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The Impact of Economic Crises on the Risk of Depression and Suicide

The Fact Sheets on Prevention of Depression and Suicide

The Impact of Economic Crises on the Risk of Depression and Suicide:

A Literature Review

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The aim of this review is to present current knowledge on impact of economic crisis on risk of depression and suicide, and actions that could be implemented to reduce the impact.

This review is based on a literature search performed in November 2009. The following databases were searched: Cinahl, Medline, SocINDEX, and CSA Social Services Abstracts. Identified reports were included in this review based on relevance for European mental health policy and scientific quality.

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A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server (http://europa.eu.int).

1. Introduction

The current economic crisis could have a significant influence on Europeans' health and wellbeing. Economic hardship, unemployment, job insecurity, and the lack of a regular living wage all have important effects on health and demand for health care[1]. The economic downturn has a potential for both negative (loss of income, insecurity) and positive (reduced work load, less traffic) effects on health[2], but the pooled effects in Europe are likely to be negative[3].

The data on the impact of unemployment on mortality rates is conflicting. There is evidence from the EU for a link between unemployment and mortality rates: i.e. the higher unemployment, the higher is all-cause mortality[4]. A 1% increase in a national unemployment rate increases the standardised mortality rate substantially, i.e. by 1,5 per 100 000 people.[4] On the other hand, the evidence across the EU that all-cause mortality increases when unemployment rises is not consistent. [5] Populations vary substantially in how sensitive mortality is to economic crises, depending partly on level of social protection.[5]

The increased risk of death due to suicide after redundancy and financial problems is greater among men than among women[6,7], perhaps because men are taught to believe more often than women that there is no appropriate source of support and help for them when things go wrong.

Times of economic instability cause psychological stress, which is linked to both the onset and course of mental illnesses.[8] Unwelcome changes in life circumstances, such as unemployment, are strongly linked to depression, anxiety disorders, and suicide.[9,10] The effects are modified by experiences like shame at losing one's job and financial hardship[11].

To some extent, the economic growth has been on the expense of the mental well being of the population[12]. Thus, the economic crisis may also bring along welcome changes, such as increase in spare time leading to increases in time spent with family members and NGO activities. How people deal with difficulties like unemployment in times of economic crisis depends on the individual's coping mechanism. The crisis may offer possibilities to strengthen social capital and to shift our value base from money to non-monetary components of life, provided that social protection is sufficient. The economic crisis offers a chance for re-orientation.

2. Potential impact of economic crisis on determinants of depression and suicide

Increased unemployment

Unemployment causes poor mental health as a result of financial strain and absence of the nonfinancial benefits provided by one's job, such as social status, self esteem, physical and mental activity, and use of one's skills[13].

The main short term health effects to be expected from the rising unemployment in Europe are psychological distress, alcohol abuse, and suicides. Prospective studies uniformly show that unemployment has causal influence on depression and suicidal thinking[14 1516]. Unemployed people are at 2-3 times more risk of suicide[17,18]. This is partly because people with mental disorders are at greater risk of losing their jobs[19], but even among people with no record of serious mental illness, unemployment is still associated with approximately a 70% greater suicide risk[20].

In the EU, there is an association between national unemployment rates and suicide rates[4,5]. In EU, every 1% increase in national unemployment rate has been associated with a 0,8% rise in suicides of people under 65 years. A more than 3% increase in unemployment was linked to a 4,5% increase in suicides. Younger populations were more sensitive to the negative health effects of rising unemployment than were those over 60 years. Middle-aged and unmarried men are an

especially vulnerable population in regard to unemployment-related suicide[5,21]. The individual impact of being made unemployed may be lessened in a context of high unemployment[22,23,24].

Young people are at risk of mental problems after job loss. The relative risk of becoming psychologically disturbed for young people (aged 15-24) after becoming unemployed is 51 % higher compared to young people who did not experience job loss[25]. Unemployment rates in young people appear to be associated with suicide rates[26].

Increased job insecurity

Job loss is not the only stress during economic crises. Recessions can be equally stressful for those still in the workplace. Their options and choices become narrower; People fear losing their jobs and experience financial difficulties; Job insecurity is associated with a 33 % increase in risk of common mental disorders[27,28]. In addition, the workload of those left in work after personnel cuts may increase.

Increase in households in high debt

In 2005, 10 % of European households reported housing, utility or credit arrears.[29] The number of households in high debt is increasing in Europe as a result of the current economic crisis. Debts and over-indebtedness are socially patterned and disproportionately affects those on low incomes.[30] By definition, large economic recessions will affect people with little previous experience of coping with hardship. These people may be at greater risk of mental health problems than others more used to financial insecurity.[31]

High debts have been identified as an important risk factor for mental disorder. Longitudinal data provides evidence that financial difficulties lead to an increased occurrence of major depression[32]. Longitudinal data also indicate that housing payment problems[33] and consumer debt[34] lead to poorer mental health. The more debts people have, the more likely they are to have mental disorders overall.[35] Nearly one in two adults with debt has a mental disorder[36]. In Finland, data shows that people with high mortgages have poorer psychological well-being and more mental disorders[37,38] People with debt are two to three times more likely to suffer from depression than the general public[36]. Single mothers in debt or borrowing money have an increased risk of depression.[39]

People with mental health problems in Britain are nearly three times more likely to report debt compared with individuals without similar conditions[35]. People in debt and suffering from mental health problems often do not seek help for their financial difficulties[40].

Debt repayment difficulties are associated with suicidal thoughts,[38] and several studies from Hong Kong have found unmanageable debt to be a predictor of suicide[41,42,43].

Increased poverty, social exclusion and inequality

The economic crisis will increase poverty in Europe. It is the poor – and those made poor through loss of income or housing – that will be hardest hit by the economic crisis[47]. Poverty is a major socio-economic risk factor for mental health problems, disorders such as depression and even suicide[44]. The deficits in cognitive, emotional, and physical development for children growing up in extreme poverty and the consequent effects on health and wellbeing across the life course are potentially enormous[1]. Suicide levels have consistently been found to be higher in deprived areas[45,46].

In Europe, it is likely that the current economic crisis will increase the social exclusion of vulnerable groups, the poor and people living near the poverty line[47]. The least well educated are those at greatest risk of ill health after job loss[48].

Data from Japan show that during a recession social inequalities widen[49]. Health gradients exist in Europe, and as people move down the socio-economic ladder due to loss of jobs and income, their health will be affected.

Adverse life style changes

Job loss leads to life style changes. Increases in spare time can have both beneficial and negative effects. Trend data suggests links between economic cycles and alcohol use with recessions linked to increased binge drinking. Even among those who remain employed, binge drinking increased substantially during economic downturns[50]. If the current recession leads to an increase in alcohol use, a higher death toll linked to alcohol is to be expected, because per capita alcohol consumption is one of the strongest single mortality determinants in Europe[4]. In European countries, mass job loss, i.e. more than 3 % rise in unemployment rate in a year, is strongly associated with an increase in alcohol-related deaths[5].

An increase in mean alcohol consumption has been associated with a post-war rise in suicide mortality in many European countries (Denmark, France, Hungary, Norway, Sweden), but not in the south of Europe[51,52]. The link seems to be more pronounced in countries where strong spirits dominate the consumption[53 54 55], and is only seen in some population groups, such as lower educational group[56].

Families under pressure

The impact of unemployment on both the worker and the family is pervasive, because work is a primary source of material, social, and psychological security within the family unit. The family unit is also derives its daily and weekly routine, place in a social network, status, and economic well-being from the labour force participation of its parental member(s).[57]

During economic recession, family economic hardship creates a risk for maternal and child mental health. Longitudinal data indicates that financial disadvantage after giving birth may lead to maternal depression[58]. Economic pressure, through its influence on parental mental health, marital interaction, and parenting, affects mental health of children and adolescents[59,60,61]. Furthermore, reduced public spending has impacts on health services and education, and ultimately on the well-being of families and the development of the community as a whole.[47]

Children often do not understand the complexity of family financial loss. This creates a feeling of helplessness alongside their desire to alleviate the turmoil created by unemployment. Feelings of confusion, anger, and insecurity may affect the attitudes of children and young people towards parents, the school, and the world of work.[59]

Research into transmission of negative emotions and mental distress within the family between parent and child is limited. However, it suggests that a parent's heightened level of mental distress may have a direct impact on the child's well-being.[62 63 64 65]

Cuts in health systems and social protection

Economies under stress may lead to recession cuts in health and social services.[66] Social protection plays an integral role in mitigating against the impact of poverty in an economic crisis and is, therefore, an important counter-cyclical social policy. However, the social protection response to the global financial crisis has been minimal, and increases in coverage have been marginal[67].

Impact on mental health services

Mental health services in Europe are underfunded[68]. Evidence from past economic crises gives us a reasonably precise idea about what is likely to happen in the current socio-economic crisis. In spite of increased pressure on mental health services[69], government expenditures on health will be

squeezed and seem likely fall, contributing to worse health outcomes. Household income to pay for health will drop. Insurance protection will decline. Patients will switch from the private to the public sector[47]. In countries without comprehensive healthcare provision, people most in need of mental health services may be less inclined to access them because of the costs involved.[70]

3. The potential impact of the economic crisis on prevalence of depression and suicide

Depression

Data described in the previous section convincingly showed that known risk factors for depression, such as unemployment, high debts, and alcohol consumption will increase due to the economic crisis. Among people loosing their jobs, the psychological impact will appear in the short term, but economic pressure will also affect families and constitute a risk factor for the longer-term mental health of children. If preventive actions are not in place, there is a risk that the toll of the crisis will be paid by the next generation: i.e. by those who now are children.

Suicides

Economic crises constitute a risk for increase in suicide rates. Whether this risk will evolve into real increased rates depends on policy measures.

The Asian economic crisis in the late 1990s was accompanied by a rise suicide mortality in several countries[71,72]. However, comparative international studies indicate that the negative impact of economic recession can be modified or even eliminated by social protection actions[73].

Two EU countries have been able to decouple economic crisis from the rise in suicide deaths. In Sweden, unemployment rose from 2.1% to 5,7% between 1991 and 1992, but suicide rates dropped. In Finland, unemployment rose from 3,2% to 16,6% between 1990 and 1993, but suicide rates dropped each year. Possible explanations for the successes in these to countries include the Nordic social welfare model with a high level of social protection and active labour market programmes[74], as well as national suicide prevention activities[75].

Evidence for protective factors also comes from the contrasting trends in suicide among male youth in New Zealand and Finland during the recession of the 1980s and '90s. Unemployment rose to a greater extent in Finland than in New Zealand, but no increase in male suicide was recorded in Finland[76,77], where, in contrast to New Zealand, social spending rose[78].

4. Potential actions to alleviate the impact of the economic crisis

Strengthening the support provided by social safety nets — whether related to health care, social protection, employment security, housing, food or informal social support — will help to buffer the effects of shifts in the economy and promote mental health.

Tailored response of health systems

The health systems in Europe can alleviate the impact of the economic crisis on mental wellbeing by better acknowledging the role of unemployment and financial strain on mental wellbeing. Improved responsiveness of health services to changes in the social, employment and income status of patients and early recognition of depression and suicidal ideas will reduce the human toll paid for recession.

Responsive health services modify their services to accommodate the population needs originating from the economic crisis. By providing psychological support in health services the effects of

unemployment can be modified. Group-based cognitive behavioural therapy for unemployed people improves mental health and facilitates return to work[79]. In times of hardship, good psychological coping skills are beneficial. Problem-solving skills may be protective against depression and suicidal behaviour[80].

Social protection and active labour market programmes

Social protection provides several societal benefits, one of them being protection against rise in suicides in times of economic hardship. Social protection policies encompassing not only adequate welfare benefits in case of unemployment, but also reinforcing activation for those most affected by the economic slowdown in line with the flexicurity approach, will be crucial in modifying the impact of the crisis.[81] EU Member States with a higher investment in active labour market programmes had a reduced association between unemployment and suicides.[5]

Debt relief programmes

Debt relief programmes help people suffering from the stress of being over-indebted. In Sweden, people in high debt who had been granted debt relief had a better mental health than those who had not been granted debt relief[82]. National debt relief legislation and debt relief programmes will help to reduce the mental health impact of the economical crisis. Community support agencies should be adequately resourced to help people with problems arising from job loss, debt, and mortgage arrears.[70]

It is necessary to try to prevent people from becoming over-indebted as well as making it easier for them to pay their fair share and to be able to return to a dignified and economically active life. This results in reduced suffering and socioeconomic benefits.[82]

In view of the extremely high co-occurrence of over-indebtedness and mental disorders, there is a need for national programmes to strengthen cooperation and improve communication between health services and debt management agencies. Debt management advisers should be trained to refer clients to mental health care when needed. On the other hand, health services need to acknowledge the burden of over-indebtedness in clients and to provide well-functioning referral links to debt advice bureaus.[31]

Strengthening social capital

In times of economic crisis, social capital is a protective factor. Social capital and social networks as represented e.g. by number of trade unions, religious congregations of sports clubs, seem to constitute a safety net against the adverse effects of rapid macroeconomic changes.[21] Strengthening the civic society will create social capital and cohesion, and promote mental health.

Alcohol policy

There is a close relationship between alcohol problems and mental health. Recessions have been linked to increased binge drinking[50], and the impact of recession on mental health and suicide rates is partly mediated by alcohol. People with mental health problems are at increased risk of alcohol problems and vice versa.[83] Reducing access to alcohol, by e.g. increasing alcohol taxation[84], reduces alcohol consumption and is one of the key actions to counteract the impact of the economic crisis on mental health and suicide rates.

Labour policies

Employers' awareness of the potential impact of job loss on mental health and suicide risk need to be heightened to ensure that workers are directed to appropriate sources of advice when facing joblessness. Likewise, health and social services as well as debt advice agencies need to have clear guidelines in work on how to identify and support people with unemployment-related distress, depression and suicidality.

Active labour market programmes that keep and reintegrate workers in jobs reduce the mental health effects of the recessions.[5,74]

Targeting youth unemployment

Special attention should be paid to the mental health needs of young people, whose labour market security is likely to be most affected by the economic downturn. If the crucial step into labour market is delayed it leads to difficulties in achieving the psychological identity of an earning adult and valued member of the society, which in turn leads to alienation, marginalisation and anomie.

Special programmes for youth in transition from school to work and re-employment training for young people left unemployed can be of benefit.[85] Training in regular educational settings of apprenticeship-type training offer most mental health benefits.[86] Youth opportunity schemes, which do not offer ordinary education or properly paid jobs, have turned out to be almost as detrimental to psychological good health as is unemployment itself.[87]

Increasing university intake to increase the proportion of young people going to university is a feasible action to relieve the impact of the economic crisis on young people in Europe. Overall, more education and training opportunities are needed also because existing students stay on and displaced workers seek to re-skill.[81]

Support children and parenting in families victimised by the crisis

At times of crisis expenditure that supports families [5], especially single parent households, are necessary. Families, friends, and communities of those affected by unemployment should be reminded of its impact on an individual's emotional wellbeing and encouraged to give support.[70] A focus on developing family and community connectedness is needed.[80]

Responsible media coverage of the crisis

There is often high profile reporting in media of suicides and suicide clusters related to job loss, such as recent coverage of events in France Telecom. Such reporting may provoke copycat suicides.[88]

Strengthening mental health systems

To meet the mental health challenges of the economic crisis, not only protection of spending on mental health services is needed, but also restructuring of services to meet the needs of the population. The primary care approach will increase access to mental health care, and shift the focus to prevention and early detection of mental health problems. The current financial crisis may create urgency and strengthen courage to both eliminate the fundamental problems in health care delivery and reduce health inequalities.[89]

5. Conclusions

The main mental health risks of the economic crisis for the next years are increased psychological distress, increased alcohol abuse and increase in suicides. However, these risks can to a large extent be avoided by policy measures. What leads to health in industrialised countries is not absolute wealth or growth but how the nation's resources are shared across the population[90]. Thus, the impact of decreased wealth on health can be modified by policy measures which strengthen social inclusion and social protection.

We can minimise the mental health impacts of the economic crisis by:

- raising awareness of mental health needs of workers and families due to the crisis
- adapting service provision in health services to the psychological needs of people hit by the crisis
- avoiding spending cuts in services for individuals and families hit by the crisis
- providing sufficient social protection and active labour market programmes for unemployed people
- providing debt relief counselling and legislation for debt relief
- increasing university intake and providing rewarded apprenticeships for young people
- strengthening the civic society and voluntary sector in order to create increased social capital
- restricting access to alcohol
- monitoring the poverty impact of the crisis

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EPIDEMIOLOGY OF DEPRESSION AND SUICIDE IN EUROPE:
Contribution of the European countries participating in the
WHO World Mental Health (WMH) surveys initiative

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The ***ESEMeD project*** was one of the first community-based epidemiologic studies of mental disorders developed in 6 European countries. The study was a cross-sectional, general population, household survey in which a representative sample of adults from Belgium, France, Germany, Italy, the Netherlands, and Spain. The project is part of the ***WHO World Mental Health (WMH) surveys initiative***. The objectives of the study were to estimate the prevalence of mental disorders in the adult population, as well as their associated factors, their health-related impact and the use of services for mental health. Participants underwent a face to face computer-assisted personal interview conducted by a trained lay interviewer. The overall response rate of the study was 61.2%.The survey instrument used was the World Mental Health Survey version of the WHO Composite International Diagnostic Interview (CIDI 3.0) (Kessler RC, 2004), a fully structured diagnostic interview to assess disorders and treatment. Detailed information about the methodology of the study is available elsewhere (ESEMeD/MHEDEA 2000 Investigators 2004a). Four other countries (Bulgaria, Northern Ireland, Portugal and Romania) have already collected similar data and soon results including all 10 European countries will be released thanks to a NEW SANCO co-funded project (SANCO contract EU-WMH 2008 13 08).

Prevalence of mood disorders in Europe

Between 9.9 and 21.0% (with a weighted mean of 14.7%) (Kessler RC et al, 2007) of the general adult (18+) population of the ESEMeD countries reported a lifetime history of any mood disorder. Within the 12 months preceding the interview, on average, 4.5% of respondents met the criteria for any mood disorder. Among the mood disorders, major depressive episode (MDE) was more common than dysthymia, in both a lifetime (13.4 and 4.4 %, respectively) and a 12-month perspective (4.1 and 1.2%, respectively) (Alonso J et al., 2007b). Projected lifetime risks (i.e. the estimated lifetime prevalence of mood disorders at age 75) were between 16.2 and 30.5% (Kessler RC et al., 2007). The median age of onset of Major Depressive Disorder is late 30s, in most countries it ranged between 35 and 43 years of age (interquartile range= 36-38) (Kessler RC et al., 2008). See table 1.

Determinants of risk of mood disorders

Women were almost twice as likely to have had mood disorders within the past 12 months. The highest rates of mood disorders were found in the youngest age groups (18–24 years old), and showed a consistently significant decline with age. Affective disorders are more common among divorced or single persons (with a respectively 90 and 54% increase). Both major depression and dysthymia were found to be systematically more common among those with chronic physical conditions, such as multiple pains (Gureje O et al., 2007). People with chronic pain were up to 2.6 and 4.2 times more likely to also meet criteria of a major depressive episode or dysthymia, respectively. This is also the case, although to a lesser extent, for chronic physical disorders, such as asthma (Scott K et al., 2007) or heart diseases (Ormel J et al., 2007).

Comorbidity with other mental disorders

Both major depressive episode and dysthymia were to a large extent comorbid with other mental disorders in ESEMeD. About 44% of respondents meeting criteria for a mood disorder also also met the criteria for another mental disorder, especially anxiety disorders (approximately 40%). The comorbidity between mood disorders and alcohol disorders was much less common (Alonso J et al., 2007b).

Functional limitation and Health-Related Quality of Life in mood disorders

Europeans with depression have substantial functional limitation and decreased quality of life (QoL), considerably more than those with most chronic physical conditions. Individuals with major depression report, on average, about 25% of work loss days, while sufferers of heart diseases or diabetes report 18% and 12%, respectively. (ESEMeD/MHEDEA 2000 investigators, 2004b). In developed countries, two thirds (65.8%) of the individuals with depression report severe interference with normal function, a much higher proportion than individuals with physical chronic conditions (including chronic pain) (Ormel H et al., 2008).

Major depression episode and dysthymia markedly reduced the mental quality of life (QoL) component (about 1 standard deviation in the SF-12). In addition, mood disorders have also a moderate impact on the physical component of quality of life (almost half a standard deviation), just a little less than the physical impact of heart disease or diabetes (which, on average, do not affect mental QoL levels). (ESEMeD/MHEDEA 2000 investigators, 2004b).

Use of health services and adequacy of treatment

In the ESEMeD study, individuals with a 12-month mental disorder which interfered 'a lot' or 'extremely' with their lives or motivated any use of formal healthcare services were defined as having a "need" for mental healthcare services. Among individuals with need, only 51.7% reported having used some type of formal healthcare in the previous 12 months, about half of whom had visited a mental health specialist. Unmet need for mental health care was estimated to affect 3.1% of the overall adult population in a given year. This estimation varied from 1.6 % in Italy to 5.8 % in The Netherlands. The likelihood of having unmet need for mental health care was higher among the youngest (18-24 years), homemakers, retired individuals and those with mental disorders whose onset had taken place more than 15 years ago.

Major depression is a disorder with well established treatment guidelines those individuals with a 12-month MDE (a) who did receive some treatment, the overall proportion of treatment adequacy was only 54.5 %. The rate of treatment adequacy varied across treatment settings, ranging from 57.4% for the specialized care to 23.3% for the general medical care Fernández A et al, 2007).. These results are similar to those found in the USA (Wang P et al 2005) where rates of minimal adequate treatment were 52.0% in the specialized setting and 14.9% in the general medical setting.

Suicidality

In ESEMeD, lifetime prevalence of serious suicidal ideas was 7.8% and of suicidal attempts 1.8% (Bernal et al, 2007). Lifetime prevalence of attempts ranked among the lowest rates obtained in previous population surveys and clinical studies (Paykel et al., 1974; Weissman et al., 1999 ; Kessler et al., 1995; Corcoran et al. 2004). Risk factors of both suicidal ideas and attempts included: women, younger individuals, and people living in large urban areas. Increased frequency of suicidal ideas in ESEMeD was associated with being woman and previously married (Bernal et al, 2007), which confirms, in a population sample, the findings of most of previously published clinical studies (Kessler et al., 1995; Moscicki, 1997; Kuo at al., 2001). Low maternal and parental bonding were also independently associated with suicidality in all countries (Heider D et al., 2007).

Germany and France presented the highest rate ratios of suicidal ideation and Belgium and France of attempts, while the lowest risk of ideas and attempts was found in Italy and Spain (Bernal et al, 2007), societies that are more traditional and conservative (Hawton et al., 1998; Levi et al, 2003; Hjelmeland et al., 2002). Although completed suicide is qualitatively different from suicide ideation and attempts, comparison of frequencies of suicidality in our study with suicide rates in those countries (http://www.who.int/mental health/prevention/suicide/suiciderates/en/) provided highly consistent results. Living in a large population was associated to a higher frequency of suicidality, which may be related to higher frequency of social isolation in cities (Middleton et al., 2004).

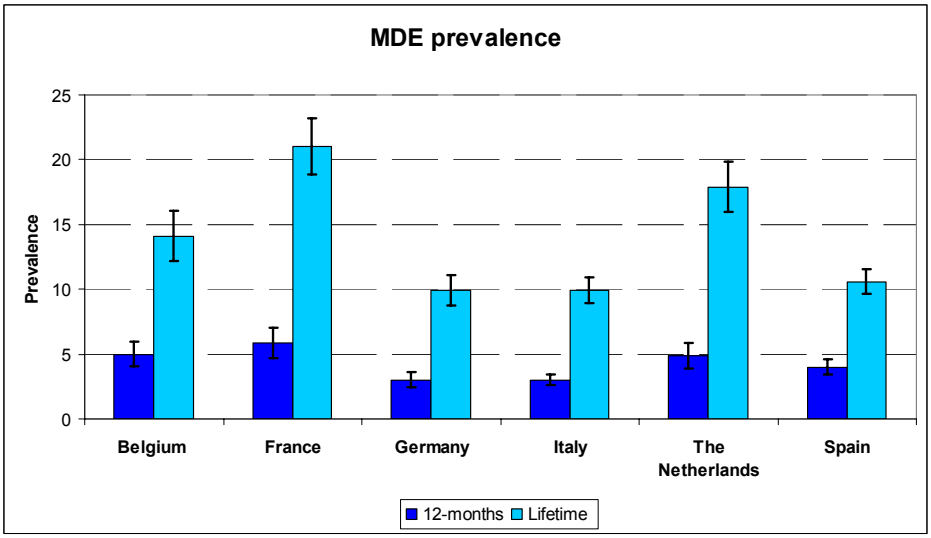
Suffering from a mental disorder was the most important determinant of suicidality. A survival analysis showed that the highest relative risk was found for major depressive episode (2.9 for lifetime ideas, 3.9 for lifetime attempts), dysthymia (2.0 for lifetime ideas, 1.9 for lifetime attempts), GAD (1.8 and for lifetime ideas, 2.0 for lifetime attempts), PTSD (1.8 for lifetime ideas, 1.9 for lifetime attempts) and alcohol dependence (1.7 for lifetime ideas, 1.8 for lifetime attempts)(Bernal et al, 2007).

Based on the larger World Mental Health (WMH) surveys data, which include all the ESEMeD countries and other developed countries, mood disorders are the most important cause of suicide ideation, the population attributable risk proportion (PARP) of roughly 62%. This suggests that lifetime prevalence of suicide ideation could be cut by almost two-thirds by preventing mood disorders (Nock MK et al, 2009). See table 1.

DEPRESSION AND SUICIDE IN EUROPE: QUESTIONS TO CONSIDER BY POLICY MAKERS

- Our results show the magnitude of mood disorders in six European countries. These disorders are frequent, affecting more than 31 million people throughout the six European countries at some time in their lives and more than 9 million every year.
- Some population groups are at a higher risk, such as women, younger and unmarried individuals and those having chronic physical conditions and they should be particularly considered in the design of specific prevention and early detection programs.
- Comorbidity is a common feature of mood disorders. Treatment of all conditions (primary and comorbid) is needed to alleviate psychiatric burden.
- The magnitude of unmet need and of minimally adequate treatment is worrisome. Fight against all barriers to effective treatment is needed. These barriers include: lack of perceived need and stigma by those with mental disorders; equipping primary care with skills and resources to identify and care for common mental disorders; facilitate the coordination of mental health specialists and primary care contact with mental health specialists. It is important to develop and effectively disseminate practice guidelines.
- Given the high prevalence of mood disorders, all levels of prevention are necessary: from treatment of cases, early detection of possible cases as well as prevention of new cases and promotion of protective factors.
- Suicide is a relatively low frequency phenomenon. Therefore, in addition to effective measures which restrict access to self-injury methods, etc., the most important focus is secondary prevention among high risk individuals, such as individuals who have committed an attempt, as well as those with mood disorders (Hegerl U et al, 2006). These efforts can be done at the primary care level but also at the work place and schools. Of course primary prevention of mental disorders would translate in a reduction of suicide rates, given their high attributable risk.

Figure 1. Prevalence of Major Depression Episode (12-month and lifetime) in the six ESEMeD countries.



SOURCE: Kessler RC et al, 2008

Table 1. Population attributable risk proportions (PARPs) of suicidality in developed countries* of the World Mental Health (WMH) surveys initiative. Estimates were adjusted by age, age-squared, age cohort, sex, person-year and all other mental disorders.

DSM – IV Disorders	Ideation	Attempt
Any mood disorder	0.620	0.586
Any anxiety disorder	0.293	0.326
Any impulse disorder	0.072	0.064
Any substance disorder	0.132	0.135
Any disorder	0.761	0.753
(n)[a]	*(27,963)*	*(27,963)*

[a] Denominator sample size; * Developed countries included: Belgium, France, Germany, Italy, the Netherlands, Spain, Israel, Japan, New Zealand and United States. SOURCE: Nock, M.K. et al, 2009

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DataPrev

FACT SHEET
2009

Preventing depression and suicide across the life-span

What works?

Major depression is a treatable disorder and suicide is a preventable act. Depression can be prevented by policy actions targeting the causes of depression throughout the lifespan. Effective psychological help can prevent depression. Suicide prevention is highly cost-effective.

The evidence for what works in this fact sheet is based on a detailed analysis of systematic reviews undertaken by the DataPrev project.

Preventing Depression and Suicide by promoting parenting

Parenting is an important determinant of mental health throughout the life course. Positive, warm, supportive parenting promotes resilience and protects against the deleterious effects of future adverse life events. Furthermore, parental mental health problems both during the perinatal period and later in childhood are the most important risk factor for mental illness in the next generation. Parenting which can be detrimental to future mental health is surprisingly common.

There is a sound and growing evidence base for the effectiveness of work to support parenting. Extensive scientific literature provides evidence for a beneficial impact on parenting as well as a beneficial impact on children's mental health.

Based on the results of a large number of reliable systematic reviews, DataPrev has identified the following programmes as effective:

- ✓ Identification and intervention with parents at risk of perinatal depression;
- ✓ Home visiting during the antenatal period and the first two years of life for parents at high risk of abusive parenting and teenage parents (e.g. Family Nurse Partnership Programme);
- ✓ Demonstration to all parents of infant capabilities in the early neonatal period (e.g. Brazelton Neonatal Assessment Scale);
- ✓ Skin to skin care in the labour ward between all parents and babies;
- ✓ Identification and treatment of mothers with post natal depression;
- ✓ Interaction guidance for families where there are problems in the mother infant relationship including in families where mothers have postnatal depression (e.g. VIPP programme); and
- ✓ Parenting programmes, both behaviour management and relationship based in families where children are at risk at behaviour problems and on a universal basis (e.g. Triple P, Incredible Years, Media based parenting programmes).

A number of other programmes have been identified which show promise, including infant massage, kangaroo care and parent infant psychotherapy for very high risk families.

All of these programmes depend for effectiveness on highly skilled delivery from practitioners who are able to establish trusting, respectful, and empathetic relationships with parents, often in the face of parental suspicion and mistrust.

Engagement and retention is an issue for many programmes and several criteria have been identified which increase these. Social and fiscal policies which support parents and parenting, and community initiatives which reduce social isolation are important background factors.

Addressing depression and suicide in children and young people through school based programmes

School based initiatives can do a great deal to address the problem of depression. Across the world, an increasing number of schools are engaging in a wide range of mental health related initiatives and policies, under a variety of headings. DataPrev reviews find a sound and growing evidence base for the effectiveness of this work. Effective programmes have been shown to reduce specific mental health problems, including depression and associated problems such as aggression, conduct disorders, and antisocial behaviour. Effective programmes have been found to develop the competences that promote sound mental health such as resilience, optimism, empathy, cooperation and a positive and realistic self concept. They also reduce risk factors for depression such alcohol and drug use, and violence and bullying. So far, over 40 recent systematic reviews have identified 16 successful evidence based school mental health programmes (or interventions) being implemented in Europe. Many of these originate in the United States; some come from Australia and some from Europe itself. Some typical examples include:

- ✓ Second Step to Violence Prevention. US in origin, now found in Sweden, UK, Denmark, Iceland, Germany, and Norway.
- ✓ Promoting Alternative Thinking Strategies. US in origin now found in UK the Netherlands, Germany, Switzerland, and Croatia.
- ✓ Friends. Australian in origin, now found in the UK, Ireland, Germany, Finland, Netherlands, and Portugal.
- ✓ Incredible years. US in origin, now found in UK, Ireland, and Norway.
- ✓ Olweus Bully-Victim programme. Originated in Norway, now found across Scandinavia.

Addressing depression and suicide in workplace programmes

The effects of work on mental health are complex. On the one hand, work is a source of personal satisfaction and accomplishment, interpersonal contacts and financial security, all prerequisites for good mental health. On the other hand, there is evidence to indicate that a high workload, precarious work, and high emotional demand, as well as work place bullying and violence, are linked with depression.

Depression is an obvious concern for employers because of its high prevalence and adverse effects on workers' productivity, but, unfortunately, there is surprisingly little scientific research that demonstrates the impact of prevention programmes based in the work place. The majority of the workplace interventions

focused on preventing depression identified by DataPrev have used pharmacological therapy as a key component and only a few have used psychosocial programmes. A computerized cognitive behavioural therapy programme for emotional distress in employees found significant decreases in depression at the end of the treatment period and at follow-up a month later. Guideline-based care of workers with mental health problems (including depression) which promoted counselling by the occupational physician facilitating return to work failed to lead to improvements in productivity and treatment satisfaction compared with usual care.

Preventing depression in older people

Depression is the most prevalent mental health problem among older adults, affecting 12% of adults aged 65 years or older in Europe. A systematic review, conducted by DataPrev found a growing body of research on the effectiveness of psychosocial interventions for mental health promotion and prevention of depression in older people. Ninety unique intervention studies have been identified.

Most of the intervention studies considered in the review have a randomized controlled design and measure the effect on depressive symptoms among older adults as the primary outcome. Most of the intervention programmes have originally been implemented in the United States, while the rest originate in Europe, Australia or Asia. The main categories of interventions for mental health promotion and prevention of depression among older people are

- Physical exercise training interventions
- Skill training interventions
- Group support interventions
- Reminiscence interventions
- Social activities
- Multicomponential interventions

The majority of the interventions considered in the systematic review have a preventive rather than promotive approach, targeting older people in high-risk of mental ill-health. The review shows that psychosocial interventions are overall effective in preventing depressive symptoms among older adults. At this stage of analyses, the most promising interventions seem to be interventions containing social activities.

What needs to be done by Policy Makers

Addressing depression and suicide in strategic frameworks

Preparation and implementation of country based, regional and municipal strategies and action plans for mental health, with prevention of depression and suicide as key components

Intersectoral approach

Effective public health action to prevent depression and suicide requires an intersectoral policy framework at all levels. The preventable determinants of depression and suicide mostly lie in the domains of non-health sectors.

Mental health policy needs to include promotion and prevention

Public health policy should encompass mental health promotion to foster resilience against depression, as well as health protection actions to prevent depression and suicide.

Raise awareness among policy makers

Securing political commitment to preventing depression in health and non-health policies by raising awareness of the prevalence of depression, including among children and young people, and the impact of depression and suicide on well-being and productivity ensures that prevention of depression and suicide is a key component in health policies at all levels. Political commitment also leads to mainstreaming the prevention of depression and suicides into relevant non-health policies, action plans and programmes.

Ensure equity and parity between mental and physical health

Building policies on the principle of equity and parity between mental and physical disorders lessens health inequalities.

Mental health impact assessment

Mental health impact assessment of all policies can support prevention of depression and suicide across sectors. It allows health agencies to have an influence on the political and social agenda and to sharpen the focus on health in interdepartmental policy making.

Setting suicide reduction targets

Setting targets for suicide reduction in policy action plans may help focus attention on suicide prevention. Targets should be set to reduce potential life years lost (PYLL) to avoid masking of an increase of suicides in younger people by a decrease in older people. Furthermore, targets need to be formulated as health inequality targets to support suicide reduction among the most vulnerable groups or the most deprived areas.

Preparation of fact sheet

This fact sheet was edited by Peter Anderson based on summary reports prepared by Sarah Stewart Brown, Katherine Weare; Czeslaw Czabala, Katarzyna Charzyńska, Kristian Wahlbeck, and Anna Forsman as part of the DataPrev project coordinated by Radboud University, Nijmegen, the Netherlands. The fact sheet draws on additional information from the background document prepared for the thematic conference on prevention of depression and suicide under the European pact for mental health and well-being, Budapest, 10-11 December 2009.

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European Alliance Against Depression (EAAD) –

An evidence-based, 4-level action programme against depression and suicidality

I. Background

The European Alliance Against Depression (EAAD) is based on the concepts and materials developed in the context of the Nuremberg Alliance Against Depression, a comprehensive intervention project which was conducted in the framework of the German Research Network on Depression and Suicidality (Kompetenznetz "Depression, Suizidalität") in 2001 and 2002. The intervention led to a decrease in overall suicidality (suicides and suicide attempts) of more than 20 percent in a target region. The EAAD combines this concept with the experiences and materials from partner countries in a European initiative (www.eaad.net).

II. 4-level approach

The 4-level approach of the EAAD is based on multiple simultaneous interventions that generate a synergistic effect. Figure 1 provides an overview of measures that were taken across the 17 participating countries during the projects EAAD I and II between 2004 and 2008.

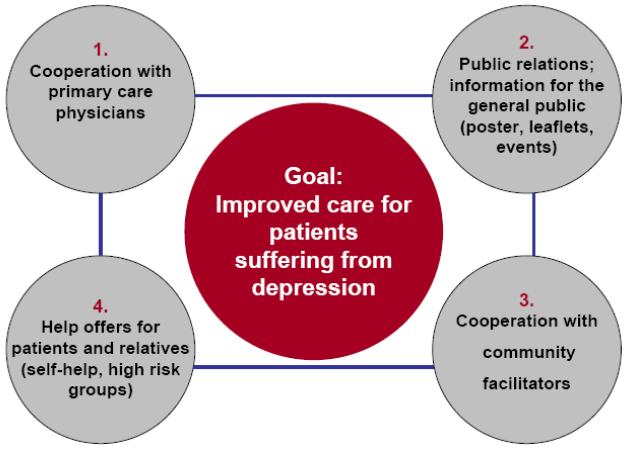

Fig. 1: 4-level approach

III. How does a regional network work?

Based on the above described 4-level-approach the model region implements its activities in three steps:

1. *Planning, design, strategy* (Status quo Analysis: e.g. analysis's of resources, recruiting of allies, engagement of a coordinator)
2. *Preparation* (e.g. involvement of patrons, integration of all relevant institutions, adaption of materials, training lectures, planning and locating first public events, contacting press/media of opening event)
3. *Implementation* (e.g. opening event, educational trainings of GP´s, workshop for multipliers, lectures/public awareness, distribution of materials, self-help activities, hotline for patients after a suicide attempt).

III. How does EAAD spread its activities?

The methods used for the growth of regional networks are:

(1) the formation/strengthening of relationships with key contacts in health politics, national professional organizations, and national self-help organizations;
(2) co-operation with regional umbrella organizations, as well as potential new regional partners, in order to promote the dissemination of EAAD to new regions, and
(3) organization of regular national level meetings.

The process of dissemination from regional to multi-regional or national activities against depression and suicidality has a strong bottom-up element. It is driven by the identification of the regional organizers and initiators with their regional alliance and a key for the success of EAAD.

IV. Evidence

Evidence concerning the efficacy of the 4-level-approach has already been delivered during the Nuremberg Alliance Against Depression. Nevertheless different research questions arose concerning efficacy of EAAD.
For further evaluations the network defined the outcomes shown in Figure 2.

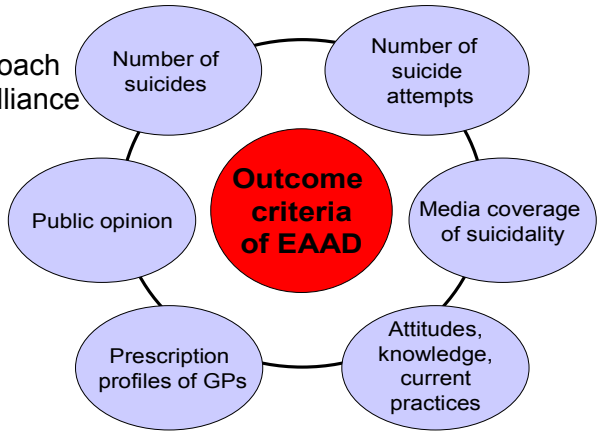

Fig. 2. Outcome criteria of EAAD

V. Dissemination of results

EAAD results were disseminated among different target groups: to the broad public, the European Commission, the media, experts and professionals as well as decision makers. Presentations to more than 60 national decision makers and also presentations on more than 60 scientific meetings and congresses took place. Further on more than 30 articles were published, are in press or prepared. EAAD has been described as best practice example in the green paper of the European Commission on mental health.

VI. Capacity Building

EAAD applied several strategies of capacity building: organisational and workforce development, partnership development and resource allocation. An evaluation of the implementation of the EAAD intervention showed that it was successful and that EAAD is well accepted and liked by the partners as well as the media which is shown in positive echoes from the media and the unbroken request in being supported by EAAD in implementing own local alliances against depression.

VII. Sustainability

A non-profit organisation was formed in 2008 based in Leipzig, Germany to continue and expand the work of EAAD. The main purpose of the society is to promote the public health and education and will furthermore promote the care and prevention of suicidality by initiating community-based intervention programmes.
Based on the work of EAAD the project "*Optimizing Suicide Prevention Programs and Their Implementation in Europe"* has been started in 2008 *(OSPI, www.ospi-comeurope.com)* (Hegerl, et al 2009).

Fig.3:
Poster used in PR campaign (EAAD)
„Depression can affect everybody"

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E-MENTAL HEALTH OPTIONS TO PREVENT DEPRESSION AND SUICIDE

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BACKGROUND

Depression is the single leading cause of non-fatal disease burden. It is also associated with premature death. Both factors (morbidity and mortality) combine to make depression one of the principal determinants of ill-health in the European Union. The corresponding disease burden is not without economic consequences. Depression generates expenditure in the health care sector and is also associated with productivity losses when people do not go to work (absenteeism) or are less efficient while at work (presenteeism). The economic costs of productivity losses exceed the health care costs by far, thus adding considerably to the economic burden attributable to depression.

EUROPEAN CONTEXT

The disease burden due to depression is universal, but attains specific significance within the EU context, where we have to rise to two additional challenges.

Firstly, the economic landscape of the EU is undergoing a rapid transformation from an agrarian/industrial economy towards an innovative knowledge and service-driven one. It is of note that today's economy places very specific demands on people's emotional, cognitive and behavioural capacities – precisely the capacities that are adversely affected by depressive disorder. What is needed is a 'healthy head' for a 'healthy economy' – now more than ever. Promoting mental fitness and prevention of depression is therefore important, even from a strictly economic point of view.

Secondly, the disease burden of depression is increasing with increasing life expectancy, and older populations are likely to articulate a greater demand for health care. The growing demand for health care may pose a problem in the long run, but there is an additional hitch. The workforce in the health care sector is also ageing. To illustrate, the mean age of an European nurse is 45 years, and a general practitioner is on average 50 years. It is a matter of time before they reach the age of retirement. The combination of a greater pressure on health care and an ageing health care workforce beg the question about the longer-term sustainability of health care. It is therefore of importance to keep ageing populations healthy. In addition, it is crucial to develop economically affordable and sustainable forms of health care.

OPPORTUNITIES

Notwithstanding these challenges, there is a message of real hope. Effective interventions for the promotion of mental fitness and prevention of depression can be delivered in a way which is at once acceptable, cost-effective, scalable and sustainable.

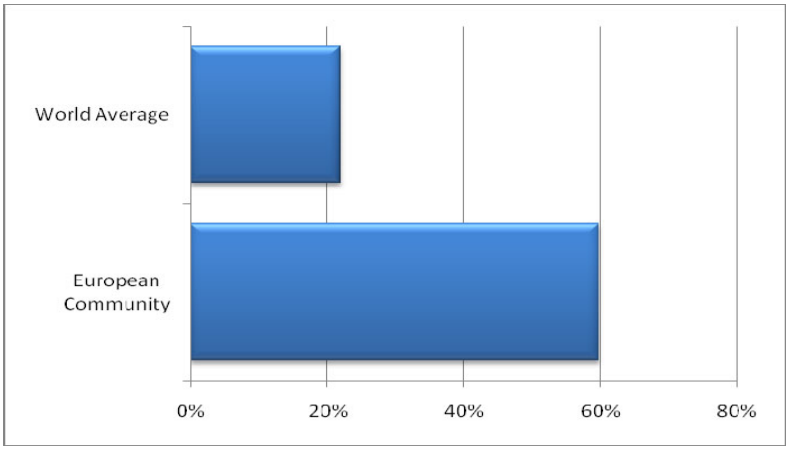
The central idea is to take full advantage of new media (such as the internet) to deliver state-of-the-art, interactive, step-by-step self-help interventions on a large scale for affordable costs. Such e-mental health interventions can be delivered to promote well-being and to prevent the onset of depressive disorder.

FOR CONSIDERATION

- There is robust evidence that brief preventive interventions reduce the onset of depressive disorder by 20-30%. More intensive forms of preventive intervention

(employing a stepped-care format) can be successful in reducing the risk of depression by 50%.

- Economic evaluations demonstrate that preventive interventions are cost-effective from a health care provider perspective – especially when the interventions are offered in a self-help format with minimal therapist guidance. Preventive interventions for depression are even cost-saving when the beneficial effects on productivity levels are also considered.
- Preventive self-help interventions provided over the internet are just as effective as brief face-to-face interventions. After all, web-based interventions can be evidence-based and state-of-the-art.
- Internet-based self-help interventions have the added benefit that they can be used by clients in the privacy of their homes without fear of stigma. However, internet-based interventions can also be designed to include (online or offline) contact with a therapist, if so required.
- It is worth noting that the EU is one of the world's leading regions with regard to internet usage (see figure below, data obtained form internetworldstats, 2009). The usage of mobile phones is even more widespread and many of these mobiles offer internet connectivity.
- One of the main reasons to be on the internet is to seek health-related information. Hence, there is an almost natural relationship between internet usage and mental health interventions offered over the web.



VARIOUS EXAMPLES

Online promotion of mental fitness and well-being

Boost your Mood is a web-based intervention for health promotion in young people. It is based on the latest evidence from positive psychology. It fosters a sense of mastery, strengthens resilience, and helps to acquire adequate coping styles. The web-based intervention *PsyFit* has similar aims, but is more suitable for adult populations.

Online screening of depressive symptoms

People presenting with sub-clinical and full-blown manifestations of depressive disorder can be screened for depression via the internet. This is a research field where good progress is being made. It is therefore envisaged that online screening will play a key role in early detection, personalised advice, and patient referral to online (or offline) interventions.

Online prevention and early intervention

Grip op je Dip [Get a Grip] consists of a series of chat sessions for young people with health professionals. It often acts as a first contact between young people in distress and mental health services.

Colour your Life is an evidence-based self-help intervention of eight sessions of cognitive behavioural therapy for sub-threshold and early manifestations of depression. It combines cognitive restructuring, applied relaxation and behavioural activation. The

intervention comes in two versions: for adults under and over 55 years of age. In the Netherlands it is offered free of charge.

Alles onder Controle [Everything under Control] takes a different approach. It is rooted in the principles of problem solving therapy, which empowers clients to address their problems in a systematic fashion. The intervention is therapist supported, but therapists typically need 105 minutes per client. The client can complete the intervention in only 4 or 5 sessions. All these interventions are supported by evidence of their efficacy and cost-effectiveness.

Online treatment

Beating the Blues is an e-mental health intervention for depressive disorder in the primary care setting in the UK. It is based on cognitive behavioural therapy. In the Netherlands, *Interapy* offers therapist support over the internet. There is strong scientific support for the efficacy of these interventions. Successful experiments have been conducted in Sweden with email-based cognitive behavioural therapy.

Online relapse prevention

DepressionFree is a recently developed (and as yet only experimental) intervention to prevent the relapse and recurrence of depression in people with a history of multiple episodes. This internet-based self-help intervention is a dedicated form of cognitive therapy and is minimally supported by a therapist. After completion of the intervention, clients can participate in longer-term automated sms-based telemonitoring of depression-related outcomes to receive personalised feedback and advice when required.

Online intervention in somatically ill people

Currently several randomised clinical trials are being conducted with online psychological interventions for depression in people who are being treated for diabetes, cancer and myocardial infarction. This appears to be both an important and a promising field for e-mental health application.

Online interventions for suicide prevention

There are various websites (e.g. *Sahar* in Israel, *Samaritans* in the US and *113online* in the Netherlands) that aim to prevent suicide. These websites question and then second-question the suicidal intention, suggest alternatives such as seeking professional help, point to the consequences of suicide for next of kin and friends, and offer direct links for further support (e.g. telephone helpline). There are also websites for family members of people who committed suicide and these websites may include access to professional counselling and a moderated online forum to meet, talk and share experiences with other people who have lost a family member.

POSSIBLE POINTS FOR ACTION

Quality Assurance

- To develop benchmarks for quality assurance of e-health interventions.
- To set up Clearing Houses to quality mark e-health interventions that meet criteria for effectiveness and patient safety.

Innovation

- To create e-mental health applications for mobile phones and to make wider use of new technologies.
- To integrate the various e-mental health interventions into (stepped-care) e-health service systems for health promotion, prevention, treatment and aftercare across all manifestations of depressive disorder.
- To integrate e-mental health interventions with online screens and online decision-making tools for both clients and professionals.
- To integrate e-mental health interventions with systems for longer-term outcome monitoring and personalised feedback.

Evaluation

- To strengthen the evidence base for e-mental health interventions, particularly in the field of suicide prevention.
- To conduct economic evaluations to inform policymakers about the cost-effectiveness of e-mental health interventions, both on the level of interventions and at population level.

Implementation

- To integrate (online) e-mental health interventions into existing (offline) health care delivery systems and into non-health settings (e.g. work).
- To integrate e-mental health interventions with electronic patient files which are accessible by both patients and health care providers.

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Executive Summary

EUREGHA Mental Health Working Group Suicide Prevention - Prevention of Suicide Attempts and of Self-inflicted harm

The EUREGHA WG started on 20 April 2009 as a platform to share experiences in policy development, in implementing preventive initiatives and in research on issues of relevance for suicide prevention.

The WG was set up by regional and local authorities who identified prevention of suicide as a major concern. The European Commission Consensus Paper of June 2008 and the Mental Health Pact raised awareness amongst the regional and local level on the importance of having this discussion on a trans-regional level and of involving the EU dimension and initiatives in their cooperation. The input from the work and findings of European projects (MONSEU, OSPI, …) in suicide prevention and from the expertise in the European Alliance Against Depression EAAD made an essential contribution to the discussions and the future work of the group.

The current Summary is open for discussion; it provides conclusions / recommendations from an internal Discussion Paper following the last expert round table on 21 September 2009. The WG focused on the *role and added value of the sub-national level in prevention of suicide, suicide attempts and self-harm as well as on the challenges or dilemmas met when setting up and implementing prevention measures.*

The discussions identified primary areas for actions:

Alertness:

Continuous awareness and alertness is required to evolve in prevention of suicide, suicide attempts and self-harm. Therefore, we like to see this process as a cycle. To have the cycle as comprehensive and effective as possible, the process is not an end in itself, but a societal evolution, where process thinking, evolvement, content, implementation and monitoring are important parts. *Prevention is everybody's everyday business, it cannot be limited to the medical and social field, it should be value-oriented and gearing towards life saving. This means cost-benefit analyses ought to be secondary.*

Pro-active prevention – trends and evolution: societal evolution

The Working Group would recommend using the momentum of the economic recovery and the 2010 European year against social exclusion as an opportunity to look into pro-active sharing of policy relevant issues for prevention and as an opportunity to emphasise the need to address people in situations at risk, such as unemployment, homelessness, family breakdown, over-indebtedness, intergenerational poverty…

Another significant aspect of our societal evolution is the technological development of the communication tools. Locally developed tools and methods to commit suicide are likely to be communicated fast, which means that trends will shift faster over the countries. *The Working Group identified a benefit in sharing accurate and timely information to address new trends swiftly.*

Regional added value

Small scale sub national levels are closer to the citizen, and therefore provide opportunities to focus on more targeted groups, to respond faster to ad hoc situations and to have client and public – oriented approaches. These are elements that reunite regions. The question however remains if and how to compare regional approaches. It is likely that the majority of regions have not opted for a comprehensive plan or strategy, but are addressing the situations on a ad hoc basis. The Working group has no intention of evaluating the validity of one or the other approach.

Multi level approach:

A comprehensive strategy or plan should rely on multi-faceted programmes and initiatives, integrating top-down opportunities as well as bottom-up experiences and aspects.

The EU with its vast area of legislation, policies and initiatives, in social and financial inclusion, in protection at the labour place, in mental health and wellbeing promotion is valuable for the national and sub-national initiatives. National and sub-national levels can use current and future EU initiatives to raise awareness.

To increase the rate of success of suicide prevention, we identify that the relevant level for action needs to be focused on. Moreover, the picture is not limited to local, regional or national cooperation. For the Member States as well as for the regions, the European arena provides an important way to foster partnerships, to promote room for cooperation and to exchange good practices, an example of this being the current Working Group.

It is recommended to organise the coordination of the different levels, intra- country, but also internationally; it is recommended to organise peer review in a wider European and international context, to foster partnerships, to bring regional and national authorities and experts together; to extend the monitoring of the implementation of plans to peer reviews at European level; and to foster assessments of the impact of legislative and policy initiatives on the regional suicide prevention.

Sharing and reviewing: a multitude of partners:

Awareness, competences, financial opportunities and approaches may vary over regions and Member States. Those differences, should not undermine each other , but they do clearly show the need for cooperation amongst the different policy levels and organisations. Besides, an exchange on policy relevant issues in suicide prevention as well as a systematic peer reviewing and comparison of plans and initiatives is relevant.

The Working Group would recommend for partnerships and platforms to focus on a large variety of experiences and of actors and to have outcome oriented discussions.

Brussels, November 2009

Annexe: November 2009 - Discussion: topics and actions

This list has evolved during the discussions in the WG. An inventory of open questions and findings will serve as a basis for the future cooperation. This inventory is a living document and will be adapted according to the discussions.

The following issues have been addressed by policy makers and in research. It was felt there might be more cooperative work to be done and to share views, successes and lessons learned. An overview on good practices and experiences will gradually be integrated.

The Group will progressively identify how appropriate mechanisms can be build to share pro-actively policy relevant issues for prevention.

Close to the individual

- Individualised follow-up and monitoring is crucial throughout treatment. To ensure this, different actors need to ensure appropriate, transparent, coordinated communication systems that follow the individual through the various treatment pathways. Focus on the risks for people who attempted suicide and organise adequate follow-up and monitoring, specifically focus on the group of younger people.

- Registration: efficiency of registration of suicide/attempts; registration and the importance of standardisation; Identify if standardisation is an opportunity going up from the local, regional to the European level.

- Address risk factors in relation to the person: such as unemployment, homelessness, family breakdown, crime, over-indebtedness, intergenerational poverty, social exclusion, …. Address risk factors in relation to society and integrate policy making: hot spots, labour place, substance abuse, alcohol…

- Specific target groups:
    - older people – young people
    - Immigrants

Capacity building, training, gatekeepers

- Gatekeepers awareness raising, empowerment and capacity building. Identify all and focus on:
    - Schools
    - Working place; skills development and financial exclusion

- Training models and capacity building: 'train the trainers' modules; training courses for professionals: training modules on depression and suicidal behaviour in medical training curriculum: Training focused on basic awareness is important during the follow up of clusters of suicide; comprehend suicidal behaviour for gatekeepers.

- Campaigning to reduce stigma: messages to be delivered or not to be delivered; use a general population approach: bring positive mental health promotion in schools, youth organisations; employment; get the media to do reporting in a positive way.

- Peer review set up for scientific experts, day-to-day actors in governmental or non-governmental settings. (eg. Platform building)

Methods and tools:

- Hotspots and methods used: identification of regional and local methods and tools; compare preventive initiatives; early alert on trends in new tools, technological evolutions; internet messages.

Policy relevant:

- Evaluation and monitoring mechanisms: process and outcome evaluations ; measurement of the impact of the implementation; longitudinal cohort studies

- Awareness raising of the political level: discussion on the driving force, the core problem for the regional approaches (plans, strategies or ad hoc initiatives): policy relevance based on evidence.

- Communication and awareness rising amongst the different levels of authority from the local to the European level.
    - Feasibility to develop EU database for the policy level to communicate news (international) on new methods; share of experiences.
    - EU monitoring opportunities of strategies and action plan: share knowledge and share policy relevant experiences(awareness raising and comparison)

- Effect of national – EU legislation and initiatives on the regional and local suicide prevention implementation.

- Platform building at EU-level: use funding opportunities to increase the awareness and the trans-regional cooperation. Compare regional campaigns and preventive measures, use and extend European wide existing experiences and methods; collect and compare problem enhancing factors, triggers and registration protocols.

EUREGHA Mental Health Working Group Suicide Prevention –

Prevention of Suicide Attempts and of Self-inflicted harm. November 2009

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INTERDISCIPLINARY APPROACHES TO PREVENTION OF DEPRESSION AND SUICIDE

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The problem: Depression and suicidality are unique conditions or crises and still little understood as individual multidimensional experiences[1,2]. In addition, clinical depression commonly accompanies general medical or psychosomatic illnesses, it is highly individualised, with high recurrence, relapse rates, and suicidal risk. Complex interventions with improved medical, psychological, social and educational services are recommended based on interdisciplinary team work approach[3].

It is essential to elaborate and further develop the following interdisciplinary work practices:

1. Interdisciplinary dialogue

We cannot draw a holistic comprehensive picture of depression without further interdisciplinary research into it: including psychoanalytic, psychosomatic, socio-cultural and historical dimensions of this phenomenon. Furthermore, we need to explore the underlying condition and the mechanism of its functioning, and to move from a phenomenological to a structural and functional approach to clinical diagnosis. Particular interest should be paid to the contemporary psychoanalytic theory and practice, because it can contribute a distinctively different view on depression and suicide act.[4]

Deepening mutual understanding during exchange with theoretical approaches is of paramount importance because it helps to revise our present view on depression, and build an interdisciplinary theoretical platform for our integrated multidisciplinary team work model. A good practice of interdisciplinary dialogue on various levels – joint research and action projects, multidisciplinary theoretical and practical seminars, case conferences, experience exchange workshops, joint publications, and public awareness raising campaigns – is very welcome.[5]

Example of best practice

Interdisciplinary Clinical Case Conferences: A longstanding practice of Interdisciplinary dialogue between university and hospital staff in the form of Psychiatric Case Presentation is occurring, on a weekly basis, in St. Vincent's University Hospital, Dublin, Ireland. There is a large variety of attendees from various multidisciplinary groups, Consultant Psychiatrists, Nurses, Psychologists and Psychoanalytic Psychotherapists, Occupational Therapists, Social Workers and Pastoral Care staff. A case is presented followed by the patient being interviewed by his/her consultant psychiatrist. A rich input is gathered from all participating from various disciplines, helping to move towards a more holistic interdisciplinary view on each case. [6]

2. Research-based developmental approach to diagnosis

Early differential diagnosis, including both medical and psychosocial aspects, based on the multidisciplinary integrated developmental approach, is highly recommended. It helps to choose the best treatment for the causes of depression at their onset, preventing or eliminating development of secondary symptoms, side-effects, and preventing the development of suicide crises.

Example of best practice

The University of Michigan Comprehensive Depression Center (USA) The all-in-one design of the environment integrates child, adolescent, adult and geriatric programmes. They achieve accelerated progress by maximizing multidisciplinary research in collaboration with other health professionals, minimizing clinical fragmentation, integrating care, and translating advances into communities practice.[7]

3. Addressing psychosomatic functions and causes of depression

Prevailing phenomenological and symptomological approaches in clinical assessment of depression and suicidal condition does not address and reveal its unique multifunctional nature or causes rooted in the underlying illness. To fully understand the material, embodied and subjective discursive aspects of experiences labelled as depression and suicide, a deeper knowledge of undergoing psychosocial and psychosomatic processes, with sensitivity to cultural diversity, is needed.

Examples of best practices:

The University of Louisville Depression Center (USA), provides a multidisciplinary treatment model that integrates biological, psychological, and social interventions through clinical services, research, and community and professional education. They offer the best- treatment practice, state-of-the-art pharmacotherapy, cognitive-behaviour therapy, and other evidence-based therapies, and develop new forms of treatment derived from clinical trials. A particular emphasis is placed on research into the root causes of mood disorders and designing new or enhanced treatments that can fundamentally alter the pathology that causes these conditions.[8]

Postpartum Depression: An Interdisciplinary Approach of Therapy and Research in Germany: Interdisciplinary team developed a multimodal and interdisciplinary study to examine women after their delivery. Along with epidemiological data and psychosocial factors, they examined personality and bonding behaviour as well as neuro-anatomical aspects. Accordingly a comprehensive range of services via a telephone hotline and therapeutic treatment was allocated. Current research data allude to PPD as not being caused by a specific "key factor", but instead being a multi-causal pathogenesis. Moreover personality structure with high self-expectation and own bonding experiences could play a certain role in PPD[9].

4. Individualised intervention programmes including psychological counselling and psychotherapy

Depression and suicide are, first of all, psychosocial responses to a very particular developmental history and life circumstances with unique adaptive or defensive function, and a suicide is often committed in response to a cause of depression, at the moment, when depression "does not work any more"[10], sometimes as a result of an inappropriate psychopharmacological treatment of the depressed psychotic patient. To ignore it would be a huge mistake. Yet prevailing available forms of treatment – pharmacotherapy and protocol guided therapies –are based on a very little if any account of the singular, unique experience of the suffering subject. Therefore deeper psychological distress factors and suicidal inclinations remain unspoken. More interdisciplinary intervention programmes need to be developed with medical, psychological, psychoanalytic/psychotherapeutic, educative, and social components.

Examples of new interdisciplinary approaches:

The Wellness & Recovery Centre of St. Patrick's University Hospital, Dublin, Ireland, offers several educative treatment programmes, specially designed for patients suffering from depression:
The Depression Management Programme aims to educate on the causes, varieties and treatments of depression, and to prevent suicide crisis. The programme also encourages coping skills with goal-setting and stress management advice. It is a three week programme consisting of five groups each week[11]. The Depression Management Programme started in 2003 and has been accredited by Joint Commission International (J.C. I.) since 2004/2005.
The Depression Recovery Programme has been developed recently by the multidisciplinary team, specifically for people who are being treated for a primary diagnosis of depression. The mission of the Programme is to promote healthy living, to inspire hope and a vision of recovery, to facilitate the participants journey towards recovery from depression, to prevent potential relapse and suicide[12].

Practice-oriented integrated treatment model for depression in Germany: This multifaceted intervention model for outpatient care of depression combines benchmarking, continuous medical education and interdisciplinary quality circles for the diagnosis and treatment of depressive disorders. Physicians who treated their patients according to the experimental model, improved the effectiveness of their clinical work.[13]

Guided self-help groups in Finland: The project was designed to engage depressed women in feminist action research and to develop guided self-help groups for them in the Finnish NHS. They draw upon an empirical study of a group of depressed women in Finland, and use a cultural ethnographic approach to depression and link it to a gender sensitive, feminist perspective. They argue that if a new understanding of women and depression is to develop, it must explicitly include ideas on how depression is shaped at the public and private interface as well as how distress and well-being may have cultural as well as gendered variations.[14]

Handling Chronic Pain Disabled by Depression: A systematic interdisciplinary approach is developed and implemented, utilizing the four perspectives of diseases, life stories, dimensions, and behaviours to evaluate and treat patients disabled by depression and chronic pain. The design of a comprehensive treatment plan involves the determination of each perspective's contribution to the patient's suffering. The process of formulation recognizes that the perspectives are distinct from one another but complementary in illuminating the various reasons for a patient's suffering. The perspectives offer a recipe for designing a rational treatment plan rather than trying to reduce the individual patient's complexity into a uni-dimensional construct. This approach was found to increase the probability of a successful treatment outcome.[15]

Multimodal Mind/Body Group Therapy for Chronic Depression: A Pilot Study is a 24-week multimodal group treatment programme whcih was piloted to assess whether psycho-education, lifestyle modification, meditation, and mind/body skills training would reduce symptomatology and improve overall balance and well-being in non-medicated patients with moderate depression. The Beck Depression Inventory (BDI-II), the Symptom Checklist-90 Revised, the Life Orientation Test, the Short Form Health Survey-12, and the Psychological Well-Being Index were used to assess outcomes. The therapy outcome, which was statistically sustained for six months, suggests that a multimodal holistic mind/body group approach can benefit a segment of the chronically depressed population.[16]

ACTIVE - Appalachians Coming Together to Increase Vital Exercise programme for individuals with type 2 diabetes (T2DM) and co-morbid depression. This interdisciplinary intervention was composed of 10 manualised CBT sessions, six exercise classes with supervised exercise, and 12 weeks of community-based aerobic activity. The ACTIVE Programme was approved as an effective and accessible treatment programme for individuals with type 2 diabetes (T2DM) and co-morbid depression. In randomised clinical trials, exercise was shown to be as effective as antidepressant medications in treating depression with the benefits of exercise extending beyond those observed in medication alone. Moreover, participants reported improvements in quality of life and social support following this demanding intervention[17].

5. Team work training and support in educational development

Special interdisciplinary intervention conceptual models[18], guidelines, manuals, and training programmes are recommended to support the multidisciplinary team work.[19] Above all, the whole mindset needs to shift towards open-mindedness to various approaches in understanding and handling of depression and suicide. Multi-professional education programmes help to train new professionals with team work attitude and skills.[20 21 22]

Example of best practice

The German Action Programme has been designed as a combination of benchmarking, interactive Continuing Medical Education (CME) sessions and interdisciplinary quality circles. Benchmarking comprises proven elements such as analysis of weak points and orientation towards models of best practice. CME training involves training for physicians in terms of clinical practice guidelines for diagnosis and treatment. Quality circles aim to reorganise the care of depressed patients and to promote changes in clinical behaviour towards evidence-based procedures.[23]

CONCLUSION

The best interdisciplinary team work practice is characterised by:

- Multidimensional research-based developmental approach in diagnostic assessment, aiming at early diagnosis of both depression and its underlying psychosomatic cause at its onset, providing opportunities for prevention of the development of illness, secondary symptoms, side effects and possible suicidal outcome.
- Interdisciplinary intervention framework (programmes), with medical, psychological, psychoanalytic/psychotherapeutic, educative, and social components.
- Individually tailored treatment plans, including individualised combinations of various intervention and therapy methods; provided by multidisciplinary team of health carers, psychiatrists, psychoanalysts/ psychotherapists, psychologists and social workers.
- Interdisciplinary treatment monitoring practice based on ongoing in-depth individual case study in multidisciplinary teams, like group supervision and multidisciplinary Case Conferences, with case presentation and patient's interviewing, followed by in-depth discussion.

- Cooperative treatment approaches, aiming at developing a working alliance with a patient and his or her family, where the sufferer's self-help and his/her family's supportive involvement is achieved.
- Well-developed infrastructure of support for interdisciplinary team work: treatment manuals, training and further professional development programs, case conferences, group supervision, expert consultations, etc.

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[1] Depression is a multidimensional condition, an experience, that manifests simultaneously on all levels of our existence, grounded in totality of our whole being. Suicide condition/crisis is also a multilayer state of affect .Depression can be seen as both a normal and an abnormal state of being. There is ongoing debate about whether depression is an illness or it is a symptom, like pain or blood pressure, only more complex, multidimensional one, - a symptomacomplex.

[2] Psychological description of the suicide condition: isolation, the fears, the pain, the confusion, the acts of self-injury, the behaviour of others that was stigmatizing, denying, abusive, the horrible sense of estrangement that exists when you are in a terrible situation and there is no one who understands what you are going through, the hatred and contempt for oneself and the world, the debilitating sense of personal weakness. See http://www.metanoia.org/suicide/ptsd.htm.

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[8] More information: https://louisville.edu/depression/

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[10] Suicide attempts are often a cry for help or the only way some people believe their pain can end-- they are not simply harmless bids for attention. Typically, there are three motives for suicide: (1)Cessation: The person wants to stop his or her conscious experience forever with death. (2) Interruption: The person wants to interrupt his or her conscious experience for a while in an attempt to feel relief. (3) Appeal: The person uses suicide as an attempt to create an emotional or behavioural change in another person. See:https://www.healthforums.com/library/1,1258,article~6229,00.html

[11] The five types of groups each week are:(1)Goal Setting and Discussion, (2) Health Education,(dealing with symptoms of depression and stress, exploring personal lifestyle and discovering personal wellness tools); (3) Occupational Therapy Group-Stress Management Group, (4) Unravelling Depression workshops, and (5) Keys to Wellbeing discussion group. More information: in http://www.stpatrickshosp.com/index.php/the-programmes

[12] The overall aims of the Depression Recovery Programme are to: (1)Provide a Therapeutic environment, (2) Reduce isolation and Enhance Peer support and identification, (3) Promote a Recovery Ethos, (4) Encourage/ Facilitate therapeutic change, (5) Enhance self awareness, (6) Educate, (7) Encourage participants to identify and challenge personal factors that maintain the depressive cycle, (8) Encourage participants to take an active role in maintaining their health, (9) Encourage the development of the Compassionate Mind, (10) Encourage participants to embrace and sustain recovery. More information: http://www.stpatrickshosp.com/index.php/the-programmes

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Building resilience against depression: the role of *Social Prescribing* or Community Referrals[1]

Lynne Friedli

1.0 Background

Depression is a pressing public health challenge, contributing significantly to Europe's burden of disease, with high human, social and economic costs.[2] Many of the factors that can contribute both to alleviating symptoms and preventing depression lie outside the health sector, in the social, economic and environmental circumstances of EU citizens. This fact sheet describes the role of *social prescribing* in building resilience through responding effectively to the social determinants of depression.

Social prescribing (sometimes called *community referral*) is a mechanism for linking patients with non-medical, non pharmacological sources of support within the community. It includes a wide range of low threshold interventions that have good outcomes as a first line response for mild to moderate depression and for prevention among high risk or vulnerable groups.

2.0 EU Context and Priorities

Action both to reduce the incidence of depression and to minimise its impact is consistent with EU efforts to improve mental health, increase social cohesion and reduce health inequities. Depression can be effectively prevented only by actions in non-health sectors as well as the health sector. Preventing depression will require a combination of population wide action (to reduce risk factors and increase protective factors for mental wellbeing) and targeted efforts to improve the circumstances of those who are most vulnerable. Effective treatment also reduces the risk of depression re-occurring. In addition, addressing many of the factors that strengthen resilience against depression (physical activity, social support, financial security, contact with nature, good diet and reducing alcohol consumption) will deliver wider health gains for EU citizens.

3.0 Discussion

Social prescribing include opportunities in the community for arts and creativity, physical activity, learning new skills e.g. literacy and numeracy, volunteering, mutual aid, befriending and self-help. Other examples are support with employment, training, welfare benefits, housing, debt, legal advice, or parenting problems.

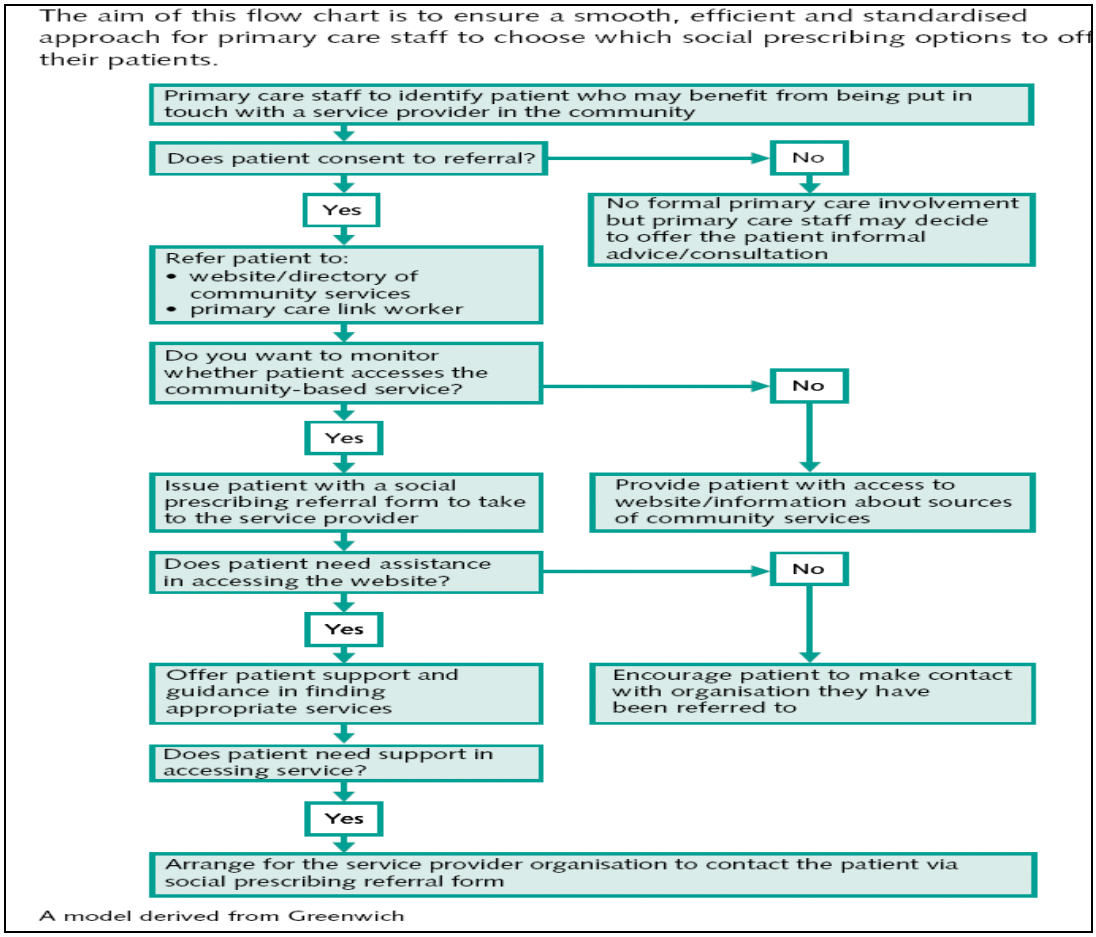
Social prescribing is usually delivered via primary care – for example, through '*exercise on prescription*' or '*prescription for learning',* enabling health professionals to monitor progress and assess clinical outcomes. However, social prescribing may also be part of wider mental health promotion/prevention programmes to raise awareness of steps that individuals and communities can take to increase resilience and reduce the risk of depression. In this case,

[1] This briefing is based on two reports: Scottish Development Centre for Mental Health (2007) *Developing social prescribing and community referrals for mental health in Scotland* www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/communityprescribing; CSIP North West Development Centre (2009) *Social prescribing for mental health: a guide to commissioning and delivery* Manchester http://www.nmhdu.org.uk/silo/files/social-prescribing-for-mental-health-.pdf

[2] *Prevention of Depression and Suicide in a time of Crisis– Making it Happen* - Background document for The Thematic Conference on Prevention of Depression and Suicide under the European Pact for Mental Health and Well-being

there may be a combination of self referral, referral via health professionals and via community groups and NGOs (see figure 1).

Figure 1: Protocol for community referral – Greenwich, UK model[3]



Social prescribing has been quite widely used for people with mild to moderate depression and has shown a range of positive outcomes, including emotional, cognitive and social benefits. Social prescribing may also be a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations, and for people with enduring mental health problems

Social prescribing for mental health provides a framework for:

- developing alternative responses to depression and expanding treatment options;
- a wider recognition of the influence of social, economic, environmental and cultural factors on mental health outcomes
- raising awareness of steps that the whole population can take to improve mental health and strengthen resilience against depression

[3] http://www.greenwichsplash.nhs.uk/2007/default.aspx?cat=7&art=7&type=l

Social prescribing projects
The most common examples of social prescribing are primary care-based projects that refer at-risk or vulnerable patients to a specific programme: for example, **exercise on prescription**, **green gyms, supported self help**, **prescription for learning** and **arts on prescription**. However, it also includes a very wide range of initiatives in which health and other professionals provide a signposting or gateway service, linking patients with sources of activity, information and support within the community, voluntary and statutory sectors.

4.0 What works: solutions and action

Expanding treatment options
Looking Forwards is a resource produced by Manchester Primary Care Trust in the UK that includes information for patients and healthcare workers on bibliotherapy, exercise referral and computerised cognitive behavioural therapy (CCBT), together with details of how to access a wide range of support from the voluntary and community sector. It also includes simple lifestyle guidance.
http://www.manchesterpublichealthdevelopment.org/mphds/download-files/pdf/mental-health/2008/Looking%20Forwards.pdf

Models for social prescribing range from supported access to information, for example via a website, (http://www.greenwichsplash.org/2007/default.aspx?cat=7&type=s), to a more comprehensive system of supported referral. It may make good operational sense to focus on establishing a whole-system approach, using just one route as a 'gatekeeper' and establishing shared protocols across a locality.

4.1 Examples of social prescribing interventions

Computerised therapy
There is review level evidence for the effectiveness of some CCBT for depression, anxiety, panic and phobias. Examples include Beating the Blues™ and Fearfighter. Good quality 'free access' CBT sites can also provide significant benefits.

Books on prescription/bibliotherapy
Bibliotherapy has high patient acceptability, a tendency to continued improvement over time and low relapse rates. It is also cost-effective.

Exercise on prescription
Referrals to supported exercise programmes can include: gym-based activity; guided/health walks; green activity; cycling; swimming and aquatherapy; team sports; exercise and dance. There is robust evidence for the mental health benefits of physical activity for clinical and non clinical populations; what is less clear is what works to increase the uptake of exercise.

Arts on prescription
Creative activities include: arts and performance (writing, painting, sculpture, photography, music, poetry, drama, dance, circus, film); libraries; museums; heritage; and cultural tourism.

Mental health benefits may relate to the development of self-expression and self-esteem, to opportunities for social contact and participation and/or to providing a sense of purpose and meaning and improved quality of life.

Green activity/ecotherapy
Schemes in which participants become both physically and mentally healthier through contact with nature. This can include: gardening and horticulture; growing food; walking in parks or the countryside; conservation activities. Access to green, open spaces is robustly associated with reduced inequalities in income related health.

Learning/education on prescription
Referral to a range of formal learning opportunities, including literacy and basic skills. Literacy reduces risk of depression, notably among women; participation in learning increases self efficacy and is associated with small but significant positive changes in health and social outcomes, notably for those with low levels of school achievement.

Volunteering/Employment
Support with employment includes vocational advice and support (as part of primary prevention), and supported employment (as part of secondary/tertiary prevention).

Time banks
A time bank is a 'virtual' bank where people can deposit the time they spend helping each other and withdraw that time when they need help themselves. Everyone's time is of equal value. The time bank can be 'person to person' or 'person to agency': in Wales, a partnership between health and municipalities enables citizens to access valued leisure activities in return for contributing their time. Some studies have shown that time banking is more successful at reaching those in areas of deprivation than traditional volunteering.

4.2 *Outcomes*
Short- and medium-term outcomes include:

- increased awareness of skills, activities and behaviours that improve and protect mental wellbeing – e.g. the adoption of positive steps for mental health;
- increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using mental health services;
- increased levels of social contact/support among marginalised and isolated groups;
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression, in line with NICE guidelines (NICE 2004);
- reduced waiting lists for counsellors and psychological services;

5.0 Conclusions
Social prescribing can increase access to activities that are effective for improving clinical outcomes and also have wider benefits in promoting and protecting mental wellbeing for the whole community. Social prescribing depends on building stronger partnerships between health and non health sectors and particularly in ensuring adequate resources for the voluntary and community sector. Social prescribing also focuses attention on the wider determinants of mental health and the relationship between social, economic and environmental factors and risk of depression.

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