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ADDRESSING ANXIETY AND DEPRESSION

A WHOLE SYSTEM APPROACH

Report of the WISH Anxiety and Depression Forum 2018

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FOREWORD

The global healthcare community has long focused its efforts predominantly on physical health, leaving mental health behind in terms of awareness, public perception and health prioritization. Over the last few years, however, we have seen a shift in awareness and understanding of mental health. People are more likely to be open about their experiences with mental health problems; media coverage has increased; and senior public figures are recognizing the importance of mental health to our society.

Hundreds of millions of people suffer from anxiety and depression. These conditions place the heaviest mental health burden on global society and are the largest contributors to years lived with disability – so much so that they can be considered as global pandemics. Attempts to prevent and treat these conditions require a persistent multifaceted approach, yet we are currently underprepared to address this major health and social issue at the local, national and international level.

This report aims to support policymakers to tackle anxiety and depression by highlighting successful evidence-based solutions to managing these conditions. It also offers a roadmap to implementing the most appropriate solutions, especially in the field of prevention. This will include next generation initiatives to address the mental health needs of the 21st century that range from novel cost-effective approaches and workplace and community schemes, to the wider application of digital solutions. The report also introduces a WISH National Anxiety and Depression Plan Checklist to assess the current policy status regarding anxiety and depression for each nation.

This report makes the case that a prioritized, focused approach to anxiety and depression can mitigate the risks of these conditions, and contribute to the health and wellbeing of any nation.

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EXECUTIVE SUMMARY

Anxiety and depression represent the most common mental health problems globally, and estimates in 2017 revealed that 322 million people have depression and 264 million live with anxiety disorders.[1]

They are the result of complex interactions of biological, psychological and social factors that emerge mostly in critical periods of life such as childhood, adolescence and early adulthood. They have far-reaching impacts over the course of people's lives, and place an enormous burden on families, societies, healthcare, education and employment.

In addition to their high prevalence, chronic nature and negative impact on daily living, anxiety and depression can lead to people taking their own lives.[2]

The complex and debilitating impact of both anxiety and depression is worsened by stigma and discrimination. This can affect many aspects of people's lives, such as asking for timely help, their quality of life and their ability to participate and contribute fully to society.[3,4]

There are worldwide challenges to meet the demands of these problems. For example, is there capacity in healthcare systems to support people? Also, how will society and other sectors, such as education and employment, play a part in taking action to prevent anxiety and depression?

Figure 1. Challenges related to anxiety and depression

High prevalence	Up to 4.4% of people have a depressive disorder and 3.6% have an anxiety disorder.
High burden	Depression is the largest contributor to years of life lost due to disability worldwide, and anxiety is the sixth largest.
High treatment gap	Only 1 in 27 people receive adequate care for anxiety or depression in some low- and middle-income countries.
High economic cost	The estimated cost of anxiety and depression is nearly $1.15 trillion every year worldwide.
Low funding and investment	Only 1–6% of total health budgets is spent on mental health across the world.
Low workforce	Only 1% of the worldwide healthcare workforce is working in mental health.

Source: WHO (2014);[5] WHO (2015);[6] Chisholm D et al (2016);[7] Thornicroft G et al (2017);[8] WHO (2017);[9] Alonso J et al (2018)[10]

There has been increased global understanding of anxiety and depression and recognition of mental health as a priority under the United Nations (UN) 2015 Sustainable Development Goals (SDGs).[11] Significant efforts and calls to action[12–15] have been made across local, national and international organizations that underline the need to tackle prevention and treatment. Also, investing in health systems and addressing the treatment gap will improve long-term health, economic and social outcomes. Such investment is forecast to produce economic returns of 2.3–3.0 to 1 by 2030[16] – this means a long-term gain of $2.30–3.00 for every $1 invested in prevention and treatment, based on reduced long-term healthcare costs plus the economic productivity of healthier individuals contributing to society.

This report describes evolving worldwide programs, initiatives and policies to prevent anxiety and depression through:

- Using a World Health Organization (WHO) model to address the needs of people throughout their lives
- National and global campaigns and programs to tackle stigma and discrimination
- Workplace mental health programs.

The report also presents the case for a whole system approach to improve availability, access and quality of mental health care in a range of cultural contexts across low-, middle- and high-income countries (LICs, MICs, HICs). It provides an overview of the evidence base, best practices and innovations with a focus on:

- Stepped-care
- Collaborative care
- Task-sharing.

These models are presented using case studies from around the world. They highlight the key role of the specialist and non-specialist workforce in the co-ordination and delivery of care in primary and community settings. The examples also describe the treatment for anxiety and depression for people with long-term physical health conditions, in maternal health and in humanitarian settings.

This report highlights the potential role that emerging digital technology could have in the future as a driver of change in the delivery of mental healthcare. It could provide tools to: increase access to services; support the extension

of workforce capacity and reach; strengthen the mental health information system; and, most importantly, empower people to take control of their mental healthcare needs.

The report concludes by suggesting a framework for action that calls on policymakers and funders to recognize anxiety and depression as a public health priority, and to include it as part of universal health coverage (UHC) programs.

In summary, the framework for action asks countries to consider a simple three-step approach:

1. **Situation analysis** – identify national readiness and capacity to tackle anxiety and depression (for example, by applying the WISH National Anxiety and Depression Plan Checklist)

2. **Priority-setting** – align national anxiety and depression goals with UHC programs, and target high-risk populations such as the young and old

3. **Implementation** – use proven cost-effective and evidence-based interventions. Build a collaborative network with patient groups, healthcare teams, institutes and communities. Consider how to increase the use of technology and digital solutions.

SECTION 1. UNDERSTANDING THE GLOBAL CONTEXT

Defining anxiety and depression

Anxiety is characterized by feelings of worry and fear, which are hard to control and affect daily life activities. There are different types of anxiety, from generalized and social anxiety to phobias.

Depression is a low mood or sadness that persists for a long time that can also lead to a lack of energy or loss of interest.

> **"The most common reaction is 'How can you be depressed? You have everything going for you. You are the supposed number one heroine and have a plush home, car, movies... What else do you want?' It's not about what you have or don't have. People talk about physical fitness, but mental health is equally important. I see people suffering, and their families feel a sense of shame about it, which doesn't help. One needs support and understanding."**
>
> Deepika Padukone, Bollywood actress, India[17]

Both anxiety and depression can be identified and clinically diagnosed with established international diagnostic tools and classification. The International Classification of Disease and the Diagnostic and Statistical Manual of Mental Disorders are used across the world. Table 1 provides an overview of the symptoms related to anxiety and depression, which can vary considerably from one person to another across gender, culture and life experience.

There are long-term, negative impacts associated with anxiety and depression that affect every aspect of a person's life, including their education, work and relationships. Discrimination and stigma can also have a significant long-term ramifications. In addition, there is an increased risk of mortality associated with these mental health problems. Depression alone can reduce life expectancy as much as smoking,[18] and significant numbers of suicides are also associated with anxiety and depression.[19, 20]

Table 1. Overview of anxiety and depression

Depression is characterized by:	
At least one of these symptoms, most of the time, for two weeks or longer:	**Other associated symptoms:**
• Persistent sadness and/or low mood • Loss of interest or pleasure • Fatigue and low energy	• Disturbed sleep • Poor concentration or indecisiveness • Low self-confidence • Poor or increased appetite • Suicidal thoughts or acts • Agitation or slowing of movements • Guilt or self-blame
Anxiety refers to a group of problems characterized by feelings of anxiety and fear, most of the time, for four to six months. Anxiety includes:	
• Generalized anxiety disorder • Panic disorder • Phobias	• Social anxiety disorder • Obsessive-compulsive disorder • Post-traumatic stress disorder

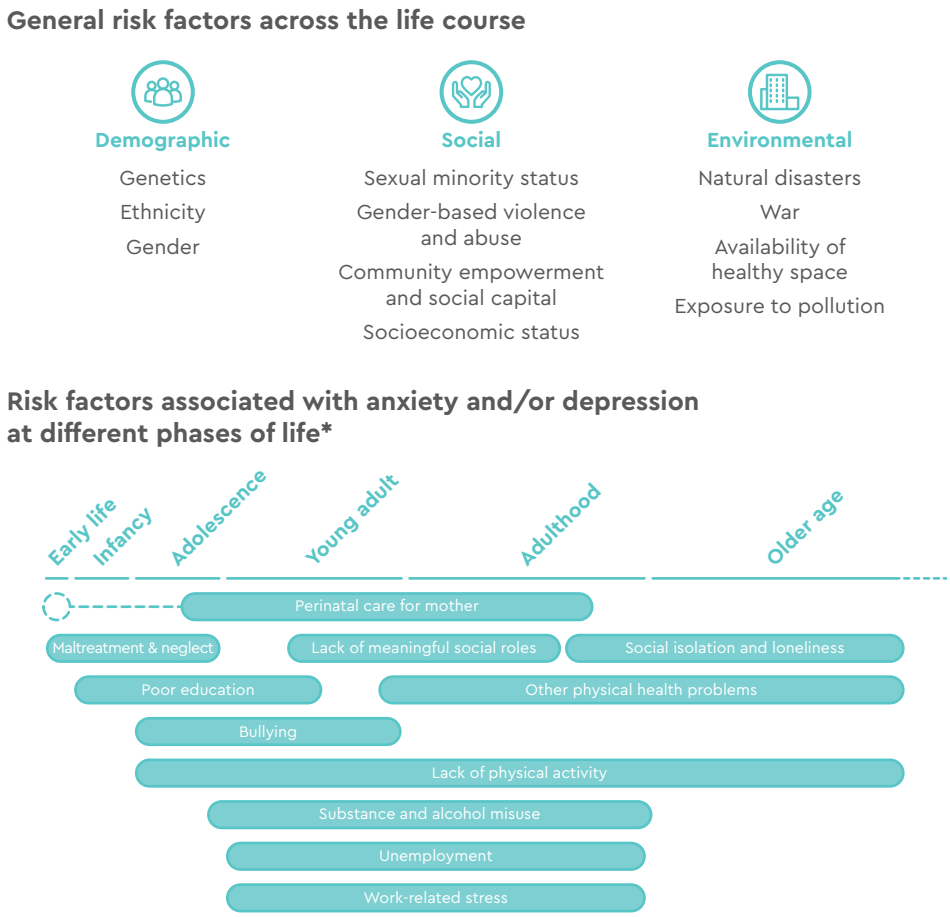
Risk factors and causes

Many aspects of a person's life and environment can contribute to anxiety or depression. Both problems can often be rooted in developmental, social and environmental factors that can affect a person across their life (Figure 2). There is a particularly strong association with child neglect and abuse.[21] Most anxiety disorders emerge in childhood, while mood disorders emerge later in adolescence. Nearly half of people with anxiety and depression have symptoms before they reach the age of 30.[22,23] This is a critical period of transition in people's lives where they start to establish their careers and set up families.[24] Gender is also a risk factor, and the number of women who live with anxiety and depression worldwide is nearly twice as many as for men.[25]

Global burden

Anxiety and depression are the most common mental health problems and among the most common health problems globally. In 2017, 322 million people had depression and 264 million lived with anxiety (Figure 3). The high prevalence, chronic nature and negative impact on daily living means that depression is the largest contributor to years of life lost to disability, and anxiety is the sixth.[26] Further, the estimated cost to the world economy is nearly $1 trillion every year from care costs and loss of work productivity.[27]

Figure 2. Risk factors across the life course



* This list is not inclusive of all risk factors, but provides key examples throughout the life course.

Current challenges

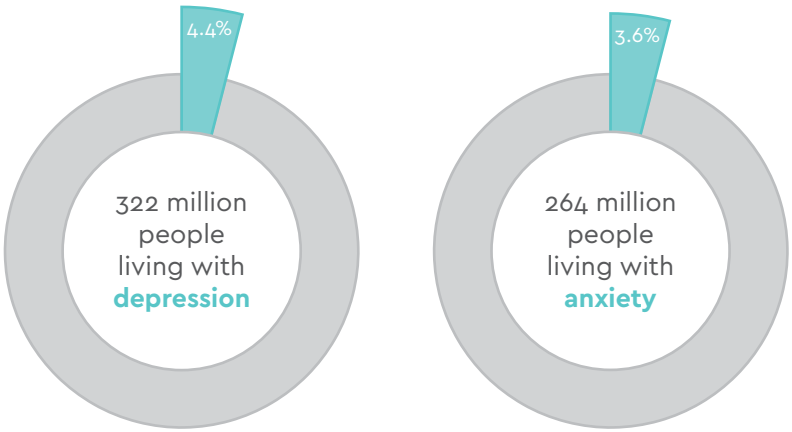
There is a chronic shortage of funding for mental health services. The WHO has reported an average spend of 1–6 percent of health budgets on mental health problems across the world.[28] This funding gap is mirrored by a low capacity in the overall health workforce. Only 1 percent of the workforce worldwide practice in mental health.[29]

The funding and workforce gap has led to a large treatment gap across systems. While some HICs treat up to one in five people with anxiety and depression adequately, it can be as low as one in 27 people in some LICs and MICs (Figure 3).[30,31]

However, because of long-term underinvestment it is highly unlikely that any healthcare system has the capacity to deal with the treatment gap, particularly in countries where the prevalence is even higher. Estimates in HICs suggest that, even with a high level of care and coverage, as many as 96 percent of people will be left without treatment.[32] Therefore, prevention

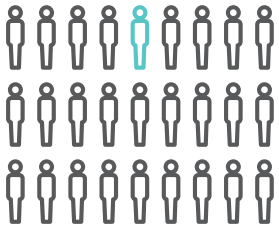
Figure 3. Anxiety and depression – facts and figures

In 2017, worldwide, there were...



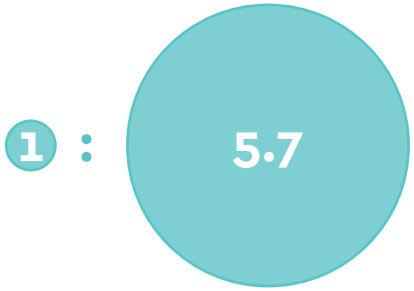
Despite this, there is a large **treatment gap**...

Only **1 in 27** get adequate help in some countries

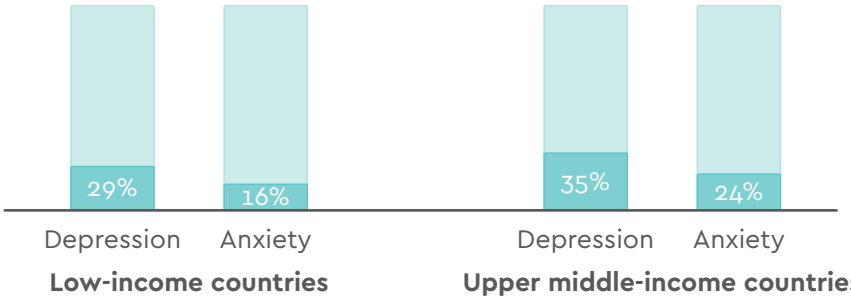


This rises to **1 in 5** in some high income countries

To expand treatment, it will cost **$184 billion** worldwide for both anxiety and depression to 2030, with a return on investment of up to...



Reducing the **treatment gap** by an additional...



Sources: Chisholm D et al. (2016);[33] Thornicroft G et al. (2017);[34] WHO (2017);[35] Alonso J et al. (2018)[36]

and promotion of good mental health through self-care and psychosocial interventions must be implemented to ease the overall burden caused by common mental health problems. Investment in services that tackle anxiety and depression in the early stages improves long-term health and economic and social outcomes – and saves money.[37]

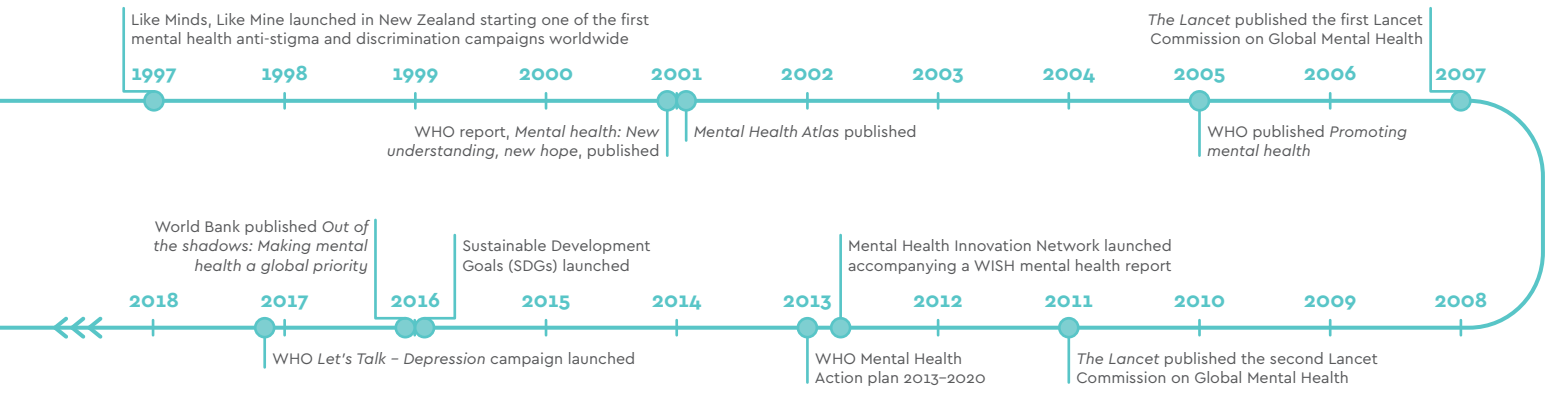
Bridging the treatment gap and working toward the demands of each healthcare system is essential to address human rights and economic issues. Investment in the actions that help to close the treatment gap in healthcare is estimated to cost $184 billion until 2030. This investment is forecast to produce economic returns of 2.3–3.0 to 1 (that is, a long-term gain of $2.30–3.00 for every $1 invested in prevention and treatment) or up to 5.7 to 1 if wider social benefits over the period 2016–2030 are included[38] (Figure 3).

Progress to date and a call to action

The scale and burden of anxiety and depression has gone unnoticed for many generations. In recent years there has been significant effort across local, national and international organizations to raise awareness, increase funding and provide more services. There have also been many reports and calls to action about mental health[39–42] (Figure 4).

The promotion of good mental health is now a development priority under the SDGs.[43] The need to tackle mental health in the context of non-communicable diseases (NCDs) and long-term health conditions is also gaining recognition.[44] Countries around the world have now started to develop strategies, such as the UK No Health Without Mental Health strategy, to improve services and outcomes across their populations.[45,46]

Figure 4. Timeline of key mental health reports and calls to action



Evidence now clearly suggests that anxiety and depression are treatable, and can be prevented. Despite the differences in culture and healthcare systems, effective interventions can be translated, accepted and adapted to different settings around the world.

There is also a diverse range of integrated models of care, and potential solutions, in the innovative use of human resources and emerging digital technology. The question to address is not what needs to be delivered, but how it can be delivered in the most sustainable way that ensures people receive the help they need, at the right time and in the right way.

SECTION 2. EVIDENCE BASE AND BEST PRACTICE

Prevention and promotion at the population level

Many countries have made progress by using the SDGs framework to develop strategies to prevent and manage anxiety and depression in their communities[47] (Figure 5).

Figure 5. Actions by EU countries to prevent depression and promote resilience

Bulgaria includes questions about depression and suicide in national surveys

Hungary has a dedicated national policy regarding the prevention of depression

Portugal includes the prevention of depression in national mental health plans

Sweden allocates resources to promote mental health and wellbeing, with efforts targeted at migrants

Denmark has developed prevention initiatives focusing on vulnerable and marginalized children, young people and suicide

Belgium has invested in increasing awareness of depression in the workplace.

Source: EU Compass for Action on Mental Health and Wellbeing (2016)[48]

This section of the report focuses on the prevention and promotion agenda in the context of three key areas: stigma and discrimination, age, and workplace.

Addressing stigma and discrimination

The complex, debilitating impact of anxiety and depression is worsened by stigma and discrimination. Stigma can affect many aspects of people's lives and can stop them asking for timely help.[49] Experience of discrimination is common among people with depression. It impacts their quality of life and ability to be a full member of society.[50] It affects their human right to live free from discrimination and with favorable work and life conditions.

The Global Anti-Stigma Alliance has defined the key approaches and principles to tackle stigma and discrimination (Table 2). The alliance says that to achieve change, focused, grassroots strategies must be combined with social marketing

and public awareness campaigns. These strategies must also be incorporated in to routine activities and implemented on an ongoing basis. This approach will prove effective, efficient and sustainable.[51–53]

Table 2. The Global Anti-Stigma Alliance key approaches and principles

Principles
Lived experience leadership and empowerment
Hope, recovery, dignity
Effective evidence-based delivery approaches
Dual focus on a wider public audience and people with lived experience
Equality and human rights
Long-term commitment
Approaches
Lived experience leadership
Social contact
Social marketing
Cultural responsiveness and relevance
A social movement
Evaluation and outcome targets
Focus at individual, community and national/institutional levels

Source: Global Anti-Stigma Alliance (GASA) (2017)[54]

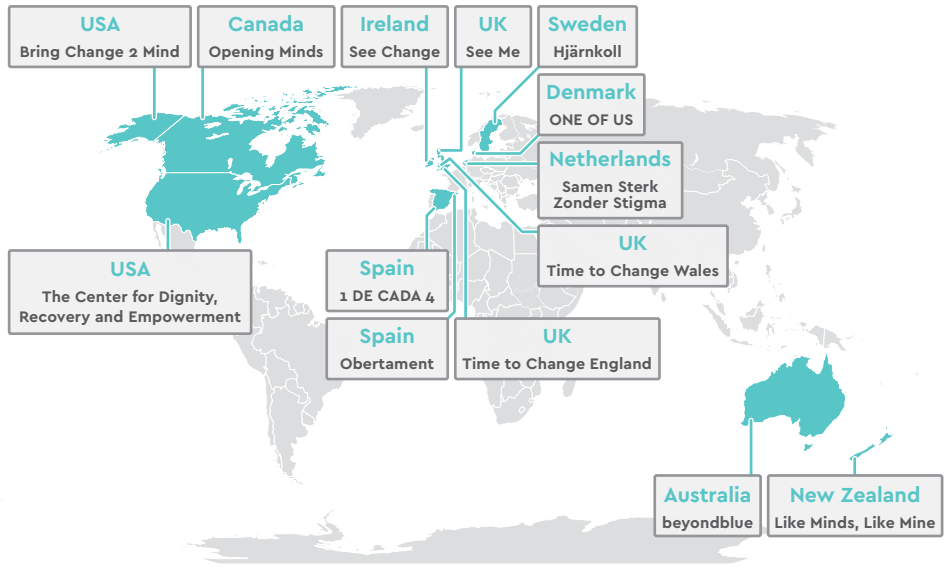
Government leadership and support is vital to address stigma and discrimination, but so too is giving people a voice. The way forward is to implement a combined approach:

- Top-down programs that focus on national attitudes and policies
- Bottom-up initiatives supported by champions and led by people with anxiety and depression, their families, friends, community groups, health-care providers, schools and workplaces.[55]

Educational programs increase awareness and knowledge, and are also likely to encourage demand for mental health services because they empower people to ask for help and treatment. This is the experience of the VISHRAM program in India.[56]

Many comprehensive, successful anti-stigma programs and campaigns have been shown to improve behavior and attitude. Among these programs are Beyondblue in Australia, Time to Change in England and Wales, Opening Minds in Canada and Like Minds, Like Mine in New Zealand (Figure 6).

Figure 6. Anti-stigma campaigns around the world



Source: GASA (2017)[57]

More needs to be done globally through legislation to ensure: equitable access to rights; promotion of social inclusion; and improvement in the quality of life of people with mental health problems.[58,59]

Young people

The global prevalence of common mental health problems among 5- to 17-year-olds is estimated to be 6.2 percent for depression and 3.2 percent for anxiety.[60] There is a huge gap, not only in the availability of services for adolescent and child mental health, but also in the suitability of many existing interventions and in the availability of data.[61,62] The lack of service provision to this group is a missed opportunity and a major target for all countries around the world.[63]

Schools and other locations used by young people are ideal hubs for the implementation of programs, from basic literacy support to treatment hubs for low-severity mental health problems.[64–66]

The role that schools take in mental healthcare depends on contextual factors, such as the availability of mental health expertise, culture and financial resources. While it is common for such prevention programs to use low-intensity

talking therapies,[67,68] a whole school approach (embraced in a previous WISH report[69]) is increasingly being used around the world. One example is the Mentally Healthy Schools program in England, which provides materials and advice to help educators understand mental health and to promote well-being in schools, as well as to develop emotional and social competencies in young people.[70]

In regions with fewer resources, lay health workers have a key role in the implementation of programs. For example, in India, the success of the School Health Promotion and Empowerment (SHAPE) program (based on the Health-Promoting Schools Initiative) demonstrates the impact that access to counseling and other general health-related programs can have across the whole school.[71] A randomized control trial of a similar program in northern India also showed improved depression symptoms and other benefits to the school environment.[72,73]

In Malawi and Tanzania, the African Guide for Mental Health Literacy program brought together community-based stakeholders, such as radio stations, schools and clinics, to increase healthcare access, expand knowledge of mental health problems and reduce stigma. The program demonstrated increased knowledge and help-seeking behavior among young people.[74] The collaboration with radio stations helped to reach large numbers of people, and encouraged adolescents to ask for help.[75] The program also provided training and support for community health teams, which improved local health workers' confidence and their abilities to identify adolescents with depression and provide appropriate help.[76]

Large-scale prevention programs often require action through government policy. In Australia, the National Youth Mental Health Foundation and *headspace* centers were established to provide an access point for mental health services in the community and for individuals.[77] *headspace* centers have demonstrated a decrease in distress among users, and nearly a third of *headspace* clients have used the digital service eheadspace, particularly while they wait to access services.[78]

Older people

As societies deal with rapidly aging communities there are concerns about the high prevalence of anxiety and depression among older people.[79–81] The risk factors that present a challenge for this age group include: living in a care home,[82] where up to 40 percent of residents may be depressed;[83] and multiple health conditions, such as dementia, where 20–25 percent of people develop symptoms of depression.[84] People with two or more chronic conditions, for example

diabetes or heart failure, have a seven-fold increased risk of depression.[85,86] It is essential to provide appropriate support to this at-risk group to prevent anxiety and depression, improve outcomes and reduce care costs.[87–89]

Preventative interventions can be effective, particularly for people with low-level depression symptoms.[90] They can improve wellbeing, reduce social isolation and loneliness, and decrease the risk of depression.[91,92] Effective interventions include:

- Increased social participation
- Increased levels of physical activity
- Continued learning and volunteering[93–95]
- Training to use the internet to increase social support[96,97]
- Improved living conditions – better home insulation and central heating contribute to the prevention of anxiety and depression[98]
- Innovative intergenerational programs to link younger and older people – which show beneficial social and wellbeing outcomes with increased self-esteem – that promote happiness and friendships.[99]

In India, the DIL model (an acronym for "depression in later life" and the word for "heart" in Hindi) involves lay health workers delivering problem-solving therapy and behavioral interventions for insomnia combined with education in self-management. DIL has the potential to prevent depression among at-risk older people in areas where there are limited resources.[100,101]

Workplaces

Mental health in the workplace is gaining worldwide attention. In 2017, this was the focus of World Mental Health Day and the subject of a report by the World Federation for Mental Health.[102] This builds on the recognition by the World Bank that mental health is a Global Development Priority and that it has a critical impact on economic development.[103] The European Union (EU) presented an excellent model when it implemented co-ordinated policy actions to promote mental health in the workplace. For example, 80 percent of EU member states have taken actions to support this by building effective cross-sector partnership and co-operation between the health and labor sectors.[104] A recent UK report also highlighted essential steps for a thriving workplace (Box 1).

Box 1. Thriving at work: a review of mental health and employers

In 2017, the UK commissioned the independent report Thriving at Work on how government and companies, regardless of size or industry, can support mental health in the workplace. The report sets out six core principles and standards:

- Produce, implement and communicate a mental health at work plan
- Develop mental health awareness among employees
- Encourage open conversations about mental health and the support available when employees are struggling
- Provide employees with good working conditions and ensure they have a healthy work–life balance and opportunities for development
- Promote effective people-management through line managers and supervisors
- Routinely monitor employee mental health and wellbeing.

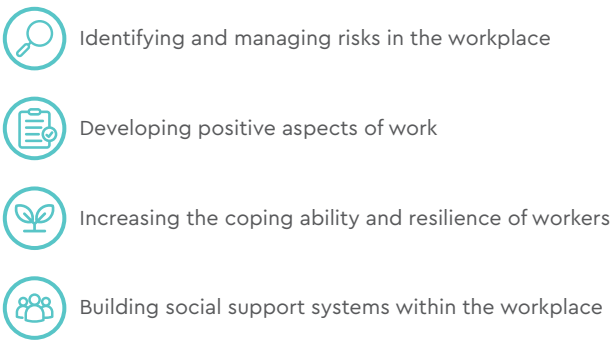
The report emphasized that mental health and wellbeing in the workplace should be a priority for policymakers. It highlighted the important roles that engaged leadership, collective action and partnership play, together with policy changes to support investment.

Deloitte presented the case for investment in a supporting study for the report, which revealed:

- Demonstrable cost of mental ill health to employers in the UK of £33–42 billion
- Return on investment for businesses of £1.50–9 for every £1 invested in supporting mental health at work.

Source: Stevenson and Farmer (2017);[105] Deloitte UK (2017)[106]

Figure 7. Prevention of psychosocial risks and work-related stress



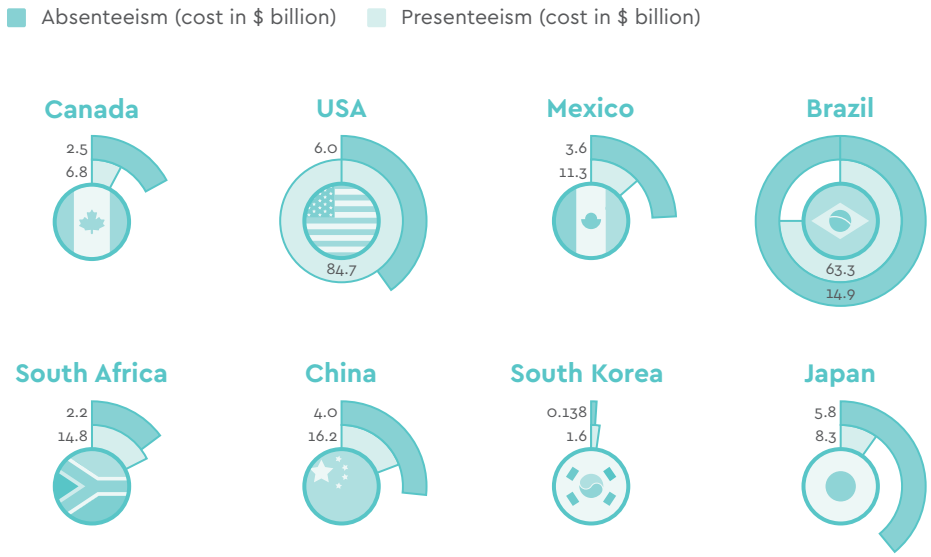
Source: Adapted from International Labour Organization, Psychosocial risk and work-related stress[107]

The World Economic Forum and the International Labour Organization encourage preventative actions to deal with psychosocial risks and work-related stress (Figure 7).

Promoting workplace mental health should be part of an integrated health and wellbeing strategy, which can be implemented through actions and measures at organizational and individual levels. For example, by promoting awareness; improving stress and time management; modifying workloads; offering flexible working hours; and providing cognitive behavioral therapy, relaxation, mindfulness and physical exercise programs.[108–110]

Organizational-level interventions have positive impacts.[111] Action against work-related stress and/or burnout has been stated as one of the most important public health issues for an economically active population (Figure 8).[112]

Figure 8. Cost of depression in the workplace across the world



Source: Evans-Lacko and Knapp (2016)[113]

The goal of such actions is to improve performance; lower absenteeism; reduce staff turnover; encourage better team performance; ensure fewer work sick days;[114] and improve economic returns (Figure 9).

CASE STUDY 1. MICHAEL'S STORY

Michael, 45 years old, is a warrant officer and trained paramedic in the police service in South Africa. He was diagnosed with chronic major depression at age 23, and since then he has battled with his 'demon' that shows its face every now and again. To maintain day-to-day functioning and employment as a police officer, he receives a package of routine and specialized mental health interventions that include medication, psychotherapy and maintenance electroconvulsive therapy.

Michael receives reasonable accommodation for his depression at work that gives him full-time access to a psychologist and social worker, and grants him time-off for follow up treatment visits. He can also alternate between operational and non-operational duties. For example, Michael can do desk duties instead of field work when he experiences depressive symptoms. His managers and colleagues are educated about his condition, and are able to identify the early signs of relapse and support him when symptoms of depression appear.

Through depression awareness and education, Michael understands his condition, which helps him manage his symptoms more effectively. He understands that depression is not a weakness but an actual medical condition. He also finds that peer support and talking about depression helps him out of his "dark moments". Despite his diagnosis and battles with recurring depression, Michael is a highly regarded police officer at his unit and received recognition for outstanding performance. In Michael's working environment he has been able to influence the negative perceptions of depression in the workplace by merely talking about his own experiences.

Figure 9. Cost-effectiveness of workplace interventions

In the UK, a multicomponent, universal, mental health promotion program was valued at...

£82.10
per person, per year

and generated a return on investment of...

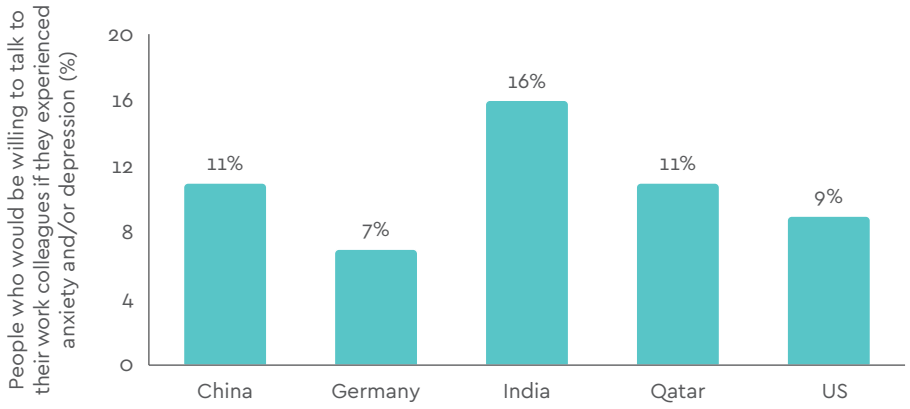
1 : 2.37

A targeted cognitive behavioral therapy intervention, offered to people who had elevated stress, showed a **1:2 return on investment**.

Source: Public Health England (2017)[115]

Psychosocial risk-assessment procedures and training in mental health first aid can equip managers with the skills and confidence to identify when employees are struggling with their mental health – and to know how to offer support.[116, 117] Targeting the stigma associated with mental health is also crucial for people who may be at risk but may not seek help because they fear stigmatization and the potential impact on their employment.[118–120] For this report, WISH commissioned a YouGov online survey of 5,438 people across five different countries assessing views on anxiety and depression. This survey found that only a small percentage of respondents would be willing to talk to their colleagues if they struggled with anxiety or depression (see Figure 10).

Figure 10. Talking to colleagues in the workplace



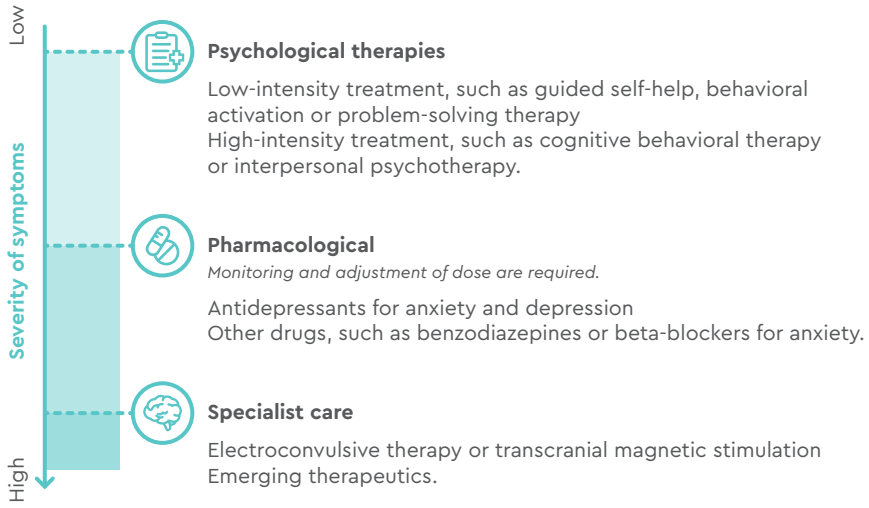
Source: YouGov survey for WISH (2018)

Integrated models of care

The prevention of anxiety and depression is essential to reducing the burden on people and healthcare systems. However, there must always be effective primary care-based services available for people who need them, integrated into health systems.

This section of the report presents three models to help develop a mental health system that supports the delivery of effective psychological therapy and pharmacological treatments. None of these models are mutually exclusive, and they all combine elements of the others. What will work best will depend on the system within which it is functioning.

Figure 11. Evidence-based treatment of anxiety and depression



Sources: Berlim M et al. (2013);[121] NICE (2014);[122] Cuijpers P et al. (2016);123 Cipriani A et al. (2018);[124] Zhang A et al. (2018)[125]

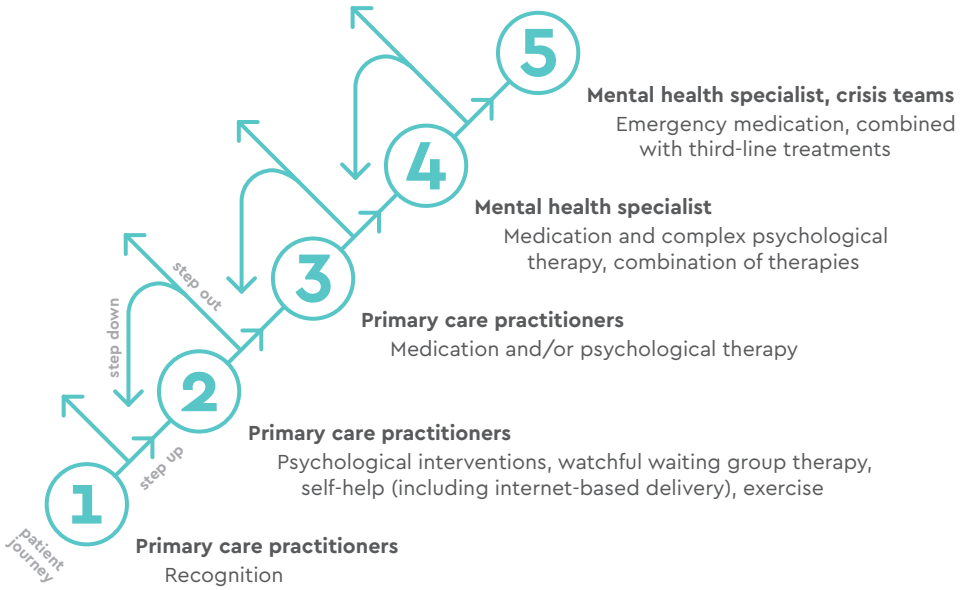
Stepped-care models

The stepped-care model is a method of care delivery that is designed to increase the effectiveness and efficiency of a health system.[126] It does this by offering care no earlier or more intensively than necessary, and no later or less intensively than necessary. The result is that the level of care should match the range of need – increasing with the level of ill health (see Figure 12). It should offer people with severe symptoms more comprehensive and intense treatment options. Examples of using a stepped-care model as part of a plan to drive healthcare change are highlighted in Case Studies 2 and 3.

Given the significant discrepancy between the demand and supply of mental health services, particularly in countries with limited financial and human resources, stepped-care has the potential to offer successful low-resource, low-cost interventions.[127, 128] For example, it can:

- Reduce the burden on existing resources
- Increase the reach and availability of services
- Maximize the number of users.

Figure 12. Stepped-care model



Source: Adapted from NICE (2014)[129]

Self-care is an important element of a stepped-care model, and it can be particularly helpful for people who might not ask for support because of the stigma; might not be able to afford other treatment options; or who have geographical or transport constraints.

Digital technology has enormous potential to enhance the effectiveness of the stepped-care model because it can provide a platform to support patients in clinical settings, and serve as a tool to deliver web-based self-help.[130] It also makes it easier to collect patient outcomes data to guide decision-making about whether further healthcare treatment is needed.

CASE STUDY 2. IMPLEMENTATION OF STEPPED-CARE IN INDIA AND CHILE

India

The MANAS trial in Goa played a prominent role in a major revision of India's District Mental Health Program. It included lay health workers to manage cases and psychosocial treatment, as well as specialist support and medication from physicians working in primary care centers.

The model led to an improvement in recovery rates, particularly in public healthcare facilities, and resulted in a total cost reduction compared to the normal enhanced care available.[131]

For every $2 spent on human resources there was a reduction of $120 in public facilities and $86 in private healthcare facilities for the total cost per recovered case.

Chile

A stepped-care program in Santiago for the treatment of depression among low-income women in primary care presented the first example of an affordable, and successful, stepped-care model in a middle-income country. The program was led by a non-medical healthcare worker, and was significantly more effective than the usual care services, with only a modest cost increase.

The model resulted in the National Program for the Detection, Diagnosis and Treatment of Depression, which was rolled out across Chile in 2003.[132,133]

CASE STUDY 3. NHS ENGLAND

The 2008 Improving Access to Psychological Therapies (IAPT) program[134] increased access to psychological treatments across England for people with anxiety and depression. The program was developed to support the National Institute for Health and Care Excellence (NICE) clinical guidelines, which endorses the use of psychological therapies.

Economists and clinical researchers advocated that increasing access to psychological therapies would largely pay for itself. They argued that the treatment would reduce other depression- and anxiety-related public costs, such as welfare benefits and medical costs, and increase tax revenues and productivity as people recover and return to work.[135]

Key features of the IAPT	Key drivers of IAPT success
Evidenced-based psychological therapies delivered by fully trained professionals, supervised and supported to continuously improve and deliver high-quality care	Performance targets, giving a commitment to results
A stepped-care model	Strong clinical leadership
Self-referral and treatment choice in primary care and in the community	Centrally controlled implementation program
Routine outcome monitoring is shared between the patient and the healthcare practitioner delivering the care	Close political investment and involvement

Figure 13. Improving Access to Psychological Therapies (IAPT)[136, 137]

Training and workforce	The program aims to train over 10,500 new therapists by 2021, and to deploy them in new services for anxiety and depression.
Access rate	The current access rate is 960,000 patients per year, representing approximately 16% of the prevalence of depression and anxiety. The National Health Service is committed to further expand IAPT to reach up to 1.5 million people a year (around 25% of prevalence) by 2021.
Clinical outcomes	One in two people recover by the end of treatment, with approximately two out of three (66%) showing reliable improvement.
Monitoring systems	Over 96% of people are assessed at the beginning and end of treatment.
Expansion	IAPT services have been integrated with physical healthcare pathways to treat adults with long-term physical conditions or medically unexplained symptoms, and to treat children and adolescents.

CASE STUDY 4. ANXIETY AND DEPRESSION SCREENING AND TREATMENTS IN QATAR

As part of the vision to deliver mental health care as closely as possible to patients' homes, in line with the Qatar National Mental Health Strategy and the foundation of the Primary Health Care Corporation in 2013, emphasis has been placed on:

- The development of clinical guidelines for treating anxiety and depression
- Ensuring the availability of psychotropic medication in health centers
- Staff training: 400 physicians received mental health foundation training; 61 family physicians received advanced training; and 1,880 physicians received mental health awareness training
- The implementation of screening programs
- The introduction of electronic health record (EHRs) across all facilities
- Raising awareness and providing psychological support in the community through local organizations such as mental health service provider Weyak, which means 'with you' in Arabic.

Notably, the vast majority of people screened are managed in primary care, with only 1 percent referred to secondary care. This illustrates that a trained and supported primary care workforce can manage most people, and that there will be a small, but significant, flow through to secondary care.

Collaborative care models

Around 30 percent of people with one or more long-term physical conditions, such as diabetes, coronary heart disease and cancer, also have a mental health problem.[138] Anxiety and depression have significant implications for these people, including poorer clinical outcomes and lower quality of life.[139–141] They are also typically associated with a 45–75 percent increase in care costs for a wide range of long-term physical health conditions. For example, in England each year £8–13 billion (12–18 percent) of all healthcare expenditure on long-term conditions is linked to poor mental health and wellbeing.[142]

The collaborative care model is an evidence-based framework, and a practical, cost-effective strategy to deliver integrated mental and physical health services in primary care. The model is based on a structured multicomponent care management plan with systematic follow-up, co-ordinated by a case manager and shared with the patient.

The model enhances collaborative systems between primary care and specialists that enable them to address the full range of patient needs. It also provides patient education and supports self-management. It has significant scope to use available resources more efficiently and reduce care costs. This can provide a solution for fragmented care systems and improve patient care by implementing system-level redesign (Figure 13).[143]

Figure 13. System-level redesign

Successful implementation of a collaborative model in routine primary care requires the removal of policy barriers, financial investment, and the adaptation of payment mechanisms and reimbursement schemes across different settings.[144]

For example, in the US, the nationwide Mental Health Parity and Addiction Equity Act and Affordable Care Act places a greater priority on integrated mental health services in primary care, with equal insurance coverage for behavioral and physical health treatment. It also increases access and quality of care for millions of uninsured or underinsured Americans.[145–147] The implementation of collaborative care for people with depression, who represent 20 percent of people benefitting from the Medicaid program, is estimated to save Medicaid approximately two percent ($15 billion) of total annual spending.[148]

CASE STUDY 5. IMPROVING MOOD-PROMOTING ACCESS TO COLLABORATIVE TREATMENT (IMPACT) IN THE US

The IMPACT program focused on adults aged 60-plus with depression in 18 primary care clinics in five states between 1998 and 2002. The model was then expanded when the IMPACT implementation center was established in 2004. This then became the University of Washington's AIMS (Advancing Integrated Mental Health Solutions) center in 2008.

The AIMS center was developed to improve the reach of collaborative care to other communities. The AIMS center has now worked with over 6,000 clinicians in 1,000 clinics around the world to implement collaborative care.

The IMPACT model has enhanced primary care practice by introducing:

- A care manager and consulting psychiatrist into the care team
- Systematic clinical processes through stepped-care to track outcomes and adjust treatments when needed.

The IMPACT programs:[149]

- Improved patient care experiences
- Improved clinical outcomes of the population
- Reduced per capita costs of each case.

Clinical outcomes

In comparison with usual care programs, people who received collaborative care:

- Were more than twice as likely to experience a substantial improvement in their depression over 12 months
- Had reduced physical pain, better social and physical functioning and better overall quality of life.

Economic evaluation

- Initial investment of $522 during Year 1 resulted in net cost savings of $3,363 over Years 1 to 4.[150]
- An incremental net benefit of $1,129 over two years of treatment.[151]
- A return on investment of $6.50 per $1 spent, with annual average savings of $841.[152]

Task sharing

Globally there is a need to increase the capacity of health systems and access to services. Task sharing is a model of giving skills to individuals for specific health interventions.[153] This can often be done through training non-specialist healthcare workers (such as nurses, doctors or midwives) and lay healthcare workers to provide psychosocial support and low intensity psychological therapies (such as problem-solving therapy).[154] The model has also expanded to task sharing with traditional and faith healers.[155]

Task sharing is supported by integrated management guidelines such as WHO's Mental Health Gap Action Programme (mhGAP) intervention guide, which has been designed to assist the implementation of mental health services in non-specialized healthcare settings.[156]

Other task sharing programs include:

- The cost-effective Healthy Activity Program (HAP) in India, where lay health workers provide better outcomes than the enhanced-usual care (EUC) typically used to treat moderate to severe depression[157]

- A pilot program based on the Friendship Bench principles in Zimbabwe aims to address the comorbidity of depression in people with HIV. Successful treatment has been shown to improve adherence to HIV medication (see Case Study 6).[158]

CASE STUDY 6. THE FRIENDSHIP BENCH – WORKING TO REDUCE THE MENTAL HEALTH TREATMENT GAP

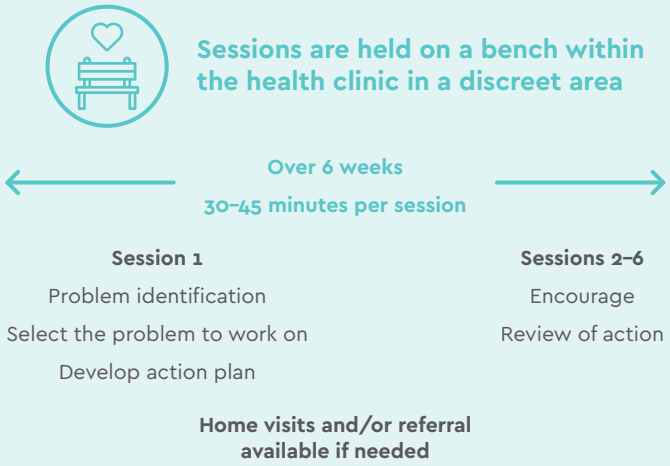
The *Chigaro Chekupanamazano*, or 'bench to sit on to exchange ideas' (Friendship Bench) in Zimbabwe, is an evidence-based problem-solving therapy. It is targeted at people with *kufungisisa* ('thinking too much' in Shona, or anxiety and depression) delivered by trained and supervised lay health workers.

The program, which has proved to be effective in reducing symptoms of anxiety and depression, is set to become the largest mental health program for depression in any low-income African country, being scalable, low cost and culturally acceptable.[159, 160] The scale-up plan aims to reach up to 50,000 patients over 60 primary care clinics.[161] In addition, further expansion of the program includes setting up:

- The YouFB (Youth Friendship Bench) for adolescents and young adults
- The Rural Bench to access different populations in rural settings.

The program is based on a task-sharing approach where local 'grandmothers' are trained by clinicians over a three-week period through a course that empowers them to use their own natural skills to improve mental health in their communities. The training of one lay health worker costs roughly $15.

Intervention structure



The Friendship Bench has also been used in many other countries around the world. For example, ThriveNYC, New York's mental health program, has used a similar Friendship Benches approach in hard-to-reach communities with peer counselors on hand to provide support and referrals for individuals. To date it has made contact with over 11,000 people.[162]

Maternal care

Anxiety and depression are common in the perinatal period and can have long-term effects on mother and child. In HICs, prevalence during pregnancy is 11 percent and rates rise to 13 percent in the postnatal period. In LICs and MICs, prevalence is higher with 15.6 percent during pregnancy and 19.8 percent post-pregnancy. Up to 13 percent of currently pregnant or postpartum women report having had anxiety in the last year in the US, with similar rates across 8 African countries.[163] Ongoing healthcare costs to support mothers and their children over a lifetime are high.[164]

The Perinatal Mental Health Project in South Africa is based on a stepped-care model in primary care antenatal care services. Screening is shared by midwives and counselors based at care centers. The midwives refer women with emotional distress to the counselors, or to psychiatrists if needed.[165] Task sharing means that over 90 percent of mothers were screened, and many were treated effectively at a key time in their lives.

The Thinking Healthy Programme uses local community workers, known as Lady Health Workers, who form part of routine care in rural Pakistan. They provide cognitive behavioral therapy in perinatal care, which improves recovery rates in women with depression and outcomes for their children.[166] The program has been adopted as part of WHO guidelines[167] and has spread to other countries, including Vietnam, Nigeria and Bangladesh.

Emergency settings

Providing mental healthcare services is a crucial feature in the response to humanitarian emergencies, where there are increased rates of mental ill health and major gaps in service provision because of weakened systems and scarce resources. Emergencies present an exceptional opportunity for mental health reform to build better mental health systems that are sustainable in affected communities.

The WHO Building Back Better report showed how diverse emergency-affected countries, such as Afghanistan, Burundi, Iraq and Sri Lanka, responded to humanitarian crises.[168]

Brief mental health interventions are the most common interventions in emergencies. They include: counseling; psychoeducation; community-based social support; structured social activities; and raising awareness. The interventions, which showed improvement in how people functioned and reduced intensity of symptoms, are often delivered by local, non-specialist workers with relevant language skills and cultural competencies. An example of these interventions are those by Médecins Sans Frontières (Doctors Without Borders) in Latin America, the Middle East and China.[169] Other programs include Problem Management Plus (see Case Study 7).

CASE STUDY 7. PROBLEM MANAGEMENT PLUS (PM+) AND STRENGTHS

Problem Management Plus (PM+)[170] was developed by WHO and uses cognitive behavioral therapy and problem-solving techniques in areas of humanitarian crises and in low-income countries where resources are limited. It provides support for people with distress, anxiety and depression, whether or not their problems are due to exposure to adversity. The programs are short and can be provided by trained lay workers. It has already been tested and implemented successfully in Pakistan, Kenya and other areas.

The STRENGTHS project[171] trains Syrian refugees to provide the PM+ mental health program to fellow Syrian refugees. The aim is to adapt and roll out the PM+ into health systems across Europe and the Middle East.

Digital technology

Digital technology is changing the way that we intervene in, and help prevent, anxiety and depression. The recent expansion in access and acceptability of digital interventions means that technology could drive a fundamental change in tackling common mental health problems. It has the advantage of being easily accessible to young people and easily used by non-specialist health workers.[172]

Digital technology breaks boundaries and has the advantage of being almost universally accessible. Linking to fitness, health and wellbeing apps also offers access to stigma-free mental health care. New forms of intervention and support have the potential to disrupt traditional healthcare and to change user relationships with the system. For example, mass online interventions or the use of artificial intelligence services gives people the opportunity to take control of their own mental health, to access services and to control their own data.[173–175]

Digital technology has particular strengths in the application of self-care and support for people to look after their own mental health. But, there is a huge challenge associated with the impact of its use, particularly on young people. There is a need to consider carefully that digital technology can have both the power to help and to harm. For example, cyberbullying affects 23 percent of young people and is associated with the increased risk of depression,[176] while peer-to-peer support benefits people who wish to share their experiences.[177]

There has been some research into digital programs that support existing healthcare systems, such as the provision of talking therapies through digital platforms.[178] For example, the European Comparative Effectiveness Research on Internet-based Depression Treatment (E-COMPARED) project is conducting research on the usefulness and cost-effectiveness of blended internet-based treatments – a combination of in-person treatment supported by internet-based therapies. The research showed that there is high acceptance of blended treatments among patients, which indicates that a gradual integration of technology into routine care may fit their attitudes and needs. It also takes into account that cost-effectiveness is identified as a primary incentive. However, there is a need to explore further how care systems can be prepared for internet-based treatments because this is one of the main barriers to implementation.[179]

For an overview of how digital technology has been deployed in supporting mental health, see Box 2. But this is by no means provides an overview of how digital technology has been deployed in supporting mental health, but this is by no means a comprehensive list of applications and potential uses.

Box 2. Digital solutions to mental health

Helplines for:

- People in crisis, looking for information or who just want someone to talk to. For example, Crisis Text Line for young people in the US.[180]

Information about:

- Services, anxiety, depression and other topics related to general wellbeing. For example, ReachOut in Australia.[181]

Connecting with:

- Services. For example, the ReachOut Next Step online self-assessment tool asks young people a series of questions to help them identify relevant services in their area.[182]
- People with lived experience. For example, the Elefriends peer-support community run by the mental health charity Mind in the UK.[183]

Training and supervision for:

- Healthcare settings. For example, e-supervision of doctors on their application of the mhGAP intervention guide in Sudan.[184]
- Schools. For example, a web-based educational course in child mental health for schoolteachers in Brazil.[185]

Prevention and intervention using:

- e-delivery of talking therapies. For example, This Way Up in Australia.[186]
- Self-assessment tools and self-care platforms to improve wellbeing. For example, MoodGYM in Australia and Good Thinking in England.[187]
- Conversational agents or chatbots. For example, Woebot in the US.[188]

Supporting delivery by:

- Screening. For example, the mhGAP depression-screening tool used by non-specialist healthworkers in primary care in rural Kenya.[189]
- Data collection. For example, the routine collection of mood and anxiety data Mental Health and Poverty Project (MHaPP) in South Africa.[190]
- Treatment support. For example, monitoring strategies to help ensure medication or therapy compliance.[191]
- Telepsychiatry. For example, a program with prisoners in Colombia.[192]

SECTION 3. CONCLUSION AND THE WAY FORWARD: DEVELOPMENT, IMPLEMENTATION AND IMPROVEMENT

There is a fundamental necessity to recognize anxiety and depression as a public health priority and to include it as part of UHC programs, supported by relevant policies, funding and implementation plans.

In order to achieve this aim, countries need to consider a simple three-step approach (Figure 14):

Figure 14. The three-steps model

Step 1. Situation analysis

Situation analysis is a crucial step to understand the state of readiness and capacity of a national mental health system and of existing services to provide care for anxiety and depression. It represents a valuable needs assessment to highlight the gaps in the system, as well as to identify available resources. This includes strategies, programs, funding, workforce and infrastructure, as well as links and collaborations with other sectors. This step is key to priority-setting and provides important background information that also informs how the implementation should be carried out.

Situation analysis is a comprehensive participatory process, which needs to be conducted with all stakeholders involved in supporting the system. For the purpose of this report, we have developed a National Depression and Anxiety Plan Checklist to help policy- and decision-makers to assess current approaches and to identify gaps and priority areas. However, there are many tools that can be used, for example the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS). This is a reference tool for collecting essential information on a region's mental health system to improve mental health care and to provide a baseline for monitoring change.

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NATIONAL ANXIETY AND DEPRESSION PLAN CHECKLIST

Strategy context, leadership and governance structures

Does your government have:

- ☐ A national mental health strategy and action plan, with a specific focus on anxiety and depression?
- ☐ Mental health (anxiety and depression) integrated into other health strategies and programs, including child health, maternal health, long-term conditions, disability and occupational health?
- ☐ An up-to-date needs assessment of the local population, including data on prevalence and risk factors for anxiety and depression, in order to inform priority setting?
- ☐ Infrastructure in place to support implementation, including policy lead, implementation team, implementation plan with milestones and performance indicators?
- ☐ An allocated ring-fenced budget and/or other funding schemes for the implementation of the strategy and the delivery of services?
- ☐ Prevention and promotion as key components of the national mental health strategy and associated implementation plan?
- ☐ National stigma and discrimination reduction programs?
- ☐ Existing intersectoral collaborations and programs (eg education and employment) to support the prevention and promotion agenda?

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Service planning and delivery

Does your healthcare system have:

- ☐ Effective and accessible services for anxiety and depression, including medication and psychological therapies, available for all sections of the population (eg children and adolescents, people with long-term conditions, older people, etc)?
- ☐ Integrated care for anxiety and depression in primary care and the community?
- ☐ Clinical practice guidelines, care pathways and referral systems to support the service delivery models?
- ☐ An integrated clinical information system and monitoring processes for the measurement of outcomes, performance management and quality improvement?
- ☐ Research capacities and plans to support the service delivery system and workforce?
- ☐ Mechanisms in place to involve people with anxiety and depression, families and communities in service planning and delivery?

Workforce

Does your healthcare system have:

- ☐ A specialized mental health workforce, including psychologists, psychological therapists and psychiatrists?
- ☐ A non-specialized mental health workforce (eg primary care staff and community lay health workers) supported by mental health training and supervision?
- ☐ Plans and structures in place to develop and improve mental health workforce capacity, including training and education, supervision and appraisal, mentoring and continual professional development?

Step 2. Priority-setting

Depending on the state of development of mental health systems in each country, we are calling on policy and decision-makers to consider entry points for investments in setting their priorities for addressing anxiety and depression. As mental health systems are resource- and context-specific, these entry points represent opportunities for development, implementation and improvement that would evolve over time. They would accompany the changes occurring in the system as it moves toward achieving UHC for anxiety and depression.

The **three key entry points for investments** take into account the identification and investment process, as well as actions for implementation to support each of the entry points:

1. **Apply effective, evidence-based interventions** through stepped and integrated care models (see page 22) to increase treatment coverage and improve quality of care. These should be targeted to specific populations and should be culturally considerate. They also need to be cost-effective and practical to implement.

2. **Build universal prevention and promotion programs** across the life course. These programs should involve multiple interventions operating across social groups within communities and involving multiple sectors of an industry (such as government, private sector, and education).

3. **Apply evidence-based stigma and discrimination reduction programs.** These should be top-down (from government) and bottom-up (from communities), using a multifaceted approach that includes education and contact-based interventions.

Setting priorities and identifying entry points for investment requires situation analysis to identify what is most relevant to the local context, needs and available resources. The process needs to be aligned with a global agenda to reduce suicide rates. For example, this strategy would also take into account human rights, health system reform, and economic and funding arguments. The process should also engage local partners and stakeholders; adapt and use local and international resources such as guidelines, frameworks, tools and policies; and ensure technical assistance and collaboration with WHO and global experts.

Step 3. Implementation

The final step in prioritizing and addressing anxiety and depression is to translate investment into action, and to expand programs in the four key areas: care, prevention, promotion, and addressing stigma and discrimination. Here are four key cross-cutting implementation recommendations:

1. **Use economic evidence to guide decision-making.** Consider the merits, feasibility and sufficiency of different health financing mechanisms, such as domestic financing, external funding and market-based financing options. Include robust economic evaluations and invest in cost-effective solutions.

2. **Promote effective co-operation and collaboration across stakeholders and sectors**. Build local, regional and global collaborations or partnerships with networks and alliances to share collective planning expertise. Develop and implement solutions and infrastructure. Work with all stakeholders to ensure ongoing support and co-ordinated action, including governments, and non-governmental and industry-wide organizations.

3. **Translate evidence-based knowledge and training into expertise and deliverable plans.** Integrate anxiety and depression into training packages for allied healthcare professionals (particularly practitioners who treat chronic physical conditions) and education and employment sector professionals. Strengthen the primary care system where mental health professionals provide support and supervision to primary healthcare workers. Ensure the quality of training and supervision is regularly assessed.

4. **Expand the use of digital technology.** Ensure digital technology is fully integrated into the health system and informed by clinical expertise and good research. It should be used as a channel to connect and engage people with services, rather than replace services and contact with health professionals. Digital technology should be used routinely to monitor activity and outcomes. This should be done in sufficient depth to target the right groups, guarantee equity of access, and adhere to guidelines and protocols. A strong collaboration between the health care system and the digital industry can offer a pathway to robust solutions for anxiety and depression.

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