Global Mental Health: Addressing the Global Burden of Depression

Introduction

This briefing note provides a summary of the discussions at a UCL Grand Challenge of Global Health seminar on mental health. Discussion focused on whether depression is considered a biomedical condition, the diagnosis, treatment and prevention of depression, issues in tackling global mental health, and the experience of developing mental health services in Mozambique.

Key themes

Depression as a human health condition

Depression is a human health condition which may be considered a creation of social and cultural phenomena, unique to western society, rather than a biomedical condition. However, research in Zimbabwe and India has shown that people do discuss manifestations of the physical symptoms of depression but they refer to them not as depression, but as an association between how they feel and their social circumstances (often with spiritual implications).

Although depression is a global human health condition, there are differences in the way it is described, its expression, and its conceptualisation and causes. There is also debate over whether a health condition can exist without the presence of measurable biochemical markers, with the view that the existence of a health condition is predicated on the phenotypic condition which is identified through a biological marker. Psychiatry as a profession has struggled to define a phenotypic description of depression, but diagnosis can draw on:

• face validity (using a description of a person with the syndrome of depression without using any diagnostic labels which is recognised by two different clinicians anywhere in the world as a cause of human suffering that they see in their everyday practice);
Depression is a real cause of human suffering and a biomedical entity across world cultures, but social factors play an important role in explaining the condition (as in other medial conditions).

**Diagnosing depression**

**Depression as a continuum of severity**

The symptoms of depression, such as low mood, fatigue and poor concentration, are common amongst the general population. There is no fixed division between what is ‘normal’ and what is not and no point at which sadness becomes depression, although it is possible to mark the point where depression becomes detrimental to health. This means that the current approach to diagnosing depression is based on an arbitrary cut off point, which has implications for those with milder or more common forms of depression who are just below that threshold.

The community burden of mild depression may be higher than is realised, making it a public health issue that is under-addressed. Whilst treatment is a priority for individuals with a more severe form of depression, it can be argued that there is also a need for a population health approach to milder depression.

**Causes and risk factors for depression**

Within the scope of risk factors associated with depression, environmental stressors must be considered. This is a complex issue because people respond to and interpret different environmental stressors in different ways. Variation in psychological interpretation of events contributes to variations in how people react and respond to stress, including physiological mechanisms. The way in which people react to events can also change the way in which they interpret them, their behaviours, and their environments.

Rather than separating biological and social causes of depression, depression should be viewed from a bio-psycho-social model which takes into account all of these causes.

**Prevention of depression**

Prevention is an important part of the medical management of most conditions. In mental health, primary prevention refers to preventing a first episode of depression and secondary prevention to a further episode. Depression responds well to secondary prevention with pharmacotherapy as well as psychotherapy (such as mindfulness-based cognitive behavioural therapy) but primary prevention is more difficult because so many causes of depression are unknown.

However, there are several known risk factors for depression, which can be used to detect those who are at risk for depression and possibly target these individuals for primary prevention. A large study in Europe and Latin America examined all risk factors for depression and distilled them to a core set that can be used to predict depression, with a trial showing that general practitioners were able to predict those at risk for depression using these set risk factors and to implement interventions successfully. This is a further confirmation that depression is both predictable and measurable.

Primary prevention on a population level has proven less successful, however, with trials looking at poverty, physical exercise, school-based interventions, and computer-based programmes showing little proven effect. Given the difficulties in implementing and demonstrating the success of intervention on a population level, it may make more sense to focus on secondary prevention, for which there is more evidence.

Whilst depression is a medical illness, a large number of existential issues (such as personality, meaning of life and loss) are all factors in life difficulties; it is thus unlikely that depression can be eradicated. However, it is necessary to acknowledge such factors when managing depression.

**Tackling global mental health**

**Stigma**

The stigma of mental health can be extremely difficult for people to deal with and lead, for example, to ostracisation from friends and family; being unable to discuss mental health freely and feeling the need to hide mental health problems and emotional guilt. These can compound mental health problems.

**Key aspects in addressing global mental health**

Some key issues to consider in tackling mental health on a global scale include:

- the relationship between mental health professionals and their beneficiaries
- the isolation of mental health service users in developing countries
- the need to implement a system, supported by beneficiaries, with no stigma and where services are available to anyone in need.

Building a mental health system in a developing country: lessons from Mozambique

For a long time it was thought that depression did not occur in countries such as Mozambique (the high number of maternal suicides illustrates the failure to address depression). However, both the presentation and the incidence of depression in Mozambique are similar to those in western countries. Improved accessibility and availability of treatment in Mozambique are therefore urgently needed to decrease suicide rates and the prevalence of depression.

Mozambique has a population of 21 million; mental health services in the country comprise just nine psychiatrists, together with 78 clinical psychologists, 122 psychiatric technicians and 23 occupational therapists. Their primary goal is to expand service coverage, acknowledging the difficulties in guaranteeing the quality of the services.

One of the main problems regarding access to mental health care is that patients often present to services after a suicide attempt because depression has not been diagnosed prior to this. Even when a patient presents after a suicide attempt, depression is infrequently diagnosed. An additional problem is that if a patient is referred to a mental health service, the treatment is over a 6-month period, meaning that the cost of continually returning to hospital can prevent patients from completing treatment; instead they return to traditional healers.

Another difficulty in Mozambique is the absence of a stock of psychotrophic medications. This results in only a few people getting the full course of treatment; these tend to be those in larger cities or those who receive treatment as part of inpatient services. This results in what is likely to be less than 1% of those with depression actually receiving a full course of treatment.

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