

Early intervention for depression in young people: a blind spot in mental health care



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Depression is a major contributor to disability across the lifespan. As a disorder that commonly has its onset in adolescence and early adulthood, and high recurrence and persistence, it is a prime candidate for early intervention. Most of the early intervention focus, however, has been confined to indicated prevention efforts. In this Personal View, we argue that early intervention for depression must expand beyond this narrow focus to include young people (aged 12–25 years old) who present with early episodes of full-threshold major depressive disorder. We discuss the development of enhanced primary care services for youth mental health, which allow young people improved access to evidence-based care. We argue that young people with severe and complex depression require particular attention: they are at high risk of lifelong disabling illness and need support to alleviate the early effects of their illnesses on their functional trajectories.

Introduction

One of the striking results of efforts to map disability across the lifespan has been the large contribution of depression.¹ The high level of disability depression causes is a consequence of its peak age of onset in adolescence and early adulthood, high prevalence, and high persistence and recurrence. Despite the high level of disability, access to quality care is often poor. In Australia, where depression awareness is relatively high, only 16% of people receive minimally adequate evidence-based treatment.² The impact of depression means that it should be a prime target for prevention, early intervention, and sustained expert care. However, depression has not been a focus of early intervention efforts.

Early intervention in psychiatry was originally introduced to provide effective care for patients with psychotic illnesses, such as schizophrenia. The aim has been to prevent functional decline and increase the probability of recovery by detecting early symptoms and offering sustained and comprehensive evidence-based care during the crucial early years of illness. This approach has been highly influential in research and health-care reform, and evidence suggests that the early trajectory of illness can be improved.³

An early intervention approach has not yet been elaborated for depression for two reasons. First, there is a history of research on treatments for child and adolescent depression: such treatments might be implicitly considered to be early interventions. However, epidemiological studies show that the median age for a first episode of major depressive disorder (we use this term as synonymous with depression in this Personal View) is 30 years, with only 20% of cases emerging before the age of 18 years.^{4,5} Patients enrolled in large clinical trials, who are arguably more representative of the help-seeking population with depression, have an earlier age of onset (with about 40% having developed depression before 18).^{6,7} Nonetheless, interventions that focus exclusively on children and adolescents will miss much early depression. When interventions for early episodes of depression are delivered in child and adolescent services, continuing care is limited by the upper boundary of age eligibility.

The second reason for the lack of an early intervention programme for depression is that one exists, but only in a limited form. It is an approach focused on indicated prevention—ie, on the identification of young people (usually high school students) with subclinical depression, with the provision of interventions that aim to prevent full-threshold illness.^{8,9} Although this approach has been effective in preventing, or at least delaying, some cases of depression, it is not effective for most individuals, who develop depression despite indicated prevention efforts.¹⁰ Early intervention for depression needs to extend beyond this limited focus.

We will outline how early intervention approaches in depression can be conceptualised as encompassing the indicated prevention of depression, the delivery of evidence-based interventions for early episodes of uncomplicated full-threshold depression, and the provision of specific interventions and support for people with severe and complex depression, focusing on functional recovery. The early years of illness are when the major effects of depression on personal development, relationships, and vocational progress are seen, and the start of comorbidity occurs. The optimal time for the identification of young people who are at high risk of developing lifelong disabling illness is early in its course. This identification requires focusing on young people who have already begun to show more severe and persistent depression, along with comorbid illnesses. Kessler's and Price's¹¹ concept of primary prevention of secondary disorders shows that this secondary comorbidity is preventable, and mandates a focus on assertive treatment of early episodes as a priority. The focus of early intervention in this Personal View is on young people, although over an extended age range (from about age 12–25 years) that captures most first episodes of illness commonly experienced between adolescence and young adulthood.

Early intervention

Early intervention for psychotic disorders emerged in the 1980s,¹² and many countries now have early intervention programmes.^{3,13,14} A major emphasis of these programmes

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has been on boosting the delivery of psychosocial interventions during the so-called critical period as a complement to pharmacological approaches.¹⁵ The early years of illness are described as such because of evidence that clear functional decline occurs in the early years after diagnosis, with a plateauing of function afterwards.^{16,17} The extent of the decline, and the severity of residual symptoms, affects functioning and quality of life through adulthood.¹⁶ By delivering interventions during this crucial window, and hence preventing substantial functional decline and establishing a framework for recovery, the burden of illness through later years is alleviated, even if the disorder itself remains present.¹⁸

Early psychosis programmes have extended their focus to include young people who are at an “ultra high risk” of psychosis.¹⁹ These are people who have prodromal symptoms or first-degree relatives with psychotic illnesses, and have themselves had a recent functional decline. Interventions for young people at ultra high risk for psychosis reduce the transition to psychosis over the following 12 months by about half.²⁰ In the past decade, early intervention programmes have been implemented for borderline personality disorder,^{21,22} and an early intervention approach has been described for bipolar disorder.²³

The course of depression

Depression and psychotic disorders have similarities, but also important differences. They have in common a peak onset in late adolescence through to early adulthood (from age 15–30 years) and they are similarly often lifelong and disabling.²⁴ Depression is more prevalent than schizophrenia, the major psychotic disorder diagnosis. Over the lifetime, depression is estimated to affect about 30% of the population,²⁵ compared with 0.7% who are affected by schizophrenia.²⁶ Major depressive episodes are shorter than psychotic episodes in schizophrenia, and last an average of 6–12 months;^{27,28} less than half the duration of psychotic episodes.²⁹

Patterns of depression recurrence are variable. Although depression is a recurrent illness for many people, most will only have one or two episodes in their lifetime.³⁰ However, even the experience of one or two episodes can interfere with educational and vocational achievement because they occur during an important developmental period, thereby causing substantial long-term consequences. A minority of patients, about a third, will have three or more episodes of depression.³⁰ Most of these patients will have a chronic relapsing course: after a third episode of depression, the chances of recurrence are about 90%, and remain at this percentage for subsequent episodes.³⁰ Early age of onset is a risk factor for recurrent depression,^{31,32} and these patients are likely to have particularly poor outcomes and severe disability.³³ Improved prospects for recovery and lower relapse after the first two episodes of depression make them a good target for early intervention.

Many young people will present with relatively uncomplicated depression, with heterogeneous symptoms, including anxiety symptoms, which often precede depression,³⁴ but with good premorbid functioning and social supports. Other young people will present with what we term severe and complex depression.³⁵ We define this as severe depression with suicidal thoughts and behaviours; non-anxiety comorbid disorders, including personality disorders, substance use disorders, and autism spectrum disorder; and poor psychosocial functioning.³⁵ The presence of these factors predict recurrent and persistent depression for: severity,^{36–38} suicidality,^{28,36} personality pathology,^{39,40} substance use,^{36,41,42} and poor functioning.^{43,44} The number of young people diagnosed with autism spectrum disorder has increased over the past decade, mainly because of the inclusion of milder cases within the diagnostic spectrum.⁴⁵ Young people with autism spectrum disorder have an increased prevalence of depression, which is often comorbid with anxiety disorders.⁴⁶ Although there are few treatment studies of depression in people with autism spectrum disorder, our clinical experience is that depression that is comorbid with autism spectrum disorder is often difficult to treat, and the prevalence of persistent and recurrent depression is high.

Early intervention and staging models

Clinical staging models were first developed for cancer.⁴⁷ They have since been proposed for mental illnesses,^{48,49} including depression.^{50,51} Staging models attempt to define the progression of illness at a particular point in time, differentiating milder presentations from those that suggest more advanced illness.⁵² They assume that illnesses begin with mild symptoms and then progress (although not inevitably) to symptoms that are more severe and persistent.

The rate of progression from one stage to the next (and whether this occurs) will differ between people. For example, many young people will have subclinical depressive symptoms that do not progress further. Other young people will show rapid progression to severe depression and will not seek clinical help until they are very unwell.

Early intervention refers to the period following the onset of symptoms, rather than a clinical stage. Because the clinical staging of illness progresses with time, patients are more likely to be at early rather than late stages of illness at their first presentation. However, their stage of illness will depend on how quickly the depression has developed, and how long it has taken for them to become aware of their impairing symptoms and to access clinical care. Although the aim of early intervention is to deliver treatments at an early stage of illness, when the opportunity to deliver effective non-pharmacological treatments that more favourably influence outcome is greater, the heterogeneity of illness and help-seeking characteristics means that early intervention needs to encompass a range of clinical stages.

Indicated prevention for depression

By definition, early interventions are treatments offered to people who already have symptoms.⁵³ Although many preventive efforts are aimed at people who are yet to experience symptoms (with the hope of preventing their onset), indicated prevention is targeted at people who are having symptoms, but not yet at a diagnostic level. Indicated prevention can therefore be considered an early intervention,⁵³ and in fact makes up most of the published literature on this topic for depression.

Indicated prevention for depression comprises psychoeducation and psychotherapeutic interventions, usually delivered in a group setting to participants who have been identified as having subclinical depressive symptoms, and therefore to be at high risk of developing depression.⁵⁴ For adolescents, interventions are usually delivered in schools, which offer a practical setting for them.⁵⁵ In the past decade, indicated preventions have been developed for delivery over the internet and on mobile devices.⁵⁶

Indicated prevention interventions are effective for depression. Meta-analyses show that they reduce the incidence of depression by about 20% during the 3–24 months of post-intervention follow up.^{10,57} To what extent the onset of depression is prevented, rather than delayed, is not clear;¹⁰ but even if only delayed, the interventions are likely to be clinically meaningful. In addition to reducing the impact of depression, the provision of psychoeducation means that when depression emerges, those who have participated in indicated prevention programmes will be more resourceful in accessing care. Indicated prevention programmes do not, however, prevent (or delay) depression for most participants. Therefore, early intervention needs to extend beyond indicated prevention, and should complement it by accommodating early episodes of depression.

Early intervention for uncomplicated depression

We describe depression as uncomplicated when it is not severe and complex—ie, when it is not associated with suicidality, non-anxiety comorbidity, or poor functioning. We make an exception for comorbid anxiety disorders, and include them as part of uncomplicated depression because they are commonly experienced with depression,⁵⁸ and their treatment is similar to that of depression. The division of depression into these categories necessarily masks more complicated symptomatic structures. Some comorbid anxiety disorders are often associated with complex presentations (eg, post-traumatic stress disorder and obsessive-compulsive disorder), but as a heuristic, the broad division between uncomplicated, and severe and complicated depression is useful.

Young people with uncomplicated depression can usually be cared for, at least initially, in primary care settings. However, many young people do not have primary care doctors who they visit regularly.⁵⁹ Therefore, alternative access pathways to clinical care

are important. The establishment of enhanced primary care services for youth mental health—where young people can refer themselves, or be referred by family, educators, or primary care doctors—has been an important development in this regard.⁶⁰ The services are known as headspace centres in Australia, and have acted as models for similar services in other countries.⁶¹ They have made early intervention for young people with threshold diagnoses of depression feasible at a substantial scale for the first time. The concepts of soft entry, no wrong door, youth friendliness, and one stop shop are indicative of this approach: barriers to young people accessing care are minimised by engaging with all young people who contact the service for help, without the need for formal referral processes.⁶¹ Alongside treatment for depression, support can also be provided for problems related to physical health, use of alcohol and other drugs, housing, education, employment, and psychosocial functioning.

Young people with uncomplicated depression can receive sufficient care from clinicians working in solo practice, particularly when they do not require assistance outside the narrow focus of the therapy. In many countries, however, private clinicians are not readily accessible to young people, particularly in outer suburban and rural areas, and often there are substantial cost barriers.⁶² Access to online therapies has gone some way to addressing this gap. Although online therapies have been shown to be effective, high rates of attrition (disengagement) remain an obstacle for their integration into mainstream treatment.⁶³

Early intervention for severe and complex depression

Young people at highest risk of disabling recurrent illness present with severe and complex depression early in its course. Their often difficult-to-treat illnesses have a substantial impact on their ability to attend educational, vocational, and social activities during an important developmental period. The clinical presentations are often a complex mixture of symptoms that defy ready nosological categorisation. Although our focus is on the depressive component, depression might be viewed in some cases as the secondary diagnosis (eg, when comorbid with autism spectrum disorder or personality disorders). Nonetheless, the onset of depression often prompts the presentation for clinical care, and it is the depression that is arguably more amenable to treatment.

Many young people with severe and complex depression do not respond to first-line treatments,⁶⁴ and this lack of response, along with the complexity of their clinical presentations, means that they are rarely well managed in solo practice settings. These patients are best managed by multidisciplinary teams, with a core team comprised of a therapist and psychiatrist (or psychiatry trainee), supported by specialists who can offer specific expertise, particularly in social, family, educational, and vocational areas.

Although this support might be provided by enhanced primary health-care services, patients with complex presentations and increased suicide risk benefit from the further level of care offered by specialist, tertiary-level services, which have an ability to respond to acute deteriorations and crises, including offering inpatient care.

Group therapy programmes provide a considerable part of the recovery for young people with severe and complex depression.⁶⁵ Many young people will have dropped out of formal education with the deterioration of their mental health, but will re-engage with it with the support and encouragement of practitioners with educational expertise.⁶⁶ Unemployment is elevated in young people with depression⁶⁷ and engagement in work can be supported by specific work placement strategies.⁶⁶ Functional recovery is as important as symptomatic recovery and it is an important factor in predicting long-term outcome.⁴⁴

Developing an early intervention for depression

Early intervention for depression is essential. As an illness that begins early in life and that is often experienced throughout adulthood, there is good opportunity for interventions that can have long-lasting effects. The aim of early intervention is to deliver treatments as early in the course as possible: when treatments are likely to be more benign, better tolerated, and have more enduring effects than late interventions. However, mental illnesses can develop rapidly and mild symptoms are often covert. Therefore, young people present for care at different stages of illness. The early intervention approach for depression must accommodate this, and encompass presentations from preclinical to mild to severe illness.

After the prodromal period—during which sub-syndromal depressive symptoms can be targeted by indicated prevention approaches—the first two episodes of depression provide the best opportunity for intervention. The risk of recurrence after the first two episodes (60–70%) is substantially less than after the third and subsequent episodes (about 90%), indicating an early potential for recovery that interventions should focus on.³⁰ Supporting the idea that early episodes of depression should be an important focus for intervention, structural brain changes are minimal during the first episode of depression, but become more evident with recurrence.^{68,69} These changes have led to suggestions that depression is itself neurotoxic: the experience of depression causes brain changes that makes further depression more probable,⁷⁰ which adds weight to the need for early intervention.

Conclusion

We have presented a framework for early intervention for depression that encompasses early presentations of illness, from mild symptoms to severe and complex depression. Early episodes of depression during

adolescence and early adulthood affect essential developmental functions. The illness causes disruption to important developmental tasks, such as completing education, commencing work, establishing intimate relationships, and starting a family. Successful navigation of these tasks establishes a trajectory through adulthood, whereas not achieving them can reverberate for a lifetime. Effective, early intervention programmes are crucial.

Although early intervention efforts should attempt to pre-empt severe and complex depression, it is this form that is most likely to endure, in both its chronicity and recurrence. We argue that this group of young people must be included in the early intervention framework, along with young people with subthreshold and uncomplicated depression. Young people with severe and complex depression are best managed in specialist youth mental health services, where expertise and support is available for them to recover.

Our focus has been on depression, but the same framework can be applied to early mental illness more broadly. Early intervention efforts have taken a trans-diagnostic perspective, recognising that early illness syndromes are fluid, and that early intervention programmes (especially psychosocial interventions, but also medications, such as selective serotonin reuptake inhibitors) have beneficial effects over a number of disorders.⁷¹ Risk factors, such as sexual trauma and bullying, are common to a wide range of mental health problems^{72,73} and should be addressed as part of early intervention efforts. The burden from mental illness is much greater than from physical health problems in young people, with depression the major contributor to that burden.^{74,75} Early intervention gives us one of the best avenues to reducing it.

Contributors

CGD and PDM contributed equally to the conceptualisation of the paper, the critical review of the scientific literature, and the writing of the paper.

Declaration of interests

We declare no competing interests.

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