

Depression: international intervention for a global problem[†]

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Since 1948 the World Health Organization has had the challenging task of trying to achieve 'the attainment by all peoples of the highest possible level of health' (World Health Organization, 1946). A central part of this work has involved assessing the extent of health-related problems in different parts of the world and advocating for the implementation of effective strategies to address these problems. For many years the World Health Organization has expressed concerns about the relatively low level of funding assigned to mental health services in many countries. Estimates based on data collected in 2000 show that in most of sub-Saharan Africa and South-East Asia there are fewer than one mental health nurse and one psychiatrist per 100 000 people (World Health Organization, 2001). Two papers produced with the support of the World Health Organization and published in this issue of the *Journal* strengthen the argument for additional funding for mental health services. In the first paper, Üstün and colleagues (2004, this issue) summarise data on the relative impact of common health-related problems in different regions of the world, and in an accompanying paper Chisholm and others (2004, this issue) estimate the cost-effectiveness of different interventions for depression in these different areas.

QUANTIFYING THE GLOBAL BURDEN OF DEPRESSION

Information on the relative impact of different health-related problems is needed if spending on health care is to be prioritised. Early attempts to try to compare the impact of different illnesses focused on causes of mortality. It is generally agreed that such comparisons are inadequate because many important health-related problems, including mental disorders, are highly disabling

but usually non-fatal. Disability-adjusted life-years (DALYs) are population health measures that attempt to combine information on mortality and morbidity in a single measure (Murray & Acharya, 1997). Data on the prevalence and incidence of illnesses together with estimates of the impact of illnesses on life expectancy and health are required in order to calculate DALYs.

Over recent years a more complete picture of the epidemiology of mental disorders in different parts of the world has emerged. Population surveys suggest that while the incidence of depression is higher in North America and Europe than in other regions, it is none the less a common condition throughout the world. Estimating the impact that mental illnesses have relative to other health-related problems is a more complex task. Depression causes disability wherever it occurs, but the data used to judge disability resulting from one condition relative to another are based largely on expert opinion. Concerns have been expressed about the validity of this approach, which led to the classification of major depression as being as disabling as blindness or paraplegia (Gold *et al*, 2002).

The data presented here by Üstün and colleagues take advantage of a wider source of opinion than that used in the calculating of previous estimates; however, the relative values assigned to different conditions remains a contentious matter and further exploration of the differences in these values in different parts of the world is required. This issue notwithstanding, depression is clearly a prevalent and disabling condition throughout the world, and the work of the World Health Organization in publicising the need for effective interventions to tackle depression is to be welcomed.

Unfortunately, there is currently very little evidence on which to base decisions about what form these interventions should take in many parts of the world. While the

effects and cost-effectiveness of a range of psychological and pharmacological interventions in resource-rich nations have been established, there have been very few intervention studies conducted elsewhere in the world. In attempting to estimate the cost-effectiveness of treatments for depression in resource-poor regions, Chisholm and colleagues have therefore had to rely largely on findings from studies conducted in Europe and North America. As a result, the interventions they evaluated reflect the dominant interest in pharmacological treatments there has been in these countries; six out of the seven different interventions they evaluated involve the prescription of antidepressant medication.

TREATMENT OF DEPRESSION IN RESOURCE-POOR COUNTRIES

The impact of antidepressant medication in resource-poor countries has rarely been studied, with two notable exceptions. Patel *et al* (2003) conducted a randomised trial of fluoxetine *v.* placebo *v.* psychological treatment among people attending general medical out-patient clinics in Goa, India. They found short-term benefits of antidepressants over placebo, which were not sustained beyond the first 2 months of follow-up. A randomised trial among primary care attenders in Santiago, Chile, compared the effects of a package of stepped care including a group-based psychoeducational programme and selective use of antidepressant medication compared with treatment as usual (Araya *et al*, 2003). This study demonstrated far greater improvement among those randomised to stepped care, with 70% recovered at 6 months compared with 30% among those given standard care. Findings from the latter study support those of studies conducted elsewhere; that antidepressant medication is more effective when delivered in conjunction with psychosocial support (Katon *et al*, 1999). Indeed, increased use of antidepressants without such support may have little effect on the prevalence of depression and associated disability (Helgason *et al*, 2004). In many parts of the world primary care and other services that would be needed to provide such support do not exist and the effectiveness of antidepressant medication in these contexts remains unclear.

[†]See pp. 386–392 and pp. 393–403, this issue.

The absence of the use of evidence-based treatments for depression in many developing countries could lead to the mistaken view that the likelihood of recovery from depression is worse than in resource-rich regions. In fact, available evidence suggests that recovery rates are no worse and may even be better. For instance, in a longitudinal study of almost 200 people in contact with traditional healers and medical staff in Zimbabwe who had evidence of common mental disorders, 59% were no longer cases at 12-month follow-up (Patel *et al*, 1998), a rate of recovery that is higher than that generally seen in countries where such treatments are more widely used. Such findings emphasise the need to develop a better understanding of factors that promote recovery from depression in these contexts, and the impact of interventions currently practised by medical and traditional healers in resource-poor countries.

THE IMPORTANCE OF MACROECONOMIC FACTORS

Although further evaluation of new and existing interventions for depression is required in resource-poor countries, the current paucity of evidence for the effectiveness of these treatments is by no means the most important obstacle to improving care for people with mental disorders. As the latest report of the World Health Organization reminds us, many areas of the world lack basic primary care services which may be needed to deliver effective treatments for depression (World Health Organization, 2003). In many regions of the world the effects of poverty combined with HIV and other transmissible diseases has led to increased infant mortality and decreased life expectancy in recent years (World Health Organization, 2003). That

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many nations have been required by the World Bank and the International Monetary Fund to restrict, and in some instances decrease, spending on health care during this period (Loewenson, 1993) emphasises the central role that industrialised economies play in determining the development and availability of health care services in resource-poor regions. The recruitment of doctors and nurses trained in resource-poor countries by the UK and other resource-rich nations further undermines the development of health care services in these regions (Patel, 2003).

Clear evidence is beginning to emerge that existing interventions for depression may be of value in alleviating the burden of mental disorders across all regions of the world. Further research is needed in resource-poor nations in order to evaluate a range of new and existing interventions for depression. However, the ability of resource-poor nations to provide these interventions will continue to depend more on macroeconomic factors, such as the terms on which world trade is conducted and the management of international debt, than on the quality of the research evidence that demonstrates their effects and cost-effectiveness.

DECLARATION OF INTEREST

None.

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