

present strong evidence that the scale of the treatment gap is greater than previously understood.

What do these new data mean? They are a sobering global account of how most people who are mentally ill are not treated, and how many countries have no effective treatment triage to separate individuals who are well from those with moderate or severe disorders. Treatment coverage is poor, and treatment targeting is weak.¹⁰ At the core of Wang and colleagues' study, however, lie several uncomfortable questions. Why do we invest so little in our mental health care?¹¹ To what extent is the underuse of services due to most people with mental illness actively avoiding help?¹² Why have we allowed this global and gross neglect to persist and be denied for so long?¹⁰ Specific actions are needed now to redress this silent scandal.¹³

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I declare that I have no conflict of interest.

- 1 Wang PS, Aguilar-Gaxiola S, Alonso J, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet* 2007; **370**: 841–50.
- 2 Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med* 2005; **352**: 2515–23.
- 3 Wittchen HU, Jacobi F. Size and burden of mental disorders in Europe—a critical review and appraisal of 27 studies. *Eur Neuropsychopharmacol* 2005; **15**: 357–76.
- 4 Alonso J, Codony M, Kovess V, et al. Population level of unmet need for mental healthcare in Europe. *Br J Psychiatry* 2007; **190**: 299–306.
- 5 Ruggeri M, Leese M, Thornicroft G, Bisoffi G, Tansella M. Definition and prevalence of severe and persistent mental illness. *Br J Psychiatry* 2000; **177**: 149–55.
- 6 Goldberg D, Goodyer I. *Genesis of common mental disorders*. London: Brunner-Routledge, 2005.
- 7 Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. *Bull World Health Organ* 2004; **82**: 858–66.
- 8 WHO. *Mental health atlas 2005*. Geneva: World Health Organization, 2005.
- 9 Simon GE, Fleck M, Lucas R, Bushnell DM. Prevalence and predictors of depression treatment in an international primary care study. *Am J Psychiatry* 2004; **161**: 1626–34.
- 10 Saxena S, Thornicroft G, Knapp M, Whiteford H. Scarcity, inequity and inefficiency of resources: three major obstacles to better mental health. *Lancet* 2007; **370**: 878–89.
- 11 WHO. *World health report 2001. Mental health: new understanding, new hope*. Geneva: World Health Organization, 2001.
- 12 Thornicroft G. *Shunned: discrimination against people with mental illness*. Oxford: Oxford University Press, 2006.
- 13 Lancet Global Mental Health Group. Scale up services for mental disorders: a call for action. *Lancet* 2007; published online Sept 4, 2007. DOI:10.1016/S0140-6736(07)61242-2.

Depression is very disabling

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“Depression produces the greatest decrement in health compared with the chronic diseases of angina, arthritis, asthma, and diabetes”, say Saba Moussavi and colleagues in today's *Lancet*.¹ From a study of more than 240 000 people in 60 countries, Moussavi also reports that respondents with angina, arthritis, asthma, or diabetes had an increased risk of depression compared with that expected in the general population. When depression was comorbid with any of these diseases, the health score was worse than with any other pair of these chronic physical diseases; diabetes with depression was the most disabling combination. This study is a head-to-head comparison of mean disability associated with five chronic diseases, as assessed in the community by use of the same method. That depression is the most disabling is a strong finding.

The first Global Burden of Disease report² had a similar conclusion. Non-fatal burden for a disease was estimated from prevalence and expert judgments about average disability level or disability weight. Many people were surprised when depression was ranked as the highest determinant of disability worldwide.² Subsequent burden of disease studies^{3,4} confirmed

the finding in developed countries, such as Australia, and worldwide (table). Surveys of mental health have defined the prevalence of depression in different countries, but estimates of average level of disability, or disability weight, continue to depend on expert opinion. Moussavi and colleagues' data lend support to the finding that depression is associated with high levels of self-reported disability.

What is known about self-reported disability? Moussavi and colleagues developed a new measure for estimation of an individual's health-state or relative disability. For analyses of data for depression, they took care to ensure that their results were not confounded by symptoms of depression. The questions to participants covered multiple health domains to measure disability—an “umbrella term for impairments, activity limitations, or participation restrictions”.⁵ Self-reported disability in depression and other chronic diseases is reliable, and is paralleled by objective measures of performance, such as work attendance and productivity.^{6,7} A plaintive response set in depression could not account for the findings.

Could different diagnostic thresholds account for the findings? The ICD-10 (International Classification

	Proportion of total years lived with disability
Australia, 1999	
Depression	7.9%
Dementias	5.6%
Asthma	4.8%
Osteoarthritis	4.8%
Hearing loss (adult)	4.1%
Diabetes (types 1 and 2)	3.7%
Alcohol-use disorders	3.5%
Chronic obstructive pulmonary disease	3.4%
Stroke	3.3%
Ischaemic heart disease	3.1%
Worldwide, 2000	
Depression	9.4%
Hearing loss (adult)	5.5%
Cataracts	5.2%
Osteoarthritis	3.2%
Vision disorders (adult)	3.1%
Cerebrovascular disease	2.7%
Dementias	2.6%
Perinatal conditions	2.5%
Alcohol-use disorders	2.5%
Chronic obstructive pulmonary disease	2.1%

Table: Ten highest determinants of disability in Australia and worldwide^{3,4}

of Diseases) diagnostic criteria for a depressive episode need four symptoms or more for the diagnosis to be made. Moussavi and colleagues used ICD-10 criteria, and thus people with subthreshold levels of depressive symptoms were not included. Identification of the four physical diseases varied, but questions were calibrated against people who had been treated for the disorder and whose diagnosis had been validated by diagnostic tests. Thus people with mild cases of angina, arthritis, asthma, or diabetes who had not sought help would not have been included. Different standards for diagnosis seem unlikely to account for the findings.

Depression is a chronic disorder that remits and recurs;⁸ the physical disorders assessed in Moussavi and colleagues' study do not. Could a remitting disorder generate such disability? Depression occurs throughout the lifespan (frequency 3.3%, lifetime risk 30% for men and 40% for women).⁹ The prevalence of depression is similar to the chronic physical diseases studied, but the lifetime risk—the number of people who cycle in and out of depression—is five to ten times greater than the lifetime risk of any of the other diseases studied. When depression occurs, it remains sufficiently disabling to

outrank the four chronic physical diseases assessed by Moussavi.

Moussavi and colleagues appeal for clinicians to improve their recognition and treatment of depression—a disorder that is simple to recognise and not difficult to treat. Why does the burden persist? If there was a laboratory test to confirm the diagnosis, doctors might be more assertive about insisting that patients adhere to treatment in this episode and the next. In Australia, less than 30% of patients receive good treatment with antidepressants, cognitive behavioural therapy, and proactive maintenance care.¹⁰ By contrast, 80% of patients with arthritis and 90% of patients with asthma receive an acceptable standard of care.^{11,12} Perhaps differential access to treatment is one reason why disability is less with the physical disorders. Treatment for depression should at least be on a par with that for other chronic diseases.

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- Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet* 2007; **370**: 851–58.
- Murray CJL, Lopez AD, eds. The global burden of disease. Harvard: Harvard University Press, 1996.
- Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Canberra: Australian Institute of Health and Welfare, 1999.
- Mathers C, Lopez A, Stein C, et al. Deaths and disease burden by cause. DCPD working paper 18. Bethesda MD: National Institutes of Health, 2004.
- WHO. International classification of functioning, disability and health. Geneva: World Health Organization, 2001.
- Kessler RC. Some considerations in making resource allocation decisions for the treatment of psychiatric disorders. In: Andrews G, Henderson S, eds. *Unmet need in psychiatry*. Cambridge: Cambridge University Press, 2000.
- Ferrie JE, Kivimaki M, Head J, Shipley MJ, Vahtera J, Marmot MG. A comparison of self reported sickness absence with absences recorded in employers' registers: evidence from the Whitehall II study. *Occup Environ Med* 2005; **62**: 74–79.
- Andrews G. Should depression be managed as a chronic disease? *BMJ* 2001; **322**: 419–21.
- Kruijshaar ME, Barendregt J, Vos T, et al. Lifetime prevalence estimates of major depression: an indirect estimation method and a quantification of recall bias. *Eur J Epidemiol* 2005; **20**: 103–11.
- Sanderson K, Andrews G, Corry J, et al. Reducing the burden of affective disorders: is effective health care affordable? *J Affect Disord* 2003; **77**: 109–25.
- Simonella L, Marks G, Sanderson K, Andrews G. The cost effectiveness of current compared with optimal treatment in adults with asthma. *Intern Med J* 2006; **36**: 244–50.
- Andrews G, Simonella L, Lapsley H, et al. Evidence based medicine is affordable: the cost effectiveness of current compared with optimal treatment in rheumatoid and osteoarthritis. *J Rheumatol* 2006; **33**: 671–80.