Consensus Statement on
Depression in Adults

How to Improve Prevention, Diagnosis and Treatment

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Alberta Health Services
Alberta Mental Health Board

MENTAL HEALTH COMMISSION OF CANADA • COMMISSION DE LA SANTÉ MENTALE DU CANADA

With support from
the Alberta Depression Initiative

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ACKNOWLEDGMENT

The Institute of Health Economics (IHE), with support from the Alberta Depression Initiative, Alberta Health Services – Alberta Mental Health Board and the Mental Health Commission of Canada, conducted a consensus development conference on depression in adults October 15th – 17th, 2008 at the Westin Hotel in Calgary, Alberta.

The Honorable Michael Kirby (Chair, Mental Health Commission of Canada) led a distinguished jury of citizens and experts to develop practical recommendations on how to improve prevention, diagnosis, and treatment of depressive disorders in adults.

Expert Panel Chair, **Dr. Scott Patten** (Professor, Faculty of Medicine, University of Calgary) led a panel of experts in presenting available scientific evidence on depression in adults.

This Consensus Statement was released on October 17th, 2008.

PROCESS

This consensus statement was prepared by an independent panel of health professionals, academics, and public representatives based on: 1) presentations by and questioning of experts working in areas relevant to the conference questions; 2) information by people living with depression; 3) questions and comments from conference attendees and speakers during open discussion periods; and 4) closed deliberations by the jury.

The conference was held in Alberta, Canada. The consensus statement therefore often refers to the situation in Alberta, although data were not only drawn from that area, but also from other parts of Canada and the United States.

This statement is an independent report of the panel and is not a policy statement of the conference partners, conference sponsors, or the Government of Alberta.

CONFERENCE QUESTIONS

The jury used the evidence presented to them at the conference to develop a consensus statement that answers the following questions:

1. **What is depression and how common is it?**
2. **What are the effects of depression for the individual, family, and society?**
3. **What are the risk factors for depression, and how can prevention of these be improved?**
4. **What are the most appropriate ways for diagnosing depression?**
5. **What are current treatments for depression and what evidence is available for their safety and effectiveness?**
6. **What are the obstacles to effective management of depression and strategies to overcome them?**
7. **What further research is needed in the field?**

Consensus Statement on Depression in Adults
How to Improve Prevention, Diagnosis and Treatment

Kirby M, et al. Consensus Statement on Depression in Adults: How to Improve Prevention, Diagnosis and Treatment. Consensus Statement #3, 2008 Oct 17;Edmonton. Edmonton:IHE, 2008

INTRODUCTION

Depression is an illness that has an impact on individuals at every level of society. Its costs in both human and monetary terms cannot and should not be ignored.

Short term disability days due to depression alone cost Canada $2.6 billion in 1998. According to the World Health Organization, major depression is the leading single cause of disability (2000). Major depression affects about 1 in 20 people in the population per year. Depression is often associated with suicide, which is the second leading cause of death in Canadian youth.

Depression is an illness that affects a person's thinking, emotions and social functioning. It also has a major impact on his or her productivity–be it at work or school. Depression also adds to physical health problems increasing the burden of many chronic illnesses.

Depression manifests itself in a social context, with its effects stretching to affect family members, co-workers, communities, and indeed, most all of us at some point or other.

At its roots, depression has many complex genetic, biological (including brain function), psychosocial, cultural and environmental determinants. Many of these can be traced back to experiences and early appearances of depression in childhood and adolescence. It affects individuals across the life span. In its presentation, depression can vary by age, gender, and cultural diversity.

In spite of the vast amount known about depression, many individuals continue to suffer from its symptoms, even when there are interventions that can and do provide relief. Stigma, ignorance, poor availability of and access to evidence-based interventions, and the general lack of a comprehensive depression strategy at either the provincial or national level, all contribute to depression being undiagnosed and undertreated.

Depression is a public health issue of the highest order requiring solutions that are universally accessible, guided by empirical evidence, and embedded in policy.

QUESTION #1

What is depression and how common is it?

Although everyone has occasional periods of feeling sad, blue, or distressed, these feelings are usually short-lived. Longer periods of distress may occur with grief, such as following the loss of a loved one. However, when feelings of sadness or distress persist and interfere with normal day-to-day life, then depression may be present.

Most people with depression will have at least some of the following symptoms: feelings of long-lasting sadness; anxiety; feelings of emptiness; pessimism; guilt; hopelessness; helplessness; feelings of worthlessness; and irritability. They may also experience an inability to feel pleasure; loss of interest in sex; lack of energy and enthusiasm; disturbed sleep; changes in appetite; or thoughts of suicide.

People who are depressed cannot just "snap out of it": their feelings are persistent and not easily altered.

Depression often goes along with other medical illnesses. For some people, depression may be accompanied by harmful drug or alcohol use. Depression may precede, cause, and/or be a consequence of these other illnesses and problems.

People's experience of depression may vary widely - it can be mild, moderate, or severe. Depression can happen only once in a lifetime, but it can also be persistent or recurring.

Depression may appear differently in men and women, across age groups, and in people of various cultural backgrounds. More women than men will experience depression.

Depression is extremely common and is the leading cause of disability world-wide.

QUESTION #2

What are the effects of depression for the individual, family, and society?

The Perspective of the Individual and Families

Depression can be a debilitating illness for people and those close to them. Depression often severely limits quality of life. It can be physically painful and may affect how people think and how they function in all parts of their life. Depression can be catastrophic to employment and to personal relationships. It leaves the people feeling less than who they are and destroys their dreams of who they might be and who they might become.

In depression, people are frequently subjected to stigma, discrimination and social exclusion.

Moreover, workplace opportunities often become limited, frequently jobs are lost, and disability supports are seldom able to replace the income previously enjoyed.

Caregivers and families face many difficulties. Many are unable to comprehend the sudden change in the family dynamics which occurs when one family member is depressed. Both the person and the family suffer from social exclusion. The situation is frequently compounded by the reluctance of the depressed person to seek help. Tragically, some people end their suffering by suicide.

If better initial screening were in place, early intervention techniques were improved, and if society, including schools and social networks, were welcoming to people with depression then the negative impact of this illness on the person and the family would be significantly reduced.

Impact on Physical Health

Depression does not act on mind and behaviour alone. It also affects physical health. For example, following a heart attack people with depression have over twice the risk of a repeat heart attack or early death. People with both diabetes and depression have increased health complications and hence use health care services more frequently. Having both depression and a physical illness complicates getting help and getting well, and is more costly to the healthcare system.

Impact on the Work Place and Society

Human and economic costs of depression are profound. The cost of mental illness in Canada annually is estimated to be over $33 billion with the biggest single factor being depression.

Mental health problems are often first noticed by others at work. There is a growing recognition that depression has a significant impact on workplace productivity, yet Canadian employers are only now beginning to understand the importance of depression in the work place and how to deal with it.

Misperceptions and lack of knowledge about depression may lead to a poisoned work environment. Many employers fear that the productivity of the depressed employee, even when recovered, will be reduced in the future. Co-workers are often uncomfortable around the employee with depression. In addition, because of stigma and the lack of a supportive work environment, the depressed worker may not seek help. As a result, the impact on employees and employers is needlessly high.

Informed employers can put in place structures and policies that facilitate early intervention and a healthy workplace. This would substantially reduce the cost of depression to the employer.

Moreover, increasingly, the treatment of employees with depression is being looked at through a human rights lens. Employers may have legal obligations which are only starting to be tested in the courts.

Access to Services for Depression

Access to services for depression is compromised: first, by the depressed person who is fearful of divulging his/her illness to a health care provider; and second, because of the lack of services to treat depression.

Canada currently has a two tier system with respect to the treatment of depression: the inadequate accessibility to care provided by the publicly funded healthcare system, and the care available to those who can afford to pay to access services, such as psychological treatment.

It is a misperception that current publically funded health services are all that is required for the recovery of the depressed person. Social services and community supports often play an integral role in facilitating recovery from depression.

Jury Recommendations

- Improved anti-discrimination practices may be required to ensure that people living with mental health problems or illness have the same rights as other Canadians.
- To allow caregivers to write off expenses incurred in supporting the depressed person, the Income Tax Act must be amended.
- CPP disability and provincial income support programs must also be applied equitably so that a disability caused by mental illness is treated in the same way as a disability caused by physical illness.
- Similarly, employment insurance, workers' compensation and short and long term disability benefits must ensure equitable access for people living with a mental or a physical illness.
- Public and private employers must be encouraged to create a mentally healthy work place and to improve support for employees with depression.

QUESTION #3

What are the risk factors for depression, and how can prevention of these be improved?

Depression is a complex disorder. Biological, social, environmental, psychological and cultural factors may contribute alone, or in combination, to depression.

Family members of a people with depression are one-and-a-half to three times more likely to suffer from depression themselves than a member of the general population.

But depression cannot be explained by genetics alone. Early experiences in childhood and adolescence can play a critical role in development of depression. Indeed, the majority of depressed people experience their first symptoms during childhood or adolescence.

Traumatic events in childhood (e.g. abuse, neglect, and household dysfunction) have an impact on physical and mental health throughout a person's life. How people think and feel about such events, whether they occurred within their family (e.g. abuse, divorce, family violence, and death) or the greater community (e.g. bullying), have a profound effect on their later development.

People are more biologically vulnerable to depression at certain periods of their life (e.g. during adolescence and after giving birth).

However, depression is not explained by biology alone. Gender, social, and cultural influences are also key. Economic disadvantage, the role expectations of men and women, and stress related to poor organizational practices in the workplace are also important factors.

Depression is more frequent in people with chronic illnesses. Other illnesses and/or their treatments (pharmacological or otherwise) can mask identification, mimic symptoms, and even provoke an episode of depression.

Lifestyle (e.g. activity, nutrition, or sleep) can have an impact on mental health either positively or negatively.

Substance use is often associated with depression. For example, people may use alcohol to relieve symptoms. But because alcohol is a depressant, it can make the condition worse. When substance use and depression occur together, treatment is more difficult.

Good self-esteem, especially among young people, protects people from depression. Healthy coping skills for day-to-day stress as well as for major life events help protect people from depression.

Increasing work demands, decreased flexibility, and feelings of little control in the workplace can contribute to depression. This is why creating a mentally healthy workplace is so critical.

Because isolation is a risk factor, strong social supports and positive confiding relationships help. This explains why marriage is a protective factor for men, while separation/divorce and living alone are risk factors for depression for both men and women.

Culture can influence how people understand depression and what they do about it. The stigma associated with mental illness in certain cultures can influence whether people will seek help for their depression, even though it is preventable and treatable.

Jury Recommendations

- Interventions for depression should be tailored for and made available to identified high risk groups (e.g. chronically ill people, trauma/abuse victims, those suffering from substance use disorders, families with a positive history for depression, post-partum mothers, and the elderly).
- Childhood and adolescence are critical periods with respect to depression. This age group must become a priority in mental health.
- A population health approach to prevention, early identification and intervention should be implemented in schools.
- The healthy management of stress and anxiety should be a particular focus for prevention efforts at home, school and in the workplace.
- People presenting for assessment of depression by health care providers should be asked about the presence or absence of trauma and adverse childhood experiences.
- A better understanding by service providers of the relationship between substance use disorders, chronic diseases and depression is essential for the optimal prevention, early detection and effective intervention of these disorders.

QUESTION #4

What are the most appropriate ways for diagnosing depression?

Early Detection, Screening, and Other Diagnostic Methods

General population screening is not warranted. However, targeted screening for at-risk or marginalized groups (e.g. street youth, frail elderly, First Nations, Inuit, and Métis, homeless people, prisoners, postpartum women, young adults transitioning to college/university, military, etc.) should be considered.

Such targeted screening and subsequent diagnosis and treatment should not take place without adequate support services being available, including but not limited to:

- Self-management tools
- Appropriate and adequate medication coverage
- Continuity of care
- Access to mental health counselors
- Access to multi-disciplinary teams, including psychiatrists and psychologists and others
- Improved and welcoming service access
- Self help/peer support

The above, when complemented with an appropriate continuing education program for all providers and integration with acute care, are reflective of a collaborative and structured care model, consistent with a "chronic disease management" paradigm of care.

A number of validated screening tools for depression are available. Some are available in languages other than English and French. Screening tools, as well as assessment tools should be:

- Culturally appropriate
- Affordable
- Reliable (reproducible)
- Valid (truly identify the condition)
- Self-administered
- Self-scored
- Brief (practical, and likely to be completed)
- Sensitive to literacy issues

Diagnosis and Follow up from a Family Physician's Perspective

In Canada, the majority of people with depression who seek help go to their family physician first. Therefore, family physicians play an important role in screening, diagnosis, treatment and follow up. Beyond identification, diagnostic tools can help all health care providers match patient symptoms with treatments appropriate to their level of severity (as recommended, for example, by the National Institute for Clinical Excellence in the United Kingdom).

Jury Recommendations

- Universal screening of Canadians for depression is not recommended. Targeted screening of at-risk and marginalized groups is recommended.
- The use of assessment tools to support a stepped care approach for depression is recommended for the family physician.
- The College of Family Physicians of Canada, the Canadian Psychiatric Association, the Canadian Psychological Association and people with direct experience with depression should develop a toolkit of recommended screening and assessment tools appropriate for Canadian settings.

QUESTION #5

What are current treatments for depression and what evidence is available for their safety and effectiveness?

People with depression will improve with treatment. The treatment of depression can be divided into two stages: acute treatment aimed at treating an episode of illness and maintenance treatment aimed at preventing a recurrence.

The treatments for depression can be categorized into several groups:

- Self-care strategies (e.g. social contact and social support, good sleep habits, exercise, nutrition, moderation of substance use)
- Supported self-management (e.g. workbooks, web-based cognitive behavioural therapy)
- Talk therapy

—— Medication
—— Electroconvulsive therapy
—— Newer therapies for which evidence is still being collected such as transcranial magnetic stimulation, vagal nerve stimulation, deep brain stimulation, herbal and nutraceutical preparations, and light therapy

People with depression, in consultation with their health care providers, choose treatment options after considering several factors. A stepped care approach is recommended where treatments that are more intense or have more side effects are reserved for more severe illness. Other factors, including cultural and spiritual practices and beliefs, people's preferences and past experience with treatment combine to make each person's best treatment plan specific to them. Social support or peer support is an important part of successful treatment.

Learning about depression and practicing self-management are useful for most people and may be all that is required for people with very mild depression. There are many self-management (self-help) books and internet resources, but their quality varies. These resources are best selected in consultation with someone knowledgeable about the material who can recommend specific resources.

There are many forms of talk therapy. Cognitive behavioral therapy is the most extensively studied and it is an effective treatment for depression - both for the acute and maintenance phase of the illness. There are few known risks associated with talk therapy and they are generally considered to be safe. There are issues with the accessibility of these treatments and currently in Canada psychotherapy is usually accessed through private funding.

Many new antidepressant medications have become available in the past twenty years. These medications are widely prescribed and are generally safe in adults, although they have side effects that can vary across medications and from person to person. Affordability of these medications may be a consideration. Older types of antidepressant medications are effective and they are not expensive, but they have more side effects and are not as safe as the newer medications.

There is ongoing research examining the usefulness and safety of these medications in children, adolescents, pregnant or postpartum women, people with other illnesses and the elderly. Everyone taking an antidepressant should be monitored regularly by a prescribing healthcare practitioner. The duration of use depends on clinical factors specific to the person, although several months appears to be the minimum time needed to treat an episode of depression. People who have had many episodes and/or complicated or difficult-to-treat depression may take medications for years to reduce the chances of recurrence and suicide.

Other treatments are reserved for people with severe depression who have not responded to medication, talk therapy, or a combination of the two. Electroconvulsive therapy (ECT) is effective for many people, even those for whom other treatments have not worked. ECT requires brief anesthesia and

some people experience memory loss. Most people who have ECT treatment for an episode of depression will need to have either maintenance ECT or take medication to prevent its return.

A number of physical treatments are in various stages of development. Transcranial magnetic stimulation is a newer therapy. It may not be as effective as ECT but it does not require anesthesia and does not appear to be associated with memory loss, although its long-term safety is still being confirmed. Transcranial magnetic stimulation is approved in Canada as a treatment for depression but it is not yet widely available. Vagal nerve stimulation and deep brain stimulation are experimental therapies that have been studied in a small number of patients with hard to treat depression.

Other therapies are used for certain kinds of depression; for example, bright light therapy is useful for some people who have seasonal or winter depression.

Nutritional supplements, such as omega fatty acids and S-adenylmethione, as well as herbal preparations, such as St John's Wort are being studied as possible treatment options.

All treatments work best when they are used appropriately, and all can have side effects or risks that are greater when not taken in consultation with a knowledgeable healthcare provider. Be an informed consumer!

Jury Recommendations

- Service innovations that could help to fill the gaps in mental health service delivery (e.g. telehealth, internet-based therapy, telephone therapy, family-practice located shared therapy, stepped care models, chronic disease management models, and alternative reimbursement models) should be investigated and evaluated.
- Studies should be independently conducted to evaluate long-term efficacy of treatment.
- Studies are needed to improve understanding of how to match culturally diverse patients with optimal treatment. Effectiveness trials of antidepressant medications, psychotherapy and combinations of them are required.
- Health system modifications are required so that effective supported self management, psychotherapy and pharmacotherapy are accessible to all people with depression. This includes commitment to training and funding practitioners.
- The effectiveness and safety of treatment approaches such as self-management, lifestyle management and therapies that involve brain stimulation need to be subject to rigorous evaluation.
- The Mental Health Commission of Canada should facilitate discussions about how to best incorporate traditional healing methods and spiritual practices from various cultures into routine treatment of depression.

QUESTION #6

What are the obstacles to effective management of depression and strategies to overcome them?

Depression is a major public health issue for Canadians. If quality of care for people with depression is to be improved then a major targeted initiative to overcome several obstacles is needed. These obstacles can be divided into: issues for the person with depression, issues for the providers of services and issues for the systems in which these services are provided.

Issues for the Person with Depression

A minority of Canadians with depression seek help. A number of reasons have been identified for this pattern. People may not recognize the signs and symptoms of depression and be unaware that there are effective treatments. Others say they are fearful of being labeled with a mental illness and how others might react. This can be related to the stigma people feel or how society in general views mental illness. Of particular concern for people with depression is the stigma and lack of meaningful accommodation in the workplace.

People may not know where to seek help. Family members and friends may not know either. The symptoms of depression can make seeking help even more challenging (e.g. feelings of low energy, mental confusion, and low self worth). For some people with severe depression there may be times when they are less able to participate actively in their care, and therefore, require greater support. Society must have mechanisms to protect the rights and ensure the best interests of vulnerable people.

The meaning that different cultures give to depression may present an additional barrier. Language and literacy issues can make help seeking even more difficult. In Canada there are geographic barriers to accessing care.

Issues for the People Providing Services

People working in health care have identified a number of barriers to providing high quality care for people with depression. Some identify the need for better information and tools. Health care providers require access to training, continuing education and supervision to ensure the best treatment approaches are adopted and quality of care is assured.

Family physicians in particular are frustrated by the lack of time to do the things that they know would be most beneficial. A particular problem is the lack of access to talk therapy.

Health care providers express dissatisfaction with the lack of access to a wider range of supports and services that would help people with depression. Such services and supports include access to disability benefits, housing, job coaching, etc.

Issues for the System

Many important obstacles have been identified as systems issues. The first point of access to treatment is typically through family physicians. However, significant numbers of Canadians do not have access to a family physician. Moreover, the family physician's service is not typically linked to the full range of services that are required by people with depression. Important developments around such linkages are emerging as part of primary care reform (such as the Primary Care Networks in Alberta where multidisciplinary teams work in an integrated manner). Funding, payment and training mechanisms have not yet been fully implemented to support primary care reform.

When family physicians identify the need to refer someone to specialized services for depression, there are further barriers to access these services. There are long waiting lists for access to psychiatrists and the publically funded system does not provide adequate access to other kinds of specialized services such as those provided by psychologists and other health professionals.

The current system is not organized to meet the needs of people with depression and their families. A redesigned system would put people with depression and their families at the centre of the system. It would not only involve people more actively in their own care through support for self-management but it would engage people in recovery in mutual aid activities, evaluation and policy decisions.

Jury Recommendations

The required changes to meet the needs of people with depression are substantial.

- The Mental Health Commission of Canada should:
  - Ensure that its knowledge exchange center has a focus on mental health literacy to meet the specific needs of people with depression
  - Develop a program that addresses the stigma associated with depression in society.
- A substantial reorganization of the delivery of services for the management of depression is required. The assessment and treatment of depression must be integrated into Chronic Disease Management and Primary Care Reform initiatives. This is compatible with the patient-centered model developed by the Canadian Collaborative Mental Health Initiative. Health care and professional funding rules must be redesigned to encourage and support system change and innovation with respect to screening and a stepped care approach, within a Chronic Disease Management model.
- Ongoing funding to facilitate the engagement of people with depression, their families and representative groups in the delivery of self-help and peer support groups and system reform is needed.

- Involving employers and insurers as partners to build additional supports and services to meet the needs of people with depression in the workplace is required.
- Methods need to be found to provide services and support to First Nations, Métis, Inuit and rural and remote communities. Targeted innovation is required in this area.
- The jury recognizes a substantive investment of resources will be required to address the current barriers to improved depression care.

QUESTION #7

What further research is needed in the field?

Depression research must be adequately supported and funded commensurate with the economic burden of the disease – the discrepancy is obvious.

Jury Recommendations

A group of partners led by the Mental Health Commission of Canada should develop a comprehensive framework for research in depression considering issues raised at the Consensus Development Conference on Depression in Adults.

Other recommendations have relevance for future research. These recommendations refer to such things as: service delivery models, the role of primary care, better aligned funding methods to support more effective service delivery, identifying risks in critical periods during people's lifetimes, and the cumulative effects of stress.

The comprehensive research framework should include but not be limited to the following themes:

- **Biomedical Studies of Depression**

  Research on depression should capitalize on the advances in the neurosciences.
  - Multi-disciplinary research teams should be funded to investigate symptoms, co-morbidities, neurochemistry, genetics or imaging that has relevance to treatment.
  - Pharmacotherapy research is required to develop more effective antidepressants. Current drugs have slow response and numerous side effects, but are safer, although more costly than older medications.

- **Prevention of Depression**

  Adequate prevention is dependent on the identification of risk factors. A surveillance system to monitor risk factors for depression is needed to evaluate the effectiveness of prevention programs that may reduce depression including:

- Prenatal programs, strategies to reduce childhood abuse and its impact, and screening for postpartum depression.
- Organizational risk factors in workplaces and the programs to produce healthy workplaces.

Economics of Depression

Because resources are scarce and the need is great limited resources must be used most effectively and efficiently. Therefore, continued investigation of the costs of depression is required including the human, workplace, social, and health systems costs.

The research agenda in this area might include:

- Economic evaluation of different interventions and approaches.
- Continued monitoring of health care expenditures to match the burden of depression.
- Examination of financing and reimbursement structures for various models of care for depression that promote access and quality in a patient centered environment.
- Examination of benefit structures to promote efficient use of services and recovery by patients.
- Examination of the optimal balance of private (e.g. workers, citizens, patients, and employers) and public funding of increased access to psychotherapy according to the models developed in Australia and the United Kingdom.

Effectiveness of Services for Depression

Models of care for depression need to dovetail with primary care reforms. A possible research agenda might include:

- Evaluation of new patient centered treatment pathways for depression integrated with other common mental disorders (e.g. anxiety disorders and substance use disorders) and common chronic diseases.
- Development of minimum guideline treatment using simple protocols and standardized rating scales.
- Evaluation of psychotherapies (including brief and group psychotherapy) and self directed treatments (e.g. web CBT).
- Evaluation of consumer mutual aid/self-help/peer support.

Epidemiology of Depression

Emphasize longitudinal studies to examine:

- The effects of critical developmental periods,
- The effect of cumulative experiences of developmental stresses
- 'Chains of adversity' and 'chains of risk'.

Ensure the inclusion of depression relevant variables in emerging or proposed longitudinal studies in Canada.

Diagnostic assumptions regarding depression and its sub-classifications need to be re-examined:

- Investigate the use of a dimensional approach to diagnosis.
- Boundaries between disorders are less clear than current diagnostic systems imply (e.g. anxiety and depression).

—— **Consumers/Patients and Families/Caregivers**

More support should be given to patient driven research. Their lived experiences are a valuable guide to the realities of mental illness.

—— **Evidence**

Mental health research needs to broaden its perspective on evidence beyond the randomized controlled trial. Qualitative methodology, narrative accounts, and others all need to be considered.

—— **Knowledge Exchange**

Any research agenda must invest in knowledge exchange activities and evaluate the outcomes and optimal approaches.

CONCLUSION

We, the jury, believe that above all else, services for people living with depression must be improved. The human cost of depression is enormous. Its impact is felt in the home, in the workplace, in the larger community – and by extension, its impact is felt by Canada.

It is essential we come to a better understanding of depression and the multiple factors associated with it. If we do not, we will not be able to prevent, diagnose or properly treat this illness.

We need to approach people with depression as people first. We need to respect individuality, experience, culture and spirituality. We must honour their treatment preferences and involve them in their own care.

Providers of care must work together with people with depression, with a clear understanding of their respective roles and responsibilities. Most importantly, we must put people with depression and their families/caregivers at the centre of the treatment system.

Efforts to improve the system must be informed by research and evidence. But the research and evidence in isolation are not enough. This knowledge needs to be reflected in policy and in practice: for service providers, for employers and co-workers, for centres of education including those that teach health care professionals and for decision-makers at all levels.

Governments at all levels need to demonstrate leadership in developing and promoting policies that will create positive changes in the treatment system. They need to champion respect for people with depression in the home, the workplace, and the community.

Depression must be recognized as the health priority it is and resourced accordingly. An investment by an informed and caring population is an investment in Canada's future.

The time for action is now.

JURY MEMBERS

Jury Chair

Hon. Michael Kirby, Chair, Mental Health Commission of Canada

Jury Members

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Dr. Garey Mazowita, Chair, Department of Family and Community Medicine, Providence Health Care; Clinical Associate Professor, University of British Columbia

Mr. Rod Phillips, President and CEO, Shepell-fgi

Ms. Shelagh Rogers, Broadcast Journalist, CBC Radio

Mr. Phil Upshall, National Executive Director, Mood Disorders Society of Canada; Special Advisor on Stakeholder Relations, Mental Health Commission of Canada; Adjunct Professor, Department of Psychiatry, Dalhousie University, Past Executive Director, Canadian Alliance on Mental Illness and Mental Health; Project Director, Mental Illness Awareness Week 2008

CONFERENCE SPEAKERS AND TOPICS

What is depression and how common is it?

Depressive disorders, symptoms, prevalence, and incidence

Scott B. Patten MD FRCPC PhD, Professor, Faculty of Medicine, Departments of Community Health Sciences and Psychiatry, University of Calgary

What are the effects of depression for the individual, family and society?

The perspective of the individual and families

Shelagh Rogers, Broadcast Journalist, CBC Radio

Impact on mortality and morbidity including other diseases

Eldon R. Smith OC MD FRCPC, Emeritus Professor, University of Calgary; Chair, Canadian Heart Health Strategy and Action Plan

Lauren Brown BScPharm MSc ACPR, PhD Candidate, School of Public Health, University of Alberta

Impact on the workplace and society

Zorianna Hyworon, Chief Executive Officer, InfoTech Inc.

Economic impact and utilization of health services

Philip Jacobs DPhil CMA, Director, Research Collaborations, Institute of Health Economics; Professor, Health Economics, Faculty of Medicine, University of Alberta

What are the risk factors for depression, and how can prevention of these be improved?

Age, sex, race, and genetics

Sidney H. Kennedy MD, Professor of Psychiatry and Psychiatrist-in-Chief, University Health Network, University of Toronto; Founding Chair, Canadian Network for Mood and Anxiety Treatments (CANMAT)

Adverse childhood experiences in relation to depression in adult ages

Vincent Felitti MD, Clinical Professor of Medicine, University of California; Founding Chair of Preventative Medicine, Kaiser Permanente, San Diego

Factors that cause different forms of stress and its relation to depression

Sonia Lupien PhD, Scientific Director, Mental Health Research Centre, Fernand Sequin Hospital Louis-H Lafontaine, Université de Montréal

The abuse of alcohol and other substances

Nady el-Guebaly MD DPsych DPH FRCPC, Professor and Head, Addiction Division, Department of Psychiatry, University of Calgary; Medical Director, Addiction Program & Centre, Alberta Health Services/ Calgary Health Region

Work related risk factors

Mary Ann Baynton MSW RSW, Director, Mental Health Works, Canadian Mental Health Association; Ontario Program Director, Great-West Life Centre for Medical Health in the Workplace

What are the most appropriate ways for diagnosing depression?

Early detection, screening and other diagnostic methods

David L. Streiner PhD CPsych, Professor, Department of Psychiatry, University of Toronto; Assistant Vice President, Research Director, Kunin-Lunenfeld Applied Research Unit, Baycrest

Diagnosis and follow up from a family practitioner's perspective

June Bergman MD CCFP FCFP, Associate Professor, Department of Family Medicine, University of Calgary

What are the current treatments for depression and what evidence is available for their safety and effectiveness?

Pharmaceutical treatment: Benefits and risks

Raymond W. Lam MD FRCPC, Professor and Head of the Division of Clinical Neuroscience, Department of Psychiatry, University of British Columbia; Director, Mood Disorders Centre of Excellence, University of British Columbia Hospital, Vancouver

Cognitive Behavioral Therapy

Keith Dobson PhD, Professor and Head of the Department of Psychology, University of Calgary; Executive Director, Council of Canadian Departments of Psychology; President-Elect, Academy of Cognitive Therapy; President-Elect, International Association of Cognitive Psychotherapy

What are current treatments for depression and what evidence is available for their safety and effectiveness?

Psychotherapy

Janet M. de Groot BMedSc MD FRCPC, Associate Professor, Department of Psychiatry and Oncology and Associate Dean, Equity and Teacher-Learner Relations, University of Calgary

Self-management

Dan Bilsker PhD, Adjunct Professor, Faculty of Health Sciences, Simon Fraser University; Clinical Assistant Professor, Faculty of Medicine, University of British Columbia

What are current treatments for depression and what evidence is available for their safety and effectiveness?

Electroconvulsive therapy

Harold A. Sackeim PhD, Professor, Department of Psychiatry and Radiology, College of Physicians and Surgeons of Columbia University; Emeritus Chief, Department of Biological Psychiatry, New York State Psychiatric Institute

Non-traditional forms of treatment of depression

Raymond W. Lam MD FRCPC, Professor and Head of the Division of Clinical Neuroscience, Department of Psychiatry, University of British Columbia; Director, Mood Disorders Centre of Excellence, University of British Columbia Hospital, Vancouver

Healing practices in the Aboriginal community

Leonard Bastien, Elder and Consultant, Native Multi Service Team, Calgary and Area Child and Family Services Authority

What are the obstacles to effective management of depression and strategies to overcome them?

Stigma

Patrick Corrigan PsyD, Professor and Associate Dean for Research, Institute of Psychology, Illinois Institute of Technology

Health care structure, financing and reimbursement systems

A. Donald Milliken MB MSHA FRCPC, Advocacy Committee Chair and Past-President, Canadian Psychiatric Association; Affective Disorders Clinic, Victoria

Mental health literacy: Tools for individuals and family

Thomas Ungar MD MEd CCFP FCFP FRCPC DABPN, Chief of Psychiatry, North York General Hospital

Access to health care for people with depression

David J. A. Dozois PhD CPsych, Associate Professor, Department of Psychology, Faculty of Social Science, University of Western Ontario

Waiting times and shortage of personnel

Patrick J. White MB, BCh, MRCPsych, Clinical Professor and Chair, Department of Psychiatry, University of Alberta; Regional Clinical Program Director, Mental Health, Alberta Health Services-Capital Health

What further research is needed in the field?

Biomedical

Glen Baker PhD DSc, Professor and Vice-Chair (Research) and Director, Neurochemical Research Unit, Department of Psychiatry, University of Alberta

Clinical

Sidney H. Kennedy MD, Professor of Psychiatry and Psychiatrist-in-Chief, University Health Network, University of Toronto; Founding Chair, Canadian Network for Mood and Anxiety Treatments (CANMAT)

Population Health

Scott B. Patten MD FRCPC PhD, Professor, Faculty of Medicine, Departments of Community Health Sciences and Psychiatry, University of Calgary

Economics

Philip Jacobs DPhil CMA, Director, Research Collaborations, Institute of Health Economics; Professor, Health Economics, Faculty of Medicine, University of Alberta

Policy

Angus H. Thompson PhD, Department of Psychiatry and Alberta Centre for Injury Control & Research, University of Alberta; Research Associate, Institute of Health Economics

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All of the jury members who participated in this conference and contributed to the writing of this statement were identified as having no financial or scientific conflict of interest, and all signed forms attesting to this fact. Unlike the expert speakers who present scientific data at the conference, the individuals invited to participate on the consensus jury are reviewed prior to selection to ensure they are not proponents of an advocacy position with regard to the topic.

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