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Research report

Identifying prevention strategies for adolescents to reduce their risk of depression: A Delphi consensus study

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ABSTRACT

Background: Adolescence is a peak time for the onset of depression, but little is known about what adolescents can do to reduce their own level of risk.
Method: This study employed the Delphi methodology to establish expert consensus on self-help prevention strategies for adolescent depression. A literature search identified 194 recommendations for adolescents. These were presented over three questionnaire rounds to panels of 32 international research and practice experts and 49 consumer advocates, who rated the preventive importance of each recommendation and the feasibility of their implementation by adolescents.
Results: 145 strategies were endorsed as likely to be helpful in reducing adolescents' risk of developing depression by ≥80% of both panels. Endorsed strategies included messages on mental fitness, personal identity, life skills, healthy relationships, healthy lifestyles, and recreation and leisure. 127 strategies were endorsed as likely to be helpful in reducing risks for depression for both junior and senior adolescents. One strategy was rated as likely to be helpful during the period of junior adolescence only, and 17 strategies were endorsed for the senior adolescent period only. Ratings of the ease of implementing the strategies during the adolescent period accorded by panellists were typically moderate.
Limitations: This study used experts from developed, English-speaking countries; hence the strategies identified may not be for relevant or minority cultures within these countries or for other countries.
Conclusions: This study produced a set of self-help preventive strategies for depression that are supported by research evidence and/or international experts, which can now be promoted in developed English-speaking communities to help adolescents reduce their risk of depression.

1. Introduction

Adolescence is a peak period for the incidence of depressive disorders, which are associated with considerable functional impairment and can have deleterious consequences that extend across the life course (Costello et al., 2003; Hankin, 2006; Hankin et al., 1998). A significant proportion of young people who experience depression are not diagnosed, or do not receive appropriate care (Slade et al., 2009). Further, even if detection and treatment rates were to improve, there is evidence that only a proportion of the burden of depression can be reduced by effective treatment alone (Andrews et al., 2004). Efforts to prevent the occurrence of depressive disorders in adolescence before they emerge, in addition to early intervention and treatment, are thus increasingly recognised as an important strategy to reduce the burden of depression at a population level.

Several reviews now support the contention that depression can be prevented, or its onset delayed, during the adolescent period (e.g., Christensen et al., 2010; Horowitz and Garber, 2006; Merry et al., 2011; Stice et al., 2009; van Zoonen et al., 2014). However, a major limitation of prevention programs is the resources required to provide them in an on-going way. While there are some universal prevention programs that can be delivered relatively cheaply via the internet or mobile phone applications, many programs developed to date have been resource-intensive, relying on a professional (e.g., a clinician or a teacher) to facilitate the intervention over a brief period of time. These interventions have often focused on those who are deemed to be at elevated risk for depression. This involves a screening element which can be inherently stigmatising and exclude a significant proportion of the adolescent population who could potentially benefit from the intervention (Pössel, 2005). Consequently, some researchers have argued that an approach to depression prevention is needed that is scalable, cost effective, and easily disseminated, given the limited resources currently available to support prevention (Cairns et al., 2014; Jacka et al., 2013; McLaughlin, 2011; Munoz et al., 2012).

The promotion of universal prevention messages within the community represents one such approach. During adolescence, young people shoulder increasing responsibility for decisions that

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can potentially influence their mental health status, highlighting the importance of educating them about prevention strategies at this time. The potential for behavioural patterns established during this period to persist over the life course and influence long-term mental health trajectories further underscores the importance of bolstering adolescent mental health prevention literacy (Gladstone et al., 2011). However, public mental health campaigns have tended to be situated at the early intervention end of the prevention spectrum, focusing on encouraging early help seeking and reducing stigma (e.g., beyondblue: the national depression initiative, 2011; Mental Health Council of Australia, 2013). There has been relatively little emphasis on equipping individuals with the knowledge and skills they need to make informed choices about factors contributing to risk of depression and other mental health problems. As noted by Jorm and Griffiths (2006), health promotion campaigns targeting other major contributors to disease burden, such as heart disease and cancer, routinely provide members of the public with information on actions that can be taken to minimise their personal risk profile. They called for this approach to be extended to campaigns targeting risk for depression (Jorm and Griffiths, 2006).

A recent systematic review and meta-analysis identified various modifiable risk and protective factors associated with adolescent depression that have a sound evidence base (Cairns et al., 2014). Risk factors identified include substance use (alcohol, tobacco, cannabis, other illicit drugs, and polydrug use); dieting; negative coping strategies (e.g., avoidant or withdrawal coping); and weight. Protective factors identified were healthy diet and sleep. Although these findings provide guidance as to the risk and protective factors that are influential in the development of depression during adolescence, they do not adequately describe specific, actionable strategies that can be readily implemented by adolescents. To facilitate the application of this research evidence into practice, these broader risk and protective factors need to be translated into specific, practical suggestions that adolescents can act on in their daily lives (Jorm, 2012). Given the relatively rudimentary stage of the universal prevention evidence base, evaluations of interventions containing this level of implementation detail across the spectrum of preventive action are scarce. Therefore, other approaches to evaluating evidence are needed.

One approach is to use researcher, practitioner and consumer advocate expertise to establish consensus on which preventive strategies are most likely to be helpful. The expert consensus approach is increasingly used in the development of practice guidelines for clinicians, and more recently in the development of mental health promotion guidelines for the public (e.g., Morgan and Jorm, 2009; Yap et al., 2014). In this paper, we report a Delphi consensus study on preventive strategies for adolescent depression. The aim was to identify strategies that are likely to be both effective and feasible for adolescents to implement without professional intervention. The delineation of these strategies could also provide a sound basis for the development of universal prevention interventions targeting adolescents (e.g., websites, mobile applications, school-based programs), much like a "behavioural vaccine" for depression (Van Voorhees et al., 2011).

2. Method

2.1. Delphi method

The Delphi method (Jones and Hunter, 1995) was used to establish expert consensus on strategies that adolescents at two developmental stages could apply to reduce their risk of depression. This involved two panels of experts independently rating the extent to which they believed a series of preventive strategies would be effective and feasible for an adolescent to implement without professional intervention. Researchers or practitioners with depression prevention expertise (hereafter "professionals") formed one panel, while consumers who had lived experience of depression during adolescence and were currently in an advocacy role (hereafter "consumers") formed a second panel. Having the former represented as a panel increases the likelihood that the preventive messages developed will conform to experts' current understandings of the evidence base. The inclusion of the latter panel was designed to enhance the relevance and authenticity of the resultant messages. Each panel was asked to reflect on the helpfulness and the feasibility of the strategies for junior adolescents (aged 12–15 years) and senior adolescents (aged 16–18 years), in recognition of the varying salience of risk and protective factors and the different developmental contexts associated with these two phases of adolescence. Following each questionnaire round, panel members were provided with summaries of the findings from the previous round, and asked to consider whether they would like to change or maintain their original rating.

2.2. Panel formation

All panellists were required to be aged 18 years or older and reside in an English-speaking, Western country. The professional panel comprised experts with a minimum of five years' experience in researching depression prevention, or who were involved in depression prevention in practice or clinical work. To identify these panellists, key publications and reviews in the fields were identified and their authors invited to participate. Further, members of key prevention research consortia (e.g., The Alliance for the Prevention of Mental Disorders; The Global Consortium for Depression Prevention) were invited to participate. Individuals known to the authors as having relevant research experience were also invited to participate. The consumer panel comprised individuals who had personal experience with depression as an adolescent, were currently well, and were active as an advocate for mental health (e.g., via peer support, public awareness raising), to ensure they had sufficient understanding of the diversity of mental illness experience. These panellists were recruited with the support of several mental health consumer organisations.

As the aim of a Delphi study is to achieve consensus rather than investigate group differences, conventional notions of statistical power are not relevant. Rather, the target sample size was based on the experience of earlier studies using this methodology. One study found that reliable results could be achieved in a Delphi consensus study using 23 panellists (Akins et al., 2005). In this study, we aimed to recruit a minimum of 30 participants per panel (i.e., 30 consumer advocates and 30 research experts) to allow for some attrition across questionnaire rounds. It is noteworthy that Delphi panels do not aim for representativeness in membership. Rather, panel members are intentionally selected to be "information rich"; thus professional panellists investigating a wide range of research foci within the broader field of youth depression prevention, and consumer panellists with lived experience and a diversity of advocacy experiences were approached to participate.

Experts were recruited via an email invitation designed to solicit interest from potential panel members. Interested individuals were instructed to email the first author with expressions of interest. Upon receipt of expressions of interest, the first author emailed potential panellists with a plain language description of the study that outlined the eligibility criteria, the contribution required by panel members, and the voluntary nature of participation. They were also emailed a link to the online questionnaire; informed consent was implied if they choose to complete the first round of the questionnaire. The project was approved by the Human Research Ethics Committee at the University of Melbourne.