ChatGPT

Usage of Depression-Related Drugs Across Socioeconomic Classes and Regions

Introduction

Depression is a common mental health disorder worldwide, and antidepressant medications are a primary treatment. However, **access to and usage of legally prescribed antidepressants** vary greatly by socioeconomic status, profession, and country. Upper-middle-class professionals (such as university professors, lawyers, and politicians in developed nations) often have more access to medical care and may use legal antidepressants at higher rates, whereas in lower socioeconomic groups and in underdeveloped countries, many face barriers to accessing these medications. This report examines: (1) antidepressant usage statistics by class and profession in developed countries (e.g. U.S., U.K., Germany); (2) comparable data or estimates from developing countries (e.g. India, Nigeria); (3) barriers to access among lower socioeconomic classes; and (4) the prevalence of **illegal drug use or self-medication** as a substitute for inaccessible legal treatment in disadvantaged groups. The findings are organized by region and socioeconomic factors, with tables and cited data from academic, government, and journalistic sources for clarity.

Antidepressant Use in Developed Countries (U.S., U.K., Germany)

Prevalence and Socioeconomic Patterns in the U.S.

In the United States, antidepressant use is relatively common and has grown over time. Recent data from the National Health and Nutrition Examination Survey show that **13.2% of U.S. adults used antidepressant medication in a given month (2015–2018)** [1]. Usage is notably higher among women (17.7%) than men (8.4%) [2], and it increases with age (highest among adults over 60). Socioeconomic factors play a role in who uses these medications. Education level, which often correlates with socioeconomic status, is associated with higher antidepressant usage rates. Adults with at least some college education had a **14.3% antidepressant use rate**, compared to about **11.4–11.5%** for those with a high school education or less [3]. In other words, **better-educated (and likely higher-income) Americans are somewhat more likely to be on antidepressants** than those with less education [3]. This disparity suggests that upper-middle-class individuals may have greater access to mental health care or are more willing to seek treatment, whereas lower-income individuals might underutilize these medications (possibly due to cost, access, or stigma).

Professional stratification data in the U.S. is limited, but **high-stress professions do show significant depression rates** that imply substantial antidepressant use. For example, a major 2016 survey of thousands of practicing lawyers found that **28% reported suffering from depression** in the prior year [4]. Similarly, studies in academia have highlighted mental health concerns among faculty; in one survey, roughly one-third of college faculty and staff reported being often or always emotionally exhausted, with many showing symptoms of anxiety or depression (though precise medication usage rates were not given) [5]. These findings suggest that **upper-middle-class professionals like lawyers and professors – despite outward success – experience high rates of depression**. Many in these professions likely seek treatment through legal channels (therapy and prescribed antidepressants) given their access to health insurance and medical professionals. By contrast, data on politicians are

scarce (likely due to stigma and privacy), but anecdotal reports and autobiographical accounts have noted that even in politics, some individuals quietly use antidepressants to manage the pressures of public life. In summary, in the U.S. and similar developed contexts, **upper-middle-class individuals and professionals have relatively high antidepressant utilization, supported by access to healthcare**. Lower socioeconomic groups in the U.S., especially those without insurance, tend to have lower usage rates of legal antidepressants, reflecting an access gap [3].

Prevalence and Socioeconomic Patterns in the U.K.

Antidepressant usage in the United Kingdom has also risen dramatically and is among the highest globally. In 2018, over **70 million prescriptions for antidepressants were issued in England** [6]. Notably, **some of the highest prescription rates occurred in low-income areas of England** [6]. This pattern indicates that in a universal healthcare system like the U.K.'s National Health Service (NHS), deprived communities — which often face higher stress, unemployment, and mental health burden — end up receiving a large share of antidepressant prescriptions. In other words, **unlike in the U.S., lower-income populations in the U.K. are heavily prescribed antidepressants**, likely because financial barriers to seeing a doctor are lower (coverage is universal) and the underlying need (prevalence of depression) is high in these communities [6]. Some researchers have even cautioned that the stressors of poverty are being "over-medicalised" – that is, treated with pills without addressing root causes [7]. Nonetheless, the data underscore that **antidepressant use cuts across class lines in the U.K., with very high usage in both affluent and especially in economically disadvantaged regions**.

On a national scale, about **10–11% of the U.K. population** is on antidepressant medication in a given year, similar to the U.S. rate [8]. Upper-middle-class professionals in Britain (e.g. academics, lawyers, civil servants) benefit from the NHS structure: they have easy access to GPs and mental health services, so those who need medication can obtain it without direct cost. At the same time, mental health awareness has grown such that being on antidepressants carries less stigma than in the past. **For instance, union surveys found that nearly 38% of U.K. educators reported being "always or often" emotionally exhausted [5], and many admitted to using either medication or other supports to cope.** Politicians in the U.K. have occasionally spoken about mental health as well — a former cabinet minister's admission of depression or a public figure's openness about therapy can encourage others to seek help, though hard statistics on antidepressant use by politicians are not publicly available.

Prevalence and Socioeconomic Patterns in Germany

Germany's antidepressant usage is comparable to that of other high-income European nations. A large 2010 study found that **7.4% of Germany's population was prescribed at least one antidepressant in that year** [9]. More recent data suggest usage has continued to rise in the 2010s. As in other countries, **women in Germany are about twice as likely as men to use antidepressants (9.7% of women vs 4.8% of men)** [10]. There are also regional differences within Germany: the prevalence ranged from about 6.3% in some eastern states to 8.7% in certain western states [10], hinting at socioeconomic and cultural factors (western regions tend to be wealthier on average, but also more medicalized in treatment approach, whereas some eastern areas might have different healthcare-seeking behaviors or demographics).

Socioeconomic status plays an interesting role in Germany. **Evidence shows that individuals under financial distress are more likely to be on antidepressants**. A cross-sectional analysis in North Rhine-Westphalia found that among people who were *over-indebted* (in serious financial debt and seeking debt counseling – a proxy for socioeconomic hardship), **12.3% were taking antidepressants**, compared to only **5.0% in the general population** [11]. Even after adjusting for other factors, being in severe

financial trouble nearly doubled the odds of antidepressant use [11]. This suggests that **economic hardship is strongly linked with depression treatment in Germany**, perhaps because those in crisis are more likely to experience clinical depression and get referred for treatment. It also reflects Germany's healthcare accessibility – even those of lower socioeconomic status (e.g. unemployed or in debt) usually have health insurance, enabling them to receive medical care and prescriptions. Thus, similar to the U.K., **Germany's lower-income or economically stressed populations do get prescribed antidepressants at high rates when in contact with the health system**, due to high need. Upper-middle-class Germans (e.g. professionals with stable incomes) also use antidepressants frequently when needed, but they might have a lower prevalence of severe depression than those under acute financial stress. Overall, the pattern in developed countries is that **antidepressant use is widespread across classes, but access to care can modulate who actually gets medication**. In the U.S., higher SES yields more access (hence more use) [3], while in Europe with universal healthcare, high use is observed even in low SES groups commensurate with their high levels of need [6] [11].

Summary of Antidepressant Use in Selected Developed Nations

To illustrate the range of antidepressant utilization, **Table 1** presents data on the number of antidepressant users per 1,000 people in several countries. This metric (users per 1,000 population) roughly corresponds to the percentage of the population on antidepressants:

Country	**Antidepressant Users per 1,000 People** (≈% of population)
Iceland	161 [12] [8] (≈16.1%) – *Highest in the world*
Portugal	139 [8] (13.9%)
Canada	130 [8] (13.0%)
Australia	122 [8] (12.2%)
United States	110 [8] (11.0%)
United Kingdom	108 [8] (10.8%)
Germany	~74 (estimate, 7.4%) [9]
Chile	90 [8] (9.0%)
India	9 [12] (0.9%) – *See developing countries section*

Table 1: Approximate prevalence of antidepressant use in selected countries. Higher-income countries in North America and Europe generally show between 1 in 8 to 1 in 10 people on antidepressants, whereas a populous lower-income country like India has fewer than 1 in 100 people on these medications [12] [8]. Iceland is an outlier with over 16% of its people using antidepressants, reflecting both cultural acceptance of treatment and possibly higher diagnosed depression rates. Germany's rate (~7–8%) is slightly lower than the Anglophone countries, but still much higher than developing nations.

Antidepressant Use in Developing Countries (e.g. India, Nigeria)

Developing and underdeveloped countries generally have **much lower rates of legal antidepressant usage** due to a combination of factors: limited access to mental health care, lower capacity of healthcare systems, cost barriers, and cultural stigma. While depression is prevalent globally, the *treatment gap* (the proportion of those who need care but do not receive it) is enormous in low-resource settings. The World Health Organization (WHO) reports that **76–90% of people with serious mental**

disorders in low- and middle-income countries (LMICs) go untreated, compared to about 35–50% untreated in high-income countries [13]. This means the majority of individuals with depression in poorer countries are not getting medical help, and thus are not obtaining legal antidepressant prescriptions.

Antidepressant Usage and Access in Countries like India

India provides a stark example. According to recent estimates, **only 9 out of every 1,000 Indians (0.9%) are using antidepressant medications** [12]. This usage rate is **an order of magnitude lower** than in Western nations (as shown in Table 1, the U.K. and U.S. are around 108–110 per 1,000, i.e. ~11%) [8]. The low figure for India is not because depression is rare – in fact, depression affects an estimated 5% or more of India's population at some point [14] – but rather because **access to psychiatric diagnosis and drug treatment is limited for much of the population**. Only wealthier, urban, and educated Indians are likely to receive prescriptions for conditions like depression. Mental healthcare infrastructure in India is underdeveloped relative to the need: there are relatively few psychiatrists per capita and mental health spending is very low (well under 1% of the health budget) [15].

Barriers to access in India and similar countries include: **cost of treatment**, since many people lack health insurance and must pay out-of-pocket for psychiatric consultations and imported medications; **geographic disparities**, with rural areas having virtually no mental health services (most psychiatrists practice in cities); and **social stigma**, which deters people from seeking help. Even when antidepressants are available, the public health system may not proactively address depression. As one analysis noted, depression is common in India but *"the public health system hardly ever addresses it."* [14] Consequently, **antidepressant sales in India have historically been low**, though they are rising recently. Notably, after the COVID-19 pandemic, India saw a **64% surge in antidepressant and mood-elevator sales** from 2020 to 2024 [16] [17]. This jump (from ₹1,540 crore market size in 2020 to ₹2,536 crore in 2024) suggests growing awareness and acceptance of treatment, driven by factors like telemedicine making psychiatric consults more accessible and a reduction in stigma [16]. Still, even with that rapid growth, the per-capita use remains very low compared to developed nations.

Within India, **socioeconomic disparities are evident**. The small segment of the population that does use antidepressants tends to be those with higher income or education, who have access to private healthcare or urban hospitals. Those in the upper-middle class of India (e.g. professionals in metropolitan cities) are far more likely to be diagnosed and treated for depression than poor, rural citizens. Lower-income individuals face both a lack of services and an affordability issue. For example, seeing a psychiatrist privately and buying a month's supply of branded antidepressants may be prohibitively expensive for a laborer earning minimal wages. Government hospitals do provide some free medications, but mental health services are scarce and overburdened. **In summary, the vast majority of Indians with depression remain untreated or rely on non-medical forms of coping, meaning legal antidepressant use is confined to a privileged minority.**

Antidepressant Usage and Access in Countries like Nigeria and Sub-Saharan Africa

Nigeria, as one of Africa's most populous nations, illustrates the challenges in underdeveloped mental health systems. **Reliable statistics on antidepressant usage in Nigeria are hard to find**, partly because usage is so low that it barely registers in national drug consumption data, and partly because health data infrastructure is limited. Nigeria has extremely few mental health professionals (for instance, only about 250 psychiatrists for a country of over 200 million people, which is roughly **0.1 psychiatrist per 100,000 population** – far below WHO recommendations). As a result, **clinical depression often goes undiagnosed and untreated**. Many Nigerians with depression or anxiety never

see a specialist; instead, care often falls to informal sectors (such as clergy, traditional healers, or general practitioners who may not have mental health training) [18].

The outcome is that **the use of legal antidepressant medications in Nigeria is minimal**. Instead of formal treatment, people frequently turn to other means. In Nigerian discourse, there is a grim joke that *"alcohol is the top-tier antidepressant for the average Nigerian"* [19] – meaning that many cope with their distress by drinking, given that psychiatric care is inaccessible. Studies in sub-Saharan Africa have found high prevalence of depressive symptoms but extremely low usage of antidepressants, reflecting a nearly 90% treatment gap [13]. Barriers to access in Nigeria and similar countries include: **lack of government investment in mental health** (often less than 1% of health budgets [15]), **shortage of medications** (antidepressants might not be stocked in rural clinics or are only available at central pharmacies in cities), **cost** (no insurance coverage for most, and medications are expensive relative to incomes), and **stigma and lack of awareness** (mental illness is highly stigmatized, deterring people from seeking care or adhering to medication).

It's worth noting that in some middle-income countries, the situation is gradually improving. For instance, **Brazil, South Africa, and China** have seen growth in mental health services and medication use, though still lower than in the West. But in the poorest nations, **antidepressant use remains a rarity**. The WHO World Mental Health Surveys found that on average only **3.1% of respondents in low- and middle-income countries had used any antidepressant in the past year**, compared to higher percentages in high-income countries [20]. In many African and South Asian countries, the percentage would be even lower than that average. Essentially, in underdeveloped regions, **depression is largely untreated with modern medicine** – it is either silently endured, addressed via spiritual/traditional approaches, or managed through self-medication with substances when available.

Barriers to Access for Lower Socioeconomic Classes

Across developing countries (and even among lower classes in wealthy countries), several common **barriers to accessing legal depression treatment** emerge:

- **Financial Barriers:** The cost of psychiatric consultations and prescription drugs can be prohibitive. In countries without universal health coverage, antidepressants might not be affordable for low-income individuals. Even in countries with public healthcare, indirect costs (travel, time off work, etc.) hinder the poor from obtaining care.

- **Healthcare Infrastructure and Availability:** Many low-income or rural areas simply lack mental health professionals (psychiatrists, psychologists) and clinics. For example, rural districts may have no mental health clinic at all. Lower socioeconomic groups often live in areas underserved by healthcare resources, leading to a lack of diagnosis and prescription.

- **Education and Awareness:** Lower socioeconomic status is often associated with lower education levels, which can mean less awareness that depression is a treatable medical condition. Some may not recognize their symptoms as depression, or they may resort first to spiritual healers. Without awareness, people don't seek out the antidepressants that might help them.

- **Stigma:** In many cultures, there is significant stigma attached to mental illness and to taking psychiatric medication. This stigma can be stronger in traditional or close-knit low-income communities. Fear of being labeled "crazy" or weak may prevent individuals from admitting they need help or sticking with treatment. Studies have noted that stigma is a major barrier in LMICs,

causing people to hide their symptoms or avoid professional care [21] [22]. This disproportionately affects vulnerable groups – the poor, minorities, etc., who may already face discrimination.

- **Trust in Medical Systems:** Lower-income individuals might mistrust formal healthcare, especially if the system has historically underserved or mistreated them. This can lead to lower uptake of services even when available.

- **Supply Issues:** In some underdeveloped health systems, essential medicines (including antidepressants) may not be consistently available in public facilities. Stock-outs and supply chain problems mean that even if a doctor wants to prescribe an antidepressant, the patient may not obtain it regularly. This unreliability can discourage continued use.

These barriers help explain why, for lower socioeconomic classes especially in underdeveloped countries, **legal antidepressant usage is far below the level of need**. The result is a large population of people with depression who are not receiving medications that could improve their condition. Many of these individuals turn to alternative coping mechanisms, which in some cases includes the use of illegal or non-prescribed substances.

Illegal Drug Use as a Substitute for Treatment in Lower Socioeconomic Groups

One concerning pattern observed is that **individuals who cannot access formal mental health treatment often resort to "self-medicating" with alcohol or illicit drugs**. This phenomenon is especially pronounced in lower socioeconomic groups dealing with depression or anxiety. When therapy and legal medications are out of reach, the readily available relief often comes in the form of substances that temporarily numb emotional pain.

Research supports the link between unmet mental health needs and substance use. For example, a U.S. national survey analysis found that people who had **unmet need for mental health care were significantly more likely to use illicit drugs and heavy alcohol**, compared to those receiving care [23]. Specifically, in that study, rates of non-marijuana illicit drug use were higher among those who didn't get mental health treatment (4.4% vs 3.2%), and **heavy alcohol use was notably higher for individuals with no mental health care (4.4%) than for those who did get care (2.7%)** [23]. These differences, though seemingly small in absolute percentage, represent millions of people and clearly align with the **self-medication hypothesis**: lacking proper treatment, people attempt to medicate their mood with readily available substances.

Socioeconomic factors amplify this issue. **Poverty and substance abuse are intertwined** in a vicious cycle. Economic stress – such as job loss, debt, and insecurity – can trigger or worsen depression, but the poor often lack access to psychiatrists or medications. In turn, those under economic strain may use alcohol or drugs as a coping mechanism [24] [25]. Studies show that **substance use disorders are more prevalent in low-income populations than higher-income ones** [25]. For instance, one analysis noted that a lower socioeconomic status substantially increases the risk of alcohol-related problems (one statistic: low SES was associated with a 66% higher rate of alcohol-related death in men, and 78% higher in women) [26]. While that speaks to health outcomes, it underscores that **the burden of substance misuse falls heavily on the disadvantaged**, who often drink or use drugs to escape their hardships. Furthermore, untreated mental health issues (like depression/PTSD in impoverished communities) contribute to substance abuse as individuals seek any form of relief [27].

In practical terms, **illegal or non-prescribed drugs fill the gap left by inaccessible antidepressants**. Some common patterns include:

- **Alcohol as a Depressant of Choice:** Alcohol is legal, inexpensive (especially home-brew or informal alcohol), and culturally accepted in many societies. It's often the first line of self-medication for depressive symptoms among those who cannot get antidepressants. Unfortunately, while a drink might temporarily dull sadness, alcohol is a depressant that ultimately worsens mood and leads to dependence. Nonetheless, in settings from Nigerian cities to American inner cities, **chronically stressed individuals frequently turn to alcohol nightly to soothe their mental pain**, essentially using it as an over-the-counter "antidepressant" (with deleterious effects) [19].

- **Cannabis and Other Illicit Drugs:** In some communities, marijuana is used to alleviate anxiety or lift mood. While illegal in many jurisdictions (or used without a prescription where medical marijuana is legal), **cannabis can be easier to obtain than formal therapy**. Similarly, in certain regions, people may use opioids, amphetamines, or inhalants to self-medicate. For example, in impoverished areas with high unemployment, some individuals may misuse prescription painkillers or heroin to escape depression. These drugs provide a short-term euphoria or numbness that people chase when they have little hope of receiving proper care. The danger is that this leads to addiction and compounds their problems.

- **Non-Prescribed Use of Psychiatric Medications:** Another phenomenon is that even when people use actual antidepressants or tranquilizers, they may do so illegally – borrowing medications from friends/family or buying smuggled pills. In some developing countries where regulation is lax, certain antidepressants or benzodiazepines can be bought over-the-counter or on the black market. The **unregulated use of these drugs by lower-income individuals without doctor supervision** is another form of coping mechanism, but it can be unsafe (wrong dosage, improper drug choice, risk of side effects without monitoring).

It's important to note that **upper-middle-class individuals are not immune to substance abuse either**, but the patterns often differ. Professionals with depression might drink or misuse drugs as well, but they are somewhat more likely to seek formal treatment first (given their resources). Lower socioeconomic groups, lacking that option, may go directly to substances. There is also an element of environment and social norm – in some deprived communities, illicit drug use rates are high and thus using substances becomes a normalized way to deal with any kind of distress.

The reliance on illegal drugs as a substitute for legal treatment is essentially a public health failure. It indicates that the healthcare system is not catching a significant portion of those in need. **When over three-quarters of depressed individuals in LMICs receive no treatment [13], it is unsurprising that many will attempt to treat themselves in other ways.** The result is often dual epidemics of untreated mental illness and addiction. For instance, researchers have observed that **low-income patients with co-occurring depression and substance abuse often see their depression go inadequately treated, which in turn makes recovery from addiction harder** [28].

In summary, **illegal drug use (or misuse of legal substances) tends to be more prevalent in lower socioeconomic groups as a maladaptive substitute for proper mental health care**. The absence of accessible, affordable antidepressants and therapy pushes people toward alcohol, cannabis, opioids, and other substances to self-medicate their emotional pain. This coping strategy is common but ultimately harmful, often exacerbating the very issues it is used to alleviate [27]. It highlights the need for better mental health outreach and services in underprivileged communities globally – addressing the root causes of both depression and drug abuse.

Conclusion

Depression-related drug usage exhibits a stark contrast across socioeconomic classes and between developed and underdeveloped countries. In high-income countries like the U.S., U.K., and Germany, **antidepressants are widely used** – roughly 1 in 10 adults or more are on these medications [8]. Upper-middle-class professionals (professors, lawyers, etc.) in these countries generally have the means and social support to obtain legal prescriptions, and many do so, as evidenced by significant percentages reporting depression and presumably receiving treatment [4]. Yet even within wealthy countries, **disparities exist**: in the U.S., those with higher education/income are slightly more likely to use antidepressants [3] (reflecting access advantages), whereas in countries with universal healthcare, deprived areas show high prescription rates commensurate with their high levels of need [6].

In contrast, in developing nations such as India, Nigeria, and much of the Global South, **antidepressant usage is a fraction of that in the West** – often well below 1% of the population [12]. The **barriers to access** for lower socioeconomic classes are formidable: insufficient healthcare infrastructure, high costs, stigma, and low awareness all contribute to a massive treatment gap [13]. Lower-income individuals, whether in a rich country's inner city or a low-income country's rural village, frequently do not receive legal mental health treatment when depressed.

One consequence of these inequities is the **substitution effect** – many in lower socioeconomic groups turn to illegal or non-medical substances to cope with depression in the absence of proper care. Data and studies indicate that **unmet mental health needs correlate with higher use of alcohol and illicit drugs** [23]. Essentially, where the **legal path (doctor consultation, prescription antidepressant) is blocked or ineffective, an illegal path (self-medication with drugs or alcohol) often emerges**. Unfortunately, this path can lead to addiction and worsened outcomes.

Addressing these issues requires policy and public health interventions: expanding mental health services to underserved populations, reducing cost barriers (for example, integrating antidepressants into primary care in low-income countries at subsidized prices), and education campaigns to reduce stigma so that individuals in all classes seek help rather than suffer in silence or resort to alcohol/drugs. The data clearly show that **depression is a ubiquitous human problem, but access to safe and legal treatment is not equally distributed**. Bridging that gap would not only reduce the reliance on illicit substance use in vulnerable groups but also improve overall productivity and quality of life across societies.

In conclusion, **upper-middle-class professionals in developed countries benefit from relatively high usage of legal antidepressants, whereas lower socioeconomic groups — especially in underdeveloped nations — face major barriers to such treatments and often end up self-medicating through illicit means**. The dual challenge is to make effective depression treatments accessible to all socio-economic strata and to address the social determinants (like poverty and stress) that contribute to both depression and substance abuse. Only by doing so can we ensure that mental health care truly reaches the *broad population in need*, rather than being a luxury of the affluent or a rarity in poor communities.

Sources:

- Brody, D.J., & Gu, Q. (2020). *Antidepressant Use Among Adults: United States, 2015-2018*. NCHS Data Brief No. 377 [3] [2].
- Republic World. *Antidepressant Users Per 1,000 People: India's Ranking* (2023) [12] [8].
- BBC News. *Stress from poverty 'over-medicalised'* (2019) [6].

- Warth et al. (2020). *Association between over-indebtedness and antidepressant use in Germany*. PLoS ONE 15(7): e0236392 [11].
- New York State Bar Association. *Report on Lawyer Well-Being* (2016 survey data) [4].
- Dörks et al. (2022). *Antidepressant drug use and regional patterns in Germany*. Int Clin Psychopharmacol, 37(5):185-192 [10] [9].
- Mascayano et al. (2015). *Addressing Stigma in Low- and Middle-Income Countries*. Front. Psychiatry 6:38 [13] [21].
- Harris, K.M., & Edlund, M.J. (2005). *Self-medication of mental health problems*. Health Serv Res, 40(1):117-134 [23].
- Virtue Recovery Center. *Effects of Socioeconomic Status on Substance Use* (2023) [24] [25].
- Times of India. *Antidepressant sales surge by 64% in India after Covid* (Dec 2024) [16] [17].

---

[1] [2] [3] Products - Data Briefs - Number 377 - September 2020
https://www.cdc.gov/nchs/products/databriefs/db377.htm

[4] One Lawyer Living and Working with Depression - New York State ...
https://nysba.org/one-lawyer-living-and-working-with-depression/?srsltid=AfmBOoqBeDQcsIciwyd-DmJOUtEt6EHKSQEFfsAF9F-z66kHmLMM_3oJ

[5] The Mental Health Crisis Among Faculty and College Staff | NEA
https://www.nea.org/nea-today/all-news-articles/mental-health-crisis-among-faculty-and-college-staff

[6] [7] Stress from poverty 'over-medicalised'
https://www.bbc.com/news/health-48258907

[8] [12] [14] Antidepressant Users Per 1,000 People Data: View India's Ranking And Elon Musk's Mysterious Reaction | Republic World
https://www.republicworld.com/info/antidepressant-users-per-1000-people-data-view-india-s-ranking-and-elon-musk-s-mysterious-reaction

[9] [10] Antidepressant drug use and regional prescribing patterns in Germany: results from a large population-based study - PubMed
https://pubmed.ncbi.nlm.nih.gov/35143440/

[11] S-EPMC7380887 - Association between over-indebtedness and antidepressant use: A cross-sectional analysis. - OmicsDI
https://www.omicsdi.org/dataset/biostudies-literature/S-EPMC7380887

[13] [15] [21] [22] Frontiers | Addressing Stigma Relating to Mental Illness in Low- and Middle-Income Countries
https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2015.00038/full

[16] [17] Antidepressant sales surge by 64% in India after Covid - The Times of India
https://timesofindia.indiatimes.com/business/india-business/antidepressant-sales-surge-by-64-in-india-after-covid/articleshow/116779871.cms

[18] (PDF) Drug utilization patterns of antidepressants in Federal Neuro ...
https://www.researchgate.net/publication/319252278_Drug_utilization_patterns_of_antidepressants_in_Federal_Neuro-Psychiatric_Hospital_Lagos_Nigeria

[19] For such an insane country, we are nowhere to be found on this list ...
https://www.reddit.com/r/Nigeria/comments/1dc0x3r/for_such_an_insane_country_we_are_nowhere_to_be/

[20] and high-income countries: a World Mental Health Surveys report ...
https://pubmed.ncbi.nlm.nih.gov/37010212/

23 Self-Medication of Mental Health Problems: New Evidence from a National Survey - PMC
https://pmc.ncbi.nlm.nih.gov/articles/PMC1361129/

24 25 27 Effects of Socioeconomic Status on Substance Use Addiction
https://www.virtuerecoverykilleen.com/rehab-blog/the-effects-of-socioeconomic-status-on-substance-use-addiction/

26 Drug & Alcohol Addiction Among Socioeconomic Groups - Adcare.com
https://adcare.com/addiction-demographics/socioeconomic-groups/

28 Does depression and substance abuse co-morbidity affect ...
https://pmc.ncbi.nlm.nih.gov/articles/PMC4268320/