NEURO-
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Le coût socio-économique de la dépression résistante et nouvelles stratégies thérapeutiques.

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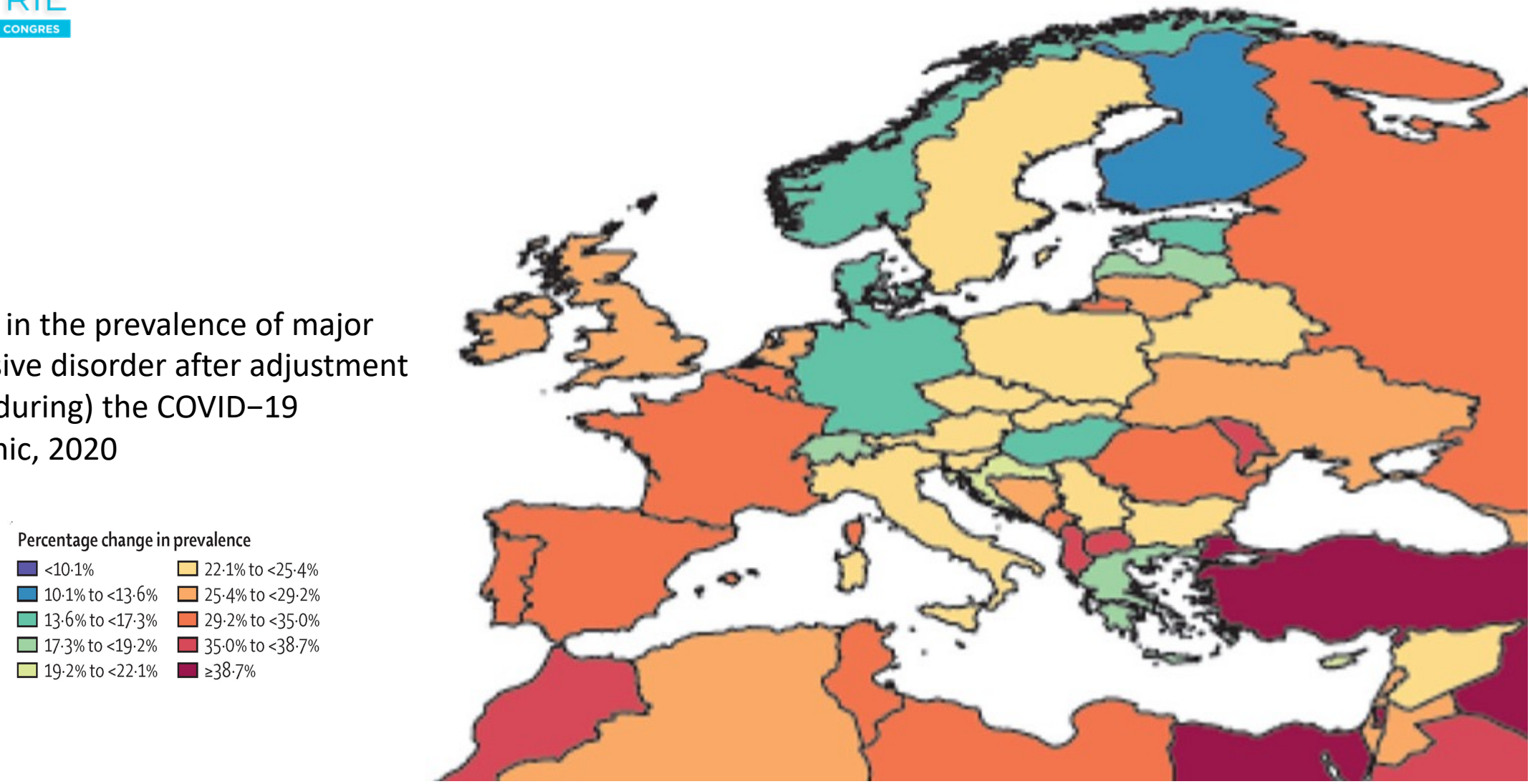
Change in the prevalence of major depressive disorder after adjustment for (ie, during) the COVID−19 pandemic, 2020



Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic . Damian F Santomauro et al. The Lancet. Volume 398 Issue 10312 Pages 1700-1712 (November 2021) DOI: 10.1016/S0140-6736(21)02143-7

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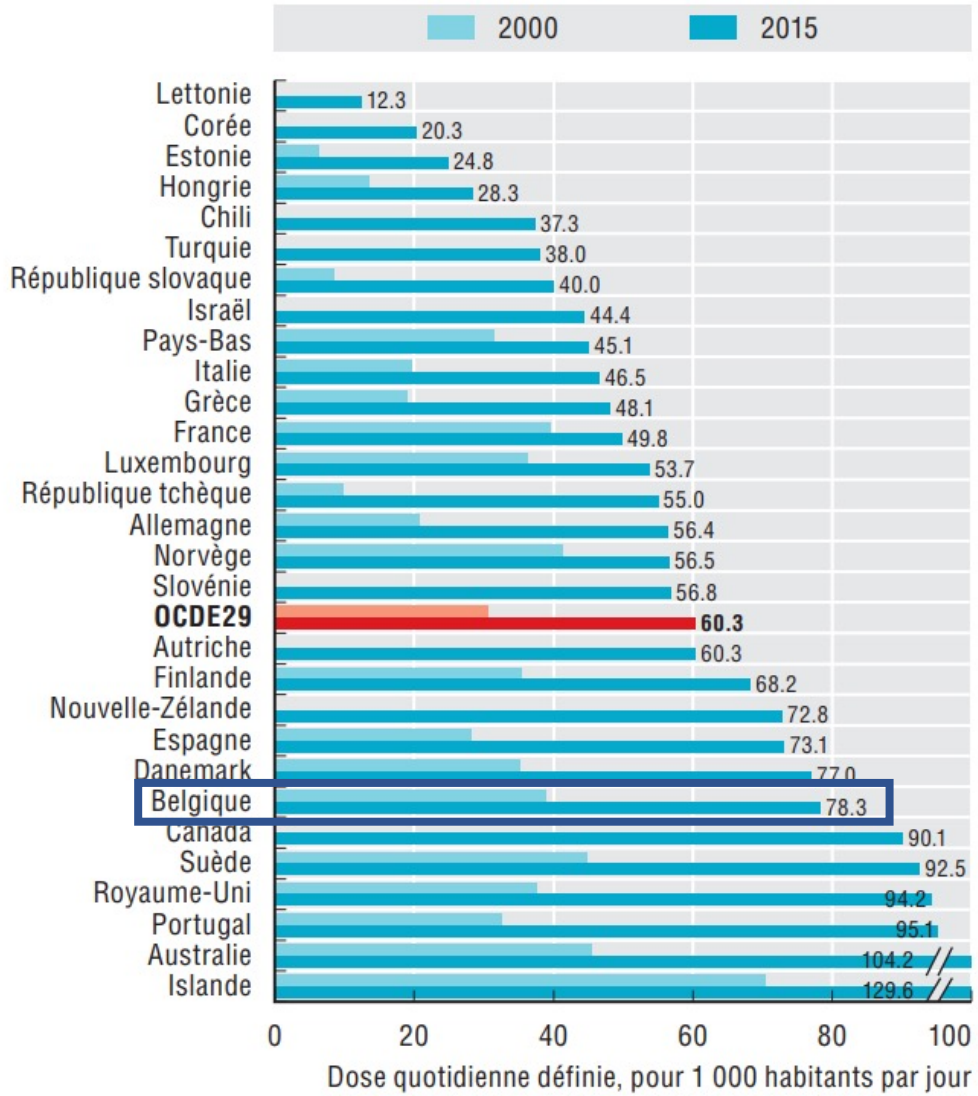
Graphique 10.9. **Consommation d'antidépresseurs, 2000 et 2015 (ou année la plus proche)**



Source : Statistiques de l'OCDE sur la santé 2017.

StatLink http://dx.doi.org/10.1787/888933610024

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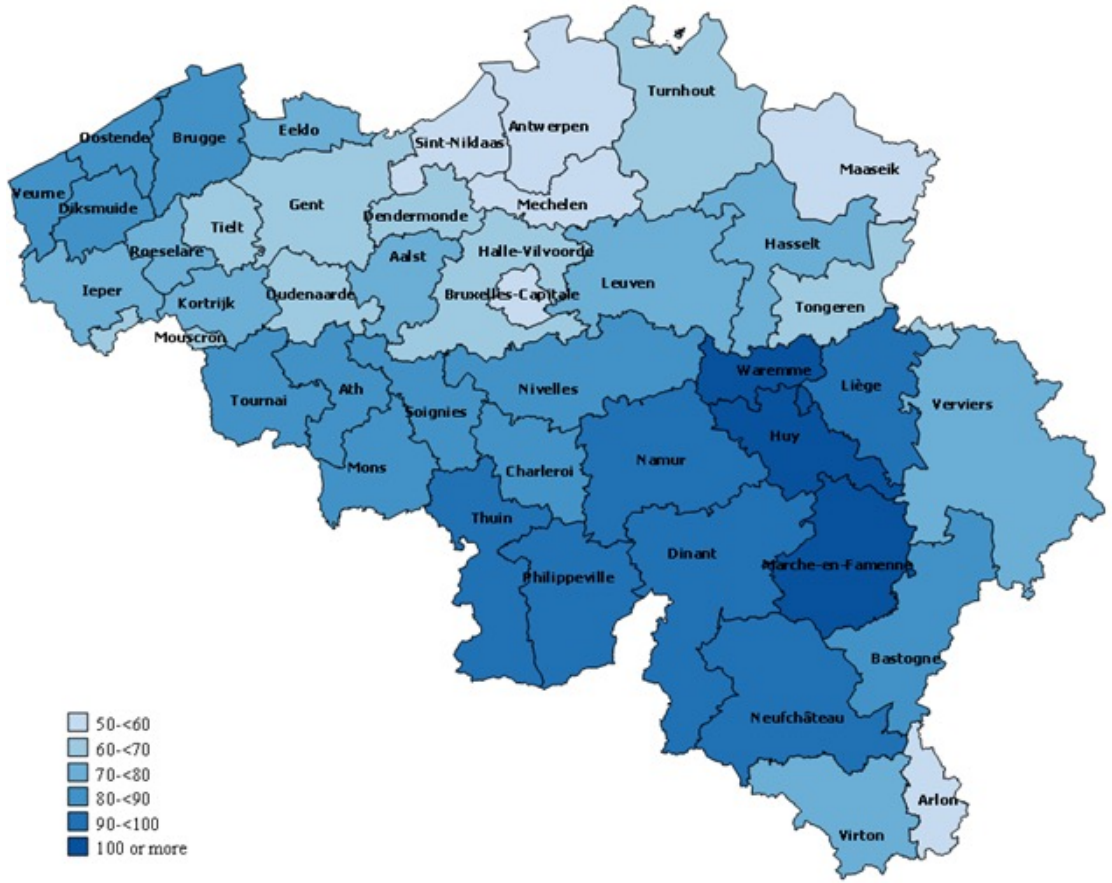
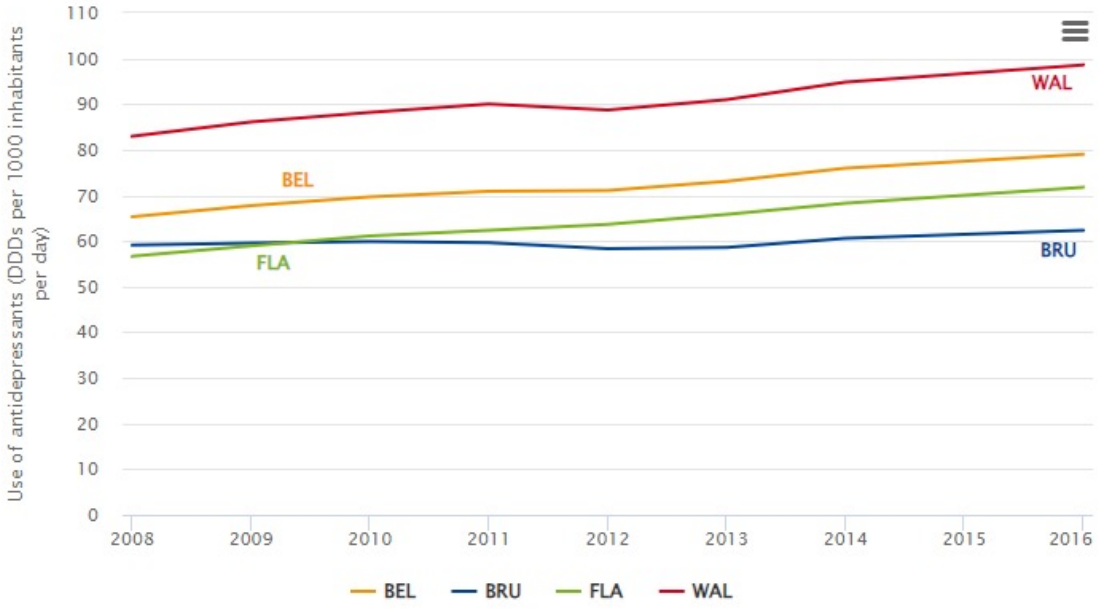
Consommations d'antidépresseurs en Belgique



National daily consumption per 1000 inhabitants = 71.4 DDD

Figure 13 - Defined Daily Doses (DDDs) of antidepressants per 1000 inhabitants per day, by patient region (2008-2016)

Data source: Pharmanet (INAMI-RIZIV)



https://www.healthybelgium.be/en/health-system-performance-assessment/specific-domains/mental-health

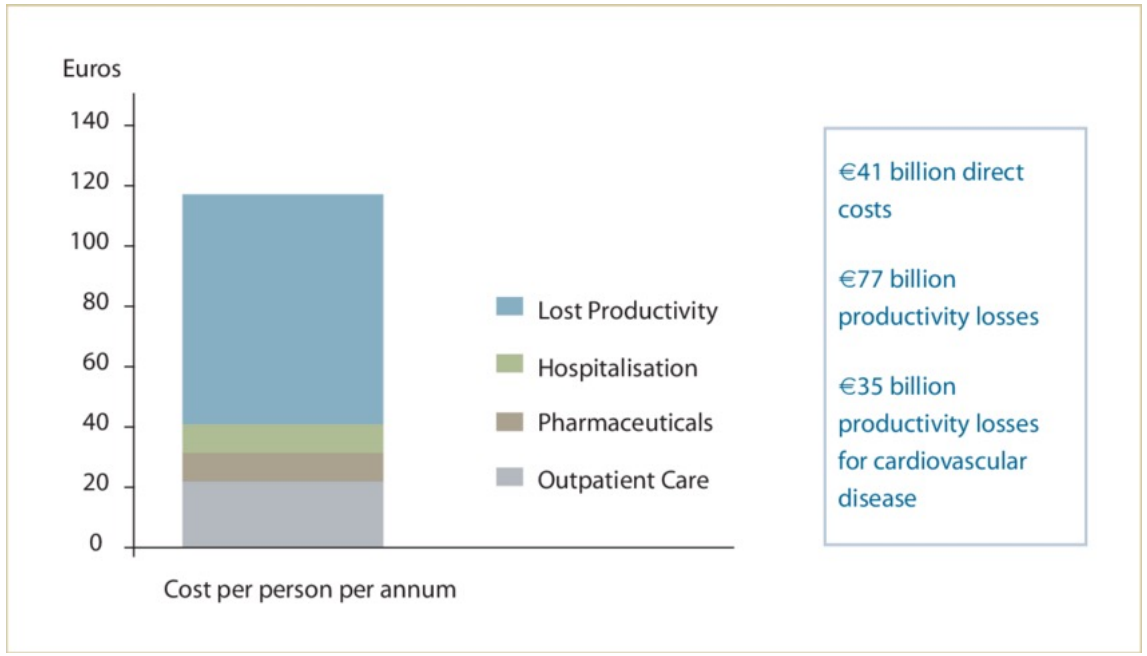
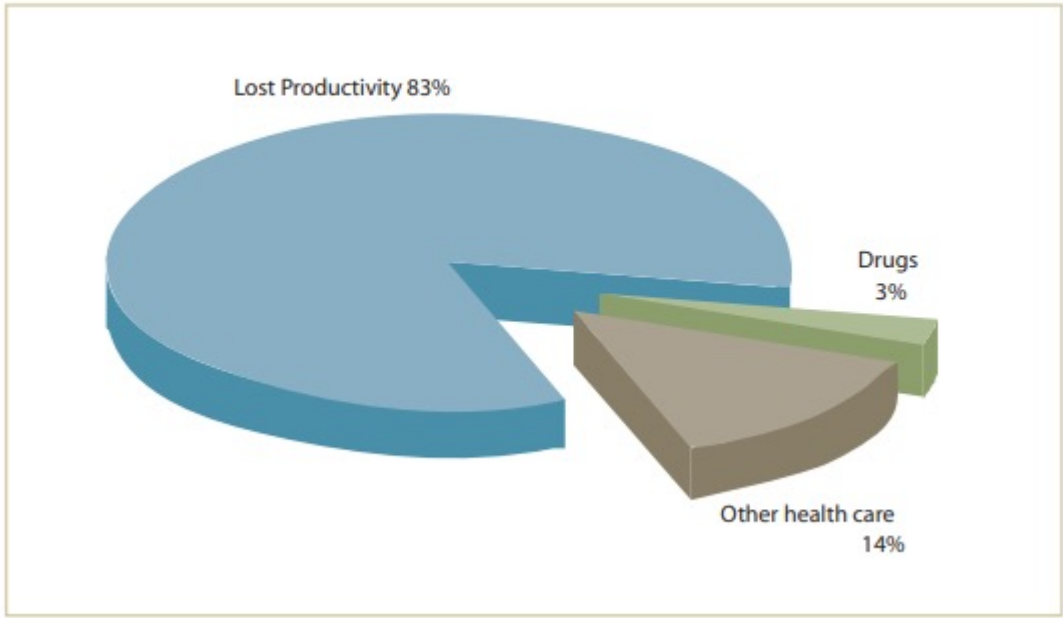
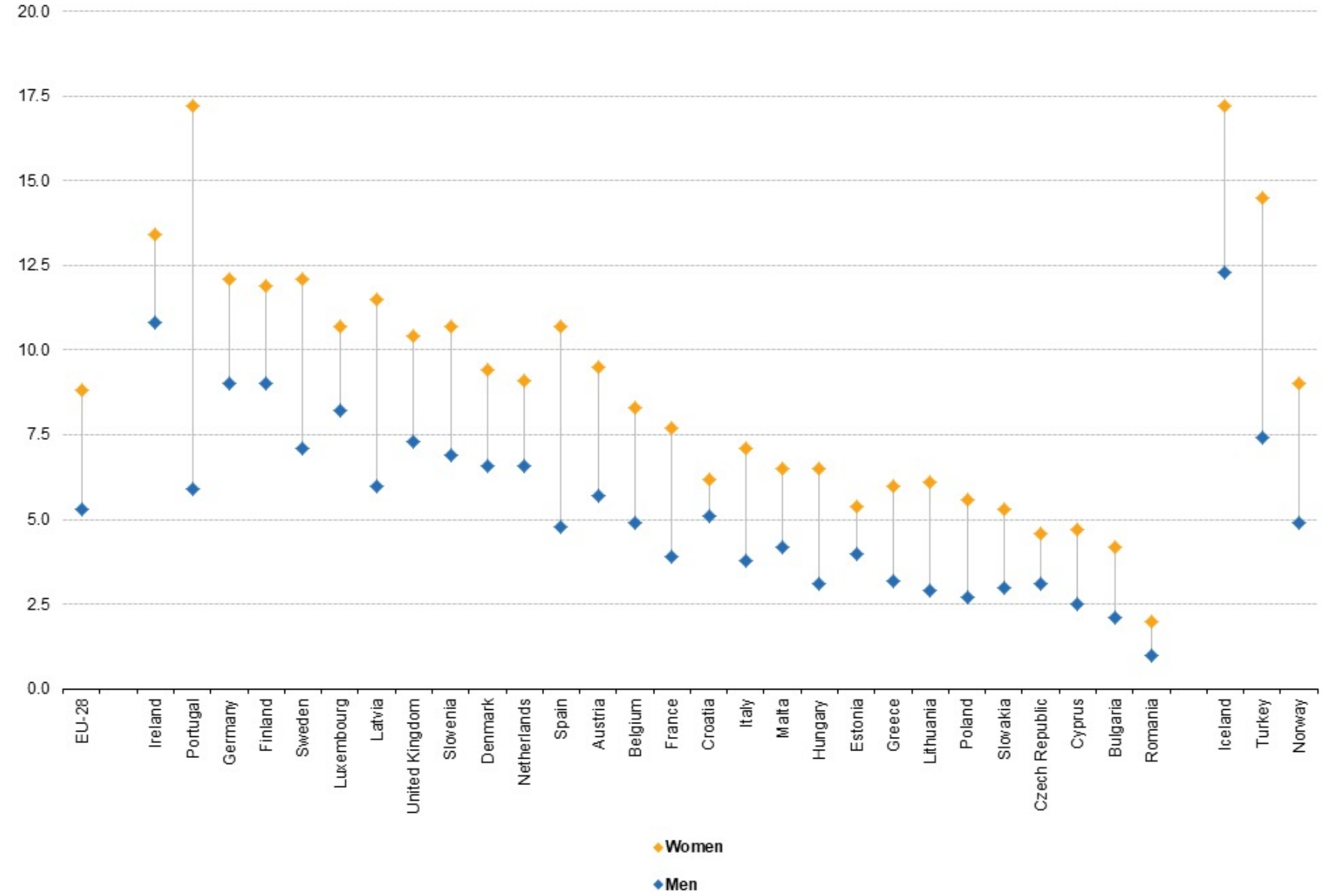


Figure 4: Cost of depression in Sweden





Note: ranked on the share of the total population reporting that they had chronic depression.
Source: Eurostat (online data code: hlth_ehis_cd1e)

BJPsych | The British Journal of Psychiatry (2017)
210, 119–124. doi: 10.1192/bjp.bp.116.188078

Undertreatment of people with major depressive disorder in 21 countries*

Graham Thornicroft, Somnath Chatterji, Sara Evans-Lacko, Michael Gruber, Nancy Sampson, Sergio Aguilar-Gaxiola, Ali Al-Hamzawi, Jordi Alonso, Laura Andrade, Guilherme Borges, Ronny Bruffaerts, Brendan Bunting, Jose Miguel Caldas de Almeida, Silvia Florescu, Giovanni de Girolamo, Oye Gureje, Josep Maria Haro, Yanling He, Hristo Hinkov, Elie Karam, Norito Kawakami, Sing Lee, Fernando Navarro-Mateu, Marina Piazza, Jose Posada-Villa, Yolanda Torres de Galvis and Ronald C. Kessler

Background
Major depressive disorder (MDD) is a leading cause of disability worldwide.

Aims
To examine the: (a) 12-month prevalence of DSM-IV MDD; (b) proportion aware that they have a problem needing treatment and who want care; (c) proportion of the latter receiving treatment; and (d) proportion of such treatment meeting minimal standards.

Method
Representative community household surveys from 21 countries as part of the World Health Organization World Mental Health Surveys.

Results
Of 51 547 respondents, 4.6% met 12-month criteria for DSM-IV MDD and of these 56.7% reported needing treatment. Among those who recognised their need for treatment, most (71.1%) made at least one visit to a service provider. Among those who received treatment, only 41.0% received treatment that met minimal standards. This resulted in only 16.5% of all individuals with 12-month MDD receiving minimally adequate treatment.

Conclusions
Only a minority of participants with MDD received minimally adequate treatment: 1 in 5 people in high-income and 1 in 27 in low-/lower-middle-income countries. Scaling up care for MDD requires fundamental transformations in community education and outreach, supply of treatment and quality of services.

Declaration of interest
In the past 3 years, R.C.K. received support for his epidemiological studies from Sanofi Aventis, was a consultant for Johnson & Johnson Wellness and Prevention and served on an advisory board for the Johnson & Johnson Services Inc. Lake Nona Life Project. R.C.K. is a co-owner of DataStat Inc., a market research firm that carries out healthcare research.

- Data come from the World Health Organization (WHO) WMH surveys, a series of 23 community epidemiological surveys administered in 21 countries.
- 4.6% of respondents met 12-month criteria for DSM-IV/CIDI MDD
- 56.7% respondents with 12-month MDD across surveys reported that they recognised that they needed treatment
- 71.1% made at least one visit to some service provider for their emotional problems (including visits to religious advisors or traditional healers)
- Among patients who received treatment, 41.0% met criteria for minimally adequate treatment (>1 month of a medication, plus >4 visits to any type of medical doctor) or psychotherapy (>8 visits with any professional including religious or spiritual advisor, social worker or counsellor).

Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, et al. . Undertreatment of people with major depressive disorder in 21 countries. Br J Psychiatry. 2017 Feb;210(2):119-124.

Table 1 Twelve-month prevalence of major depressive disorder (MDD), perceived need for treatment, receipt of any treatment and receipt of minimally adequate treatment

Country by income category[a]	% (s.e.) A, % with 12-month diagnosis of MDD	B, % of those in A who had a perceived need for treatment	C, % of those in B with a 'perceived need' who received any 12-month treatment	D, % of those treated in C who received minimally adequate treatment	E, % of those in A who received minimally adequate treatment	*n*[b]
I. High income						
Belgium	5.2 (0.7)	64.7 (7.4)	81.7 (4.8)	55.7 (8.9)	29.5 (6.0)	105
France	5.6 (0.7)	59.3 (4.5)	79.5 (3.8)	48.7 (7.4)	23.0 (4.9)	158
Germany	3.1 (0.3)	60.6 (7.4)	78.5 (3.9)	66.3 (4.0)	31.6 (4.2)	109
Israel	5.9 (0.4)	54.0 (3.0)	72.5 (3.5)	40.3 (4.3)	15.8 (2.2)	280
Italy	2.9 (0.2)	52.3 (5.0)	73.5 (4.6)	43.4 (5.5)	16.7 (3.7)	119
Japan	2.4 (0.3)	50.4 (7.7)	80.1 (1.9)	54.9 (2.8)	22.2 (5.0)	81
Murcia, Spain	6.9 (0.5)	72.6 (4.8)	89.0 (3.5)	29.2 (5.3)	18.8 (3.5)	154
The Netherlands	4.9 (0.7)	61.0 (7.1)	82.0 (5.2)	66.2 (6.9)	33.1 (5.1)	125
Portugal	7.0 (0.5)	65.4 (2.6)	88.3 (1.6)	32.5 (4.1)	18.8 (2.7)	290
Spain	3.8 (0.3)	74.2 (3.4)	79.5 (4.2)	46.0 (5.1)	27.2 (3.2)	231
USA	6.7 (0.3)	74.0 (1.5)	77.4 (2.6)	46.4 (3.1)	26.6 (1.9)	646
Argentina	3.7 (0.5)	66.4 (4.7)	55.3 (4.1)	48.9 (3.3)	17.9 (2.7)	170
Total	5.2 (0.1)	64.9 (1.1)	77.9 (1.2)	44.2 (1.6)	22.4 (1.0)	2468
II. Upper-middle income						
São Paulo, Brazil	10.1 (0.7)	56.1 (3.4)	63.8 (2.7)	41.7 (5.4)	14.9 (2.0)	489
Bulgaria	3.0 (0.3)	50.7 (4.0)	63.3 (3.8)	21.0 (6.3)	6.7 (2.3)	145
Lebanon	4.9 (0.7)	41.0 (3.3)	56.8 (6.9)	30.3 (6.2)	7.0 (1.7)	126
Medellin, Colombia	3.8 (0.4)	51.7 (4.9)	53.5 (7.7)	32.4 (7.3)[c]	9.0 (2.7)	151
Mexico	3.7 (0.3)	58.3 (3.5)	43.4 (4.5)	25.4 (2.9)	6.4 (1.5)	231
Romania	1.5 (0.3)	23.8 (7.3)	90.3 (3.5)	63.0 (14.6)	13.5 (7.5)	40
Total	4.7 (0.2)	52.2 (1.9)	59.6 (1.9)	36.7 (3.5)	11.4 (1.2)	1182
III. Lower-middle income						
Colombia	5.3 (0.4)	49.2 (4.7)	41.3 (6.1)	24.6 (9.4)	5.0 (2.4)	241
Iraq	3.9 (0.4)	17.0 (3.9)	69.7 (2.0)	20.7 (0.7)	2.5 (2.4)	182
Nigeria	1.1 (0.2)	22.3 (3.0)	86.0 (6.3)	0.0 (•)	0.0 (•)	72
Peru	2.7 (0.3)	60.3 (6.1)	50.6 (5.7)	2.8 (2.9)	0.9 (0.9)	99
Beijing/Shanghai, PRC	2.0 (0.4)	39.3 (8.8)	60.3 (12.7)	• (•)	• (•)	87
Total	3.2 (0.2)	34.6 (2.5)	52.6 (3.4)	20.5 (3.4)	3.7 (1.6)	681
IV. Total all countries	4.6 (0.1)	56.7 (1.0)	71.1 (1.0)	41.0 (1.4)	16.5 (0.7)	4331

PCR, People's Republic of China; •, number could not be estimated because of sparse sampling/low responses.
a. See footnotes to online Table DS1 for an explanation of why Colombia appears in two categories.
b. Number meeting criteria for MDD.
c. 20.1 (5.1).

The New York Times

Many People Taking Antidepressants Discover They Cannot Quit

Victoria Toline needed nine months to taper off Zoloft. "I had to drop out of school," she said. "My life's been on hold."
Ruth Fremson/The New York Times

By Benedict Carey and Robert Gebeloff

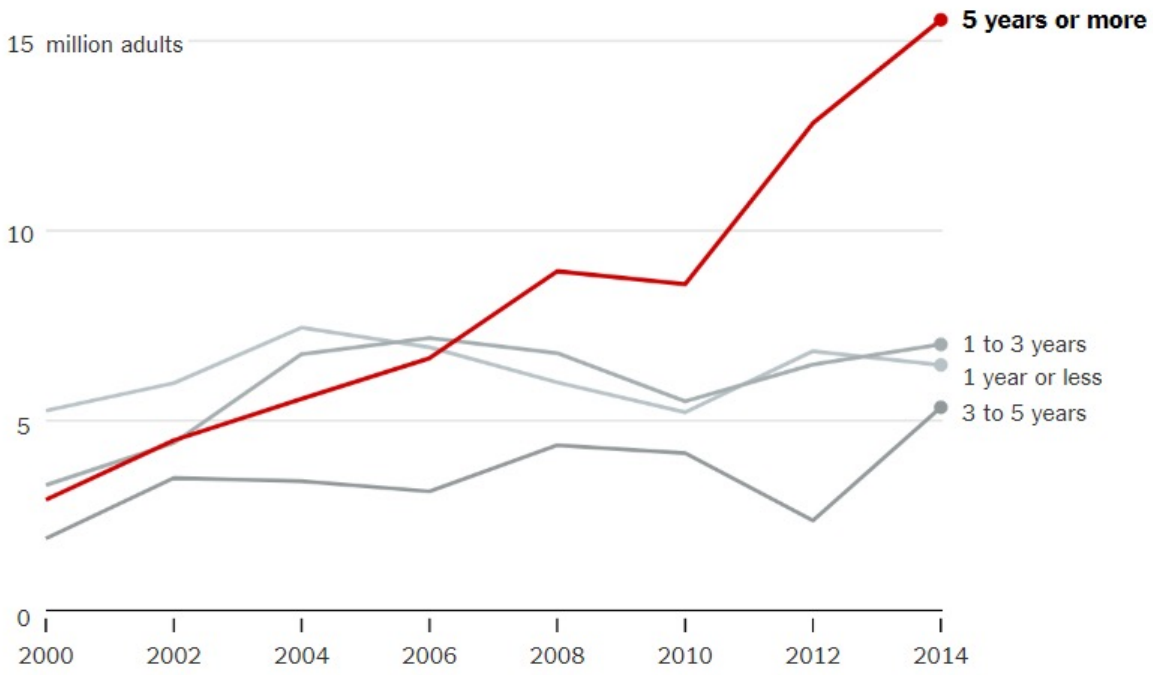
April 7, 2018

1135

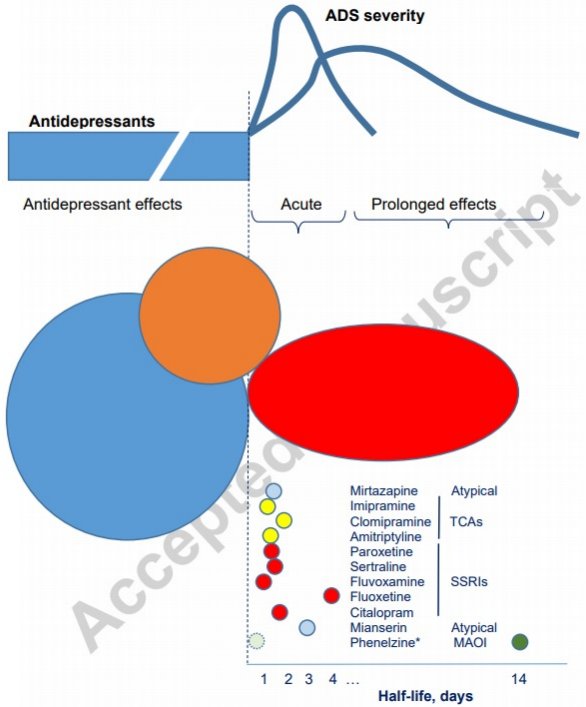
New-York Times, 7 avril 2018

Long-term Antidepressant Use

Nearly 7 percent of American adults have taken prescription antidepressants for at least five years.



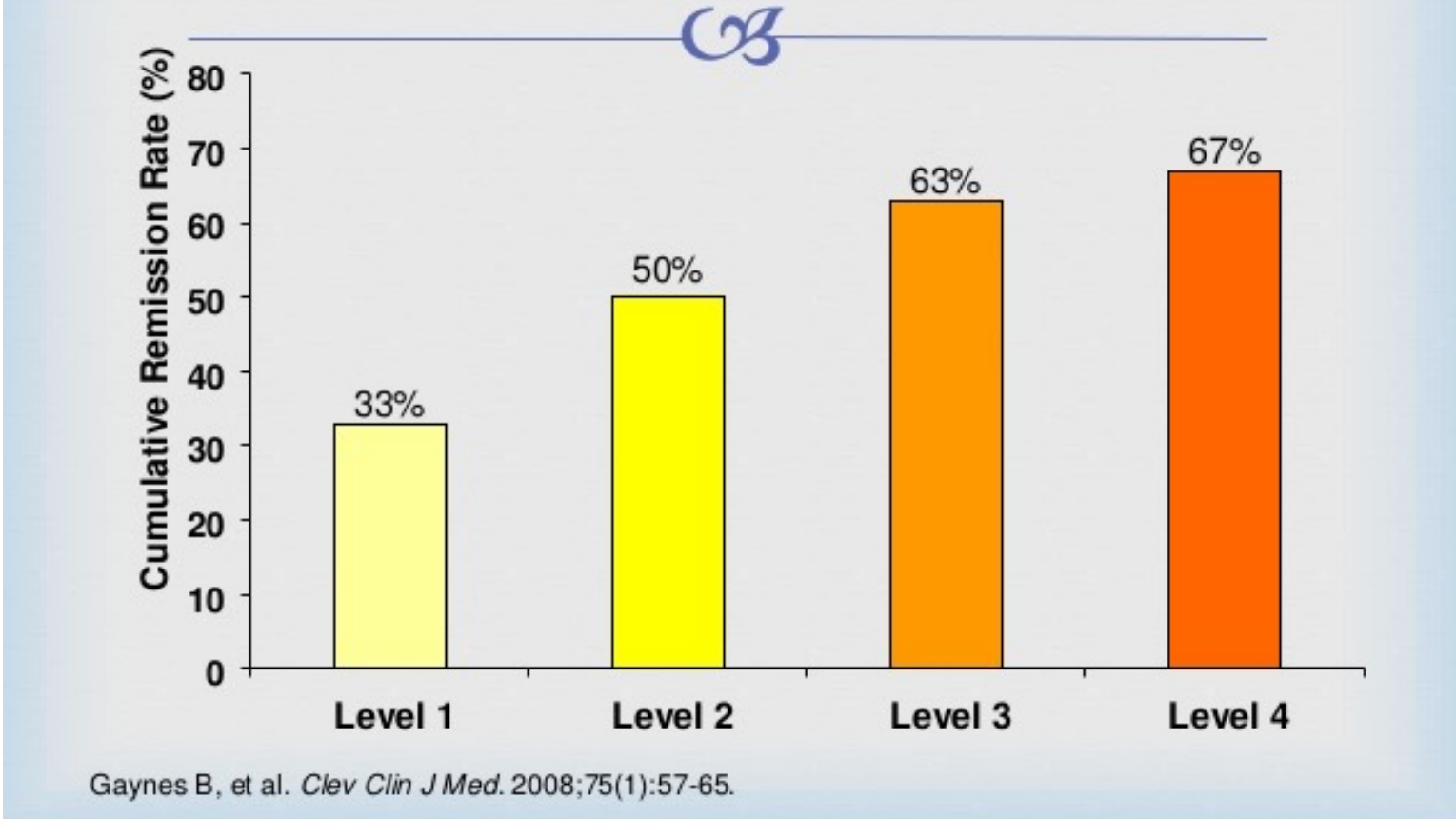
By The New York Times | Source: National Health and Nutrition Examination Survey



Antidepressants	Drug group	Prescription (mln items purchased)	Calls about ADS	Discontinuation index*
Higher ADS risk				
Tranylcypromine	MAOI	0.22	43	194
Moclobemide	MAOI	0.27	19	70
Isocarboxazid	MAOI	0.05	3	66
Phenelzine	MAOI	0.27	14	51
Paroxetine	SSRI	24.32	690	28
Nefazodone	Atypical	0.67	19	28
Fluvoxamine	SSRI	0.33	9	27
Mirtazapine	Atypical	3.49	76	22
Venlafaxine	SNRI	12.18	252	21
Reboxetine	NRI	0.46	8	17
Lower ADS risk				
Nortriptyline	TCA	1.15	13	11
Escitalopram	SSRI	1.75	16	9
Sertraline	SSRI	11.01	84	8
Citalopram	SSRI	19.30	141	7
Imipramine	TCA	2.61	17	7
Clomipramine	TCA	3.58	25	7
Lofepramine	TCA	5.57	27	5
Fluoxetine	SSRI	30.31	133	4
Trazodone	Atypical	3.60	13	4
Dosulepin (dothiepin)	TCA	24.36	76	3
Mianserin	Atypical	0.0004	1	2
Doxepin	TCA	1.18	2	2
Trimipramine	TCA	1.79	4	2
Amitriptyline	TCA	33.53	46	1

Zabegalov KN, Kolesnikova TO, Khatsko SL, Volgin AD, Yakovlev OA,
Et al. Understanding antidepressant discontinuation syndrome
(ADS) through preclinical experimental models. Eur J Pharmacol. 2018 Jun 15;829:129-140.

STAR*D Cumulative Remission Rates



Gaynes B, et al. *Clev Clin J Med.* 2008;75(1):57-65.

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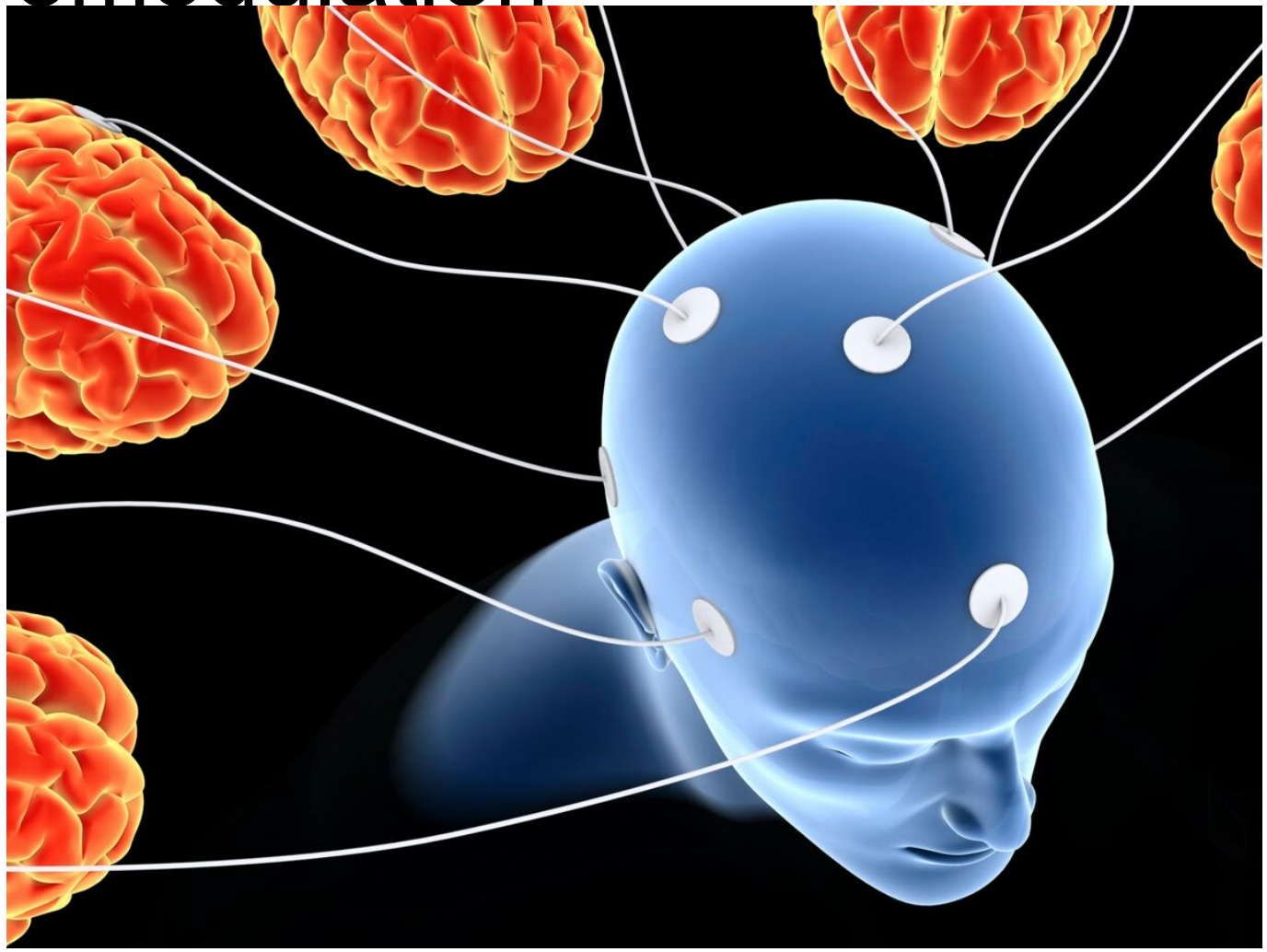
2. Neuromodulation



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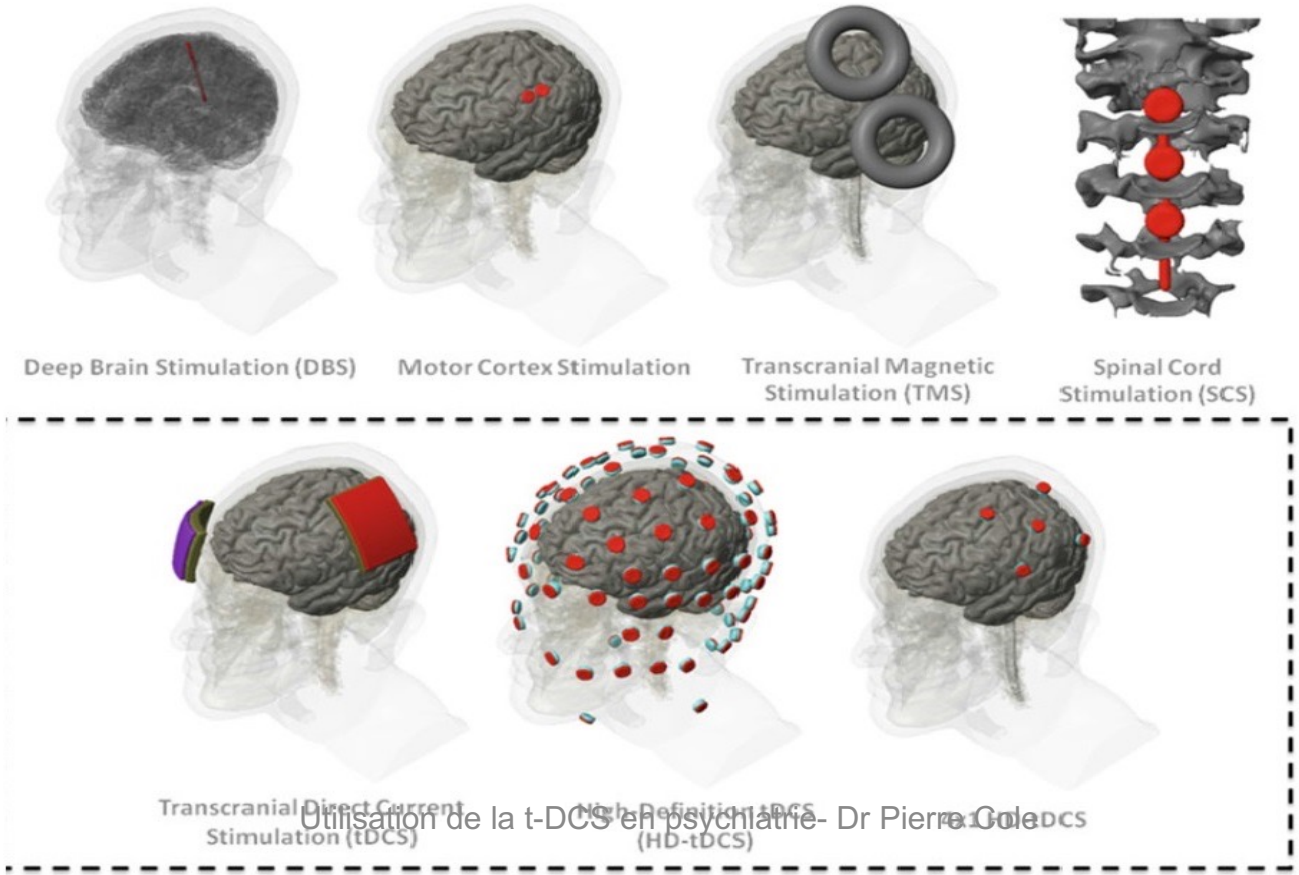
DIFFERENTS TYPE DE TECHNIQUES DE NEUROSTIMULATION

- Deep brain stimulation (DBS)
- Electrochocs (ECT)
- Stimulation magnétique transcranienneTMS et rTMS
- Stimulation électrique transcranienne (tES): tDCS, tACS, tPCS, tRNS



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Transcranial direct current stimulatiion (t-DCS)

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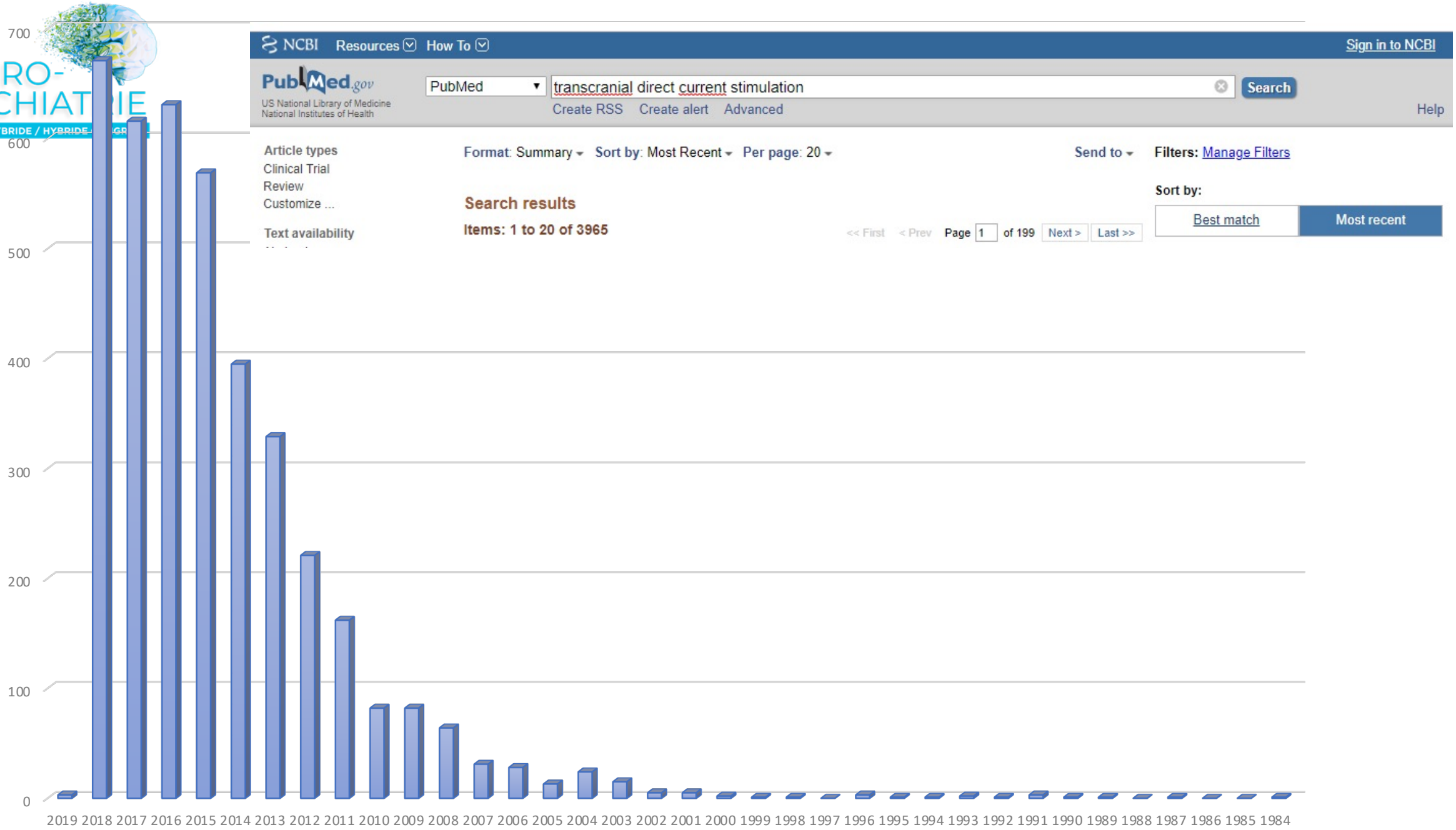


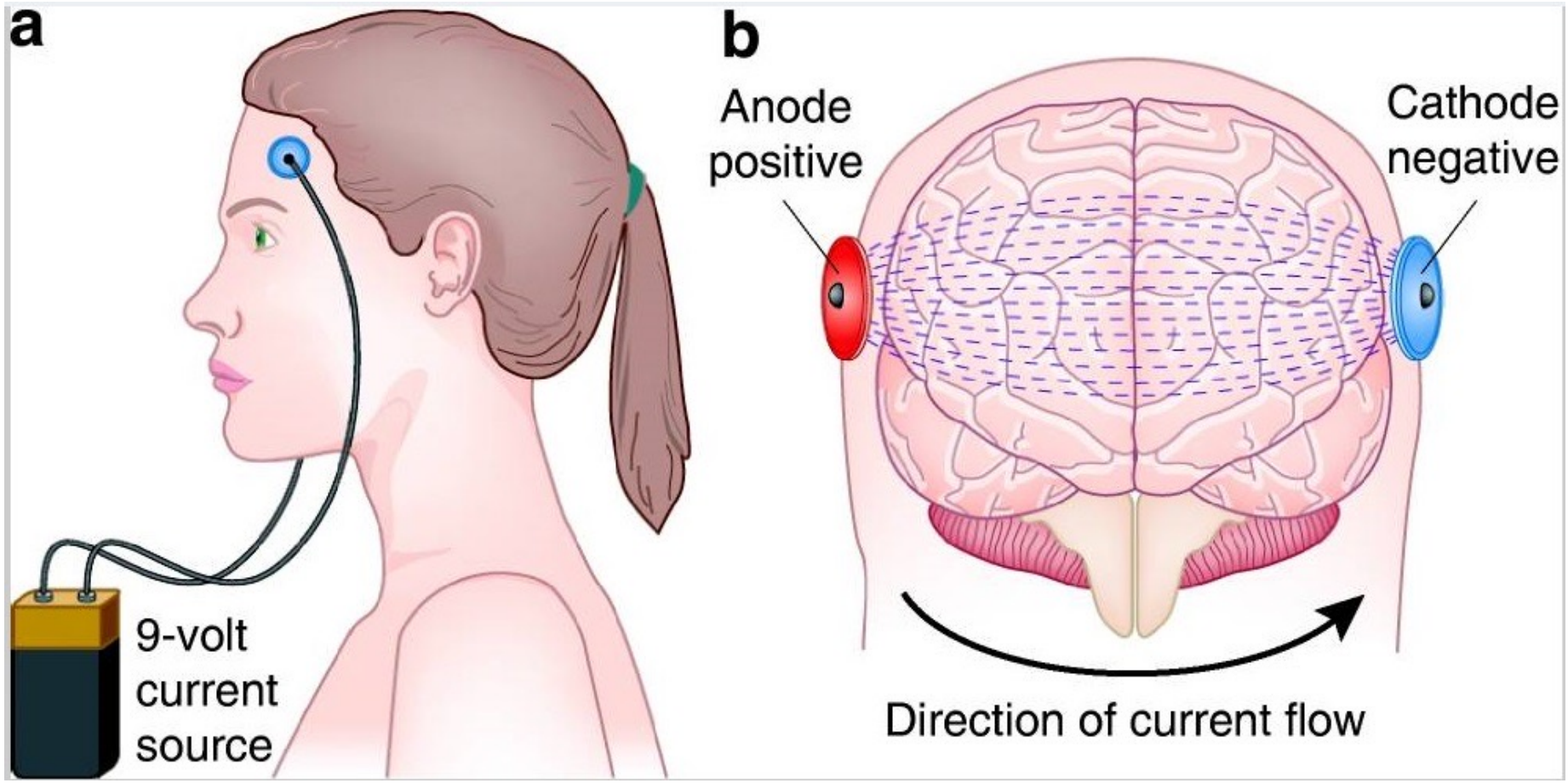
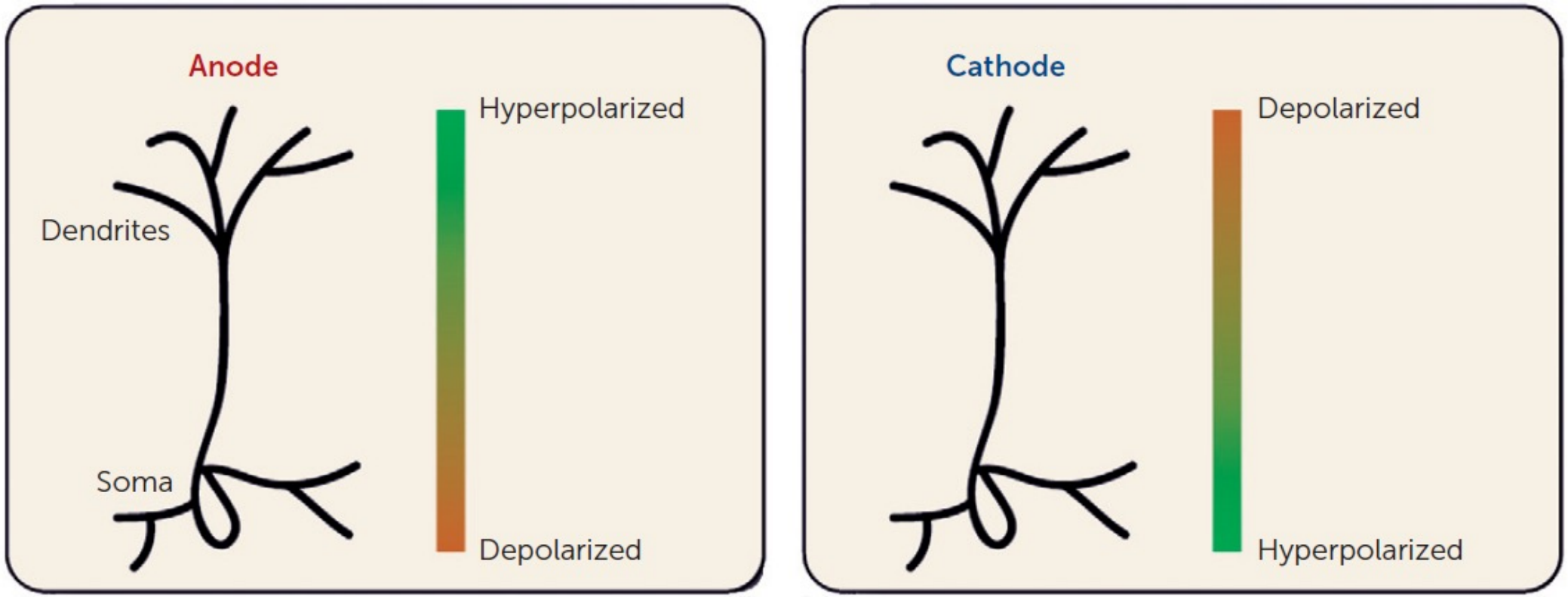

a
9-volt
current
source
b
Anode
positive
Cathode
negative
Direction of current flow

FIGURE 2. Model of Anode Versus Cathode Stimulation[a]



[a] The schematic diagram represents effects of anode and cathode stimulation on neuron resting potentials. Placement of the anode over a brain region leads to a depolarization that increases the likelihood of neuronal firing in the cell body (left). In contrast, placement of the cathode leads to hyperpolarization, which decreases the likelihood of neuronal firing (right).

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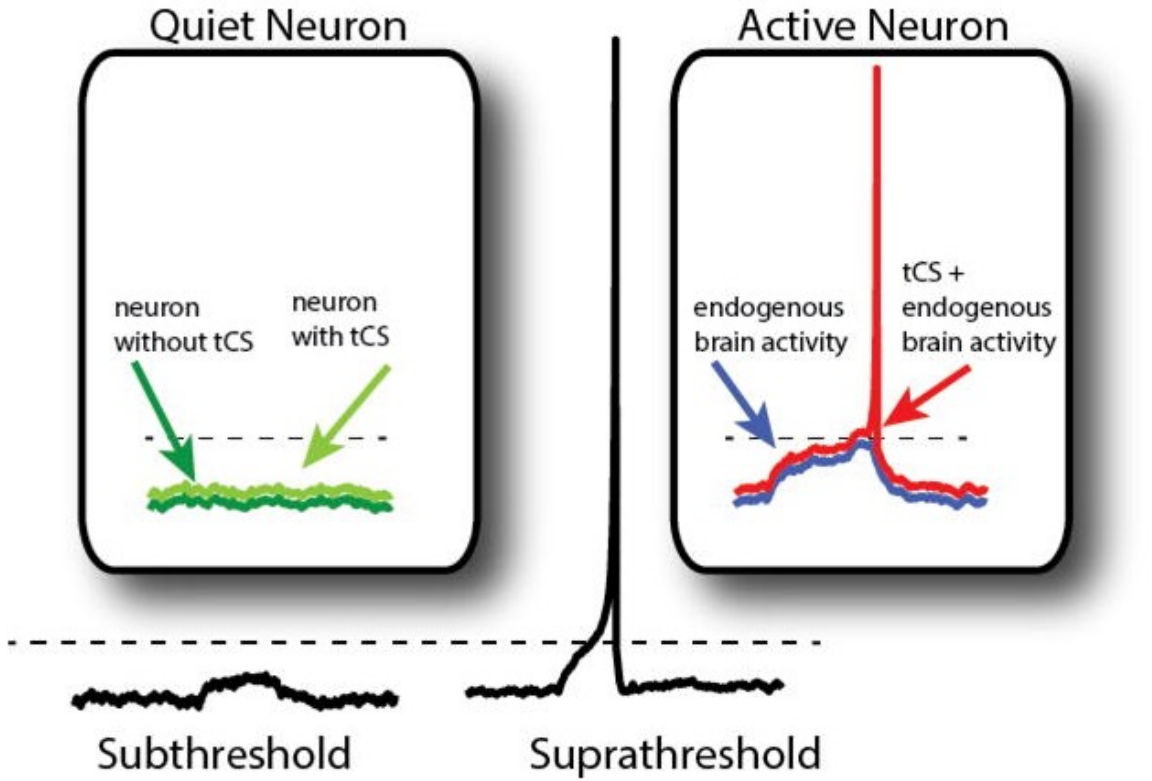
Figure 1A



Sub- and Suprathreshold Energy Input on Neuronal Action Potentials

Subthreshold membrane fluctuations are not sufficient to generate an action potential (left). However, if intrinsic fluctuations in a neuron's membrane voltage move it closer to its threshold, application of an inherently subthreshold input, such as tCS, can trigger an action potential (right). Dashed line indicates threshold.

Philip NS, Nelson BG, Frohlich F, Lim KO, Widge AS, Carpenter LL. Low-Intensity Transcranial Current Stimulation in Psychiatry. Am J Psychiatry. 2017 Jul 1;174(7):628-639.

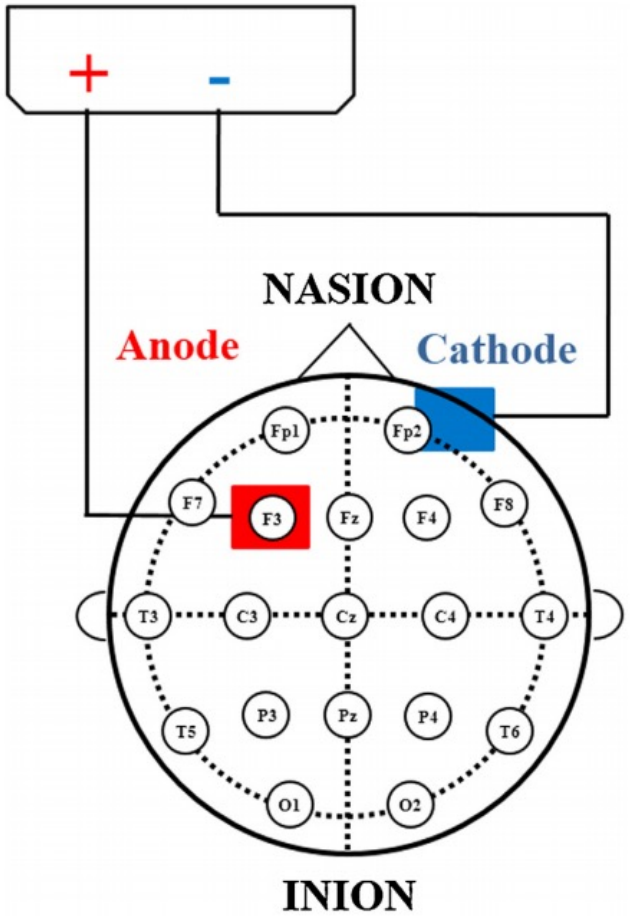


Fig. 2. Electrode locations used for tDC stimulation. 'Anode' denotes the electrode with positive potential and 'cathode' denotes the electrode with negative potential. In our experiment, the anode was located at F3 and the cathode was located in the supraorbital area.

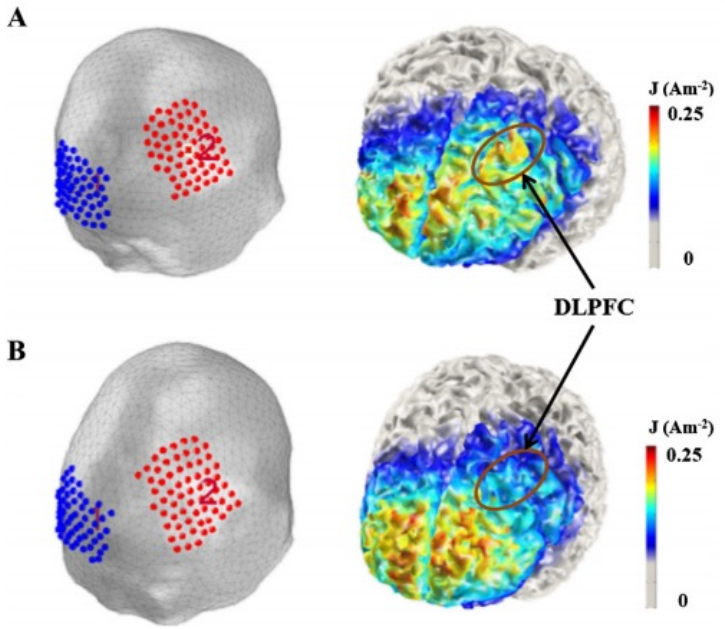


Fig. 3. Examples of individual current density maps of two subjects. (a) The cortical current density distribution of a participant (subject #3, PE group) and (b) that of another participant (subject #13, NE group).

3. Results

Fig. 3a shows an example of the current density map of a subject in the PE group and Fig. 3b shows that of a subject from the NE group. Despite the fact that both subjects were stimulated by tDCS using the same 10-20 electrode position (anode: F3; cathode: supraorbital), two current density maps showed distinct differences, especially around the DLPFC because of anatomical differences between subjects. Fig. 4a and b shows the scatter plots between current density at DLPFC and changes in accuracy

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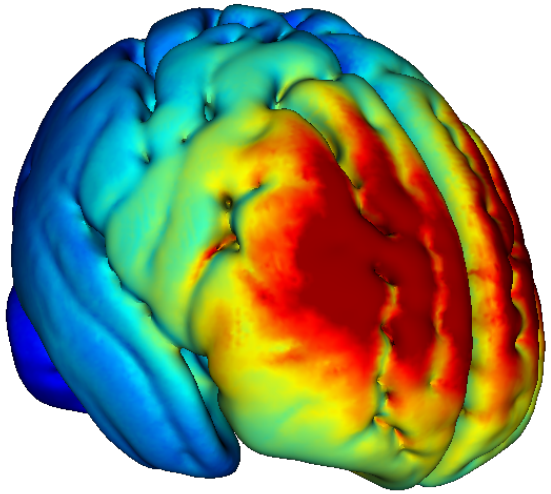

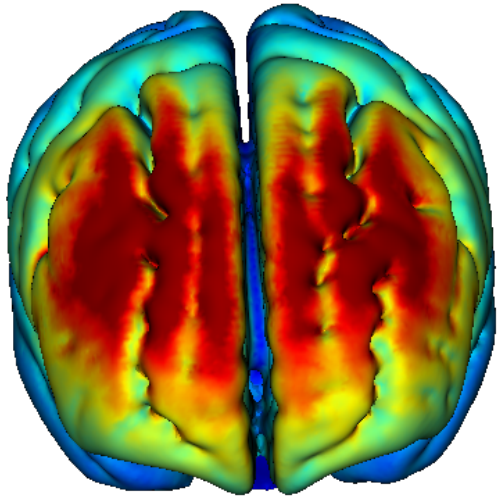

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Trial of Electrical Direct-Current Therapy versus Escitalopram for Depression

A.R. Brunoni, A.H. Moffa, B. Sampaio-Junior, L. Borrione, M.L. Moreno, R.A. Fernandes, B.P. Veronezi, B.S. Nogueira, L.V.M. Aparicio, L.B. Razza, R. Chamorro, L.C. Tort, R. Fraguas, P.A. Lotufo, W.F. Gattaz, F. Fregni, and I.M. Benseñor, for the ELECT-TDCS Investigators*

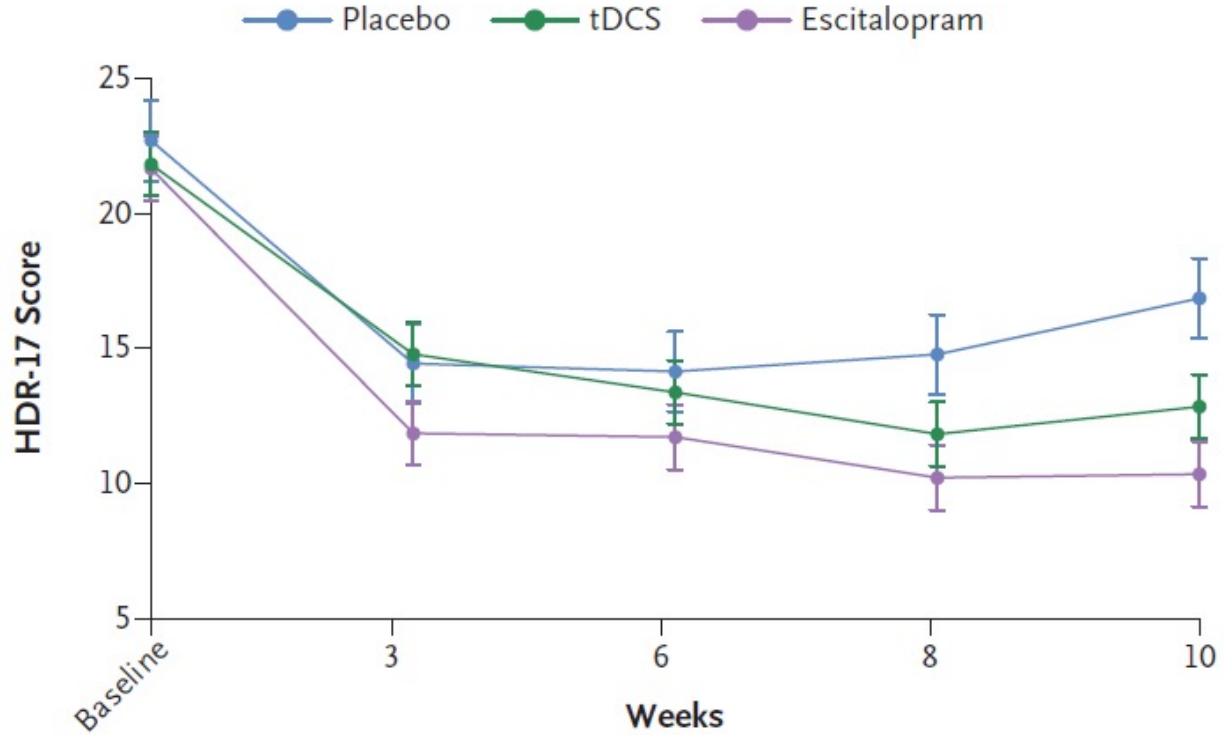

Figure 2. Change in Depression Score over Time.

Shown are the mean scores (intention-to-treat analysis) in the trial groups from baseline to 10 weeks. I bars represent ±1 SD. HDRS-17 scores range from 0 to 52, with higher scores indicating more depression, and a score of 24 or more indicates severe depression; the minimal clinically significant difference is 3 points. Treatment with escitalopram was superior to placebo at all time points except baseline ($P=0.008$ for the comparison at week 3, $P=0.01$ at week 6, and $P<0.001$ at weeks 8 and 10). Treatment with tDCS was superior to placebo at weeks 8 and 10 ($P<0.001$ for both comparisons). Treatment with escitalopram was superior to tDCS at weeks 3 ($P<0.001$) and 10 ($P=0.004$).

Table 8
Repeated tDCS session protocols in depression.

Articles	Number and type of patients (protocol design)	Stimulation electrode location	Stimulation intensity, session duration, total number of sessions (protocol duration; follow-up)	Clinical results	Class
Anodal tDCS of the left DLPFC with right orbitofrontal cathode					
Boggio et al. (2008a)	40 patients (non-medicated MDD) (21 active DLPFC, 9 active occipital, 10 sham)	Anode: left DLPFC (F3) or occipital cortex (Oz). Cathode: right orbitofrontal region	2 mA, 20 min, 10 sessions (2 weeks; FU: 30 days)	Mood improvement (HDRS, BDI) after active vs. sham tDCS of the left DLPFC	II
Loo et al., 2010	34 patients (MDD, including 20 non-medicated, MADRS >20) (19 active, 15 sham)	Anode: left DLPFC (F3). Cathode: right orbitofrontal region	1 mA, 20 min, 5 active or sham sessions (1.5 week), followed by 5 active sessions (1.5 week; FU: 1 month)	No difference in mood improvement (HDRS-17, MADRS) after active vs. sham tDCS	II
Loo et al. (2012)	60 patients (MDD, including 17 non-medicated and 8 bipolars, MADRS >20) (31 active, 29 sham)	Anode: left DLPFC (F3). Cathode: right orbitofrontal region (F8)	2 mA, 20 min, 15 active or sham sessions (3 weeks), followed by 15 active sessions (3 weeks; FU: 1 month)	Mood improvement (MADRS) after active vs. sham tDCS, but no difference in responder rate (13%)	I
Palm et al. (2012)	22 patients (drug-resistant MDD, including 2 bipolars) (crossover)	Anode: left DLPFC (F3). Cathode: right orbitofrontal region	1–2 mA, 20 min, 10 sessions (2 weeks; no FU)	No difference in mood improvement (HDRS-24) after active vs. sham tDCS, but a better efficacy for the first study phase of the crossover trial and an increase in positive emotions after active tDCS	II
Bennabi et al. (2015)	23 patients (drug-resistant MDD, no bipolar, MADRS > 25) (12 active, 11 sham)	Anode: left DLPFC (F3). Cathode: right orbitofrontal region (FP2)	2 mA, 30 min, 10 sessions (1 week; FU: 30 days)	No difference in mood improvement (HDRS, MADRS), responder rate, or changes in neuropsychological tests after active vs. sham tDCS	II
Recommendation: anodal tDCS of the left DLPFC with right orbitofrontal cathode is probably effective in patients with no drug-resistant major depressive episode (Level B) and probably ineffective in patients with drug-resistant major depressive episode (Level B)					
Anodal tDCS of the left DLPFC with right DLPFC cathode					
Blumberger et al. (2012)	24 patients (drug-resistant MMD, HDRS-17 >21) (13 active, 11 sham)	Anode: left DLPFC (F3). Cathode: right DLPFC (F4)	2 mA, 20 min, 15 sessions (3 weeks; FU: 1 month)	No significant difference between active and sham tDCS.	II
Brunoni et al. (2013b)	103 patients (non-medicated MMD, very few drug-resistant, no bipolar, HDRS-17 >17) (27 active + Sertraline, 26 active + placebo, 24 sham + Sertraline, 26 sham + placebo)	Anode: left DLPFC (F3). Cathode: right DLPFC (F4)	2 mA, 30 min, 10 sessions (2 weeks), followed by 2 additional sessions (4 weeks; FU: 6 month)	Greater mood improvement (MADRS, HDRS-17, BDI) after active tDCS + sertraline compared to all other groups. Active tDCS only was significantly superior to placebo, but no difference between active tDCS and sertraline taken solely.	I
Brunoni et al. (2014a)	37 patients (non-medicated MDD, no bipolar, HDRS-24 >21) (20 active, 17 sham; combined with cognitive control therapy)	Anode: left DLPFC (F3). Cathode: right DLPFC (F4)	2 mA, 30 min, 10 sessions (2 weeks; FU: 2 weeks)	Greater mood improvement (HDRS-21, BDI) after active vs. sham tDCS only in older patients and those who presented better performance in the cognitive task	III

No recommendation for anodal tDCS of the left DLPFC with right DLPFC cathode in patients with depression.
BDI: Beck Depression Inventory; DLPFC: dorsolateral prefrontal cortex; FU: follow-up; HDRS: Hamilton Depression Rating Scale; MADRS: Montgomery-Åsberg depression rating scale; MDD: major depressive disorder.

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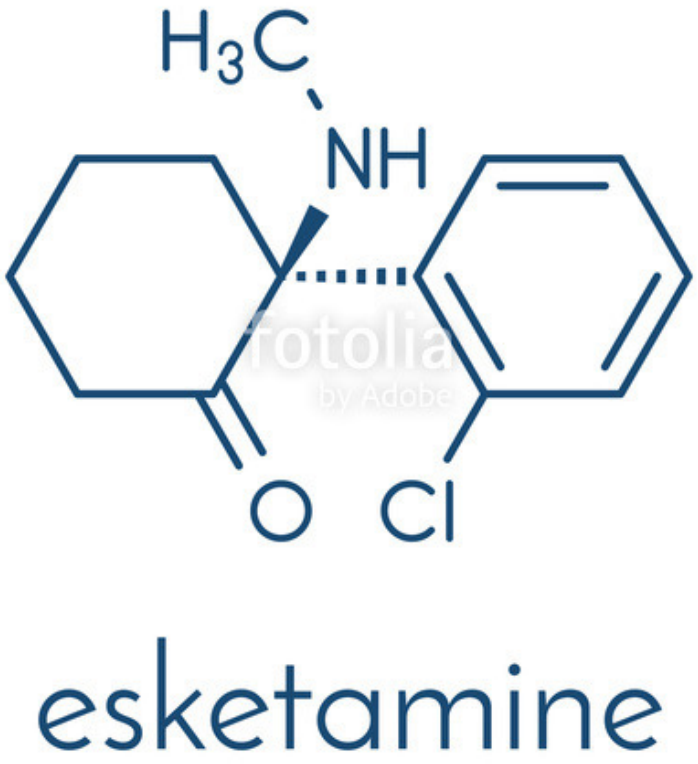
3. Esketamine




SPRAVATO
Esketamine

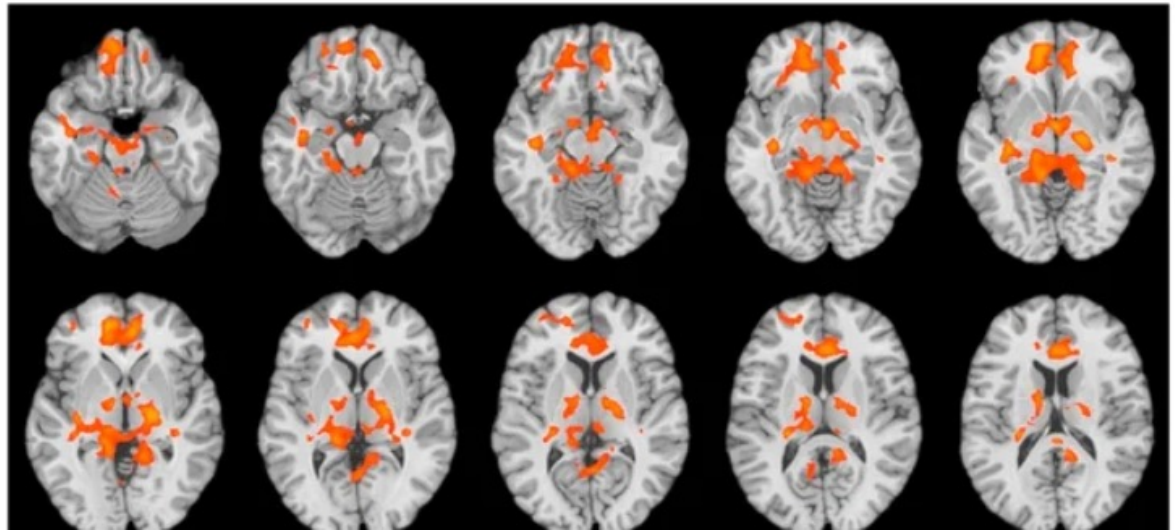

Spravato
(esketamine HCl)
nasal spray
28 mg per device
Rx only

In an Old Drug, New Hope for Depression

The science behind antidepressants has not advanced in half a century. New discoveries, including research into the anesthetic ketamine, could change everything.

This article was created for the Icahn School of Medicine at Mount Sinai, in New York City, by Scientific American Custom Media, a division separate from the magazine's board of editors.

October 19, 2018



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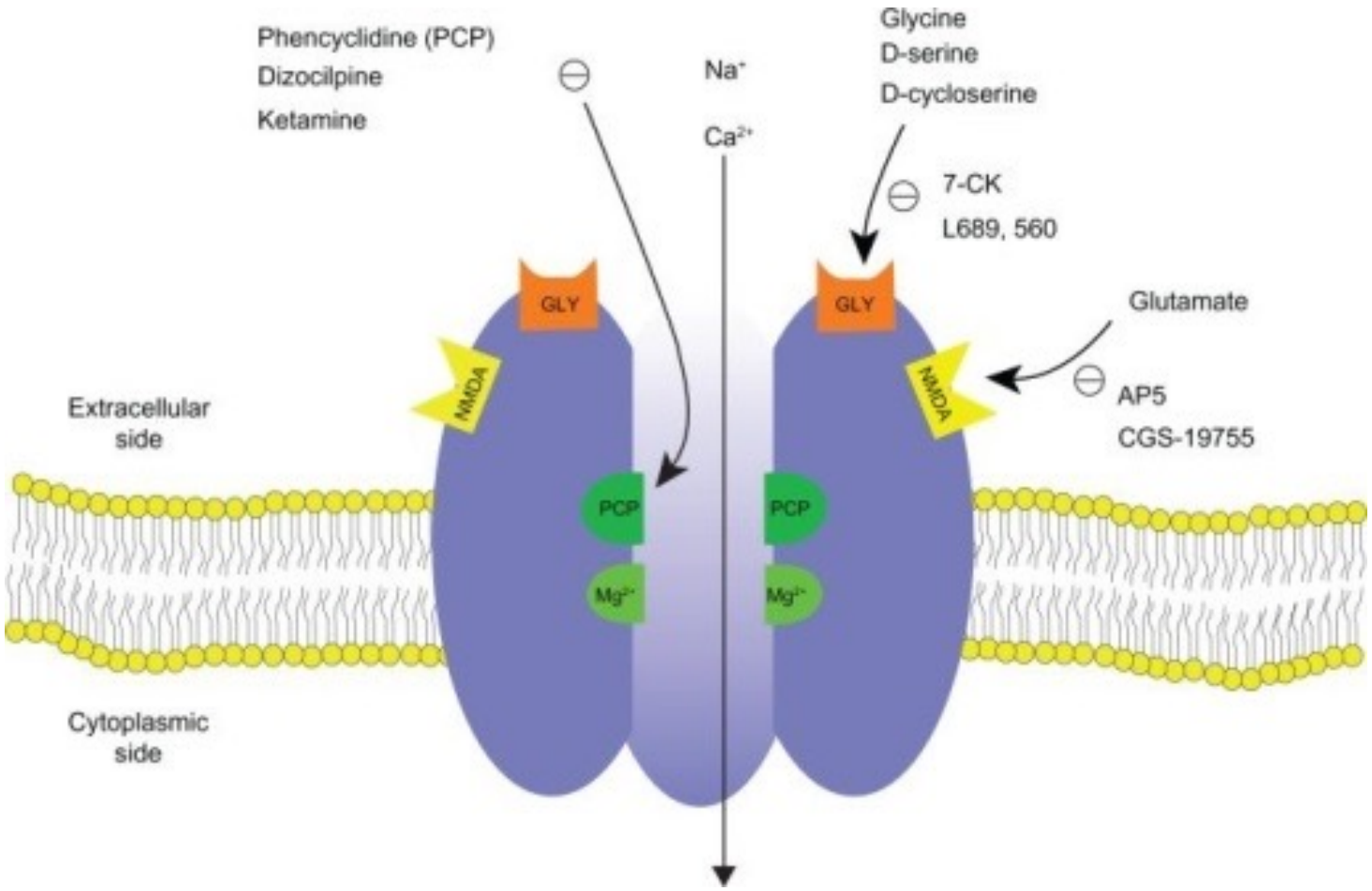
N-methyl-d-aspartate receptor (NMDAR) antagonists



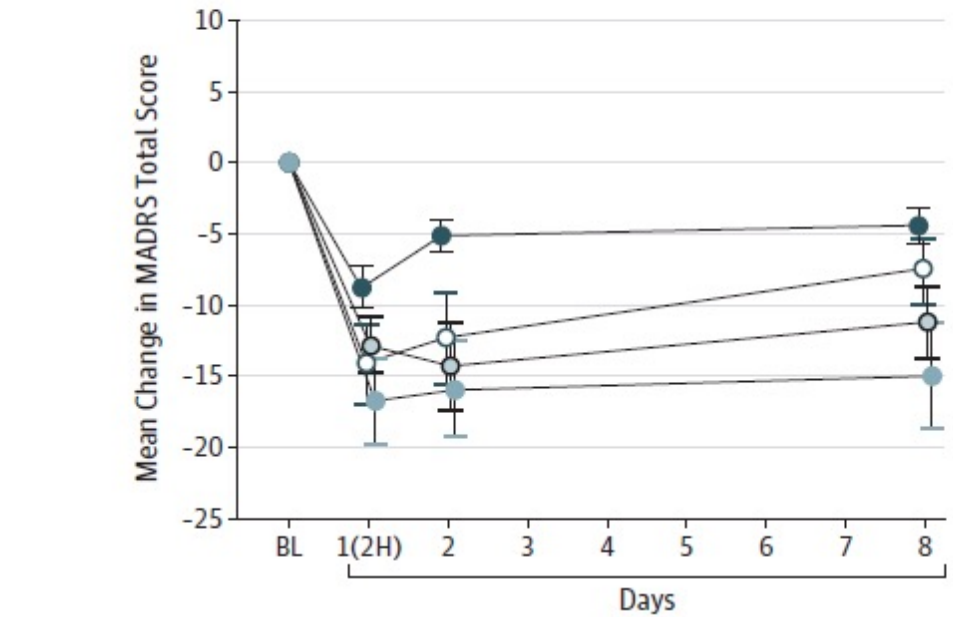
JAMA Psychiatry | Original Investigation

Efficacy and Safety of Intranasal Esketamine Adjunctive to Oral Antidepressant Therapy in Treatment-Resistant Depression

A Randomized Clinical Trial

Ella J. Daly, MD; Jaskaran B. Singh, MD; Maggie Fedgchin, PharmD; Kimberly Cooper, MS; Pilar Lim, PhD; Richard C. Shelton, MD; Michael E. Thase, MD; Andrew Winokur, MD, PhD; Luc Van Nueten, MD; Husseini Manji, MD, FRCPC; Wayne C. Drevets, MD

Figure 2. Mean Change in Montgomery-Åsberg Depression Rating Scale (MADRS)



No. of participants				
Placebo	33	33		33
Esketamine 28 mg	11	11		11
Esketamine 56 mg	11	11		11
Esketamine 84 mg	12	12		12

Changes shown in periods 1 (A) and 2 (B). Period 2 consisted only of participants who had received placebo in period 1 and had moderate to severe symptoms (n = 28). Period 1 (days 1-8) and period 2 (days 8-15) are discussed in the Design

NEURO-PSYCHIATRIE
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Efficacy and Safety of Intranasal Esketamine for the Rapid Reduction of Symptoms of Depression and Suicidality in Patients at Imminent Risk for Suicide: Results of a Double-Blind, Randomized, Placebo-Controlled Study

Carla M. Canuso, M.D., Jaskaran B. Singh, M.D., Maggie Fedgchin, Pharm.D., Larry Alphs, M.D., Ph.D., Rosanne Lane, M.A.S., Pilar Lim, Ph.D., Christine Pinter, M.S., David Hough, M.D., Gerard Sanacora, M.D., Ph.D., Husseini Manji, M.D., Wayne C. Drevets, M.D.

Objective: The authors compared the efficacy of standard-of-care treatment plus intranasal esketamine or placebo for rapid reduction of symptoms of major depression, including suicidality, among individuals at imminent suicide risk.

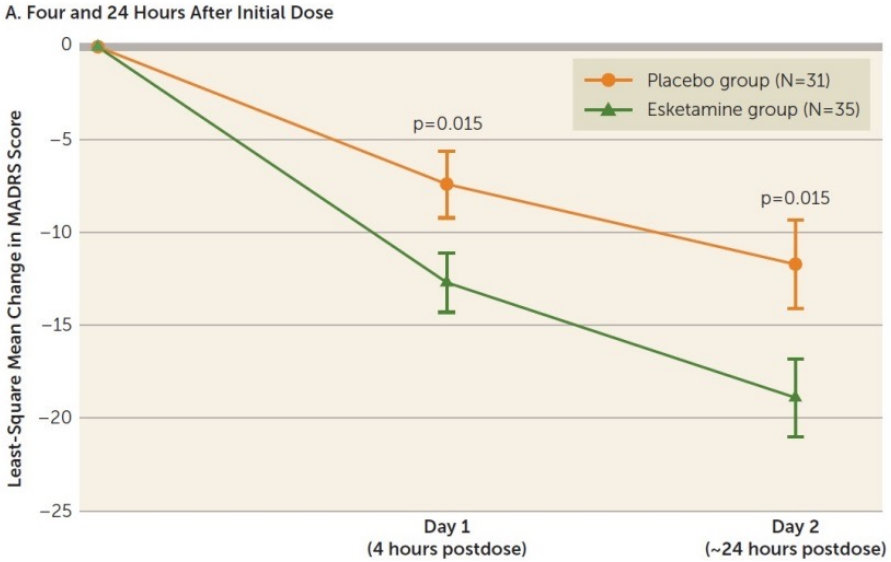
Method: In a double-blind, multicenter, proof-of-concept study, 68 participants were randomly assigned to receive esketamine (84 mg) or placebo twice weekly for 4 weeks, in addition to comprehensive standard-of-care treatment. The primary efficacy endpoint was change in score from baseline to 4 hours after initial dose on the Montgomery-Åsberg Depression Rating Scale (MADRS). Clinician global judgment of suicide risk (from the Suicide Ideation and Behavior Assessment Tool) was also assessed. Secondary endpoints included these measures at 24 hours and double-blind endpoint at day 25.

Results: A significantly greater improvement in MADRS score was observed in the esketamine group compared with the placebo group at 4 hours (least-square mean difference=−5.3, SE=2.10; effect size=0.61) and at ~24 hours (least-square mean difference=−7.2, SE=2.85; effect size=0.65), but not at day 25 (least-square mean difference=−4.5, SE=3.14; effect size=0.35). Significantly greater improvement was also observed in the esketamine group on the MADRS suicidal thoughts item score at 4 hours (effect size=0.67), but not at 24 hours (effect size=0.35) or at day 25 (effect size=0.29). Between-group reductions in clinician global judgment of suicide risk scores were not statistically different at any time point. The most common adverse events among participants in the esketamine group were nausea, dizziness, dissociation, unpleasant taste, and headache.

Conclusions: These preliminary findings indicate that intranasal esketamine compared with placebo, given in addition to comprehensive standard-of-care treatment, may result in significantly rapid improvement in depressive symptoms, including some measures of suicidal ideation, among depressed patients at imminent risk for suicide.

Am J Psychiatry 2018; 175:620–630; doi: 10.1176/appi.ajp.2018.17060720

FIGURE 2. Change From Baseline in Montgomery-Åsberg Depression Rating Scale (MADRS) Score in a Study of Intranasal Esketamine for Rapid Reduction of Symptoms in Patients at Imminent Risk for Suicide Who Received Standard-of-Care Treatment (Last Observation Carried Forward)[a]



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5. Et après

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The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Trial of Psilocybin versus Escitalopram for Depression

Robin Carhart-Harris, Ph.D., Bruna Giribaldi, B.Sc., Rosalind Watts, D.Clin.Psy., Michelle Baker-Jones, B.A., Ashleigh Murphy-Beiner, M.Sc., Roberta Murphy, M.D., Jonny Martell, M.D., Allan Blemings, M.Sc., David Erritzoe, M.D., and David J. Nutt, M.D.

ABSTRACT

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Dr. Carhart-Harris, Ms. Giribaldi, and Dr. Watts contributed equally to this article.

N Engl J Med 2021;384:1402-11.
DOI: 10.1056/NEJMoa2032994

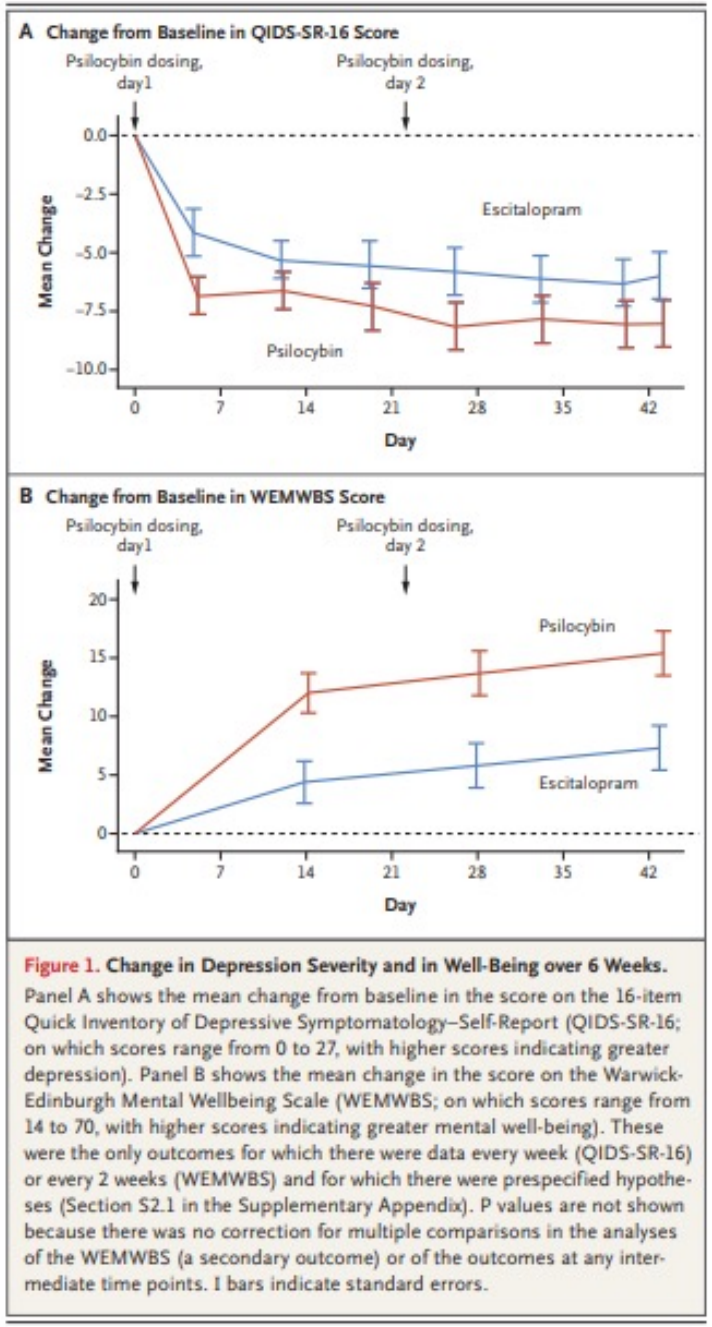

Figure 1. Change in Depression Severity and in Well-Being over 6 Weeks.
Panel A shows the mean change from baseline in the score on the 16-item Quick Inventory of Depressive Symptomatology–Self-Report (QIDS-SR-16; on which scores range from 0 to 27, with higher scores indicating greater depression). Panel B shows the mean change in the score on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; on which scores range from 14 to 70, with higher scores indicating greater mental well-being). These were the only outcomes for which there were data every week (QIDS-SR-16) or every 2 weeks (WEMWBS) and for which there were prespecified hypotheses (Section S2.1 in the Supplementary Appendix). P values are not shown because there was no correction for multiple comparisons in the analyses of the WEMWBS (a secondary outcome) or of the outcomes at any intermediate time points. I bars indicate standard errors.

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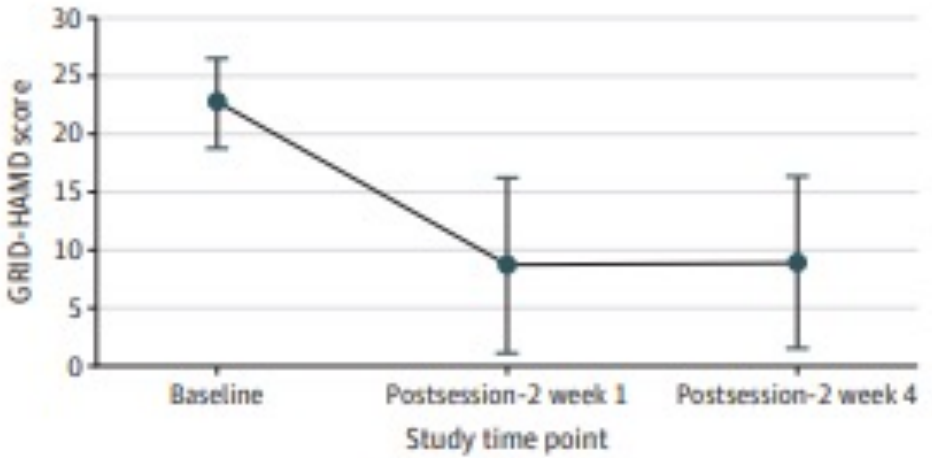
JAMA Psychiatry | Original Investigation

Effects of Psilocybin-Assisted Therapy on Major Depressive Disorder
A Randomized Clinical Trial

Alan K. Davis, PhD; Frederick S. Barrett, PhD; Darrick G. May, MD; Mary P. Cosimano, MSW; Nathan D. Sepeda, BS; Matthew W. Johnson, PhD; Patrick H. Finan, PhD; Roland R. Griffiths, PhD

JAMA Psychiatry. 2021;78(5):481-489. doi:10.1001/jamapsychiatry.2020.3285
Published online November 4, 2020. Corrected on February 10, 2021.

Figure 4. Decrease in the GRID Hamilton Depression Rating Scale (GRID-HAMD) Scores at Week 1 and Week 4 Postsession-2 Follow-up in the Overall Treatment Sample



The mean (SD) GRID-HAMD score was 22.8 (3.9) at baseline, 8.7 (7.6) at week 1, and 8.9 (7.4) at week 4. Effect sizes (Cohen *d* with 95% CI) and *P* values reflect the results of a paired sample *t* test that compared scores between baseline and week 1 (Cohen *d* = 2.3; 95% CI, 1.5-3.1; *P* < .001) and week 4 postsession-2 follow-up (Cohen *d* = 2.3; 95% CI, 1.5-3.1; *P* < .001).

THANK YOU