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The ethical context of population-level interventions against depression

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Abstract

Depression is often seen as a growing public health issue, and this is reflected in a growing number of interventions. This paper discusses the ethical implications of interventions conducted at the population, as opposed to the individual, level. We start by outlining the main ethical considerations of such approaches. Particularly we argue that given the stigma associated with diagnoses and labels of mental illness, including depression, allocation or adoption of such labels greatly effects the lives of sufferers. While long-term social and legal efforts may be made to reduce stigma and discrimination, the potential consequences of such labels must be recognised and greater sensitivity to this must illuminate discussions and practice of diagnosis, intervention and treatment. With this in mind, we proceed to consider several specific large-scale interventions to address depression. These include: web-based interventions; over the counter sales of anti-depressants; school-based interventions and interventions in the young and environmental interventions. We conclude that many types of large-scale intervention are not ethically unproblematic and that there is a significant difference between treating people who seek help, and searching for people whom we think need help. Consequently, in the current climate of prevailing attitudes towards mental health generally, and depression in particular, the use of population-level interventions raises serious ethical considerations that cannot be ignored.

Keywords

Depression; Intervention; Ethics; Stigma; Screening; Population-level; Self-care

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Introduction

This paper was originally published in Germany as a chapter in a book titled *Volkskrankheit Depression? Bestandsaufnahme und Perspektiven* (Holm & Burgess, 2006). The book was a response to the perceived increase in the prevalence of depression. The remit of this chapter, which was part of a section on interventions, was to discuss the ethical context of conducting large-scale (population-level) interventions to address depression. Our work was written in English and translated into German. This working paper reproduces our original English language draft and is published nowhere else in English. A few alterations have been made but these are mainly grammatical and contextual rather than substantive.

Depression is a major public health problem. On any kind of burden of disease measurement depression appears as one of the main courses of ill health and loss of earnings across the life cycle. In discussions about ethics in psychiatry there has been a tendency to focus on the ethical problems raised by the treatment of individuals, for example issues concerning compulsory detention and treatment (Bloch et al, 1999; Hirsch and Harris, 1998). In this chapter we will leave aside these traditional concerns of the ethics of psychiatry and instead look at some of the ethical issues that are raised when we try to tackle depression at the population level through large-scale interventions. In this area many parallels can be drawn to ongoing discussions in public health ethics (e.g. to general discussions about screening) but there are areas where public health interventions targeting mental illness differ from the standard public health interventions targeting physical diseases. The interventions that we will discuss in this chapter fall into two categories:

1. **Untargeted primary prevention**, e.g. changes to the built environment aimed at reducing the incidence of depression
2. **Targeted primary or secondary prevention**, e.g. interventions aimed at people who during screening have been found to have increased

risk of developing depression, or have sub-clinical depression. This can either rely on mass screening, on professional screening, or on self-identification possibly aided by easy access to screening tools on the internet.

In this chapter we will give a brief overview of the main ethical issues and then proceed to discuss stigma and screening, followed by an examination of some intervention strategies including some aimed at adult populations; school-based interventions and interventions aimed at children or adolescents, and a brief discussion of environmental interventions.

An overview of the main ethical issues

What are the main ethical issues that mass interventions for depression raise? There are at least five that will recur in our discussion:

1. Is there evidence that the intervention strategy works? It is ethically problematic to waste resources on interventions that do not work?
2. Are there negative consequences for those labelled as “at risk” for depression?
3. How reliable are the methods used for labelling persons as “at risk”?
4. Are there any elements of coercion or paternalism involved in the intervention strategy?
5. Will the intervention promote justice in health or health care?

The first three of these ethical considerations are discussed in more detail later, but here we will briefly discuss the two last issues.

Respect for self determination is a central concern of medical ethics; and for any public health intervention that involves coercion or some form of paternalism we need to look carefully at whether it is justified to breach peoples right to self determination. In the current context direct coercion is not the concern, no one will presumably be forced to take a screening test for depression as part of a public health intervention, but if screening takes place in institutions like schools there may be a significant element of informal coercion (e.g. “everyone else in the class participates, so why won’t you?!”).

In the health promotion context paternalism is often what we could call informational paternalism. We, the public health professionals, only include part of the truth in our health promotion messages either because we believe that people cannot process complex information, or because telling people the whole truth would make the message much less convincing. An example of such misguided informational paternalism was the, now fortunately no longer used slogan “Cancer that is discovered in time can be cured”. This is either tautological (i.e. the definition of a “cancer that is discovered in time” is that it can be cured), or false.

The justice consideration arises because we know that unless public health interventions are very carefully designed there will often be differential uptake in different social groups, and that it is often the well educated who will benefit the most. This means that a public health intervention may benefit the public health, while at the same time enlarging the differences in health status between different social groups. This is clearly a non-desirable outcome, especially if the intervention is paid for by public money.

A final introductory consideration that is important for the ethical evaluation of different intervention strategies is “*Qui bono?*”. Who benefits from the recent growth in the estimates of the number of persons in the population suffering from depression? Many commentators have remarked on the temporal co-incidence of the growth in the estimates and the introduction of the Selective Serotonin Reuptake Inhibitor (SSRI) class of anti-depressants and suggested that it is the pharmaceutical industry that, with the collusion of psychiatrists, have been influencing the way depression is conceptualised, thereby influencing the number of people classified as depressed.

Stigma and screening

In psychiatric disease, we can see a contemporary expression of the mind-body dualism that has long preoccupied Western culture. Fear and paranoia surrounding non-corporeal disease mean that to anyone suffering from any psychiatric disorder and being labelled as such, will be attached certain stigma. While the problem of stigmatising mental illness is well documented (Crisp *et al*, 2000), mental health literacy among the public is still poor (Jorm, 2000). Consequently, someone labelled as having a psychiatric disease may find that this label dominates their life as much as the disorder itself. The stigma attached to the label becomes a window through which the sufferer may view themselves, and through which the wider world will view the sufferer. While public prejudices and stereotypes will vary between particular diseases (Crisp *et al*, 2000), generally these can lead to social inequality for sufferers, for example by limiting their access to employment and insurance. This has been echoed by Benedetto Saraceno, as the director of the World Health Organization's Department of Mental Health and Substance Abuse:

> *"Mental disorders are inextricably linked to human rights issues. The stigma, discrimination and human rights violations that individuals and families affected by mental disorders suffer are intense and pervasive."*
>
> (WHO, 2004:3)

Although not suffering a mood disorder like depression, Gordon's description of her own personality disorder highlights one fear of being labelled as mentally ill:

> *"I fear that now I have been given this label I will be seen by all subsequent professionals in the light of my label without being given the chance for the real me to show through."*
>
> (Gordon, 1994:420)

The fear of being forever labelled, and always being subjected to the stigma attached to that label, is key to why a person with symptoms of psychiatric disease (assuming they are even aware of what their symptoms mean, or that they are treatable) may be reluctant to present this to a GP (Halter, 2004). Being labelled as suffering from depression is no different, despite the fact that it is a one of the most prevalent forms of psychiatric disorder (Halter, 2004; WHO 2004). Indeed, the stigma attached to depression is possibly complicated by the fact that the word has a lay usage as well as a clinical one. As a result, depression is often seen as synonymous with merely being sad. Clearly, there is an urgent ethical need to address the stigma attached to depression in order to remove the social inequality experienced by sufferers. Education is often seen as key to achieving this (Paykel & Priest, 1992), with interventions to address public perceptions of depression taking a central role. In the UK, for example, the *Royal College of Psychiatrists* and the *Royal College of General Practitioners* undertook a 5 year project (1992-1996) called the *Defeat Depression Campaign* one of the aims of which was to reduce the stigma associated with depression (Royal College of Psychiatrists, 2005). While evaluation of the scheme suggested that it had a positive affect on public attitudes towards depression, these effects were small and could not be conclusively attributed to the campaign (Paykel *et al*, 1998).

However, in dealing with the stigma of depression, it is important to note that health education interventions are slow to produce effects (Crisp *et* al, 2000). In addition, while such interventions may seek to reduce stigma around depression by increasing public understanding of it, it has been suggested that stigmatising opinions do not necessarily result from a lack of understanding of mental disorders (Crisp *et al*, 2000). To particularise Crisp *et al's* generalised conclusions to depression, stigmatising opinions are hard to change, consequently strategies must directly address discrimination towards people with depression (e.g. in the work place' (Glozier, 1998)), alongside increasing public understandings of depression, in order to reduce the social injustice experienced by the depressed. A part of this must be attention to representations of depression in the media (Crisp *et* al, 2000), where indirect cultural messages reinforce more directed, public health ones. Complex interventions which reduce the stigma associated with depression and actively address discrimination through legal and social action, are clearly necessary to improve social justice for sufferers and to encourage those who do suffer to seek treatment. However, these are long-term strategies and in the meantime the stigma of depression continues to have a profound and complex impact on the lives of those who suffer from it. Consequently, those involved in diagnosis must be sensitive to the social consequences of the label that their diagnosis imparts, as well as the clinical ones.

It is documented that once sufferers do present with symptoms, despite the fact that several different tools exist to assess the presence of depression (Bowling, 2005; McAlpine & Wilson, 2004), it often remains undetected within primary care (Gilbody *et al*, 2003; McAlpine & Wilson, 2004; Paykel & Priest, 1992). In order to improve referral and treatment of depression, the occurrence of accurate diagnosis needs to be increased. However, large-scale solutions to this may be problematic. The US Preventative Services Task Force (USPSTF), for example, have recommended the use of routine screening programs for depression in clinical practices in order to improve diagnosis of depression (2002). While clinical criticism of the use of screening methods tends to go against the accepted opinion of the medical establishment (Palmer & Coyne, 2003), screening all patients for depression, regardless of whether they are showing symptoms raises serious ethical concerns regarding patient rights, obligations, enforcement and social justice. This is particularly important as it has been suggested that such a screening program may have a minimal impact on detection rates (although it may pick up the less severe cases that are generally missed by practitioners) (McAlpine & Wilson, 2004). Issues surrounding screening are made more acute with growing interest in genetic screening for pre-disposition to depression. Is there a future where people are genetically labelled from birth as being at risk of depression, thus subjecting them to discrimination and social inequality from birth or youth? The answer to this question lies in who collects this information; who has ownership of and rights to it and where it is stored. If insurance companies and potential employers, for example, can buy the results of population-level testing or even demand individual genetic or psychological screening for all applicants, this raises serious ethical concerns.

Screening programs are often promoted as being for the good of the depressed by increasing detection rates. While there is probably a legitimate argument that diagnosis aids treatment, it is not as clear cut as this. There is clearly an alternative discourse in which corporate agendas (i.e. profit) clash with the rights of the individual to manage their own symptoms, and the way that they are presented within the world.

In the public and professional discourse surrounding screening programs there is also a need to acknowledge and disseminate the pluses and minuses of different screening procedures and treatments in order to avoid the kind of informational paternalism discussed in the introduction. Acknowledging the social stigma attached to depression and its consequences, means that public interventions, such as mass screening programs, have to be seen in a social as well as a clinical light. At the patient level, diagnosis also needs to be supported by good and appropriate treatment which is not always the case (Gilbody *et* al, 2003; McAlpine & Wilson, 2004; USPSTF, 2002). Perhaps treatments should always include preparation for dealing with the stigma and discrimination attached to sufferers both by the rest of the world and by themselves, with the stigmatising effects of depression necessarily being dealt with at the practitioner and patient level as well as the public one.

While long-term social and legal efforts must be made to reduce stigma and address discrimination suffered by those with depression, these issues still affect the lives of sufferers. Greater sensitivity to this must illuminate discussions and practice of diagnosis, intervention and treatment. Sufferers from depression experience social injustice resulting from their clinical diagnosis, therefore, any discussion of large-scale interventions must consider this. Equity of population-scale interventions against depression does not just concern equality of clinical outcome but also social justice for the depressed.

A discussion of some particular population-level interventions

Web-based psychological interventions

A number of groups are currently developing ways of delivering cognitive behavioural therapy (CBT) interventions against depression automatically via a web-site (Christensen et al 2002 & 2004; Clarke et al 2002 & 2005; Patten, 2003). CBT is itself a well validated therapy for depression (Elkin et al, 1989; Scott, 1996; De Rubeis et al 1999; Huibers et al, 2003), but if it can be delivered in an effective manner without involving a human therapist, it can be used as part of interventions at the population level. One possibility would be a health promotion campaign encouraging persons who feel depressed to go to a screening web-site and then directing those who have scores indicating depression to the CBT site. Current evidence seems to indicate that web-based CBT is effective against mild depression, but it has as yet not been used in a population-level intervention.

A web-assisted health promotion campaign would to some degree circumvent worries about stigmatisation, because the users of the screening and the treatment would not be identifiable. It would, however, raise issues of justice since the users would be unlikely to be a cross-section of the population. Internet access is not evenly distributed across society, and the propensity to use a cognitive therapy like CBT might also differ according to educational attainment. A web-assisted health promotion campaign would thus have to be only a part of a larger health promotion intervention if the aim was to reach the whole population at risk.

An issue for any program involving web-based screening or other forms of self-screening by potential patients is the quality of the screening tools, and whether they are validated for this specific kind of use. Given the issue of stigma discussed above it is very important that the screening tool does not have a high false positive rate. One of the scales commonly used is the self-rated Goldberg Depression Scale. This scale has been validated in general practice populations, but never for population screening, and never for internet use in particular, and it has furthermore, like most rating scales only been validated in a few countries and languages (Holm et al, 2001). We therefore do not know what the false positive rate for this scale is when used at the population level, and this is also the case for all the other rating scales currently used on the internet.

Over the counter sale of anti-depressants as an intervention strategy

Allowing over the counter (OTC) sales of (some) anti-depressants is a possible population intervention strategy directed towards the milder end of the depression spectrum. Newer anti-depressants have less side-effects, are less toxic, and have less potential as suicide agents than the older ones; and it is therefore at least in theory possible to allow people who diagnose themselves as suffering from depression to buy these drugs without prescription. There are plenty of validated depression screening tests available on the internet (as discussed above) and in popular books, so it would be possible for people to screen themselves before buying the drugs.

The main positive feature of this strategy is that it reduces the risk of stigmatisation. The person does not have to seek professional help to get access to effective treatment, and he or she will not be registered anywhere as a buyer of anti-depressants as they would be if the drugs where bought on prescription.

There are, however, also significant problems. The first problem is a problem with the evidence: we do not know whether and how well the strategy will work, since it has not been trialled or evaluated (including issues surrounding self-screening). The second cluster of problems are all concerned with whether we, as a society want to extend the use of anti-depressants. Would people who were not depressed but just sad start taking the drugs, or would non-depressed and non-sad people take them to become happier? There is an extensive literature on whether it is problematic that the new anti-depressants are used by healthy people as so-called “life style drugs”, and an even more extensive literature on whether there is anything wrong in principle with healthy people enhancing themselves through pharmaceutical means. The basic point of controversy is whether there is anything special about pharmaceutical enhancement that makes is more problematic than other kinds of enhancement. Most people try to enhance themselves in various ways, for example by reading academic books, and we do not normally find that wrong. A possible difference in the psychiatric area is that enhancement obscures the “authentic self”: if I make myself happier and more carefree with SSRIs I am no longer myself. The strength of this argument is, however, disputed, partly because it is very difficult to define with any precision what a person’s authentic self is (as evidenced in the common comment that “it is only when he is drunk that you realise how nasty he really is”).

A final problem for this intervention strategy is that in most countries marketing rules for OTC products are more liberal than the marketing rules for prescription only products, for instance by allowing direct to consumer advertising. Moving anti-depressants into the OTC category might therefore allow the pharmaceutical industry to induce demand for these drugs through advertising (Spurgeon, 1999; Consumer Association, 2001; Evans et al, 2002; Mintzes et al, 2002; Holmer, 2002; Colin-Thomes, 2004; Evans, 2004; Coulter, 2004).

School-based interventions and interventions in the young

Childhood depression has become a major health issue (Merry *et* al, 2005; Sanci *et* al, 2000) with increasing numbers of children being treated for it (Timimi, 2004; Ramchandani, 2004). The association of childhood depression with “poor academic performance, social dysfunction, substance abuse and attempted and contemplated suicide” (Merry *et* al, 2005: 2), with even mild depression having a detrimental effect, explains the increased interest in preventative interventions over the past decade (Merry *et* al, 2005). Risk of depression increases throughout adolescence (Ramchandani, 2004) making the need for prevention seem even more acute.

Such preventative measures raise ethical concerns. A preventative program necessitates some element of screening for predisposition to depression. However, symptoms of depression are common in childhood, often disappearing without clinical intervention (Ramchandani, 2004). Evidence for the effectiveness of preventative interventions in youth is still limited (Beardslee *et al,* 2003; Merry *et al*, 2005; Spence *et al*, 2003) as is evidence for the benefits of routine screening of youth for depression (USPSTF, 2002), with a Cochrane Review recommending that the implementation of preventative programs is premature (Merry *et al*, 2005). It has, for example, been argued that increasing reporting of adolescent depression may be the result of changing concepts of childhood including an over-medicalising of childhood emotion and that the symptoms of the children diagnosed as depressed do not reflect adult symptoms as is often claimed (Timimi, 2004). Potential failings in diagnosing childhood depression have severe implications for the application of any subsequent intervention, particularly in preventative programs involving mass screening: the unnecessary labelling of a young person as depressed may be highly problematic for that child. At particularly vulnerable times during development, they may be tagged with an identity which affects the way that they both see and present themselves, and the way in which the world will see them. This could have negative repercussions throughout their lives. Having already identified the social stigma still attached to such labels, it is worth emphasising that the social environment of school students is very effective at labelling and discriminating against anyone perceived as deviant from normalised behaviour or character. Any pupil labelled as depressed by either themselves, their peers or adults will have to negotiate this identity within the school environment.

Clearly, there are both social and financial cost implications associated with large-scale primary prevention interventions. It would seem impossible to target such interventions effectively and fairly. While it has been shown, for example, that children whose parents are depressive are prone to developing psychiatric disorders themselves (Beardslee *et al*, 2003; Timimi, 2004), it is impossible to disentangle environmental and biological determinants of child depression (Timimi, 2004). This suggests that the accurate identification of adolescents pre-disposed to depression is unachievable, meaning that preventive programs would need to remain broad and untargeted. Accepting all the above evidence, it would seem necessary for the development of any large-scale preventive program for adolescents to consider the risks of the program to the adolescents it is seeking to help. In the absence of better evidence for broad interventions, it would seem wise to focus on secondary interventions for depression in the young. However, these should be undertaken in the light of more research into and debate around what adolescent depression is, and what adolescent depression is not, as these will influence methods of treatment. If adolescent depression is different to adult depression, then perhaps it requires different treatments. Certainly, there are questions, for example, around the increasing use of antidepressants with children (Jureidini *et al*, 2004). If adolescent depression is no different to adult depression and is even a precursor to likely adult depression (Fombonne *et al*, 2001) then this has implications for lifelong treatment of depression, and would seem to advocate early detection and intervention.

While these debates are important reflections of understandings of depression and the treatment of it, through all these discussions the young sufferer of depression (however they are labelled) must not be forgotten and it is crucial that they find support from those around them. Clear information targeted at both adolescents themselves and those that care for them, such as some of that to emerge from the *Defeat Depression Campaign* (Graham & Hughes, 1995; Royal College of Psychiatrists, 2005), is crucial in maintaining this support. As stigmatising attitudes appear to form early, there is also scope for educational campaigns within schools to reduce this stigma (Crisp *et al*, 2000).

Whether preventative or curative, it is a fair assumption that interventions into depression among the young are likely to be located in schools, raising several ethical issues. Schools are often identified as appropriate sites for many types of health promotion (Evans-Whipp *et* al, 2004; Lynagh *et al*, 1997; Nutbeam & Aaro, 1991). Consequently, schools can feel over-burdened with responsibility for researching and promoting health at the expense of what is seen as their primary function, education (St Leger & Nutbeam, 2000; Samdal *et al*, 1998). Any school-based depression intervention must respect this, minimising disruption to teaching while benefiting the school and its students. If an intervention program is of uncertain benefit then it is unethical to use up both school and pupil time on this. An exception to this might be during the trialling of an intervention.

If a school-based intervention is adopted, other ethical issues are raised. It is easy to say that any intervention should be conducted in such a way, and in such a location as to allow the confidentiality of pupil participants. But to what extent is this actually the case? If during screening a pupil is diagnosed as depressed, who has the right or need to know this, and who controls this information? Certainly, it is easy to argue for a pupil's right that their peers are not informed: they do not operate on behalf of the student and therefore have no need to know. However, parents, schools and health professionals all act on behalf of minors, so who should be informed of the diagnosis, and who should give consent to treatment? Answers to these questions may also be affected by the age of the child, and national legal understandings of the age at which they can make autonomous decisions. This is particularly pertinent if the student has sought out counselling on the school site for themselves.

However, if the child is not judged to be old enough to make these decisions, and often even if they are, rights and responsibilities post diagnosis often need to be resolved between school and parent, ideally in an agreed partnership. Who has the right to know this information and make decisions about the child; who has the need to know this information and make decisions about the child and is there a difference between a right and a need? Parents, staff and pupils may view these rights and needs very differently, and there are important questions as to why access to information and decision making may be necessary or desired. A school may argue, for example, that they need this information to facilitate the child's education. Parents may argue that they do not want the school to know in order to avoid the stigmatisation of their child. The child themselves might feel that they are the only one who has the right to know. While alternative sites (e.g. youth clubs, clinics) may be seen as a solution to the problem of school-based interventions, many similar ethical issues would be raised with any intervention based around the treatment of minors. Interest in addressing youth depression can be seen as another expression of the tendency for health policy to try to achieve long-term population health gains by targeting youth health in order to establish lifelong patterns of healthy behaviour. However, due to the stigma associated with depression; uncertainty around diagnosis and treatment of depression in the young; and the legal status of minors, depression screening and interventions in the young, particularly when school-based, raises many ethical issues that should be considered by those involved with them.

Environmental interventions

Environmental interventions appear to suggest vast possibilities in addressing depression. Environment is a term that is constructed to mean many things. For example writing on mental health and the environment includes work on symbolic meaning and therapeutic landscapes (Wilson, 2003); geographies of the mentally ill within cities (Gleeson *et* al, 1998), and the spatial experiences of those suffering from mental illness (Segrott & Doel, 2004). Such insights into the lived experience of mental health could lead to innovative interventions to help address psychiatric disorders including depression. However, the literature on environment and health tends to be mainly located within planning and is dominated by the theme of the built environment and the impacts of urbanisation on health. However, this appears most often to consider physical health. Where mental health is considered it is more often as a generic term rather than with reference to specific conditions such as depression. This would appear to suggest that planning interventions may not be particularly sensitive to mental health issues despite their importance as interventions in the relationship between environment and health. Similarly, while Health Impact Assessment is increasingly undertaken alongside environmental and planning policy (Kemm & Parry, 2004), it seems to lack an explicit focus on mental health.

Interestingly, of all psychiatric disorders, depression is the most commonly singled out for attention by the planning literature. The reason for this appears to be at the heart of a very important matter. Somewhere in some broader social consciousness, depression, in its broad and lay meaning, is often associated with the cities. Crucially, this fixation with health and the urban would appear to echo the popular urban-rural dualism in which the urban (unhealthy) is dichotomised with the rural (healthy). Such a notion of the rural idyll has long been challenged within changing understandings of rural areas (Cloke *et al*, 1994; Hoggart, 1990). This concentration on health and the urban evokes images of the preoccupation with cities as miasma-laden places of contagion and disease in the late 1800s (Halliday, 2001; Susser & Susser, 1996). If these ideas still persist, consciously or sub-consciously within planning, then these dominant interventions may overlook mental health problems in rural areas, despite a body of literature demonstrating the needs of these areas (Philo *et al*, 2003). Consideration of any planning intervention to improve mental health needs to ask to what extent the intervention is based upon evidence, and to what extent is it drawing upon folklore and myth. Where primarily the latter is involved, it would be hard to justify the expense of such costly and sweeping interventions.

Areal variation in health has been observed for more than a century (Ellaway *et* al, 2001), and links between human health and the built environment are increasingly recognised (Jackson, 2003). For example, evidence indicates an association between poor housing conditions and poor health, including incidence of depression (Blackman *et al*, 2001). Before conducting any environmental intervention though, it is important to understand the reason for these trends. For example, are these differences due to character of the area itself (contextual), or the characteristics of the people who live there (compositional) (Ellaway *et al*, 2001)? Or perhaps it is due to an interplay of both of these. If the fabric of the area is causing depression, then interventions to change the physical landscape and architecture might be appropriate. However, if the people living in an area are more prone to depression, successful interventions must understand why this may be the case. This may be due to perceptions of the local environment (Ellaway *et* al,

2001) (suggesting an interplay between physical environment and people); the socio-economic status of the area (a key determinant of health) or the role of social capital at both the individual and community levels (Ellaway *et al*, 2001; Ziersch *et al*, 2005).

If risk of depression is linked to a person's environment, then this suggests that there is inequality in our physical landscape. Whatever the nature of this association, again depression can be seen to be a social justice issue. Improvement of environmental interventions can occur by broadening understandings of the relationship between health and the environment. Not only should more planning draw on a wider literature to increase its effectiveness in reducing depression, but the profile of alternative environmental interventions, drawing on different understandings of the relationship between depression and the environment, should be raised.

Conclusion

To reiterate, this paper represents the English-language publication of a chapter translated into German for a book written in response to the perceived increase in the prevalence of depression. With this rise has come an increase in attempts to address it and this chapter, part of a section on interventions, discusses the ethical context of large-scale (population-level) interventions to address depression. In this chapter we have tried to show that many types of large-scale interventions against depression are not ethically unproblematic. There is a significant difference between treating people who seek help, and searching for people whom we think need help. This difference is especially important in contexts where acquiring a certain kind of diagnostic label has significant negative implications for the person in question. As our discussion of stigma has shown, getting a psychiatric label is often more stigmatising than getting some other diagnostic label. If the mere fact that I have been labelled as "at risk for developing depression" affects my life negatively, then it becomes important that we do not implement interventions that use screening tools with low diagnostic accuracy. While the problem of stigmatisation does not affect population-level intervention strategies that aim to reduce the incidence of depression through a general change in the physical or psychological environment, such interventions are not (yet?) supported by the same kind of evidence as more individualised strategies are. Consequently, in the current climate or prevailing attitudes towards mental health generally, and depression in particular, the use of population-level interventions raises serious ethical considerations that cannot be ignored.

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