EDITORIAL

Developing effective strategies for the management of depression and suicidal thoughts

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In the article titled "Contextual risk factors of depression and suicidal thoughts in Brazilian adults: a multilevel analysis," Carpena et al.[1] explore the relationship between the presence of depression and suicidal thoughts as ascertained using the PHQ-9 and a number of contextual factors, including the availability of Psychosocial Care Centers (CAPS), the gross domestic product, the Gini index, and others. Surprisingly, and counter to what others have reported,[2] there was no apparent effect of these factors on prevalence of depression or suicidal thoughts. However, personal factors, such as income and level of education, did show the expected effect.

The lack of effect of the availability of CAPS on the occurrence of depression and suicidal thoughts is notable. Several European studies have demonstrated a relationship between training primary care physicians in the treatment of depression[3] and decreases in suicide rates, presumably due to better treatment of depression. Furthermore, multiple studies around the world have documented an inverse relationship between antidepressant prescriptions and suicides. However, the number of available physicians in these settings is likely to be quite different than in Brazil.

In this study, the point prevalence of depression averaged around 4%,[1] somewhat lower than rates reported for low and middle income countries (6.7%)[4] based on the World Health Surveys. However, knowing the point prevalence of depression is only partially helpful in calculating the need for care. For example, if the 12-month prevalence of depression in Brazil is similar to that observed in the U.S. (10.4%),[5] one would expect that 2,080 patients out of a population of 20,000 would need care for depression in any given year. How many CAPS would be needed to care for this population? Without some estimate of the capacity of each CAPS, and the variability in capacity across CAPS, the data are difficult to interpret. For example, if an average CAPS can only accommodate treatment of 500 patients (understanding that depression is only one of the conditions that is treated), then whether there are one or two CAPS per 20,000 population could make a difference in the point prevalence of depression and suicidal thoughts. On the other hand, if one CAPS can provide treatment for 2,000 patients, then having

two CAPS will make no difference, and the relationship between the availability of CAPS and the presence of depression in the population will no longer be meaningful.

Planning for mental health services is complex because of the need to take into account not only the prevalence of the condition, but also the availability of human resources, whether evidence-based treatments are employed, and the quality of the training received by the clinical staff, among other parameters. But at a minimum, the relationship between the annual prevalence of the condition in question and the capacity of the facilities to address the condition needs to be delineated. The authors conclude that depression and suicidal thoughts may not be related to the number of CAPS because of potential deficits in the quality of services rendered or because the distance between the patients in need of care and the CAPS is too great. While that is a possible explanation, the relationship between service supply and demand needs to be part of the equation.

Disclosure

References

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