specific agency or department for mental health within the national Ministry of Health, which can lead to confusion among various agencies and authorities throughout the country.[106]

In 2020, almost 628,000 men (about 3.2% of the population) and more than 1.4 million women (7.2%) were diagnosed with depression.[107] A National Health Survey in 2017 reported that instances of depression diagnoses in women were twice the rate of men: 9.2% to 4.0%. This trend is also represented in prescriptions and consumption of antidepressants and stimulants. Almost 8% of women were likely to use antidepressants and stimulants versus 3% of men.[104] It has been suggested that one explanation for the wide gap between men and women could be the high number of education and other programs targeted at women, which may have increased the frequency of diagnosis of depression and anxiety.[104]

Women in Spain have also been found to have more instances of subclinical depression, which, is rarely formally diagnosed or treated.[108] This could be one reason that indirect costs related to long-term sick leaves/ permanent disabilities make up over 60% of the total cost of depressive disorder in Spain.[108] Alternatively, it could be because of the relatively low number of psychiatrists—just 106 per million inhabitants, amongst the lowest in Europe.[109]



Summary table

6.0%	**Prevalence of depressive disorders**[55]
73.1	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
30 of 156	**World happiness ranking**[66]
7.7	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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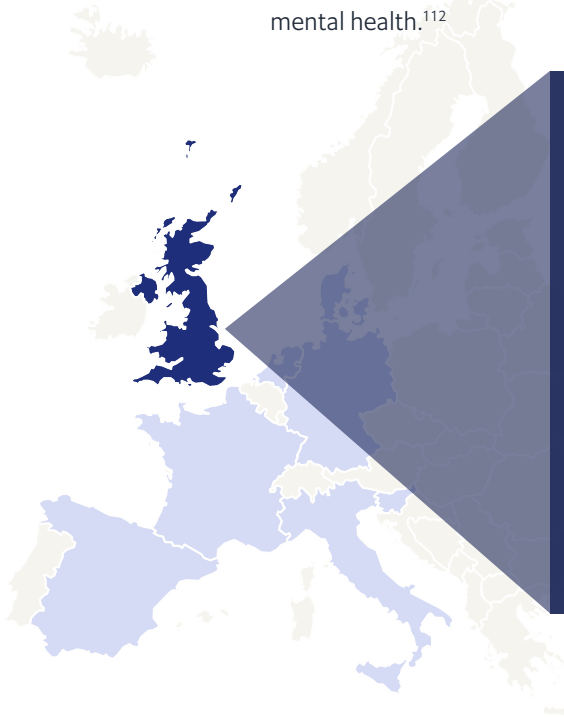
United Kingdom: promising policies that are slow to materialise

The UK is often praised for its community-based mental healthcare model. It has created strong links between social support services, such as employment and housing assistance, and psychological and medical interventions. Though these efforts have established one of the better mental health systems in Europe, critics suggest there is much to be done.[110]

Despite new policies and intentions to improve access to care, many people do not have access to any mental health support, with only 25% of adults with depression likely to receive treatment.[111] Racial disparities are also present: depression is more prevalent in Black, Asian and mixed or other ethnic groups.[111] A systematic review in 2012 determined that an average of 17.1% of older adults in the UK will experience a depressive disorder, with 9.3% experiencing a major depressive episode.[111] These numbers increase if one is living in a care home. Up to 40% of these residents will experience depression, with many more instances likely going undetected. In terms of business expenses, UK employers spend £3.1 billion on replacing staff who leave their jobs because of poor mental health.[112]

Measuring and paying for mental healthcare also remain a key challenge, despite decades of policy promising to improve both factors.[113] For example, there are no "currencies" (the units of healthcare for which a payment is made in the UK) in mental health in the UK, despite currencies having been established for many years for physical conditions[114]—hampering efforts to create parity of esteem. Better metrics to understand the true burden of depression, such as housing or employment status, would also provide vital information. Though the IAPT (Improving Access to Psychological Therapies) programme was recently rolled out nationwide, broader issues remain for the integration and colocation of mental healthcare professionals.[113]

During the covid-19 pandemic, the impact of depression was even more pronounced, especially among those aged 16-39, women and people who were financially compromised.[115] The pandemic also led to significant pressure on Child and Adolescent Mental Health Services.[116] Almost one in five (19.2%) adults reported symptoms typical of moderate to severe depression during the pandemic, up from around one in ten before the pandemic.[115]



Summary table

7.4%	**Prevalence of depressive disorders**[55]
94.2	**Rate of antidepressant consumption**[65] (defined as daily dose per 1000 people, per day)
15 of 156	**World happiness ranking**[66]
7.9	**Suicide rate**[67] (defined as rate per 100,000 people)
Yes	**Healthcare system covers psychological treatment**[62]

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Theme 1: Awareness

Attitudes to depression vary substantially across Europe. Stigma is decreasing in many north-western parts of the continent, where there have been dedicated campaigns to educate the public. At the same time, there is still a lack of recognition of depression as a mental illness in many parts of eastern and southern Europe. "Stigma is affected by culture and politics", says Mr Saunders. "It is very prevalent in places with conservative views and discrimination around how you engage with society". Not surprisingly, people are more likely to seek help if they live in an environment in which there is less personal stigma linked to depression.[117]

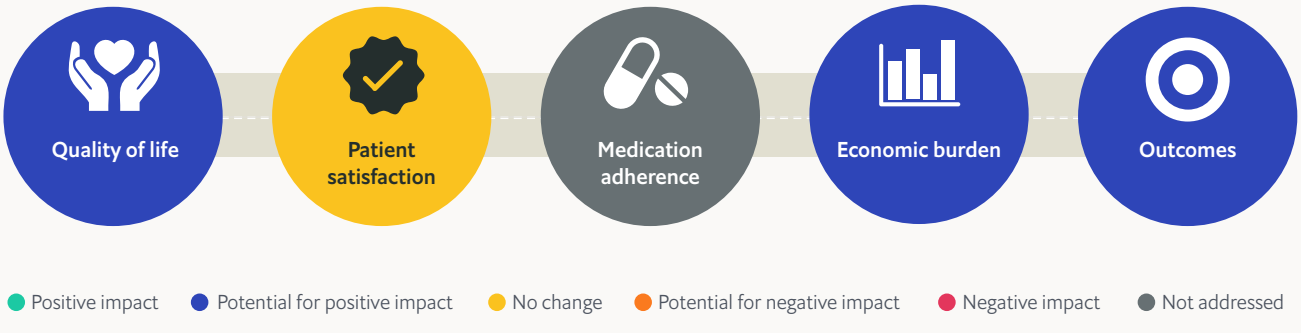
An absence of awareness or unwillingness to recognise depression also undermines efforts to confront it. It means it is less likely that there is targeted investment of health resources for depression, and it means people experiencing depression are more likely to be ostracised or penalised or be made to feel like outsiders. In many places, this lack of awareness makes it difficult to put a name on what appears to be a nameless problem.

Finally, awareness is also needed to ensure that physical comorbidities of depression are recognised. Without this, family members, who take on the lion's share of the role in caring for those living with depression, are likely to feel even more isolated.

For the purposes of this paper, we have looked at three different aspects of awareness. *Recognition* is the extent to which the public is aware of the terminology of depression. *Attitudes* refer to the way in which people relate to depression as a condition. *Knowledge* conveys a broader understanding of depression as a condition and the kinds of support that clinicians can provide.

FIGURE 8. Evidence snapshot: awareness

To better understand the importance of awareness, we reviewed relevant literature for evidence of an effect on the burden of depression and associated outcome measures. We synthesised this evidence to determine whether there was an impact, potential for impact or no change to the outcome measures as a result of increased awareness of depression. For more information regarding the literature review and corresponding analysis, see Appendix 1.



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Recognition

Recognition implies not only the ability of the general public to spot signs of depression, but the capacity of clinicians or trained staff in the community to assess levels of severity of depression. Those living with depression and their families or carers also must have a vocabulary to identify the symptoms of a depressive episode. In places where there is a lack of cultural familiarity with depression, this process is more complicated.

Improving diagnosis and identifying cases of depression at an earlier stage can not only improve quality of life and outcomes, but can reduce costs for health systems, Ms Simon says. "In almost half the cases, people have one episode of depression connected, for example, to a life event, and if they get early identification and therapy, they will have no additional episodes," she says. "If people are not diagnosed on time, depression may become chronic or relapsing with increased diseases and economic burdens. I don't see that we need a golden bullet. I think where we are wrong is that we often recognise and deal with depression when it is too late. The understanding of its increasing incidence and relevant preventive actions are also limited and should reach out beyond the healthcare system."

Even those with an awareness that their symptoms are possibly due to depression are not always willing to seek help, often for fear of being stigmatised. An online survey of health science students (n=1139) found that only 21% of students with severe depression were willing to seek help, with the remainder apparently fearful of documentation on their academic records.[118]

Guidelines may advise clinicians, but their advice is not always followed. For example, although NICE guidance recommends an annual review of mood for patients with rheumatoid arthritis, it was found that stigma and a prioritisation of physical over mental health concerns affected patients' ability to seek help. By contrast, those with good relationships with their GPs felt better continuity of care would make them more likely to disclose mental health problems—whether or not that is outlined in the guidelines.[119] Evidence suggests that opportunities to diagnose depression in older adults during hospital stays are also being missed due to a lack of awareness on the part of clinicians treating them in general medical services.[120]

Not that recognition always leads to improved outcomes. For example, although depression and anxiety are common in people with heart failure and clinical guidelines recommend screening for this group, a study of patients in Germany failed to find a demonstrable link between GPs' awareness of their patients' psychosocial distress and an improvement in the patients' quality of life.[121] Interventions therefore need to be suitably focussed and relevant to the target group.

Attitudes

Improving awareness of depression requires an evolution in attitudes towards depression, including that of providers, the public and patients, as well as employers and educational institutions. In Denmark, for example, research has highlighted differences in the personal attitudes of people working in the social services towards those with depression and schizophrenia.[122] Mr Ronnenberg Møller notes

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that many of those living with depression in Denmark are worried about discrimination at work. His organisation surveyed five hundred people with depression and bipolar disease, and around one-third said they would not tell their workplace about their condition.

"People feel they could be fired if they are not performing at 100%", he says, adding that more education on mental health is important to bring public attitudes up to speed. "There is no nationally driven effort to change this; if we see the television shows that can be mobilised around cancer, there is nothing of the kind happening in the psychiatric scene".

Evidence is mixed about the ability of public campaigns to change attitudes towards mental illness. One Cochrane review found that mass media interventions for reducing stigma might reduce prejudice, but their ability to reduce discrimination was limited.[123] The review cited a 2009 survey of public reactions to depression in 15 countries globally and found significant levels of stigma in all countries. A US study using the same methodology found 47% of the public said they were unwilling to work closely with people with depression, and 30% were unwilling to socialise with them.

These attitudes may partly explain the disparities seen in fundraising among therapeutic areas. Public donations account for 2.7% of mental health research funding. Compare this to cancer research, where spending by fundraising charities makes up 68% of funding, and dementia, where it is 28%.[124]

Such attitudes can vary significantly among countries, Ms Simon observes. She notes that in her home country of Hungary, which once had Europe's highest suicide rate, people will argue that there is no such thing as depression, while in Austria, where she is a professor, "every second or third person has a psychiatrist". Research from the second German Depression Patients' Congress found that there was often a gap of several months before those suffering from depression were willing to seek help; stigma was cited as a possible reason for this.[125]

Even programs that have successfully raised public awareness about depression can have varied impact depending on the local culture. OSPI-Europe, a suicide prevention program piloted in four European countries—Germany, Hungary, Ireland and Portugal—centred on a public awareness program. Those living in intervention countries reported less personal depression stigma than those in control regions, and those

"The best anti-stigma policies are to use media and social media to encourage people to talk about it."

John Saunders, executive director of the European Federation of Associations of Families of People with Mental Illness (EUFAMI)



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who were aware of the campaign were more open to seeking professional help than those who were unaware of it.[117] At the same time, more negative attitudes were evident in Hungary, especially among older men with lower educational levels who were living alone. The researchers concluded that public awareness campaigns should highlight the "credibility" of the mental healthcare sector and be tailored to local cultural norms.

Sometimes the perception of stigma can be worse than the reality. The Viewpoint survey of mental health users in England from 2009 to 2014 found that although nearly 73% had concealed their mental illness from their workplace and nearly 54% had anticipated workplace discrimination, fewer than 27% reported experiencing it. Those with depression were nevertheless more likely to report work-related discrimination than those with schizophrenia and schizoaffective disorder.[126] Obligations to colleagues can also make it difficult for those living with depression to feel that they can be honest about their feelings at work, according to a joint UK and Australian study.[127] There are also suggestions that managers who offered support and help to those living with depression, rather than avoiding them, can reduce rates of absenteeism. It is, nonetheless, unclear whether this contributes to greater productivity.[128]

"The most significant factor in the promotion of stigma is silence and the way to deal with stigma is to break the silence, communicate and talk about the issue, bring forward information to make it clear that depression is not a life sentence and that people can recover and lead a meaningful life," says Mr Saunders. "The best anti-stigma policies are to use media and social media to encourage people to talk about it."

Knowledge

Knowledge about depression as a condition is clearly as important as recognition, both in terms of clinical knowledge and patients' knowledge of their own condition and treatment options. Knowledge can improve access to treatment and support, says Mr Saunders and others interviewed for this paper. "The awareness is not the problem, if we take awareness as people being aware that this condition is present in the community", says Mr Vinko, head of the Public Mental Health Expert Group at the National Institute of Public Health of Slovenia.

When it comes to expanding knowledge about depression, explicitly targeted work-based or education-based programs are likely to be more effective than broad-based awareness programs alone, Ms Simon says. A national telephone survey of more than one thousand people in Germany presented a series of vignettes indicating signs of mild, moderate or severe depression. Slightly over half of those surveyed (55%) identified depression as the health problem indicated by the vignettes, with those hearing the vignette with moderate symptoms most likely to recognise the problem as depression. By contrast, participants were less likely to recognise mild depression.[129]

There are also efforts to increase mental health literacy among middle-aged and older men, who are less likely to use health services for depression and are more likely to remain depressed for longer.[36] In general, though, knowledge about depression in Europe among the public is limited.[130]

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Case Studies

First European Art Festival for Mental Health in Greece

Expanding awareness of mental ill-health in a way that reduces stigma is a careful balancing act. The NEFELE Festival, launched in October 2016 in Greece as part of the Creative EuropeCulture programme, aims to address this problem by connecting art to mental health in order to defend the rights of mental health patients, as well as play a role in therapeutic approaches. The festival is a joint project of the European cultural, social and health sectors.

The festival's main objectives were fighting stigma and connecting art and mental health through the establishment of similar festivals across Europe, as well as the internationalisation and dissemination of works of professional artists and mentally ill people. In addition, organisers sought to increase public awareness and offer welfare and business opportunities to mentally ill people with special talents. The transfer of expertise and peer advice were particular goals of the project, as was the provision of community-based mental health services and suicide prevention.

Organisers found that the wide variety of groups involved with the project helped raise its profile. Public interaction with the events of the festival was also strong, with a report on the project concluding that "it was evident that the arts are an appealing and appropriate vehicle to employ in order to create conversations around mental health".[131]

This Is Me prevention programme in Slovenia

Adolescents living with depression are one of the most challenging groups to reach. Slovenia's "This Is Me" e-counselling project aims to make contact with 13- to 17-year-olds in the places where they spend the most time: online and in school. As part of the programme, teenagers can post questions or concerns online and a team of experts responds. Since 2001, the e-counselling service has used a multidisciplinary network of fifty-six voluntary experts to answer more than 42,000 questions.[132]

The project is further supported through a programme of ten self-image development workshops in a number of schools around the country. Each session addresses one of the important fields of adolescent experiences and behaviour (such as self-respect, individuality, taking responsibility and managing emotions). The workshops are designed to improve mental health literacy and awareness. They also aim to develop social and emotional skills, which empower adolescents to deal more effectively with the challenges of growing up, and build better relationships, personal strength and resilience". The program has been the recipient of national and international awards, including from the European Commission and WHO.

Suicide Prevention Action Networks (SUPRANET Community) in the Netherlands

While stigma around mental health is present in many countries, the stigma attached to suicide is especially strong, and often prevents a barrier to people seeking help. In 2017, the Netherlands introduced the European Alliance against Depression (EAAD) through the creation of six Suicide Prevention Action Networks (SUPRANET Community). The EAAD's first intervention was a national suicide prevention awareness campaign, aimed at encouraging the general public to talk about suicide. A recent study found that in 2018, only around 40% of Dutch adults who committed suicide were enrolled in mental health treatment at the time of their death.[133]

Organisers carried out a series of surveys to determine the impact of the public awareness campaign, which showed that it was predominantly visible among the younger generation. Respondents who indicated having seen the public awareness campaign showed more openness towards seeking professional help and were considerably more likely to be familiar with the Dutch helpline than those who reported not having seen the campaign.

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What if...?

Egå, Denmark, 2032

Josefine, a young mother in Denmark, has noticed signs of depression in one of her neighbours, an 85-year-old woman whose children live several hours away. Josefine does occasional shopping for her neighbour, who has spoken to her about feeling lonely. She also admits to sleeping more during the day.

Most people in their small suburban community are knowledgeable about depression, thanks to regular public service campaigns via radio, internet and social media about how to recognise the signs and symptoms of depression and anxiety in others. Special awareness campaigns have targeted older people and teenagers, and have helped to reduce stigma associated with depression. Josefine recognises that her neighbour may be suffering from moderate depression.

The campaigns have also publicised the new community mental health hubs that the health service has set up. The hubs, staffed with both mental health specialists and trained volunteers, are linked to primary healthcare networks and can provide face-to-face or online counselling.

In addition, greater public understanding of the way in which depression can affect particular age groups has spawned a number of innovative projects. One of these is a drop-in centre for older residents of Josefine's community, colocated in the mental health hub.

Josefine knows she has resources she can use to help her neighbour. She suggests the drop-in centre and offers to take her there on a weekly basis when she is going into town.



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Building resilience through . . . raising awareness

Primary responsible stakeholder: everyone!

1

Stigma remains a factor
Although the stigma associated with poor mental health is decreasing in some cases, progress is uneven across countries and demographic groups. And there is some evidence that depression still retains greater stigma than other mental health illnesses such as schizophrenia.

2

People fear revealing their depression to work colleagues and others
There remains a concern that bosses will not understand and that jobs will be at risk. On the plus side, more people anticipate discrimination at work due to their depression than those who actually experience it. Nevertheless, the world of work will be at the forefront of attitudes to depression for the foreseeable future, as the epidemiology of the condition changes to include more of those who are young and still in the workforce.

3

Health literacy needs to include depression literacy
People tend to be better at recognising moderate depression than either its mild or more severe varieties. This can have serious consequences, both in terms of lost opportunities to identify those with mild depression and the possibility that severe cases of depression that need urgent referral might be missed. Better awareness on the part of both specialists and laypeople could improve recognition.

4

Everyone agrees on improved awareness in principle but . . .
Awareness is not the end-point. After awareness comes knowledge and changes in behaviour. It is one thing to acknowledge depression is relatively commonplace and can affect anyone, but it only really becomes meaningful when paired with new behaviour. And behaviour change is difficult to sustain.[134]

5

Good examples of practice in Europe include . . .
Our case studies describe the role of festivals and other programmes to raise awareness, the modification and implementation of prevention strategies that are relevant to young people and take place in a suitable setting, and ensuring the people know where to turn if they have suicidal thoughts.

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Theme 2: access to treatment and innovation

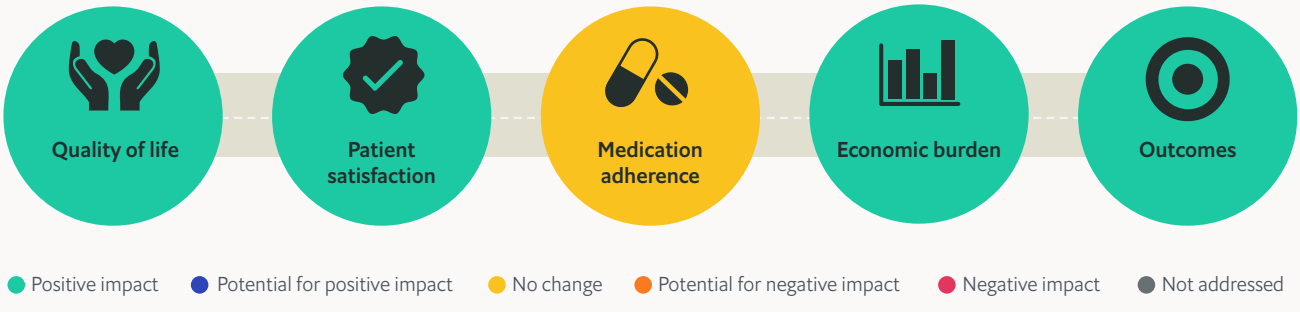
The past two years of covid-19 and associated lockdowns have made access to services for people with depression more difficult, but also spurred innovation in areas such as telemedicine. This has taken place against the backdrop of an undeniable increase in demand for care. Indeed, a WHO scientific brief in March found that the covid-19 pandemic has triggered a 25% increase in the global prevalence of anxiety and depression.[135]

As a result, mental health, and rising rates of depression and anxiety, have leapt up the global health agenda in recent months. It nevertheless remains unclear to what extent, and within what time frame, this growing concern is likely to manifest itself in new policies and greater access to care. There are clearly efforts in some countries to focus resources on specific groups that have been identified as vulnerable following two years of lockdowns: adolescents, young adults and the elderly are notable examples, as are traditionally marginalised groups such as those from ethnic minorities.[136-138]

"Access is primarily about knowledge: are people able to access the types of services they want?" says Mr Saunders, executive director of EUFAMI, a pan-European organisation supporting families affected by mental ill health. "In some places, there is a large population and insufficient resources. There are huge problems and variations in the supply of psychiatric nursing and medical psychiatry".

FIGURE 9. Evidence snapshot: access to treatment and innovation

To better understand the need for improved access, we reviewed relevant literature for evidence of an effect on the burden of depression and associated outcome measures. We synthesised this evidence to determine whether there was an impact, potential for impact or no change to the outcome measures as a result of increased access. For more information regarding the literature review and corresponding analysis, see Appendix 1.



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"We cannot expect everything from the healthcare system and from treatment. Depression is an area where we need to move away from the narrow medicalised approach and look at it in a policy frame"

Judit Simon, professor of health economics at the Medical University of Vienna





"Theoretically, patients have access to treatment, but in practice, no", says Mr Ronnenberg Møller, secretary general for the Danish Association for Depression (DepressionsForeninge), which represents people in Denmark living with bipolar disorder and depression and their families. "If you are depressed and have been in the system for years, you have your psychiatrist and can get medications and have help. If you are newly diagnosed, then it's a problem—we do not have enough psychologists and psychiatrists who work under the welfare system".

Treatment for depression is often divided between pharmacological interventions and nonpharmacological, or "talk-based" interventions. We describe here four broad groups of interventions: technology-based, community-based and "talk-based" interventions, and interventions for underserved groups.

Technology-based interventions

Technology has been introduced more slowly into mental health treatment than in the treatment of physical diseases (a notable exception being electroconvulsive therapy). However, many new interventions use technology to extend or improve access to treatment or supervision. These include telemedicine-enabled websites to allow patients to access therapy online, which saw wider adoption during the covid-19 pandemic.[139] An evidence base is beginning to emerge. An evidence map of 161 randomised control trials looking at the use of technology in the clinical care of depression found that 145 studies reported a positive outcome in depression symptoms at follow-up, compared with baseline measurements.[140]

Health services, particularly in the UK, have been given wide scope to prescribe web-based applications and other technological interventions over the past decade in order to extend access to treatment.[141] These tend to be focussed on mild to moderate depression. In Germany, the GET.ON Institute operates an online mental health service delivered through the use of internet and mobile-based psychological interventions.[131] However, for these interventions to be successful, healthcare services must ensure that cultural and other obstacles to patients engaging with technology are eliminated.[142]

"You cannot change access to treatment unless you manage to get healthcare professionals behind it, together with those who pay for care and those who make the relevant policy decisions," says Ms Simon. In order to win that support, healthcare professionals have to perceive the tools as both time-saving and improving the quality of care for patients.[143]

Not all new technology is aimed at patients. A technology intervention directed at clinicians is PsyScan, an e-tool designed to help GPs diagnose and manage a host of psychological problems.[144] And it is not all about communication technologies. For example, the development of technologically based therapies such as transcranial electromagnetic stimulation (TMS)—is a noninvasive use of magnetic fields to stimulate nerve cells in the brain to improve depression.[145]

When it comes to new medications, there has been little in the way of new antidepressants since the advent of serotonin and norepinephrine reuptake inhibitors in the 1980s and 1990s.[146,147]

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However, during the last couple of years there have been a couple of regulatory approvals for new drug therapies, though it is too early to tell how enthusiastically they will be adopted by healthcare providers and payers.[147,148]

Community-based interventions

Community-based interventions can tackle many goals of mental health policy simultaneously. They may increase awareness, reduce stigma and help find ways of managing patients with less severe forms of depression, while avoiding the need for expensive inpatient treatment.

Projects in four European countries looked at the impact of training community facilitators, such as teachers and social workers, to improve knowledge and attitudes relating to depression and suicidal behaviour. The projects were most successful when they were targeted at those with low basic skills in this area.[149] Other projects have aimed to reduce the stigma around mental health, such as the first European Arts Festival for Mental Health (NEFELE) (see the case study above).[131] The festival aims to offer welfare and business opportunities to artists and performers with mental health problems.



Community interventions can help target hard to reach groups. For example, a recent study looked at the impact of community support groups for men and found that they provided a judgement-free environment and could fill gaps in existing services.[150] Support groups that encourage people to discuss their low mood are valuable, as GPs most often miss cases when patients are reluctant to talk about depression, or clinicians lack confidence in discussing the subject.[151]

More broadly, there is a need to understand ways in which not just the community but the entire environment can exacerbate depression, Mr Ronnenberg Møller says. "There should be national attention on how we could create a healthy society rather than always repairing it". Ms Simon agrees: "We cannot expect everything from the healthcare system and from treatment. Depression is an area where we need to move away from the narrow medicalised approach and look at it in a policy frame".

Talk-based interventions

Access to talk-based interventions (or talk therapy) is in short supply in many European countries. This is often due to both a shortage of psychotherapists and psychiatrists and to a preference to initially prescribe medicines to save costs. Cultural factors are also influential, says Mr Saunders of EUFAMI. "I think in many cultures, the aspiration is that people will have access to the biopsychosocial model, but because of history, in many places, it is more about the biomedical model", he says, adding that most European countries are in a process of transition to a greater or lesser extent, from a purely medical model to a biopsychosocial one.

Cognitive behavioural therapy (CBT) is one of the more widely used forms of talk therapy, and for good reason: it works.[152] It can also be useful as a way of treating depression in patients with physical diseases. A pilot eight-session cognitive behavioural group therapy program in Germany,

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known as STEpS, could help patients with chronic physical diseases and comorbid depression to handle long waiting periods in outpatient care.[153] While there is less data for person-centred experiential therapy, evidence suggest that it is equally effective to CBT in cases of moderate to severe depression up to the 12-month mark.[154]

Incorporating new therapies into pre-existing pathways can be a challenge. For example, despite evidence that it can be used to help prevent relapse of depression, access to another form of talk-based therapy, mindfulness-based cognitive therapy (MBCT), remains patchy in the UK, where the health service has tried to integrate it into care pathways.[155,156] Even when access to talk-based therapies is improved, it may not impact the balance between pharmaceutical and nonpharmaceutical interventions. For instance, the UK's introduction of the Improving Access to Psychological Therapies (IAPT) initiative in 2008 did not curb rates of prescribing antidepressants. Prescribing rates in England continued to increase by 10% annually between 2008 and 2011.[157]

Another way to improve access is to deliver talk therapies as "low-intensity" interventions. These involve briefer time with therapists, using either a limited number of sessions, group interventions, self-help manuals or task-shifting to options delivered by nonspecialists. These interventions can be easier to integrate into primary care or community settings and may improve access, but can potentially lead to higher relapse rates.[158]

Finally, talk-based therapies are not necessarily an alternative to medication, but rather, complementary. Indeed, the evidence suggests that the combination of talk-based therapy with antidepressants may be the best choice for patients with moderate depression.[159] The combination of therapies is also more likely to be tolerated than antidepressants alone.

"I really think future innovation will rest on blending all types of technologies with face-to-face contact, and then placing a bigger emphasis on self-management and autonomy of patients as well as personalization of treatment", opines Ms Riper. "I think in the future much more focus on artificial intelligence and prediction models will be important".

Interventions for underserved groups

Access to treatment is a particular issue for underserved groups. Female and black carers are most likely to report stigma-related treatment barriers,[160] while a Dutch study from 2018 looked specifically at the treatment of depression in Turkish and Moroccan-Dutch patients and at the need to widen diversity training to improve outcomes.[161]

In France, research suggests that underserved populations are less likely to consult GPs for depressive episodes. This was due to the stigma of depression and negative perceptions of treatment, as well as social and environmental factors and issues relating to the doctor-patient relationship.[162] While research indicated that 60% of patients visiting a free clinic were depressed, only half of them discussed their depression with a care provider. Older patients are more reluctant than younger patients to discuss depression with their GPs,[163] and if they do speak up, they are less likely to be prescribed talking therapies, even when it is recommended in clinical guidelines.[164] Similarly, German and Dutch researchers found that socioeconomic and age barriers often prevented GPs from recommending blended psychotherapy, an approach that combines internet-based and face-to-face therapy.[165]

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Case Studies

Using technology to improve mental health in France, Germany, the Netherlands and the UK

With demand for mental healthcare rising in Europe, digital health technologies are seen as an important part of the armoury. However, the digital delivery of mental health treatment in Europe varies substantially. Rollout has, for the most part, been slow. Ensuring that therapists have the right skills to work in an environment that blends traditional and digital therapeutic approaches is key.

The e-Mental Health Innovation and Transnational Implementation Platform North-West Europe (eMEN) was designed to accelerate and improve e-mental health services. eMEN is a project focusing on six countries, including four of those covered in this paper: France, Germany, the Netherlands and the UK. The UK and the Netherlands were comparatively more advanced in the uptake of e-mental health, while Germany and Belgium lagged behind.[90] Countries participating in the project faced barriers ranging from fragmented health delivery systems to inadequate legal frameworks for introducing e-mental health.

The eMEN consortium offered a series of recommendations that would increase equitable access to technology for all individuals with depression, including marginalised groups. These included the promotion of strong governance and leadership for the development and dissemination of e-mental health, alongside adequate financing to ensure long-term viability. Also, the consortium identified the need to increase awareness and trust in e-mental health and enhancement of digital health literacy. Finally, the group recommended integration of e-mental health into existing care models and areas of interest, including mental health in the workplace and mental health in schools.[90,166]

When the project concludes later this year, it is estimated that average use of e-mental health solutions across the participating countries will have more than doubled, to 15% from 7%, since 2016. On top of this, the project has led to the development and piloting of seven e-mental health interventions, one quality-test method for development and implementation and a transnational policy solution for e-mental health implementation.[167]

Peer support workers (Médiateur de Santé Pair) in France

Mental health problems are frequently stigmatised, which presents additional barriers to people accessing care. The French program Médiateur de Santé Pair,[168] or peer support workers, trains people who have experienced mental health issues to be peer mediators in a clinical setting. The project, which followed a pilot in 2012, started in 2017. It trained thirty-one students with experience of mental illness, who qualified in 2019 with a bachelor's degree in health and social sciences and a specialty in peer mentoring. Graduates are now able to work in mental health teams and receive continued education and support.

The "peer health mediators", as they are known, are most often employed in public psychiatry teams. They have, by the very fact of their physical presence in the services, helped to shape the ways the teams practice, as well as the way in which providers talk about the patients. Beyond their presence, the mediators develop specific support practices, which have an impact on users and teams.

The project achieved a high rate of return to employment for people who had been on long-term sick leave. Three years after they completed the course, 86% of participants were working or studying, and more than half were working in peer support roles. The program has also received support from health professionals and management, many of whom want to work with peer support workers. The program also has expanded access by increasing the number of service providers and improving the quality of life of peer mediators and patients.[166]

There are still barriers to making the peer mediator role sustainable. The recognition of peer mediators as a profession is still a work in progress. Neither is there a commonly recognised body of knowledge or skills recognised for the role.[169] Nevertheless, this case shows the value of using peer mediators to help coordinate among health professionals, patients and their families in the community.

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Case Studies



Self-help for less severe mental illness in the UK

Improving the treatment of mild to moderate mental illness is a significant goal for health services. Individualised approaches to care may help avoid the further decline of mental health, which in turn can put too much pressure on specialised services.

A pilot program in Renfrewshire, Scotland, aimed to address common mental health problems such as anxiety and depression in an individually tailored way.[170] Under the Doing Well program, primary care mental health teams (PCMHT) provide information and support to adults with anxiety or depression with the goal of improving overall health and wellbeing. The service includes access to self-help materials, short "advice clinic" appointments and psycho-educational groups. Where necessary, patients would be given "step-up" care, considering pharmaceutical treatment or courses of brief individual therapy.

Doing Well employs self-help support staff who are psychology graduates but may have no previous clinical experience. These workers receive in-house training from clinical psychologists; the approach could therefore serve as a signpost for how to provide mental healthcare in areas with a shortage of professional psychotherapists.

An evaluation found that 79% of those who completed the programme had at least a partial recovery, while 42% were considered to be in remission from their original symptoms.[171] The programme implemented changes in four areas of service delivery for treating those with depression. (1) It undertook a comprehensive, integrative reorganisation of services. (2) It sought to use information more effectively by electronically recording personal health questionnaires at every contact, using staff to deliver care, record outcomes and distribute work within the team while developing objective measures for assessing depression severity. (3) It established guided self-help as the default psychological approach to care. (4) It invested in staff training and wellbeing to support their engagement and relationship with patients.

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What if...?

Frankfurt, Germany, 2032

Hanna, a Frankfurt-based banker, suffers from anxiety and low-level depression. However, she maintains a busy work schedule that includes business trips within Europe several times a week. Ten years ago, following the clinical guidance at the time, Hanna was on a regular dose of a selective serotonin reuptake inhibitor (SSRI), which generally maintained her condition at a baseline level, but was not always sufficient to stop her panic attacks.

Now Hanna, like most other people living with depression within the EU, is a member of the European Depression e-Network (EDEN). The e-Network offers a one-stop-shop platform that enables her to access flexible online therapy sessions, emergency prescriptions for the new class of rapid-action antidepressant medications designed for acute episodes of her condition and conveniently scheduled online support groups, operated on a "drop-in" basis by trained facilitators.

The platform is available throughout Europe, uses all EU languages, and users can register automatically through their GP using their patient registration sites. EDEN is available through a website or an application for smartphones and tablets. The service includes a directory of peer support workers. These are trained volunteers in all major cities and small towns who work shifts and are available for a face-to-face meet-up (most commonly in coffee shops).

For full-time workers, especially those in high-pressure professions, EDEN has a number of benefits. Therapy sessions are available from 7 am to midnight, wherever the patient is. This provides both additional flexibility and higher treatment adherence because services, both pharmacological and nonpharmacological, are easier to access. For the broader population, including those experiencing social isolation, the opportunity to access therapy online has increased the number of people opting for talk therapy.

While traditional face-to-face talking therapies are still available, the positive reaction to EDEN, which was rolled out in 2029, encourages healthcare policymakers to recommend it for other groups who find it difficult to access in-person treatment, such as those with disabilities.



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Building resilience through . . . improving access

Primary responsible stakeholder: payers

1

Rising and changing demand is being placed on a system that was already struggling
The increasing prevalence of depression will be challenging for healthcare systems that were already struggling with demand before the pandemic. While governments often talk of increasing access to mental health interventions such as talk therapy, the number of psychologists, psychiatrists and psychiatric nurses regularly fails to meet the demand. Coupled with this is the rising number of cases among the young, whose preferences and expectations of care are likely to differ from those of older adults.

2

Digital health is opening up access
eHealth, mHealth and other innovations are offering expanded access to care. However, they need to be supported via payment systems and incorporated into patient pathways. While not suitable for everyone, they may allow for more face-to-face care for the most serious cases.

3

Community interventions can help people who will not or cannot talk to their GP
Many hard-to-reach groups, whether it be men, immigrants or older adults, may feel uncomfortable talking to healthcare providers. Community interventions offer a nonjudgemental setting for vulnerable people, supported by their peers.

4

Innovative therapies are not easily available
Nontraditional interventions remain difficult to access. Creating a framework for allowing temporary access to such treatments for populations most likely to benefit would support development of an evidence base for such treatments. The pipeline for new therapies remains sparse.

5

Everyone agrees on improved access in principle, but . . .
One of the chief barriers to better access is the lack of staff. Talk therapy waiting lists are consistently long. A more diverse range of experts may help, allowing different intensity of interventions according to need. Alongside healthcare professionals should be trained mentors and other peer support, who offer an understanding and nonjudgemental ear.

6

Good examples of practice in Europe include . . .
Our case studies describe approaches to improving access in an imperfect world. These include the use of digital health to broaden access, the creation of a peer support system and the support and empowerment of a self-care programme.

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Theme 3: integrated approach to care

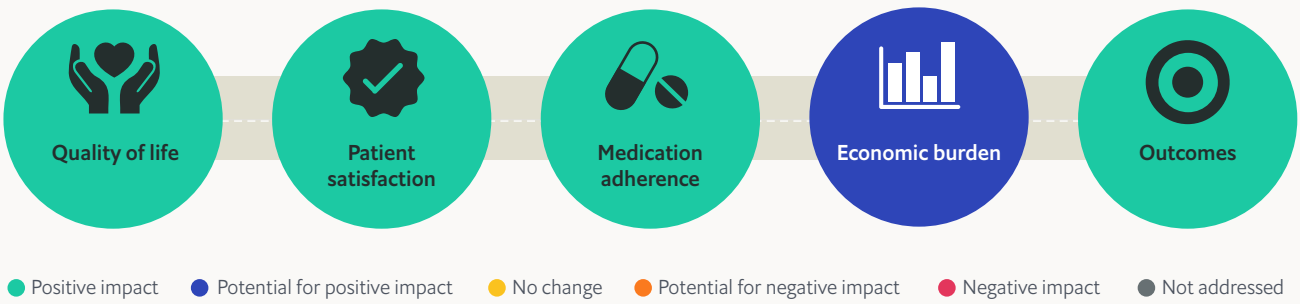
Designing systems that integrate mental healthcare with primary care is an approach that mental health advocates have long supported. In a climate of tight healthcare budgets and labour resources, integrated care may help to make the delivery of healthcare more efficient, more flexible and ultimately more cost-effective. In the UK, where the approach is arguably most developed, integrated care systems play a key role in the National Health Service's Long Term Plan; all parts of England have been covered by one of forty-two integrated care systems since April 2021.[172]

Integrated care offers many benefits. It can help draw links between physical and mental health problems and enable those with depression to be identified and monitored earlier, says Rafael Bengoa, co-director of the Institute for Health and Strategy (SI Health) in Bilbao, Spain, and a recent vice chairman of the European Commission's Advisory Group of Horizon 20/20 on Health, Demography and Wellbeing. "There is very little opportunistic screening or early detection (of mental health conditions) when someone comes in for another reason, even though almost all of the chronic conditions have evidence linking mental and physical health".

In the case of depression, the integrated approach allows primary care providers to implement prevention measures and offer a co-ordinated support system for patients' physical health, mental health and wider social needs, without duplicating services. At the same time, the emphasis on providing integrated care in the community makes this structure a good fit for depression, where identification and treatment of the condition before it becomes more difficult to treat is a central aim.

FIGURE 10. Evidence snapshot: integrated approach to care

To better understand the significance of an integrated approach to care, we reviewed relevant literature for evidence of an effect on the burden of depression and associated outcome measures. We synthesised this evidence to determine whether there was an impact, potential for impact or no change to the outcome measures as a result of an integrated approach to care. For more information regarding the literature review and corresponding analysis, see Appendix 1.



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"We know that prevention works", remarks Ms Riper. "We have evidence for it that even shows early detection of subclinical complaints, and addressing this can prevent major depression by 25%. But if you look at the budget, what is available for prevention in comparison to the treatment budget is only around 2%".

We describe here three components of integrated care: collaborative care, patient-centred care and family engagement. There is some overlap among these concepts since they all focus to some degree on the communication between health professionals, and between health professionals and the patient, family and carers.

Collaborative care

Collaborative care involves multiple health professionals from different backgrounds working together with patients and their families to deliver improved care. A standard model involves cooperation between primary and secondary physical health services and specialist mental health services. Teams jointly identify problems and agree on goals for intervention, frequently led by a case manager who oversees the work of the team, often supervised by a senior mental health professional. Implicit in the notion of collaborative care is the importance of long-term care coordination and follow-up.[173]

Collaborative care can also help to create an effective triage system. It can identify those with mild or moderate depression, who can sometimes be treated in the community, while specialist resources and interventions are focused on those with more serious illness. "We cannot get away from the crisis without organising people with bipolar syndrome, depression and severe depression", Mr Bengoa says. "If they are not on the radar, they are less likely to come into care".

Collaborative care can also be an important component of delivering interventions to prevent relapse of depression, something that poses significant health risks and costs.[174] It can also allow patients to be treated for both their depression and chronic physical conditions that are often comorbidities of depression.[175]

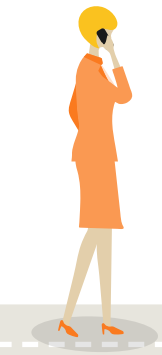
Collaborative care improves quality of life, patient satisfaction and engagement, and medical adherence in people with depression (Figure 6). Teams of clinicians working together with patients can create significant short-term improvement in outcomes for adult patients with depression and anxiety, compared to standard care, although evidence for long-term benefits is less clear.[176]

While collaborative care sounds deceptively simple, it may require extensive restructuring of existing care pathways. In Denmark, for example, community services are often split in focus, according to Mr Ronnenberg Møller, secretary general at the country's Depression Association (DepressionsForeningem). In practice, this means GPs and psychiatrists taking care of a patient's medical needs on the one hand, and municipalities taking care of the social aspect of care on the other, he says. This makes implementing collaborative care a challenge. Therefore, despite the evidence for collaborative care, it is not always clear how best to encourage take-up.[173]

Patient-centred care

Patient-centred, or person-centred, care is defined as care that "sees the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health".[177] This is a holistic form of care delivery that aims to be flexible and responsible to the individual and their needs, including establishing bespoke objectives

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> **"We cannot get away from the crisis without organising people with bipolar syndrome, depression and severe depression."**
>
> Rafael Bengoa, co-director of the Institute for Health and Strategy (SI Health) in Bilbao, Spain

and shared decision-making, information and education. This method of delivering care also involves close coordination with family members, integrated both into decision-making, as well as empowering and educating them.[178]

Although patient-centred care has a weaker evidence base behind it than collaborative care,[178] health policy in Europe is increasingly emphasising the empowerment of patients and their families.* This is something that is seen as especially important in the area of mental healthcare, as the approach can address the problem of hard-to-reach, vulnerable populations, for whom depression poses a significant burden.[179]

"Sometimes it's about restructuring your system to make sure you can provide those services, making sure you have community services, integrated services, tailor-made responses to people's needs, putting the person at the centre", says Mr Saunders, executive director of EUFAMI, a European organisation that supports families affected by mental ill health.

Mr Saunders and other interviewees also describe how depression impacts families as well as patients, with carers confronting particular burdens on their own mental health, their careers and livelihoods. In addition, children with depressed parents are at higher risk of developing a mental disorder themselves. In these cases, preventive interventions such as CBT have been shown to lower the incidence of mental illness.[180]

Family engagement

A third area of discussion about integrated care is patient and family engagement. This approach looks to extend the concept of patient-centred care by not only integrating patients and family members into care delivery but involving them in the design, planning and delivery of health services. It emphasises the desirability of helping nonclinicians make choices about treatment options or participate in strategic decision-making on how health resources are spent.[177]

Patient and family engagement—with its provision of a support system and efforts to improve the relationship among patients, providers and families—is somewhat better supported by research, especially regarding family engagement.[181] Carers often suffer a social and economic burden from their support of those with depression. Allowing families to feel some sense of ownership of the care delivery process could help to mitigate this impact.

"Caring for a family member with severe depression makes it hard to maintain a job and income; you aren't paid for this", says Mr Saunders, noting that many families face a loss of ambition, lower income and isolation. "Governments need to focus on maintaining financial or other support for families, to support the right kind of care to individuals".

* Note that there is an evidence review underway, looking at the evidence for patient-centred care. Protocol available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8153256/

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Case Studies

Identifying comorbidities to support integrated care pathways in the United Kingdom

Populations living in socially deprived areas frequently have high levels of chronic physical health conditions and are at particular risk of poor mental health as well. Populations with high rates of multiple morbidities are more likely to have worse outcomes and greater healthcare needs, and comorbid depression is especially challenging to health services, as 60% of depression cases are accompanied by one or more comorbidities.[182]

Waltham Forest, one of the most deprived boroughs, in England has a diverse, youthful population and was looking to reduce health expenditures and improve clinical outcomes. From 2011 to 2012, it instituted a clinical improvement programme that collected data comparing comorbid diagnoses of depression and other chronic conditions by looking at accident and emergency use. The borough used the health analytics software to record attendance, hospital admissions, outpatient attendance, GP appointments and the diagnoses of long-term health conditions.

The data showed that when patients had both depression and other long-term health conditions, the cost of treatment increased significantly and was associated with greater use of accident and emergency, or "episodic," care. Because scheduled care is less costly and more effective, Waltham Forest is in the process of developing collaborative health approaches in primary care that can manage comorbid long-term conditions alongside depression.[183]

Using primary care as a gatekeeper in the Netherlands

In 2014 the Netherlands introduced a major mental health reform with the aim of shifting patients from specialised care to primary care, where GPs function as gatekeepers for the Dutch mental healthcare system. Under the new legislation, GPs were no longer allowed to refer patients without a psychiatric disorder to mental healthcare. Those with less complex problems were to be treated in primary care, where interventions consisted of psychopharmacological treatment and/or short-term online counselling or brief therapy.

To cope with the increased demand, the majority of Dutch GPs worked with a mental health nurse to help monitor their referrals. A study of the reforms—carried out in a large primary care centre in the northern part of the country, with specialist mental healthcare services—found that patients generally improved after three months. This improvement was seen regardless of whether patients were treated in primary care, in an even less specialised setting or referred to specialist mental healthcare.

Integrated, person-centred primary healthcare produces results in Slovenia

Many countries in Europe are pushing for greater cooperation between different levels of healthcare system. Slovenia has, in some ways, been at the vanguard of this process. When it was still part of the former Yugoslavia, the country had primary healthcare centres staffed with psychiatrists and other mental health professionals; some of these centres were disbanded after the break-up of Yugoslavia, and not all were able to maintain interdisciplinary teams. Nevertheless, the country has been educating general practitioners about the medication and treatment of depression for nearly two decades and more recently has started to set up new integrated centres in a systematic way, according to Mr Vinko, head of the Public Mental Health Expert Group at the Slovenian National Institute of Public Health.

Part of the new system will involve a network of mental health centres for adults and children, operating as organisational units of the primary health centre. GPs or paediatricians can refer patients internally, Mr Vinko says, although the core principle of the centres is that the patient can show up there without the need to get an appointment beforehand. He added that the country currently has thirty-one such centres, and is aiming for fifty to fifty-five.

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What if...?

Bristol, UK, 2032

Jack, a first-year physics student at Bristol University, has been struggling for weeks. He is unable to sleep for more than a few hours a night and has been missing lectures due to regular headaches and stomach pain. Friends and his tutor suggest that he arrange to have a full NHS Health Check (a health "MOT", as it is called in the UK) with his GP.

While these general check-ups were previously only available for people over 50, worsening physical and mental health after the covid-19 pandemic led the government to increase funding to general practice to identify health problems early and prevent the cost of treating them from spiralling out of control. In addition, an increase in suicide rates at universities in the early 2020s led to the NHS identifying students as a vulnerable population to be prioritised.

Part of this new approach is a comprehensive integration of mental health into primary care systems, with a trained, designated mental health lead in each facility. This allows for better screening and diagnosis, early identification of higher risk patients, and better coordination with secondary care, if necessary. With all but the most serious cases able to receive treatment in primary care (such as CBT, which is now embedded in practices), patients are spared what was previously a Kafkaesque search for scarce NHS "talking" therapy or expensive private providers. The health system, meanwhile, has found that every pound spent on expanding its mental health provision in primary care has saved an additional £10 on indirect costs to society from undiagnosed mental health problems. As a result, the National Institute for Health and Care Excellence (NICE) now conducts most of its economic evaluations from a societal perspective, rather than based on health providers' perspective.

The challenge of integrating physical and mental health services has meant some long-term reforms in healthcare delivery. Smaller GP surgeries, which were already looking unviable given the increasing demands on primary care, have been folded into large practices that coordinate healthcare (mental and physical) with social services, including help with housing and benefits. This further increases the potential contact points for identifying health issues and rapidly diagnosing and treating them. For more rural areas, the NHS and local councils have established regional health hubs, with trained mental health practitioners and GPs. Emergency services (ambulance and police) are colocated with these hubs, as they are often the first responders to physical and mental health crises.

Back in Bristol, Jack's physical quickly reveals that he is suffering from mild depression and anxiety. He is prescribed medication and a series of CBT sessions, which can be renewed as necessary. His electronic medical record, which is linked with the University's health service, keeps track of his condition so that he can be monitored periodically. At the same time, Jack retains the right to control the services with which he shares his information.



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Building resilience through . . . integrating care

Primary responsible stakeholder: providers

1

Being "on the radar" means the most vulnerable are supported
An important benefit of integrated care is that partnered institutions can together identify and contact hard to reach and other vulnerable populations. Better task shifting of mild and some moderate cases of depression to trained practice nurses or community support workers could free up specialist care for those with more severe illness.

2

From episodic care to pathways: prevention, treatment and follow-up
Improved collaboration promises not only better identification and chances for prevention, but also at the other end of the pathway it supports improved follow-up. Better patient satisfaction with care also leads to improve adherence.

3

Primary care is the original "integrated care"
Designing interventions around a patient's needs could help prevent relapses or the need for inpatient care. In addition, better understanding of the whole patient and their background and support network could make it easier to treat comorbidities of depression, including unhealthy lifestyles and long-term conditions.

4

Extending benefits beyond the patient
Depression is a heavy burden on the patient, but it can also impact carers, families and friends. Supporting family and carer engagement will help the patient to recover while also preventing harm to those around them.

5

Everyone agrees on better integrated care in principle but . . .
The chief barrier to better integrated care is the siloed nature of health and care needs. Patient pathways reach across institutions, settings and teams. This is not an easy problem to fix. A good place to start may be for relevant institutions to develop common patient pathways.[184]

6

Good examples of practice in Europe include . . .
Our case studies describe (1) the use of big data to identify the vulnerable, (2) the strengthening of primary care with more diverse staffing and (3) the creation of dedicated mental health centres in the community.

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Theme 4: parity of esteem with physical health

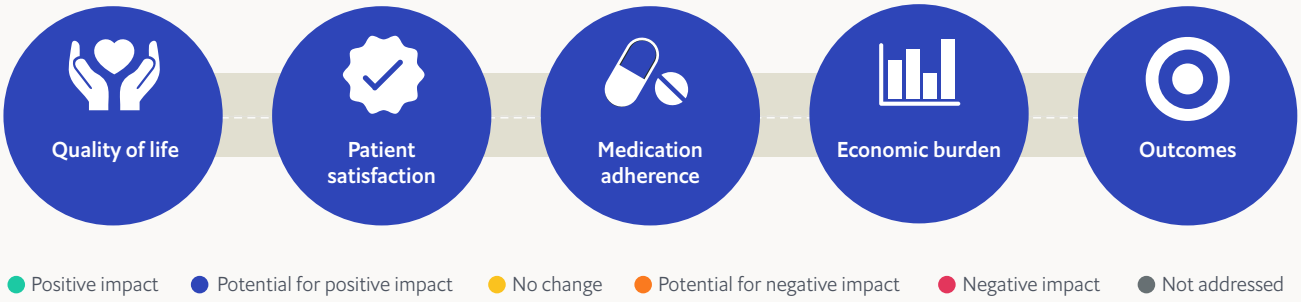
Politicians and stakeholders increasingly speak of the need to create a level playing field between mental and physical healthcare. Fulfilling the objective of "parity of esteem" would require attention across the entire patient journey, including prevention, early detection, education and support at the workplace and in the community. However, European health systems are at different stages of the journey toward parity, and none have the finish line in sight.

"The mental and physical connections in medicines are not established in Spain, not even in medical school, so the links are not made", says Mr Bengoa of the Institute of Health & Strategy. "It's fairly important, because you end up with a strict separation and in Spain that separation becomes structural".

The principle of parity of esteem was adopted in the UK as part of the Health and Social Care Act of 2012[185] and enshrined in the NHS Constitution in England in 2013. In 2014, the NHS Five Years Forward View committed to achieving parity by 2020.[186] Elsewhere in Europe, the Joint Action for Mental Health and Well-Being was launched in 2013 with a joint statement by seventeen organisations, including EUFAMI, in which parity of esteem was the first recommendation.[187]

FIGURE 11. Evidence snapshot: parity of esteem with physical health

To better understand the need for parity of physical and mental health, we reviewed relevant literature for evidence of an effect on the burden of depression and associated outcome measures. We synthesised this evidence to determine whether there was an impact, potential for impact, or no change to the outcome measures as a result of parity of esteem. For more information regarding the literature review and corresponding analysis, see Appendix 1.



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In Spain, Mr Bengoa continues, the country's political parties have agreed to address mental healthcare legislation in the current parliament, but legislation should be careful about the way it interprets parity. "This is the kind of issue that won't be resolved by having more hospital beds—mental health needs to be resolved outside in the community", he says. "The law should make loud and clear that medication is important but that psychologists are also important and nurses need to be trained".

Parity of esteem therefore implies care in which there is equivalent consideration of physical and mental health. We discuss here components that support such parity: access and utilisation, quality assurance, resource allocation, education, and treatment goals and outcomes.

Access and utilisation

Parity is predicated on the notion of equal access to safe and effective services. The OECD has noted that while one in two people will experience a mental illness at some point, 80% of those with a common mental disorder, and up to 50% of those with a severe mental disorder, will not seek or receive treatment.[188] Those living with mental illness are often more likely to have long-term physical conditions or unhealthy lifestyles as well. Parity of esteem requires better identification of these comorbidities. A lack of collaborative thinking between mental and physical services means that patients with mental illness receive inferior medical, surgical and preventive care and die 10-20 years prematurely.[189]



Identification of such cases requires effective use of data, noted a 2016 report by the UK's joint medical colleges.[190] The report recommended that national data on the mortality of people with severe mental illness be used to develop strategies and make regular assessments of the physical health needs of people with severe mental illness.

Increasing access also means ensuring that there are mental health specialists colocated in primary care. However, a report by the British Medical Association (BMA) in 2021 suggested that access would be negatively affected by a lack of growth in the mental health workforce over the past decade—this at a time when there has been a 21% rise in demand for mental health services since 2016. Recruitment into psychiatric specialties has remained a challenge during that period.[191]

Further, in the UK—which has been the busiest of among the countries in our discussion of parity—a 2018 survey of more than 1000 general practitioners by UK mental health charity MIND found that two in five appointments involved mental health. Schemes such as Improving Access to Psychological Treatments (IAPT) in England are meant to help with this. IAPT was meant to provide coordinated services for the 40% of people who suffer from depression or anxiety and have a long-term physical condition as well as the 30% of people with long-term conditions who have mental health comorbidities.[192]

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However, even with IAPT, England has seen a decrease of 48% since 2008 in the number of people with mental illness who receive such care. At the same time, direct NHS expenditure was reduced in some local areas by up to 32%.[193]

But such access schemes can work when fully implemented. A study of Norway's version of IAPT, Prompt Mental Health Care (PMHC), found that those admitted to PMHC with mild to moderate depression or anxiety had a reliable recovery rate of 58.5%, compared with 31.9% in a control group.[194]

Resource allocation

Access and utilisation inevitably bring us to funding. Despite its clear economic and social burden, mental health is arguably underfunded. For example, in 2010-11 it was observed that while mental illness represented 22.8% of the disease burden in England, it accounted for just 11.1% of the health budget the same year. A report by the King's Fund, a UK health charity, found that many mental health trusts were still struggling to make up for significant cuts to their budgets in cash terms between 2012 and 2016.[195]

There is always pressure for more funding. In the UK, the British Medical Association recommended that Clinical Commissioning Groups (CCGs), which are responsible for allocating healthcare funds in England's regions, be given enough funding to allow them to double mental health spending.[196] Across the North Sea, while Denmark is currently developing a national plan for psychiatry, the DKK600 million (about €80.5 million) invested so far is "a fraction of what is needed", Mr Ronnenberg Møller says, adding that at least DKK4 billion is necessary to do sufficient technical planning to create a strategic agenda and implement it.

Elsewhere in Europe, an October 2020 statement by the European think tank Friends of Europe asked governments to allocate sufficient funding to mental health support and care, and particularly to peer support, community-based services and integrated care.[197]

It is not only healthcare systems that are overlooking mental health. The number of clinical research programs for mental health undertaken by the major pharmaceutical companies has fallen by as much as 70% in the last ten years, with major firms focusing on other areas.[198] Indeed, psychiatry represented just under 4% of new clinical trials in 2020 compared to 25% for oncology and 18% for infectious diseases.[199] These figures reflect a wider decline in expenditure in mental health research than physical health. For example, from 2014 to 2017, just over £9 was spent on research year for each person affected by mental illness. By contrast, £228 was spent on cancer research per person affected with cancer—twenty-five times more.[124]

Quality assurance

Improving the quality of care in an equitable manner must be measured across a number of levels. Establishing a consistent structure of care delivery makes it easier to establish whether services are improving outcomes.[200] Psychiatric mapping tools are one way of helping to assess population-based estimates of disease risk and expected morbidity using a format that can be applied to other disorders or geographic regions.[201]

Quality assurance measures are often focused on primary care and prevention, including efforts to dissuade people with severe mental illnesses from health risks such as obesity and tobacco smoking, which can be modified by behaviour.[190]

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Efforts to improve quality of care in specific areas are also taking place, including policies to provide psychosocial cancer care in the UK.[202]

One issue where parity in quality is not always evident is in follow-up care, according to Mr Ronnenberg Møller, who contrasts the "follow-up you get, and support, if you break your finger versus if you get ECT treatment". Follow-up is also often poor for those with severe depression who have been hospitalised, he says, adding that "many people are kicked home before they are ready".

Quality assurance—as well as other components of quality care—requires a solid evidence base. Hence there is an argument that parity should extend to research published in medical journals. A 2016 study looked at the frequency of psychiatry, cardiology, oncology and respiratory medicine articles and compared it with the expected number based on the burden of illness; it found that psychiatry was substantially underrepresented.[203]

Education

Education of clinicians is vital to enable them to diagnose, refer and treat those with depression. It is necessary, therefore, that training and continuing education on mental illness keeps pace with training on physical diseases.

One of the ways of ensuring this happens, according to the BMA, is ensuring that mental health is not taught separately in medical training but is integrated into the core curriculum. In addition, workforce planning should ensure that junior doctors and those training for general practice have a placement in psychiatry or intellectual disability.[189]

Training staff to recognise the interaction between mental illness and physical ill health has also been advocated. A paper by the UK Academy of Medical Colleges recommended that training for psychiatry be adapted to support examination in several relevant topics, including acute physical illness and management of long-term conditions. The authors also recommended that the curriculum include areas relating to the physical health of people with severe mental illnesses. The College made similar recommendations for the development of new competencies and skills in the registration and training of mental health nurses.[190]

Treatment goals and outcomes

A 2010 study looked at sixty-one comparisons of preventive care from twenty-six studies across Europe and North America for people living with and without psychiatric illness. Twenty-seven of the comparisons showed inferior preventive healthcare in those with mental illness. There is a paucity of ambition for mental health outcomes.

Other evidence suggested inequalities in dental care and the monitoring and assessment of comorbid physical health.[189] England's No Health Without Mental Health strategy aimed to integrate mental health concerns within local government, employers, education and the third sector. It included a master's course to help GPs interested in mental health develop skills that will allow them to redesign services to integrate mental health services into the community.[204]

Again in the UK, the BMA suggest that prevention and other services can also be assisted by providing ring-fenced funding to local authorities, allowing them to increase spending on public mental health. Additionally it was suggested that there is a need to encourage national and local government and NHS bodies to take a mental impact assessment of all new policy proposals.[196]

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Case Studies

Policymakers enshrining a road to parity in the UK

Creating a policy strategy and framework for establishing parity of esteem is the essential starting point for efforts to eliminate inequalities between physical and mental health. The UK set out the notion of parity of esteem in 2011 with the Coalition Government's mental health strategy, "No Health without Mental Health", still the most comprehensive such strategy in Europe.[205] The cross-government mental health outcomes strategy made giving equal priority to mental and physical health its key strategy, but also set out the Coalition's plan to improve people's mental health and wellbeing and improve services for those with mental health problems. The strategy's implementation framework envisaged schools, employers and local authorities working together to support people's mental health.

The Health and Social Care Act of 2012 contained the first explicit recognition of the secretary of state for health's duty towards both physical and mental health. This was followed by a commitment in the NHS constitution that the NHS is "designed to diagnose, treat and improve both physical and mental health". This impetus was especially significant for members of vulnerable groups, including young people.

In a 2014 blog, Martin McShane, then the NHS England director for people with long-term conditions, noted that although 75% of all chronic mental health problems start before the age of eighteen, research suggested that only a quarter of children and teenagers up to fifteen years of age with mental health problems receive help from any services.[206] Creating real parity, Mr McShane suggested, requires more than improvement in physical health and clinical services for those with mental health illnesses; it also involves better information for planning and funding care, as well as for treatment, as well as raising the level of skills for those commissioning development of care.[206]

Since 2015, the UK government has set objectives for parity of esteem in successive NHS Mandates; for example, the NHS Mandate 2018-19 states that there should be "measurable progress towards the parity of esteem for mental health enshrined in the NHS Constitution, particularly for those in vulnerable situations".[207]

First aid for mental health in the Netherlands

General first aid training for members of the public is widely available, but first aid for mental health is not. An innovative program in the Netherlands trains the lay public to approach, support and refer individuals in mental health distress. Members of the "community can expect to have contact with someone experiencing a mental health problem" and should be prepared to do so.[131]

Mental health first aid (MHFA) aims to improve participants' knowledge, attitudes and behaviours related to mental ill health. The programme trains participants to understand day-to-day interactions with people who have mental health vulnerabilities. Trainees learn to recognise signs and symptoms of mental health problems including depression, anxiety disorders, addiction, psychosis and autism.[208]

The program also aims to tackle the stigma of poor mental health by improving knowledge. Many people are unable to recognise mental illness or may have beliefs about causes and treatment that are not in line with evidence. One of the causes of stigma and discrimination is a lack of knowledge and skills in families, friends, colleagues, civil servants (sometimes even professionals) and the public. This results in disengagement and isolation, one of the most disastrous social stressors.[131] The content of the training is based on guidelines that were generated by panels including clinicians, mental health consumers and their families.[209]

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What if...?

Lyon, France, 2032

Guillaume, an executive at an IT consulting firm, has been experiencing stress at work and grief due to the death of his father. Earlier in his career, he would have felt pressure to carry on as normal; colleagues never discussed emotional pressures at work.

But since the French government approved legislation in early 2023 designed to extend the breadth of the French national health service to comprehensive mental health provision, other spin-off laws have followed. One law requires all workplaces in the country to designate a mental health safeguarding lead, usually part of the human resources operation. In addition, all new employees are required to go through a mental wellness course as part of their mandatory training. The course teaches them to recognize the signs of stress, depression and anxiety. New employees are also paired with a workplace mentor who has been trained to identify red flags for poor mental health and to refer their mentees to a variety of support options.

All workplaces, in addition, have access to a wellness portal. The portal connects them to CBT and other forms of therapy, workplace support groups (which have become increasingly common since the 2023 parity laws were put in place), self-management tactics and more holistic options, including yoga and reflexology. Access to these services is a statutory right for all French residents, including new immigrants.

The workplace programs do not exist in isolation, however. Children and teenagers now have age-appropriate classes in school to recognise mental distress in themselves and others. Mental health literacy has improved throughout local communities, with religious groups and sports teams hosting their own avenues of support. Guillaume's rugby club offers weekly "de-stressing warm-ups" before a regular happy hour.

This new environment has kept Guillaume's stress and anxiety at a manageable level. And the economic results are felt nationally. In the seven years since the new legislation, rates of suicide and self-harm have fallen by nearly 25%, and direct mental health expenditures, especially on inpatient care, have been halved.



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Building resilience through . . . parity of esteem

Primary responsible stakeholder: policymakers

1

Parity of training would improve outcomes
Including mental health training as a requirement in all courses for training clinicians would widen knowledge. Better training of the primary care workforce in particular could allow these providers to take on the triaging of those presenting with mental health issues, freeing up specialists to take care of those with more severe mental illness.

2

Parity of research, and the collection of real-world data, should not be overlooked
One of the key requirements for improving care is conducting high-quality research and monitoring community records so that health systems can get a better idea of who is most vulnerable to mental illnesses and how to best serve them. Better data also make it easier to continuously evaluate outcomes and determine where care delivery needs to be improved to ensure parity.

3

Political will trumps all
Parity of esteem will only occur if there is political will and a level of ambition that is strong enough to see the necessary changes through. Funding is important, and we discuss it in the next point, but parity of esteem is not a single sum gain: it is not seeking for mental health budgets to prosper as a result of physical health budgets being cut. Rather, the focus is on ensuring mental health considerations are "at the table" throughout pathway development, service planning and other key decision points.

4

Everyone agrees on parity of esteem in principle but . . .
Funding remains a barrier. Even in the UK, the best example of long-term focus on parity between physical and mental healthcare, commitments to mental health funding have not always been maintained. In addition, the funding provided does not always stretch to all aspects of prevention, diagnosis, treatment, research and specialist training. Investments must be funded throughout their lifecycle.

5

Good examples of practice in Europe include . . .
Our case studies describe the importance of setting out a clear strategic imperative on the parity of esteem between mental and physical health (even if implementation remains a challenge, the statement of intent means that there is always something that can be used to push for access) and an example of a physical health intervention, first aid, being applied to mental health.

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Building resilience: policy takeaways

As we emerge from the covid-19 pandemic, care for depression is going to be stretched

Cases of depression are already growing in the wake of the past two traumatic years of pandemic and the number is likely to escalate amid growing economic strains and social stress. Demand for mental health treatment is set to rise sharply over the next few years, and health systems will need to be nimble to avoid being overwhelmed.

To make matters worse, depression is both hard to prevent and hard to treat. No reduction in the global prevalence or burden has been detected since 1990.[34,210] It has been suggested that achieving health gains will require not just financial resources but committed and sustained efforts to address a range of other barriers, such as paucity of human resources, weak governance and stigma.

This report has described four broad themes that are likely to be critical in ensuring access to high-quality care while avoiding overwhelming providers. Integrated care models, which permit teams of professionals to communicate and coordinate treatment, need to be the foundation of any sustainable improvement in care delivery. More holistic care will also be a precondition for better treatment of depression. This means not only understanding the connections between mental and physical health but recognising the social determinants of health more fully, something that will require better links with stakeholders outside the health system and within communities.

Health services are also going to have to become better at using resources creatively to improve access for all of those living with depression and avoid overburdening health budgets. Task-shifting to nonspecialist clinicians such as nurses, or to peer mediators in community settings, combined with better training, can help with this task. Policymakers and others need to push for parity of esteem with an enthusiasm and sense of ambition that will carry others with them. It is not just about battling for more funding, but to make sure that mental health always has a place at the table during service design discussions.

Underlying all of this are the challenges of recognition, attitudes and knowledge. Mr Ronnenberg Møller talks of the dinner table test: is depression something that can be discussed openly and nonjudgementally in the way other health conditions can be? That answer remains no, at least for most households in Europe. Change is happening, but slowly.

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Key principles around which future policy can build

Each of the four thematic chapters in this report concluded with pointers on how resilience can be built within care systems and their wider context. For each of our themes, we have suggested who the key stakeholders are. Healthcare providers need to take the lead in integrating care. Silos in health and care are often bemoaned, but they have understandably emerged from cultures of excellence. It is more useful to think about building bridges rather than breaking down walls. Payers and commissioners need to take the lead on access. HTA and reimbursement decisions are an important part of the conversation, but so are questions of staffing and supporting new technologies and other innovations. Parity of esteem must be led by policymakers because political will is required to lead wide-ranging changes in funding decisions, education and resource allocation. Finally, raising awareness and reducing stigma requires action across all stakeholders—most likely pushed along by advocate groups and patient organisations.

We list here five principles around which policymakers can focus their thinking while planning how to prevent depression in those people at risk and improve outcomes and societal integration for people with depression.

Healthcare systems need to remain adaptable as rates of depression are rising in most European countries, particularly among the young

Covid-19 has exacerbated the stresses that contribute to poor mental health, particularly in the young. European healthcare systems and societies need to remain flexible and open to new ways of promoting prevention and offering care to ensure they can best mitigate and manage the burden of depression. There are many examples of good practice—particularly where they try to integrate care settings and pathways—but they are rarely scaled-up to larger populations.

Awareness needs to be targeted to remove stigma

While public awareness campaigns around mental health can improve understanding of depression, they are not always sufficient to change attitudes. Targeting awareness programs at workplaces or educational facilities, where discrimination may be rife, can have a particularly strong impact. Projects such as the NEFELE program—described in this report as a case study—can make it easier for the public to engage with those living with depression and confront preconceptions they might have about mental health conditions. Depression is one of healthcare's last, and most difficult to shift, stigmas—even as the condition itself becomes more prevalent.

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More support is needed to get treatments to people, whether it is digital health, talking therapies or other innovations

Staffing shortages remain a barrier to access, as do payment systems for digital health and other new innovations. Improved data collection would make it easier to evaluate outcomes and make sure that access to treatment is available for all patients who need it. Better measurements are also needed to track progress in the effort to ensure parity of esteem. Effective coordination of IT systems will enable the integration of care, improving outcomes for the most vulnerable. We have spoken very little about new pharmacological innovations because there are so few of them. Stakeholders, including industry, regulators, HTA organisations and payers, need to work together to identify why.

Healthcare systems should be integrated on all levels, leading to both more efficient and resilient care delivery

Improved coordination between mental health and physical specialities and between primary and secondary care will help ensure that those with more serious cases of depression are "on the radar" of health authorities. This will improve prevention activities and allow clinicians to triage people within primary care so that those with milder or more temporary cases of depression do not have to compete for the resources of specialist services. Primary care needs to be re-established as the home of integrated, co-ordinated, patient-centred care—though there need to be referral pathways so that, as necessary, patients can quickly be escalated to specialist care. There is widespread agreement across most stakeholders in most countries that this is the future of care, but apart from a few pilot programmes, the reality of care remains stubbornly fragmented.

Family and carers should be included in treatment plans

Carers and other family members living with a depressed person experience the consequences in their own lives as well. This is particularly true for children of depressed parents. Taking family dynamics into account helps to make treatment a broader process and, in some cases, can help to prevent relatives from suffering longer-term emotional harm. Families and family life can be one of the stressors that causes depression in some individuals—but with the right focus and interventions, family can also be the greatest support.

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Appendix: creating the "Evidence snapshots"

Method

To obtain a landscape view of the strength of evidence behind each of our four themes, we reviewed a selection of the relevant literature. With a focus on systematic reviews and other high quality articles, we examined the strength of evidence for the following outcome measures:



We determined the *potential impact* reported by each paper according to the following criteria:

Positive Impact

Literature shows improvement in the outcome measure as a result of the topic including:

- Papers that demonstrate statistically significant improvement in the outcome measure;
- Papers that include data to show improvement in the outcome measure without discussing statistical significance;
- Case studies that show improvement in more than 1 patient

Potential for Positive Impact

Literature discusses the potential for positive impact on the outcome measure including:

- Papers that provide anecdotal evidence of improvement;
- Policy documents that are based in evidence that demonstrates improvement;
- Aspirational discussions of topic in policy or study planning

No change recorded by relevant literature

Literature shows no change in the outcome measure as a result of the topic

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Potential for Negative Impact

Literature discusses the potential for negative impact on the outcome measure including:

- Papers that provide anecdotal evidence of negative effects

Negative Impact

Literature shows a negative impact on the outcome measure as a result of the topic including:

- Papers that demonstrate statistically significant negative effects on the outcome measure;
- Papers that include data to show negative effects on the outcome measure without discussing statistical significance;
- Case studies that show negative effects for one or more patients

Not Addressed

Literature does not discuss the outcome measure in relation to the topic

After assessing the potential impact, we gave each paper a numerical score based on a) publication type and b) evidence function. Scores for publication type and evidence function were added for each source to determine which direction of impact was most supported by the literature. Lower scores indicate a greater strength of evidence.

Score	Publication type
1	Systematic and Other Reviews
2	Experimental Studies Observational Studies
3	Qualitative Studies Case Studies
4	Narrative Expert Opinion
5	Policy Documents

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Score	Evidence function
1	**Measure** The outcome measure is: • A variable measured in a study; • The paper's conclusion
2	**Background/Assumption** The outcome measure is: • Presented as evidence in the background of the paper; • Provided as additional evidence to support the paper's conclusion; • An assumption that underlies the paper's hypothesis
3	**Aspiration** The outcome measure is: • The goal or objective of a policy • Described as an attainable goal based on other evidence in the paper

For example, the paper *Strategies for engaging patients and families in collaborative care programs for depression and anxiety disorders: A systematic review* measures quality of life as a main study outcome. The authors of the article concluded that the theme (in this case integrated care) has a positive impact on quality of life for people with depression.

- Publication type: Systematic Review
- Publication type score: 1
- Evidence function: Variable measured in the study
- Evidence type score: 1

The score for this paper was then added to the scores for other papers on integrated care that had evidence of a positive impact on quality of life (see below for a list of the evidence sources used).

We repeated this process for each direction of impact (positive impact, potential for positive impact, no change, potential for negative impact, and negative impact). The category with the lowest average score—and therefore, the strongest support in the literature—was included in the evidence snapshot for the theme.

Limitations

This rapid synthesis process offers a snapshot of the current evidence landscape for each theme. The snapshots do not, and cannot, offer the level of comprehensiveness, nuance or confidence of a proper systematic review.

There are four particular limitations to be aware of. First, we cannot be certain that all of the most relevant literature was reviewed, though we took a structured approach to searching the literature, via searches in EMBASE and Medline. Second, the categories of positive to negative impact are necessarily subjective. However, by providing the criteria we used we make an effort to be as transparent as possible.

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Third, the method of scoring did not incorporate a formal appraisal processes, although by ranking studies by publication type, we made an effort to prioritise articles based on the EBM evidence pyramid. Fourth, the breadth of the themes and the evidence base we covered, from awareness though integrated care and access, to parity of esteem, means that we can only offer a top-level view of the evidence base.

Evidence review sources

The following papers were included in calculating scores in the evidence snapshots.

Awareness

Eisele M, Rakebrandt A, Boczor S, et al. The association of general practitioners' awareness of depression and anxiety with change in quality of life in heart failure patients: Results of the prospective observational RECODE-HF cohort study. Family Practice. 2021; 25: 25.

Evans-Lacko S, Knapp M. Is manager support related to workplace productivity for people with depression: A secondary analysis of a cross-sectional survey from 15 countries. BMJ Open. 2018; 8(6): e021795.

Kohls E, Coppens E, Hug J, et al. Public attitudes toward depression and help-seeking: Impact of the OSPI-Europe depression awareness campaign in four European regions. Journal of Affective Disorders. 2017; 217: 252-9.

Lindheimer N, Karnouk C, Hahn E, et al. Exploring the representation of depressive symptoms and the influence of stigma in Arabic-speaking refugee outpatients. Frontiers in Psychiatry. 2020; 11: e579057.

Machin A, Hider S, Dale N, et al. Improving recognition of anxiety and depression in rheumatoid arthritis: A qualitative study in a community clinic. British Journal of General Practice. 2017; 67(661): e531-e7.

Perestelo-Perez L, Rivero-Santana A, Sanchez-Afonso JA, et al. Effectiveness of a decision aid for patients with depression: A randomized controlled trial. Health Expect. 2017; 20(5): 1096-105.

Ridge D, Broom A, Kokanovic R, et al. Depression at work, authenticity in question: Experiencing, concealing and revealing. Health (Lond). 2019; 23(3): 344-61.

Rona RJ, Burdett H, Khondoker M, et al. Post-deployment screening for mental disorders and tailored advice about help-seeking in the UK military: A cluster randomised controlled trial. Lancet (London, England). 2017; 389(10077): 1410-23.

Shastri A, Aimola L, Tooke B, et al. Recognition and treatment of depression in older adults admitted to acute hospitals in England. Clin Med. 2019; 19(2): 114-8.

Yoshimura Y, Bakolis I, Henderson C. Psychiatric diagnosis and other predictors of experienced and anticipated workplace discrimination and concealment of mental illness among mental health service users in England. Social Psychiatry & Psychiatric Epidemiology. 2018; 53(10): 1099-109.

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Access to treatment and innovation

Cuijpers P, Kleiboer A, Karyotaki E, et al. Internet and mobile interventions for depression: Opportunities and challenges. Depression and Anxiety. 2017; 34(7): 596-602.

Dockery L, Jeffery D, Schauman O, et al. Stigma- and non-stigma-related treatment barriers to mental healthcare reported by service users and caregivers. Psychiatry Research. 2015; 228(3): 612-9.

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