Reducing the global burden of depression: a *Lancet*–World Psychiatric Association Commission

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Depression is the leading cause of mental health-related disease burden globally, affecting an estimated 300 million people worldwide.[1] It represents a barrier to sustainable development in all regions.[2] Depression prevents people from reaching their full potential, impairs human capital, and is associated with premature mortality from suicide and other illnesses.[1]

Over the past decades, understanding of depression has increased. Depression is now thought to have similar core features across many cultures.[3] Research has identified risk factors for depression, such as childhood neglect, trauma, and violence, and acute life events, such as bereavement or financial crisis, that are associated with onset and maintenance of the disorder.[2] Studies of genomic and biological predictors and mechanisms suggest factors likely to be involved in its genesis as well as pathways to the experience of depression.[4] Depression typically has its onset in young adulthood.[5] A relapsing or chronic course is not uncommon, with adverse effects through the life course for individuals with depression and for their children, families, and broader social networks.[2]

Major advances have been accomplished in developing and testing the efficacy of interventions to treat and prevent the syndrome of depression.[6,7] Effective treatments include a range of psychological therapies, antidepressant medications, transcranial magnetic stimulation, modified electroconvulsive therapy, and deep brain stimulation.[6–8] Preventive interventions for high-risk groups with subsyndromal symptoms or risk factors are also effective.[9] These interventions, however, have reached few of those in need in low-income, middle-income, or high-income countries.[10] Increasing contact with mental health services is only part of the treatment challenge. A long-term perspective is essential and the goal of treatment is not only to achieve remission in the short term but also freedom from new episodes in the future.

There has been a failure to address the global burden of depression for many reasons. Prominent among these are ambiguities and confusion about the concept of depression[11] and the stigma associated with the condition.[12] Other reasons include the role of comorbidity, the pervasive dearth of investment in mental health care, the fairly low demand for depression care, the weaknesses in health system capacity to deliver quality care, and the absence of reliable and valid biomarkers. Together, these factors are constraining progress in applying effective treatments and preventive interventions at scale.

Dominant diagnostic classification systems for depression are based on a binary approach. But most research in the field points to the continuous and dimensional nature of depression.[11,13] The risk factors, course, outcome, subtypes, and presentation of depression are substantially heterogeneous within as well as across cultures. Temporally, depression varies across a spectrum from acute distress states to acute full episodes, to relapsing course, and finally to chronic unremitting course. To acknowledge this dimensionality and to facilitate early intervention, as well as crisis and long-term care, a hybrid model that defines a series of clinical stages has been proposed.[11,13] A challenge now is to develop appropriate staged models of care, complemented by interventions that support young people in distress, women and girls with, or at risk of, perinatal depression, and people with so-called treatment-resistant depression.

Recognising the urgent need to implement interventions to reduce the global burden of depression, *The Lancet* has partnered with the World Psychiatric Association to establish a clinical Commission on

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depression. The Commission has assembled leaders from around the world, including experts from disciplines such as economics, epidemiology, neuroscience, primary care, psychiatry, psychology, and public health. Preliminary work has identified several key messages that are likely to frame the Commission's report and guide the development of its recommendations: we know a great deal about the burden of depression; prevention and treatment work if delivered well; we have failed to address the global burden of depression for multiple reasons; we know what needs to happen now to reduce the burden of depression; and there are still substantial knowledge gaps that need to be addressed to discover more effective interventions and ways to apply them at scale.

Closing the treatment gap and expanding prevention for depression will demand efforts at many levels. Investments are needed to improve the delivery of quality, evidence-based approaches to care and prevention. At the same time, individual, family, and community engagement will be essential to enhance demand for and acceptability of interventions. Investment in research is needed for discovery of new forms of intervention and specific subtypes of depression and their markers, along with research and service investments in more targeted interventions and precision psychiatry. Timely intervention can save future generations and enable people to fulfil their potential and contribute to society.

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1 Patel V, Chisholm D, Parikh R, et al. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. *Lancet* 2016; **387:** 1672–85.

2 Lund C, Brooke-Sumner C, Baingana F, et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry* 2018; **5:** 357–69.

3 Haroz EE, Ritchey M, Bass JK, et al. How is depression experienced around the world? A systematic review of qualitative literature. *Soc Sci Med* 2017; **183:** 151–62.

4 Wray NR, Ripke S, Mattheisen M, et al. Genome-wide association analyses identify 44 risk variants and refine the genetic architecture of major depression. *Nat Genet* 2018; **50:** 668–81.

5 Kessler R. The epidemiology of depression across cultures. *Ann Rev Public Health* 2013; **34:** 119–38.

6 Holmes EA, Ghaderi A, Harmer CJ, et al. The *Lancet Psychiatry* Commission on psychological treatments research in tomorrow's science. *Lancet Psychiatry* 2018; **5:** 237–86.

7 Cipriani A, Furukawa TA, Salanti G, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *Lancet* 2018; **391:** 1357–66.

8 McGirr A, Berlim MT. Clinical usefulness of therapeutic neuromodulation for major depression: a systematic meta-review of recent meta-analyses. *Psychiatr Clin North Am* 2018; **41:** 485–503.

9 van Zoonen K, Buntrock C, Ebert DD, et al. Preventing the onset of major depressive disorder: a meta-analytic review of psychological interventions. *Int J Epidemiol* 2014; **43:** 318–29.

10 Thornicroft G, Chatterji S, Evans-Lacko S, et al. Undertreatment of people with major depressive disorder in 21 countries. *Br J Psychiatry* 2017; **210:** 119–24.

11 Patel V. Talking sensibly about depression. *PLoS Med* 2017; **14:** e1002257.

12 Lasalvia A, Zoppei S, Van Bortel T, et al. Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *Lancet* 2013; **381:** 55–62.

13 McGorry P, Nelson B. Why we need a transdiagnostic staging approach to emerging psychopathology, early diagnosis, and treatment. *JAMA Psychiatry* 2016; **73:** 191–92.