

Proactive depression services needed for at-risk populations



Over the past decade the personal, family, societal, and global negative effects of depression have been unequivocally demonstrated.¹ Untreated depression is a major public health issue that affects both mental and physical health and many aspects of personal and public life, including relationships and educational outcomes. Despite the growing evidence base highlighting the need to reach populations at increased risk of developing depression and the importance of intervening in the adolescent period,²⁻⁴ primary care and mental health services have remained poorly resourced and, therefore, predominantly reactive. The group most likely to receive treatment for depression are those able to seek services and engage with the treatment approaches on offer. Some subgroups are poorly represented, such as children,⁵ who are dependent on adults to identify their needs, advocate for them, and enable them to access services. In most high-income countries, less than half of the children who need mental health services are actually seen;⁵ these figures are considerably worse for low-income and middle-income settings.⁶ It is therefore essential to address why the majority of children do not access services in a timely or consistent manner.²

In *The Lancet Psychiatry*, Stephan Collishaw and colleagues⁷ present findings from a community sample of parents with recurrent depressive episodes studied over 4 years. They report on a small subsample of offspring who were more resilient than the others—only 53 (20%) of 262 study children (mostly adolescents) did not experience concerning psychological symptoms or had better than expected outcomes. They explore the possible explanations for these better outcomes and highlight some protective factors. The factors that bestow greatest protection include the presence of supportive co-parents, good quality social relationships, self-efficacy, and regular exercise.

This study highlights the combined role protective factors might have for adolescents at risk of depression as the offspring did better with increasing protective factors present. Further studies will hopefully conduct more detailed multidisciplinary enquiry of a greater range of protective factors investigating several domains (such as those within families, peer groups, schools, communities, and beyond). Multiple perspectives, including the voice of the young person, can only

improve our understanding of the many potential influences at play. Focusing on protective factors adds an important dimension to preventive interventions. These findings, alongside other key studies, reinforce the importance of thinking about family-approaches to identifying and treating depression. For example, the data from STAR*D⁸ highlighted how the treatment of maternal depression significantly improves the mental health outcomes of school-aged offspring. Patton and colleagues⁴ showed the importance of early identification and treatment for adolescent depression, as good outcomes are more likely if the first episode of adolescent depression is identified early and treated.

Two important messages need to be emphasised. First, for those treating adults with a depressive disorder, an appreciation of the risk to any offspring must be acknowledged and addressed. In the study reported here,⁷ most children with depressed parents had symptoms of concern. The majority of depression is managed in primary care settings, but a proportion are managed in secondary care and yet family-based approaches supporting carers and offspring are poorly studied and rarely available. The treating clinician might experience philosophical and practical barriers to identifying and including the highest risk family members within their treatment plan, yet some examples of family-focused care and family-friendly in-patient spaces are promising steps towards a new perspective on how to deliver integrated mental health care across the lifespan and to whole families.

Second, a public health approach is urgently needed for the children of parents with recurrent depressive episodes, since their risk of developing depression is high. Depression can affect all developmental trajectories from social functioning to educational and occupational attainment. If depression were perceived as a chronic disease such as diabetes, it would be inconceivable that these children would not be screened. Yet stigma still casts its long shadow over mental illness and feeds into a fear of being labelled and what this might entail. Schools and primary care settings are the environments where early identification will be most feasible.⁹ However, any screening would need to take place alongside innovative approaches to provide accessible, acceptable, and appropriate interventions and services.



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As the global burden of depression is great; interventions to prevent the development, promote the treatment, and limit the effect of depression within families must be seized. The children at highest risk of developing depression include those whose parents have a mental illness; those for whom early social, economic, and emotional deprivation has been present; or those who suffer from another chronic illness or disability. New models are therefore needed to deliver not only reactive but proactive and integrated mental health services (be that in primary care or general hospital settings); in child and family-friendly spaces, including schools and local religious and voluntary organisations; and within existing mental health provision. A focus on protective factors and how to foster these are likely to open new arenas of preventive interventions and help depressive symptoms as well as a broad range of other vital outcomes.

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