6.15 Depression

See Background Paper 6.15 (BP6_15Depression.pdf)

**Background**

Depression is a common mental disorder that is characterized by loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration, insomnia or hypersomnia, and occasionally suicidal thoughts. Depression often occurs as a result of adverse life events, such as: the loss of a significant person, object, relationship or health. However, it can also occur due to no apparent cause. These problems can become chronic or recurrent and lead to substantial impairment in an individual’s ability to take care of their everyday responsibilities.

The ICD-10 classification of mood disorders includes different forms of depression such as: bipolar affective disorder, depressive episode, and recurrent depressive disorder. The American Psychiatric Association’s DSM-IV clinical classification for mood disorders divides them into three groups: major depressive disorders (MDD); bipolar disorders; and depression associated with medical illness or alcohol and substance abuse.

Depression is associated with a combination of genetic, psychological, environmental, and biological factors. Risk factors for depression include pregnancy, childbirth, (peri) menopause, hormonal factors and menstruation, (low tolerance to) stress, impulsive behaviour, alcohol or substance abuse, and family history of depression, alcohol abuse or suicide. Other factors such as poverty, severe or chronic medical conditions, insomnia, being a female, intimate partner violence, (childhood) sexual abuse and tobacco use are also associated with depression.

Depression in young people may be expressed differently from that in adults, with manifest behavioural disorders (including irritability, verbal aggression and misconduct), substance abuse and/or concurrent psychiatric problems, suicidal thoughts, hopelessness, social isolation, overeating and oversleeping, and rage. In the elderly, the physical and behavioural symptoms of depression are usually so intense that they mask the psychological ones, up to the point that they may seem to suffer “depression without sadness”. The coexistence of several chronic conditions complicates the diagnosis. Meanwhile, many different classes of drugs that elderly people receive could potentially induce depression.

In 2010, MDD accounted for 2.5% (63.2 million) of DALYs worldwide and 3.4% (8.4 million) in Europe alone. Europe also accounted for more than 13% of the total DALYs caused by MDD worldwide. Between 1990 and 2010, there was a 37% increase worldwide in the number of years of life lived with disability (YLDs) due to MDD (up
from 46 million YLDs in 1990 to 63 million in 2010). Depression is more common among females (Figure 6.15.1)

The severity of MDD is associated with increased treatment costs, unemployment, and with reduced performance at work. The available literature on the impact of treatment for all forms of depression on worker productivity costs suggests that the gains made in reduced absenteeism and improved productivity at work may offset the treatment costs. Very little research has been done to estimate the economic burden of depression in Europe. In the United States, the total economic burden of depression was estimated to be US$ 83.1 billion in 2000, of which US$ 26.1 billion (31%) were direct medical costs, US$ 5.4 billion (7%) were suicide-related mortality costs and US$ 51.5 billion (62%) were workplace costs.

Figure 6.15.1: DALY rate for Major Depressive Disease per 100 000 by gender and region.

![Graph showing DALY rate by region and gender](source)


Key interventions for treating MDD are antidepressant medicines and different forms of psychotherapy. Less used interventions are electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS).

In the general population, depression is often undiagnosed or misdiagnosed and, even more often goes untreated. Though methods have been developed to help facilitate the diagnosis of depression among patients, it is estimated in New Zealand that 80% of young people who suffer from depressive symptoms that warrant intervention do not receive treatment.
Developments since 2004

During the most recent World Mental Health Day (October 2012), the World Federation for Mental Health called for “public education and awareness campaigns on mental health in all countries” so as to “reduce stigma and discrimination, increase the use of mental health services and bring mental health and physical health care closer to each other.”

There are currently over 50 projects funded by the EC Sixth and Seventh Framework Programmes (FP6 and FP7) specifically doing research on depression (19 under FP6 and 36 under FP7).

Remaining challenges

Many patients are not able to tolerate available antidepressant medications due to side-effects. Studies show that as many as 50% of subjects may discontinue antidepressant treatments within the first six months of therapy, reporting adverse effects as a major reason for discontinuation. Poor adherence to pharmacological and psychosocial treatments for depression, especially in the elderly, is an additional barrier to the effective treatment of patients suffering from depression. Factors linked to this high non-adherence rate amongst the elderly include lack of information and misperceptions about mental illness and its treatment, stigma, lack of family support, cognitive impairment, and poor physician-patient communication or relationship. Long-lasting (depot) preparations have been suggested as an alternative strategy for non-adherent severely depressed patients.

The development of psychiatric drugs is considered high-risk due to the high failure rates of trials and the high costs associated with a research programme. As a result, many pharmaceutical companies have halted R&D into medications to treat MDD and other mental disorders.

Research needs

In Europe the relative burden of depression is higher than in the rest of the world. Research initiatives through European partnerships are important to help reduce the burden of disease and raise awareness of mental disorders.

Raising awareness and reducing stigma and discriminatory attitudes are important steps towards better diagnosis and treatment. The United Kingdom-based National Institute of Health and Care Excellence (NICE) included research recommendations in their 2009 guidelines on depression, and identified multiple research gaps. These included:

- Optimal treatment of initially poor responders
- Place and cost-effectiveness of cognitive behavioral therapy and antidepressants in different population groups
- Optimal treatment of sub-threshold depressive symptoms
Other research gaps include:

- Identifying the best treatment strategy for different populations and age groups
- Effectiveness of the long-term use of antidepressants
- Development and usage of antidepressant depot preparations
- Clinical research on the impact of genetic variations for personalizing therapy
- Development of new, safer and more effective antidepressants that are based on a completely new mechanism of action.

References


