

requires training in skilful use. Reconceiving access as an extension of the therapeutic clinical encounter means that patients should receive guidance on how to access their records, on the benefits and potential downsides of reading notes, and on how to constructively raise concerns with clinicians.⁹ Likewise, clinicians will need patient-informed training on how to augment care via clinical note-sharing. A web-based course in how to construct notes that are direct, accurate, and understandable, while using respectful and supportive language, resulted in increased confidence in clinicians to share online access and communicate difficult information.¹⁰ Sharing clinical notes in mental health settings will be more complex than in other clinical specialties; however, for most patients it will be feasible and, if carefully implemented, an empowering tool that could improve care.

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Treatment outcomes for depression: challenges and opportunities



Depressive disorders are common, costly, have a strong effect on quality of life, and are associated with considerable morbidity and mortality. Effective treatments are available: antidepressant medication and talking therapies are included in most guidelines as first-line treatments. These treatments have changed the lives of countless patients worldwide for the better and will continue to do so in the coming decades. However, although treatments are effective for some people, there is great room for improvement. This Comment highlights ten key statistics relating to the limitations of depression treatment outcomes that we feel warrant greater attention.

A considerable proportion of, particularly child and adolescent, patients show improvement without treatment,¹ while a substantial number of patients do not show improvement with treatment (table).⁵ This finding means that patients are taking treatments with the risk of negative side effects, who either might have

recovered without treatment (whether medication or psychotherapies) or might not improve with treatment.⁴ Moreover, all types of recovery without treatment have been generally grouped together as so-called spontaneous improvement. The multitude of ways in which people might recover have been largely understudied, such as exercise, community engagement, and engagement with nature.⁶

Although many new refinements to treatments have been developed in the past decades, their efficacy has not improved over time.¹⁰ Moreover, predicting who is most likely to benefit from which interventions or approaches is not currently possible. People are often exposed to different forms of help before they find one that works for them. The underlying mechanisms of how different interventions work are still not largely understood.³ Some of this is due to lack of clarity about what depression is, its boundaries, and possible heterogeneity.

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	Definition	Source	Reference
54% of adults show improvement after antidepressant medication	50% reduction in symptoms	Meta-analysis of 165 placebo controlled trials	Levkovitz et al (2011) ²
35–40% of adults show improvement after a pill placebo in randomised trials	50% reduction in symptoms	Meta-analysis of 252 placebo controlled trials of 1st and 2nd generation antidepressants	Furukawa et al (2016) ³
62% of adults show improvement after psychotherapy (66% in CBT)	Not meeting MDD criteria in diagnostic interview	Meta-analysis of 35 randomised trials	Cuijpers et al (2014) ⁴
43% of adults show improvement in care-as-usual control groups of psychotherapy trials	Not meeting MDD criteria in diagnostic interview	Meta-analysis of 11 randomised trials	Cuijpers et al (2014) ⁴
33% of children and young people with anxiety or depression show improvement in treatment as usual conditions	Recovery (scoring below a predefined cutoff)	Meta-analysis of 38 trials presenting pre-post differences	Bear et al (2020) ⁵
53% of adults with untreated depression show improvement in 12 months	Study-defined remission rates	Meta-analysis of 19 waitlist control groups and observational studies	Whiteford et al (2013) ¹
60% likelihood that a randomly selected youth receiving psychotherapy would be better off after treatment than a randomly selected youth in a control condition	Range of outcome metrics	Meta-analysis of 655 randomised trials	Eckstain et al (2019) ⁶
Estimated 50% of people who have depression only have it once in their lives	Recovery	Narrative review	Monroe et al (2012) ⁷
25–40% of patients who recover after treatment will have another depressive episode within 2 years, 60% after 5 years, and 85% after 15 years	Recurrence defined as new episodes of MDD	Narrative review	Richards (2011) ⁸
Less than 10% of all interventions not involving a professional that have been suggested to address depression or anxiety in young people have been scientifically researched	Interventions	Scoping and systematic review	Wolpert et al (2019) ⁹

CBT=cognitive behavioural therapy. MDD=major depressive disorder. *Percentages come from different studies and samples, and direct comparisons between any given points might not be warranted.

Table: Ten key statistics about the treatment of depression*

Our lack of knowledge cannot be put down to a scarcity of research in existing treatments. In the past decades, more than 500 randomised trials have examined the effects of antidepressant medications, and more than 600 trials have examined the effects of psychotherapies for depression (although comparatively few are conducted for early-onset depression). However, less than 20% of drug trials and less than 30% of therapy trials have low risk of bias, making the outcomes uncertain. Typically, such trials do not have sufficient statistical power to examine for whom a treatment is effective, resulting in no reliable evidence on who benefits most from which treatment. Also, many different outcome measures are used in treatment research, making it impossible to merge the results of trials without interfering noise. Additionally, longer-term effects are not examined in most trials. Despite more than 1000 trials having been done, very basic questions of real-life importance to people with depression and those trying to help them have not been answered. For example, should adolescents with depression be treated differently to young adults? Should individuals having a first-ever

episode be treated differently from patients who had a depressive disorder in the past? What is the best next treatment when an individual does not respond to the first treatment? What sort of approaches or interventions outside current treatments might be helpful for which people and in what contexts?

There is much still to learn in relation to effective approaches to prevent or treat depression. In part to address this problem, the Wellcome Trust has launched its new priority mental health programme strategy which focuses on both depression and anxiety in youth (14–24 year olds). The strategy is to create a more integrated and inclusive field of mental health science that can capitalise more effectively on existing siloed knowledge and agree on new ways forward, including shared metrics with a greater focus on what might be the core components of effective interventions, defined to include the widest possible range of approaches. The hope is that over the next 10 years health-care professionals, funders, and researchers have the potential to find and promote the next generation of approaches and treatments for prevention, inter-

vention, relapse-prevention, and ongoing management for depression.

MW leads the Mental Health Priority Area at the Wellcome Trust. The views expressed in this Comment do not necessarily represent the views of the National Institutes of Health, the Department of Health and Human Services, or the United States Government. All other authors declare no competing interests.

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Leadership and management training for African psychiatrists in the era of task-sharing



Psychiatrists in many regions of Africa might not be receiving appropriate training for their context. Given the large burden of mental illness in Africa and the shortage of specialists, psychiatrists in this region often have to train and supervise non-specialist mental health workers, and they frequently take on administrative and advocacy roles, for which many receive minimal training. To respond to the demands of these changing roles, specialist psychiatric education needs to be revised to include leadership and advocacy training.

Psychiatry education in most of Africa occurs primarily in tertiary-level units, and it places a greater emphasis on clinical expertise than exposure to primary care and community-based work. However, owing to the shortage of specialists, many African countries have introduced task-sharing programmes to increase patient access to basic mental health services outside of specialist institutions.¹ Task-sharing models often involve a stepped-care approach, in which non-specialist workers, such as community health workers, non-specialist nurses, and general practitioners, manage patients with mental health disorders and refer complex cases to higher levels

of care, all with training and supervision from specialists.¹ As a consequence of this shift, early career psychiatrists with little management experience might have to enter into challenging leadership and supervision roles.²

Additionally, given the stigma and poor public understanding of mental health problems, the role of mental health workers must also include explaining mental illness to the community and advocating for the rights of patients. Psychiatrists often find themselves stepping into advocacy roles if they work in policy making or in health-care systems, or if they are called on to communicate with the media and the general public.

There have been calls for leadership training for psychiatry trainees worldwide.^{2–4} Accreditation bodies, such as the Accreditation Council for Graduate Medical Education in the USA⁵ and the Royal College of Psychiatrists in the UK⁶ have emphasised leadership and management training as key requirements for psychiatry graduates. In addition, there is growing evidence that leadership training is important for strengthening global health-care systems,⁷ for which leadership skills might be even more crucial in the context of resource constraints



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