Submission to:

SENATE SELECT COMMITTEE ON MENTAL HEALTH

May 2005

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beyondblue: opening our eyes to depression throughout Australia

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1. RECOMMENDATIONS AND EXECUTIVE SUMMARY

beyondblue is pleased to have the opportunity to present this submission to the Senate Select Committee on Mental Health. In making this submission *beyondblue* has focussed on the high prevalence mental disorders: depression, anxiety and related disorders and has responded to the Inquiry's terms of reference that are most relevant to our work.

The speed of reforms underway in Australia's health system is impressive with improvements in diagnosis, access and treatments for many chronic illness areas including asthma, diabetes, heart disease and cancer. While these reforms encompass evolving good practice, reforms in mental health have not progressed in the same way – stigma and discrimination is rife, workforce shortages, limited access and breaches of standards are common. A social and health coalition approach is urgently required with national targeted strategies for mental health reform to address the burden of mental illness in Australia.

We know from our research that more than a million people in Australia have depression and related disorders at any one time, but less than half are receiving medical care. These are appalling statistics for a progressive country. If the rates of diabetes, cancer and heart disease were similar there would be swift response. While effective treatments are available, stigma, limited access to services, varying quality of treatment, diminishing mental health workforce numbers and lack of choice remain key areas to be addressed.

Substantive changes have taken place in the last ten years in mental health servicing and treatment under the National Mental Health Strategy. However, policy and services across states remain inconsistent and lack integration and standards. *beyondblue's* partnership activities and success in increasing awareness of depression and its impact across Australia have begun to reveal the extent of the problem – a mental health and primary care system in crisis with more than 1 million lives affected.

Apart from the social impact of depression, we know that over $3 billion is lost to our economy each year by not addressing the illness. These costs are not just to the health sector but include indirect costs that impact on other portfolio areas, for example welfare and disability support costs. A Coalition of Australian Governments response is needed to develop a national agreement on the urgency and importance of federal leadership and national commitment in this field. There is a need to set new national targets for mental health outcomes around such areas as: proportion of people with mental disorders provided with care; national disability costs attributable to mental disorders; and national suicide rates. This would allow agreed targets to be set and better monitoring of achievements and progress of the National Mental Health Plan.

One billion dollars is required as an injection for mental health, with the Federal Health Minister taking on portfolio responsibility to lead a reform agenda. The wider costs associated without a social coalition approach cannot be underestimated.

Key points

Depression, anxiety and related illnesses are the most prevalent mental health disorders in Australia yet have received little attention in comparison to specialist health domains and acute care. Depression is now Australia's most debilitating illness with over one million people affected each year. Depression is often preventable, treatable and effective treatments are available.

Non-government organisations play a vital role in the delivery of programs to support people with depression and other mental illnesses and need to be adequately supported to do this.

New and improved antidepressants have reduced the burden of depression and research indicates that there is appropriate restraint in their use. However, there are some issues that need to be addressed in regard to the use of selective serotonin reuptake inhibitors in the treatment of young people and children. Non-pharmacological treatments, such as cognitive behaviour therapy, are effective and therefore need to be more accessible to the general community through improved access to psychologists and allied health.

There are a number of population groups that require particular attention:

- **Indigenous peoples and people from culturally and linguistically diverse populations** – little is known about depression in these populations and how to best address it.
- **persons with comorbid mental health and substance use disorders** who face many barriers to accessing help
- **young people** whose mental health is not improving as expected. There is a need for wider implementation and evaluation of youth-specific prevention and treatment programs
- **the elderly** - a number of preventative strategies have been identified that could reduce the incidence of depression and other mental illnesses in this group which need to be investigated. There is a pressing need for studies of the efficacy of non-pharmacological in primary care settings
- **new and expecting mothers** - the incidence of perinatal and postnatal depression is of concern. There is a need for a national screening program and follow up services to ensure that cases of depression among expectant and new mothers can be identified and treated early
- **people with co-occurring depression and chronic physical disorders** - very little is known and available in regard to effective treatments and early intervention models
- **people in the workplace** - the delivery of training and education to workplaces should be supported and widely implemented. A national strategy addressing depression and mental illness in the workplace, under an occupational health and safety framework, should be developed to advance equal employment opportunities for people with mental illness.

beyondblue will continue to contribute its efforts with a social coalition approach to tackling the issues associated with depression. Priorities include tackling stigma, targeted populations and improving access. We offer the following examples of unmet need under our priority areas:

a) Community awareness and destigmatisation

Communities, particularly men and people in rural areas, need further education about the signs and symptoms of depression and the benefits of early intervention. Awareness raising and destigmatisation initiatives must be sustained to address the disturbing levels of stigma, discrimination and ignorance in the Australian community regarding depression and related disorders.

b) Consumer and carer participation

The personal experiences of those with the illness and those who care for people with depression indicate that there is work to be done to improve the interaction between healthcare services and consumers and carers. blueVoices, the consumer and carer arm of *beyondblue* has written a submission to this Inquiry that outlines the specific needs and perspectives of people with depression and their carers.

c) Prevention and early intervention

- Prevention and early intervention of depression and other mental illness across the life cycle has great potential. The systematic evaluation of both broad community strategies and more targeted interventions should be a priority.
- Research is needed to tell us more about depression in Indigenous communities and effective interventions. Models of care to support primary health care providers are showing great promise and need to be further investigated.
- Organisations and services for Australians from culturally and linguistically diverse backgrounds must be supported to continue their work with culturally and linguistically diverse communities and health care service providers to improve understanding of depression and access to appropriate services.
- It is important that the potential of internet-based mental health care as a health service delivery tool be recognised and investigated more broadly.

d) Primary Care (and allied health)

- Improving primary care workforce participation through the Better Outcomes in Mental Health Care Initiative is proving successful. Early improvements in training and support must be sustained and expanded, particularly in rural and remote areas.

- Allied health workers, such as psychologists and counsellors, play a crucial role in the delivery of mental health care for people with depression. However the majority of patients with depression are seriously compromised by the cost required to access appropriate services. There is a need to expand the currently restricted access to allied health services.

e) Targeted research

- The National Health and Medical Research Council could play a lead role in addressing gaps in mental health research by increasing their focus in regard to high prevalence mental health disorders, with particular investigations into public health innovations and service delivery models.

- The National Survey of Mental Health and Wellbeing should be conducted on a regular basis (every ten years) to ensure we can monitor prevalence and service utilisation.

2. INTRODUCTION

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia. Established in 2000, initially by the Commonwealth and Victorian Governments, *beyondblue* is a bipartisan initiative of the Australian, state and territory governments with a key goal of raising community awareness about depression and reducing stigma associated with the illness. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression, to bring together their expertise. Our five priorities are:

1. Increasing community awareness of depression, anxiety and related substance misuse disorders and addressing associated stigma
2. Providing people living with depression and their carers with information on the illness and effective treatment options and promoting their needs and experiences with policy makers and healthcare service providers
3. Developing depression prevention and early intervention programs
4. Improving training and support for GPs and other healthcare professionals on depression
5. Initiating and supporting depression-related research.

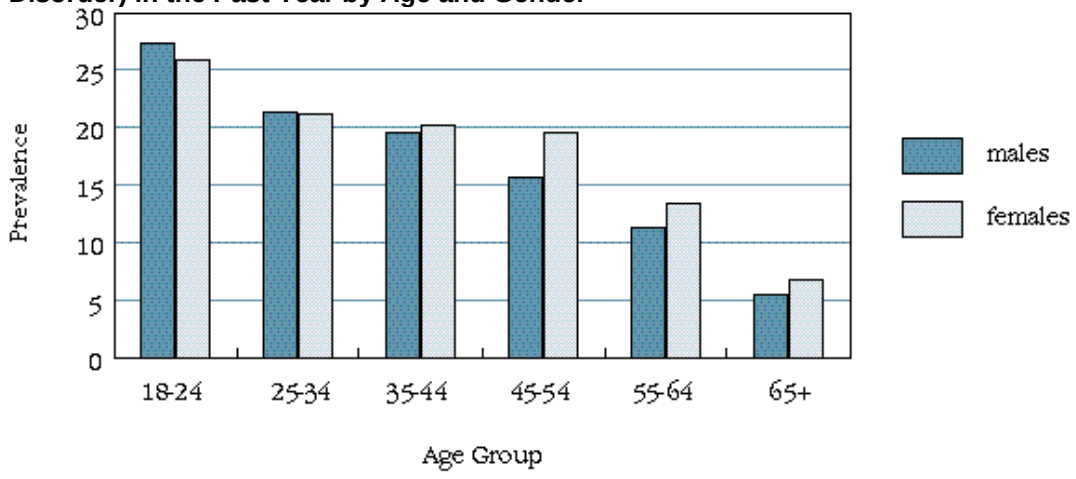
3. ABOUT DEPRESSION AND RELATED ILLNESSES

Depression is now Australia's most debilitating illness, accounting for 8% of all years lived with a disability and over $3 billion annually in direct and indirect costs[1]. Other depression related disorders, such as anxiety and bipolar disorder, add significant additional costs.

On average one in five Australians will experience depression at some point in their lives[2]. Anxiety is common, affecting 9.7% of adults in a 12 month period and similarly substance misuse affects 7.7% of adults in a 12 month period[1]. Together depression, anxiety and related substance misuse are by far the most prevalent mental health problems. In fact, depression is currently the most debilitating illness, even when compared with all other mental health *and* physical health conditions.

High levels of depression-related disability result from the fact that 62% of people with depression commonly do not seek treatment for their condition[2]. Depression and related disorders are more common among younger adults with 27% of people between the ages of 18 and 24 having one or more of the disorders[2].

Figure 1: **Prevalence (%) of Any Mental Disorder (any Anxiety, Affective or Substance Use Disorder) in the Past Year by Age and Gender[2]**



Specific areas of concern that pose challenges for the future include an increasing incidence of mental disorders in young people, often in association with alcohol or other drug misuse

problems, and an increase in the prevalence of mental disorders among older people due to the long term untreated high prevalence disorders and the ageing Australian population.

4. RESPONSE TO RELEVANT INQUIRY TERMS OF REFERENCE

4.1 The National Mental Health Strategy

In 1992 all Australian Health Ministers and Governments adopted the National Mental Health Policy which has since been implemented through a series of National Mental Health Plans under the umbrella of the National Mental Health Strategy. Depression was identified as a priority under the Second National Mental Health Plan following a National Survey identifying more than 800,000 people have depression and less than 40% receive medical treatment. Depression was subsequently adopted as the first area of focus for mental illness, one of six National Health Priority Areas. In March 2000, in response to the National Depression Plan and its recognition of the huge personal, social and economic impact and burden of the illness, the Commonwealth Government, in association with the Victorian Government, established *beyondblue: the national depression initiative* to raise awareness of depression and address the stigma associated with the illness.

beyondblue underwent an independent evaluation of its activities in 2004. The evaluation confirmed that *beyondblue's* activities are making a substantial impact across Australia and can claim much of the credit for improved awareness, literacy and understanding of depression[3]. That said, while *beyondblue* has achieved a significant amount in a relatively short space of time, there is still some way to go. *beyondblue* has been funded for a further five-year period to allow many of the partially-achieved objectives to be fully realised in order to maximise Australia's potential to reduce depression and address its impact.

beyondblue supports the National Mental Health Strategy and considers it a world-leading population-based mental health policy. However, we note and share the concerns expressed by many in the mental health sector that the implementation of the strategy has not been fully achieved[4,5]. Lack of strategic focus, national leadership and quality accountability and reporting systems in mental health maintains the current variation of service delivery and breach of standards, lack of access and limited treatment options. The variability also reflects the separateness and lack of integration in service planning and delivery, preventing the integration of mental health across health and other key portfolios.

Australia's national health spending is growing, however spending on mental health has remained below 7% as a proportion of this expenditure. While new funding for mental health has been delivered, it has been estimated that this represents only 10% of the federal government investment that is needed[4]. A similar increase in state and territory funding for mental health is also required. An investment of $1 billion over 4 years in addition to current funding levels would ensure the adequate delivery of prevention, early intervention, treatment and specialist services across the lifespan. Considering that untreated depression costs the community $3 billion annually, this investment is worthwhile. It is also imperative that a dedicated federal mental health portfolio be established, closely overseen by the Federal Minister for Health.

Specific areas that we consider require attention and sustained action are discussed below.

4.2 Models of care for people with a depression-related illness

Prevention and early intervention

Until recently there has been too great a focus on enhancing specialist domains of emergency and acute care for serious mental illnesses that do not cater for high prevalence mental disorders such as anxiety and depression and do not engage in prevention and early intervention. New funding is urgently needed to focus on innovative models for prevention and early-intervention.

Prevention has long been the 'poor relation' in the health sector, possibly because the outcomes of successful prevention efforts are sometimes not evident for many years, for

example, immunisation initiatives. While the prevention of depression and related illnesses is now receiving more focus, its slow uptake across national and state policy has resulted in a patchy evidence base about what interventions work in the Australian context. There is still a lack of professional, clinical and government commitment to the implementation of population-based interventions[6].

There are many opportunities across the life cycle to prevent depression which depend on community-wide, and not just individual, behavioural change and *beyondblue* is supporting large population-based trials across a wide variety of interventions and populations. Early intervention depends on earlier recognition of signs and symptoms, greater awareness among primary care and other medical workforces, and promotion of attitudes that encourage persons of all ages to seek care. Particular interventions that show promise include:

- awareness raising and destigmatisation campaigns
- screening for antenatal and postnatal depression
- whole-of-community programs to enhance family and school environments
- training programs for the appropriate recognition and management of depression in the workplace
- enhancing the capacity of general practitioners and other primary care practitioners to identify and respond to depression-related illnesses
- increasing access to parenting skills training
- promoting better physical health in older persons

Systematic evaluation of both broad community strategies and more targeted interventions should remain a priority.

Prescribing of antidepressant medications

There has been an increase in the level of prescribing of antidepressant medications in Australia, particularly during the 1990s, with the introduction of the selective serotonin reuptake inhibitors (SSRIs) and other new antidepressants. There is growing evidence that increased exposure to antidepressants through prescribing in general practice may have produced a measurable reduction in the burden of depression. In particular, the increase in antidepressant prescribing has been associated with benefits such as a decline in suicide rates in those who access care. Older adults had the highest growth in antidepressant use and the greatest decline in suicide[7]. Despite this there have been concerns expressed in the wider community about whether this increase in the use of antidepressants is appropriate. An examination of the trends in general practice prescribing indicated that the pace of growth for antidepressants has slowed and that doctors are prescribing in a manner consistent with accepted pharmacological advice[8].

There are some specific issues in regard to the prescribing of antidepressants in regard to young people and children, with little being known about the optimal duration of treatment and the effectiveness of pharmacotherapy in this group. There have been calls for the withdrawal of SSRIs for young children and protocols regarding labelling to highlight potential side effects, including suicidal ideation and attempts. *beyondblue* has facilitated a national focus group including The Australian Medical Association, The Mental Health Council of Australia, The Royal Australian College of General Practitioners and The Royal Australian and New Zealand College of Psychiatrists and the group are developing a joint statement and highlighting the research in regard to the use of anti-depressant medication in the treatment of depression in children and young people, with a view to ongoing review of this issue.

Non-pharmacological treatments

There is a wide range of effective non-pharmacological treatments for depression, such as cognitive behavioural therapy (CBT), however these are not readily available in the community. Psychological treatments such as CBT are highly effective, particularly for persons who have mild to moderate depression and anxiety, however for more severe cases, medical treatments may also be necessary. The effectiveness of these psychological

treatments, together with the preference for non-drug treatments in the community, highlights the importance and strong support for national initiative such as the Better Outcomes in Mental Health Care Initiative which serves to provide consumers with access to a wider range of treatments.

In addition to non-medical treatments, national surveys have found that many Australians also state a preference for self-help and complementary therapies for depression and anxiety and also use self-help interventions more commonly than professional treatments when they have anxiety and depressive symptoms. *beyondblue* commissioned two reviews investigating the effectiveness of complementary and self-help treatments for depression and anxiety and is also undertaking large trials to examine the effectiveness of natural approaches to preventing depression.

Self-care strategies for depression and anxiety are an increasingly important part of the mix of treatments that need to be available to the wider community. While these treatments are not as well supported by evidence as standard treatments, such as antidepressants and cognitive behaviour therapy, the community needs information about which treatments are likely to be effective, which are not, and which have not been adequately evaluated.

Co-existing mental illness and substance misuse

Comorbidity of mental disorders and substance use disorders is common. The 1997 National Survey of Mental Health and Wellbeing found that about one in four persons with an anxiety, affective or substance use disorder also had at least one other mental disorder[9]. Persons with comorbid disorders often have a poorer treatment response and a worse course of illness over time. They are also more impaired, suffer greater social disability and generate larger social costs[10]. Of particular concern is the prevalence of comorbidity among young adults aged 15-24 years with nine out of ten leading causes of burden of disease and injury in young males, and eight out of ten leading causes in young females, being substance use or mental disorders.

People with comorbid mental disorders and substance use disorders often fall into the gap between alcohol and other drug services and mental health services as standard interventions do not cater, and sometimes exclude, these individuals. While there was good national leadership via the National Comorbidity Project conducted jointly under the National Drug Strategy and the National Mental Health Strategy, there is a sense that this has had little impact on the ground[11]. Major barriers to service provision are the lack of adequate research to specify best practice for the treatment of comorbidity and lack of commitment by government funders to implement service reforms.

Areas recommended as most likely to produce best outcomes include community screening and treatment for disorders in childhood and well-trained service providers who are adequately versed in the detection, management and referral of people with comorbid problems[12]. Particular focus is being placed on primary care as a key setting for the identification and treatment of comorbid alcohol misuse and mental health problems and, while a number of small projects underway are investigating potential models for comorbid clients, there is little focus on comorbidity with high prevalence disorders. More focus and investment in this area is required.

4.3 The role of the private and non-government sectors

Non government organisations (NGOs) play a vital role in the delivery of programs to support people with a mental illness as they often deliver some services more efficiently and/or effectively than the government or private sectors. This has been recognised with the role of NGOs expanding over the past decade. In 1993, less than 2% of total mental health expenditure was allocated to NGO programs to provide support for people with a mental illness in the community. This has increased three-fold and now accounts for 5.5% of total state mental health expenditure[5].

The *beyondblue* non-government bipartisan model has been successful. *beyondblue* works in partnership with a wide range of organisations – government, non-government and corporate. Government and private sector support has been a crucial element of *beyondblue's* work.

There remains, however great potential for the private sector to better support non government organisations working to reduce the burden of mental illness in the community.

4.4 The special needs of population groups

4.4.1 Young people and families

The mental health of young Australians is not improving as one would expect, rather we are seeing a rising tide of psychosocial disorders that significantly impact upon the well-being of this population group. The onset of potentially serious disorders including depression and psychosis generally occurs in adolescence and early adulthood (16-25). With young people between the ages making up 23% of the population, the need for early diagnosis and intervention is crucial.

Since the Second World War there has been a substantial increase in psychosocial disorders in young people. A number of psychosocial factors have impacted upon the mental health of young people, this includes an increase in juvenile crime, rise of alcohol use and widespread use of illicit drugs, increase in depressive disorders and a sharp increase in suicidal and self-harming behaviours[13]. It is clear that the severity of these disorders varies significantly and is influenced by a number of variables including gender, age socio-economic status and cultural background. Existing mental health services in all developed countries are struggling to mount an effective response, made more complex by the division in Australia of mental health services into child/adolescent and adult with an artificial division at 16-18 years. Many have argued the need for a separate system dealing with youth psychiatry or mental health, particularly given youth onset mental disorders are arguably the most serious problems of their developmental period both in mortality and morbidity[14,15,16]. Notwithstanding this, clinical and public health responses have been few, piecemeal and relatively ineffective to date.

The terms 'adolescent' and 'young person' or 'youth' are often used interchangeably, however in order to understand the onset of many disorders a distinction needs to be made between the two. The World Health Organisation describes adolescence as the period from 10-19. This incorporates the developmental transition from childhood to adolescence (encompassing puberty) and from adolescence to early adulthood. This is important because it is becoming evident that the latter transition can be more troublesome than the immediate adolescent years themselves[14]. This encourages the use of the term 'youth' or 'young people' for people aged 15-24, as an alternative to adolescence and ensures the special needs of late adolescents and young adults are considered. Furthermore, the specific data on youth suicide, showing that most of the excess occurs in the 20-24 age group, rather than those aged 15-20, also suggest that enhancing the services up to age 18 alone will prove to be an inadequate service response.

To date the service structure is such that upon turning 18 a young person must utilize the services of an adult service only if they have a defined 'serious mental illness' (meaning in most cases psychosis, especially schizophrenia). Therefore the mental health problems of most young people in the 18-25 age group largely go either undetected or receive no intervention whatsoever.

In order to develop appropriate services which aim to promote positive mental health and prevent the onset of mental illness in young people, a project of national significance is required which can develop a best practice approach to early intervention and prevention of youth mental health problems. Key to this would encompass service reform which is underpinned by three key pillars: the expanded developmental phase to encompass a youth population; the epidemiology of mental disorders in young people; and young people's access to standard health care systems.

Depression is one such disorder which is highly prevalent amongst young people, where 50% or more of those who develop depression have their first onset before age 25. Epidemiological studies suggest that up to 20% of young people have experienced at least one period of major depression by the time they are 18 years old[17]. Moreover, between 15% and 40% of young people report symptoms of depressed mood and depressive symptoms[18]. Depression is the most common factor associated with suicide in all age groups. The majority of suicide victims meet criteria for depressive disorder in the weeks before death[18].

This evidence suggests that levels of many lifestyle-related risk factors for major causes of disease burden are higher in young people than in any other age group. This continued poor, or worsening health risk profile of young people, suggests that future population wide morbidity and mortality patterns are unlikely to shift in a favourable direction as successive cohorts enter adulthood. This recognition underlies the growing public health interest in the scope for preventative and health promotional interventions in adolescence and early adulthood.

Initiatives such as *beyondblue: the national depression initiative* are indeed a step in the right direction to developing a more preventative and early intervention approach. However it is not enough to expect these initiatives alone will have a serious impact upon the growing burden of disease in this age group.

This Inquiry provides an opportune time to consider the development of age appropriate services and interventions which can meet the developmental needs of young people aged 16 to 25. This can be achieved by building on many of the current initiatives that already exist, particularly with a prevention or early intervention focus. However from a service delivery perspective the need to develop age appropriate services for this age group is well documented. Young people are often reluctant to seek help and are discerning with regards to who they seek assistance from. How a service orients itself towards young people is critical. Particularly for young people who don't necessarily have a 'serious mental illness', and even for those who do, the stigma associated with attending a mental health clinic is significant.

This strengthens the argument for maintaining and further developing mental health services with a youth focus, and at the same time ensuring the primary care sector is resourced and supported to detect and manage the more high prevalence problems like depression, which largely remain undetected.

4.4.2 Elderly

Population surveys have reported the prevalence rate of depression and anxiety in Australians over the age of 65 years as 6.5%[2]. This is generally lower than all other age groups, leading some to suggest that depression declines in old age, however it is important to note that people living in residential care such as nursing homes are often not included in epidemiological community studies. The prevalence of major depression among older people living in residential care is reported to be very common with rates of up to 26%[19].

A report written by the Australian Institute for Suicide Research and Prevention highlights that in Queensland the rate of suicide is higher among men aged 75 years and over than for young men aged 15-24 years[20]. With the ageing of the Australian population, the number of depressed elderly Australian is expected to double by 2021.

Evidence also suggests that awareness of depression among older people is poor, as compared to all other population groups. A recent survey found that when asked to identify the major mental health problem in Australia, the identification of depression was lowest among older respondents, particularly those aged 65 years and over, when compared with all other age groups[21].

A recent *beyondblue*-funded study of 300 elderly low-level care residents, conducted by the Centre for Health Risk Behaviours and Mental Health at Deakin University, sought to investigate depression rates among older people living in residential care and to identify appropriate depression screening instruments to enable early detection of depression in older people. The study found that nearly half of the sample presented with symptoms of depression at the time of assessment and/or were currently prescribed antidepressant medication[19].

Depression in older people, particularly those residing in aged care, has long been recognised as a major health issue, but it hasn't been well addressed on a national basis, across health and aged care services, nor in community and acute care settings. While there is chronic under-treatment of depression in all populations, older people are the most vulnerable. This is partly because healthcare providers are failing to recognise depressive symptoms that may be

described differently in older patients or be seen as side effects of medical illness. A range of strategies have been identified that could contribute to preventative programs:

- increasing literacy about depression in old age
- improving recognition/diagnosis in primary care
- promotion of physical exercise to alleviate symptoms of mild to moderate depression
- nutritional supplements
- incorporating depression screening in the Aged Care Assessment Instrument

Many of these strategies are the focus of the large *beyondblue* research project into depression and the elderly, the Beyond Ageing Project. In response to the unmet needs of older people, *beyondblue* has established maturityblues, a national voice for older people with depression in Australia and their carers.

A review of treatments for depression of patients over 60 years of age[22] found that there is little evidence of effectiveness for a variety of treatment approaches for depression in older people in primary care, particularly in those with less severe depression. There is a pressing need for studies of the efficacy of non-pharmacological interventions for the elderly with depression in primary care settings.

4.4.3 Mothers (post natal depression)

Postnatal depression affects about 14% of women who give birth and recent evidence suggests that many women may in fact be depressed during their pregnancy. Research has linked depression at this time to chronic depression, marital difficulties and behavioural and cognitive delays in children. Despite the prevalence and consequences of depression occurring antenatally and postnatally, most women commonly remain unidentified and untreated.

The *beyondblue* Postnatal Depression (PND) Program aims to research and promote early intervention into postnatal depression within Australia through addressing community and health professional awareness of antenatal and postnatal depression and reducing the social stigma that many women face when diagnosed with this illness. The program has investigated the use of a brief mental-health screening tool, the Edinburgh Postnatal Depression Scale (EPDS), in an Australian population, to identify women who may be at risk of antenatal and postnatal depression. Women screened as part of this program were approached through the antenatal clinics at major maternity hospitals and all women received an educational booklet, 'Emotional Health During Pregnancy and Early Parenthood', which provided resources and contact numbers should they require further help.

In addition to the education booklet and referral to GPs occurring nationally, each state developed specific treatment programs. The Program is currently running in Victoria, South Australia, Western Australia, Queensland, New South Wales, Tasmania and the Australian Capital Territory.

Initial findings highlight that many women are experiencing depression during pregnancy and that there are important gaps in knowledge about pregnancy-related depression, particularly in the areas of detection of antenatal depression and the different type of treatment options available. The project has assessed the effectiveness of widespread depression screening and education. Professional and community attitudes and knowledge of pregnancy-related depression has been assessed as well as referral patterns, usage of services and management of depression.

The project data is currently being analysed. *beyondblue* is now working to establish a national postnatal depression screening program and will be seeking the support of governments in its national implementation.

4.4.4 Rural/remote communities

Rural Australians have poorer health overall and have higher morbidity and mortality when compared to metropolitan communities. In relation to depression, while the literature does not agree about the incidence and prevalence of depression in rural communities, recent research suggests that the rates of depression across metropolitan, rural and remote Australia are similar[23,24]. Despite this, suicide rates have consistently been found to be higher in rural communities and higher still in remote populations, particularly amongst men[24,25]. This may be due to the fact that people with depression in rural areas commonly do not seek help for the illness.

Help seeking for depression

A recent study found that only 11% of young rural men with a mental health disorder had accessed care for that disorder[24]. This lower utilisation of services by young men has also been found for other conditions, and is not unique to mental illness[26]. Further, GPs in rural and remote areas have lower rates of patients presenting for psychological problems[27].

A variety of factors may influence a decision to seek help. Importantly, factors may include: perceived helpfulness of service providers and treatments offered by them; knowledge of risk factors and causes of mental illness; attitudes towards seeking help for mental health problems; and attitudes to towards mental illness[23]. In addition to mental health literacy, a number of attitudinal factors may be important. It has been suggested that self-reliant and resourceful attitudes found in rural Australian residents make it difficult for people to acknowledge that they are experiencing problems or distress. Stigma is another factor which has been identified as a barrier to help-seeking in rural communities. A number of cultures value emotional control and perceive emotional expressiveness to be undesirable traits. Individuals in these cultures are often fearful of emotions and, as a result, reluctant to seek help. Farmers, for example, are widely regarded to value this cultural attribute.

It needs to be noted that a campaign to encourage rural men and women to seek professional help for depression is an immediate priority for *beyondblue* and their activities will probably increase the number of rural Australians who seek help for depression from their rural GP – and increasingly scarce health resource.

Primary health care provided for depression

Like most Australians, people in rural areas mainly access GPs for their primary health care. However, many communities (with or without access to a GP) nominate a community or remote area nurse, a bush nurse or an Aboriginal Health Worker as their main primary health care provider.

We know that rural and remote Australians have poorer access to health care than metropolitan people[28]. Rural Australians also tend to have a higher stage of disease and severity when they seek help[27]. This may be due to the undersupply of GPs in rural and remote areas and the difficulties in accessing a GP which mean people choose to delay consulting the GP for minor symptoms and wait until the symptoms become more severe, often acute.

In rural areas, depression is more frequently managed by the GP[27] and they are more likely to prescribe antidepressants to their patients. In contrast, GPs in metropolitan areas generally refer their patients on to psychiatrists or psychologist.

If a person from a small rural or remote area is not able to access a GP trained in mental health, it is be very difficult for that person to access an alternative provider of services, without travelling a significant distance, often at great expense, and may mean that the person will not seek ongoing care for the mental health problem or symptom.

In metropolitan and regional areas, the community will have access to more than one primary health care provider and most probably a hospital service. Solo GPs and GPs in areas of high workforce shortage require the greatest support to enable them to access mental health training out of their community.

Specialist mental health services

Rural and remote Australians access specialist mental health services (psychiatrist or mental health nurse) at a significantly lower rate than their metropolitan counterparts[29]. Figure 2 shows the striking difference in the way that rural and metropolitan communities access psychiatric services.

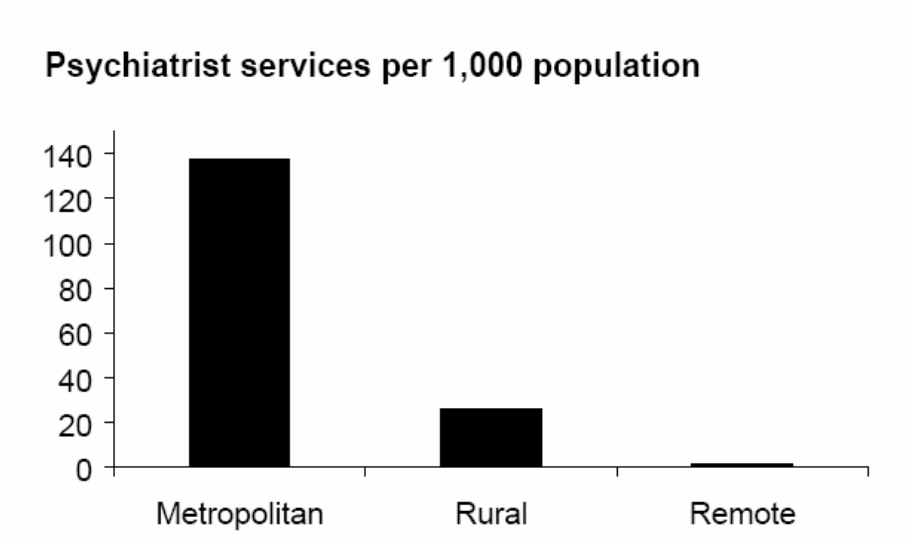


Figure 2: Medicare-funded psychiatrist attendances per 1,000 population by RRMA 2002-03[29]

This may be accounted for by the fact that the number of psychiatrists, even when expressed in proportion to the more spare population characteristic of rural Australia, is strikingly lower in rural and remote Australia, as shown in Figure 3.

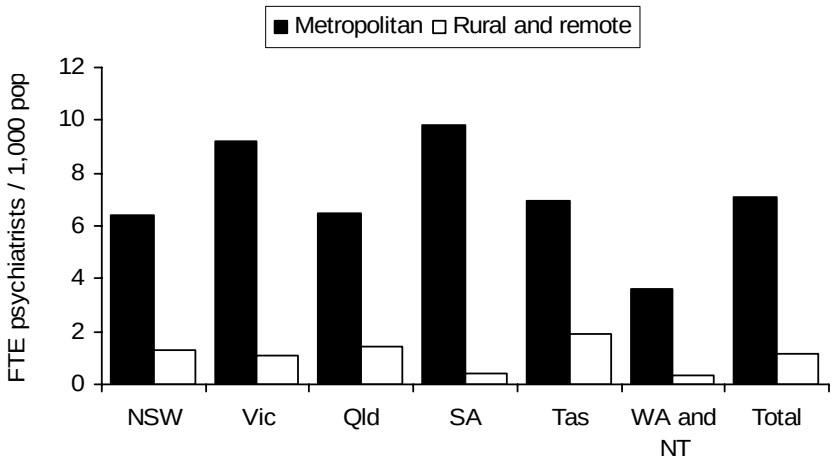


Figure 3: FTE Psychiatrists per 1,000 population by RRMA 2002-03[29]

Taken together, it is evident that psychiatric services are inaccessible to many Australians who reside outside capital cities.

Because of the lack of specialist mental health clinicians, particularly in small rural and remote communities, primary health care providers and people with depression do not have access to specialist services. This is particularly relevant for people with a higher level of morbidity or complexity in their depression.

There are very few mental health specialists (psychiatrists, psychologists and mental health nurses) providing services in small rural and remote communities although there has been a recent increase in the provision of outreach psychiatry services to a small number of

communities through the Australian Government's Medical Specialists Outreach Assistance Program. Outreach services have been shown to assist GPs in providing ongoing care to patients[30] through the provision of services to patients in the presence of, or in consultation with, the GP. This has been found to alter the GPs clinical behaviour regarding patients with a mental illness[23]. However, it is not known whether this leads to better patient outcomes.

Because of the lack of specialist mental health care services in small and rural remote areas, GPs in these areas are often the sole provider of local services for people with a mental illness. It is, therefore, imperative that these GPs are trained adequately in the diagnosis and management of mental health problems.

There is an urgent need to educate communities, particularly men, about the signs and symptoms of depression and the benefits of early intervention and rural and remote GPs need to be supported with the knowledge and tools to manage depression. Nearly 40% of practices employing a GP trained and registered with the Better Outcomes in Mental Health Care Initiative are in rural areas. This is to be applauded and highlights the need for expansion of the Initiative. The potential alternative models of help to facilitate rural and remote access to specialist care (such as e-health) should also be explored.

4.4.5 Indigenous peoples

The *Bringing Them Home* report recognised and acknowledged that Indigenous family structures suffered lasting damage as a consequence of past colonial policies and practices.

Children from Indigenous families were sometimes removed from their families while in hospitals and Aboriginal or Torres Strait Islander people were historically excluded from care (including hospital and the Royal Flying Doctor Service)[31]. Taken together, this has led to some distrust of the health care system which needs to be considered in the development of mental health promotion and services for this target group of people.

Indigenous people have higher rates of unemployment, less adequate housing, lower education and higher rates of imprisonment. They have a shorter life expectancy by 20 years, higher death rates for all ages, and are significantly more likely to be hospitalised. In addition, those Indigenous people who live in rural and remote areas are additionally disadvantaged through lack of access to local health services and infrastructure.

We do not currently know the rates of the most common mental health disorders amongst the Indigenous population. However, we do know that the rate of suicide amongst the Indigenous population is 1.6 times higher than for the non Indigenous population[32] (1.8 times higher in men and 1.3 times higher in women). However, when Victoria and New South Wales, ACT and Tasmania are excluded from the data (as their recording of Aboriginality is known to be unreliable), the ratio is 1.9, with 2.1 for men and 1.5 for women.

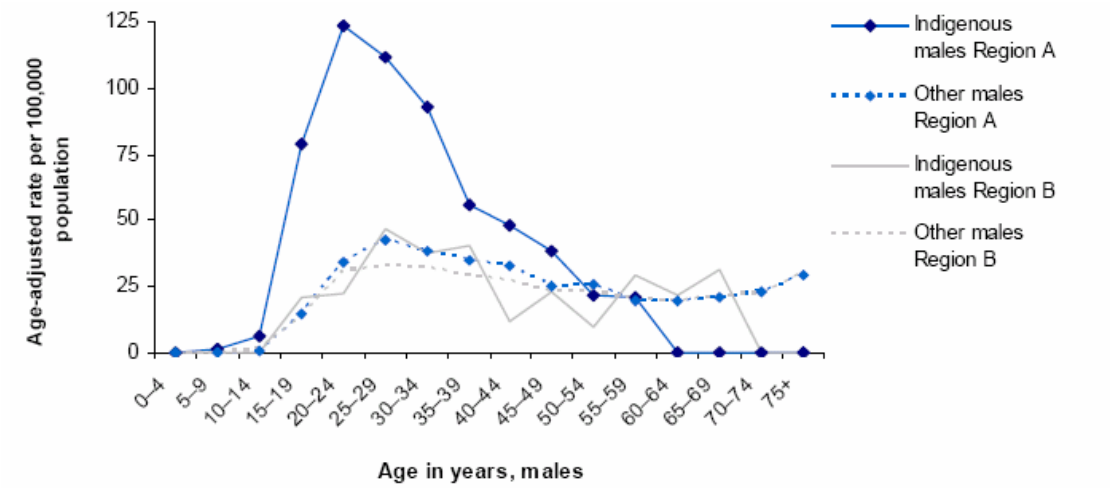


Figure 1. Total deaths due to Suicide registered 1997-2000, Aboriginal and Torres Strait Islander and other Australian males by age, regions A and B[32].

It has been suggested that the symptoms and treatment of depression need to be reviewed for the Aboriginal population[31] and consideration needs to be given as to whether culturally valid assessment tools are necessary.

Therapies such as CBT may not be appropriate 'feeling better by changing the way you think', and that validating past experiences and understanding the lived reality – other forms of psychotherapy such as art therapy, narrative therapy, drama may be more effective. Many primary health care providers have difficulty understanding mental illness and treating Indigenous people. For example, symptoms of being 'away from country' may replicate some mental illnesses (eg. vivid dreams of being visited by ancestors).

The Aboriginal Mental Health Worker program, a pilot program funded by *beyondblue* and the Alcohol Education and Rehabilitation Foundation has recently been evaluated. The program involved the employment of a community liaison Aboriginal Mental Health Worker to work alongside GPs, in a general practice environment, similar to the practice nurse model. The program was shown to be effective in providing culturally appropriate information and mental health promotion to communities in the Northern Territory. In addition, the program was able to build the capacity of general practitioners to understand cultural aspects of symptoms to assist assessment of mental illness amongst the Indigenous community. Models such as this program are consistently effective locally and need to be more widely trialled and implemented through the Better Outcomes in Mental Health Care Initiative.

There is currently a poor evidence base surrounding depression in Indigenous communities which needs to be addressed via research to determine appropriate terminology, messages and services for the Indigenous population.

4.4.6 Culturally and linguistically diverse (CALD) people

People born in countries where English is not the main language spoken account for 14% of Australians with a mental disorder. While prevalence rates for mental disorders in people born in non-English-speaking countries show that the rate is lower than for people born in Australia[33], it should be noted that respondents with poor English language are not included in these surveys.

To address this shortage of information the *beyondblue* has funded the Centre for International Mental Health to conduct a national scoping of activities relating to depression and ethnic minority communities. Results to date indicate several broad themes that need to be addressed in meeting the mental health needs of ethnic minority communities.

Many of those who come to Australia as refugees have experienced displacement, war and trauma, placing them at increased risk of post-traumatic stress disorder and major depression. Children, adolescents and young adults from culturally and linguistically diverse backgrounds, including second generation migrants, may experience heightened uncertainty related to cultural identity, discrimination, peer relations, cultural views on sexuality and work and family demands, particularly at times of transition in their lives. The Queensland BRiTA project illustrates the effectiveness of applying language and sensitivity to cultural issues, rather than assuming generic-style health programs will suit all target groups. It involved the delivery of a set of learning modules specifically designed to build resilience in young people from CALD backgrounds. Piloted in Townsville, Logan City, Gold Coast and Canberra, it is now being adapted for primary school-aged children and for nurses working with CALD and refugee children and young people.

It is important that people with CALD backgrounds are supported and have access to relevant information. Good work is being done to improve awareness of depression among people from diverse backgrounds but there is still much to do with an analysis identifying that access to information on depression that is relevant and significant to people from CALD backgrounds should be more available on the internet[34]

Postnatal stress and depression is a significant health issue for women of non-English speaking background with the stigma associated with depression and mental health problems in CALD communities preventing many women from speaking openly about their emotional state. To help address these issues, *beyondblue* has translated several post natal depression resources and screening tools into 19 languages.

beyondblue is supportive of the Framework for Implementation of the *National Mental Health Plan 2003-2008 in Multicultural Australia* and believes that organisations such as Multicultural Mental Health Australia need to be resourced to continue their work with the CALD community and health care service providers to improve access and understanding relating to services for Australians from diverse backgrounds with depression.

4.4.7 People experiencing comorbid depression and chronic illness

Just under half of Australians with any mental disorder have a chronic physical disorder (43%), such as asthma, chronic bronchitis, anaemia, high blood pressure, heart disease, arthritis, kidney disease, diabetes, cancer, stomach or duodenal ulcer, chronic gall bladder or liver trouble[2]. Major depression rates among older people with comorbid conditions such as heart disease, stroke, arthritis, Alzheimers and cancer are much higher than average[35].

beyondblue is funding significant investigations into this issue that are exploring the association between depression and chronic illness in regard to heart disease, musculoskeletal pain, stroke, HIV/AIDS and diabetes. The association between comorbid depression and chronic illness needs to be explored and addressed.

4.4.8 People experiencing comorbid drug and alcohol dependence and depression-related disorders

As discussed earlier under section 4.2, persons with comorbid disorders often have a poorer treatment response and a worse course of illness over time. There is an urgent need to remove the barriers to accessing help for this group.

4.4.9 Depression in the workplace

The impact of not recognising and responding to depression and related disorders in the workplace is substantial. Untreated depression can result in a significant reduction in work performance and productivity, with depression accounting for high rates of absenteeism, three to four days off work per month for each person experiencing depression. This equates to over six million working days lost each year in Australia[2] .

beyondblue's qualitative research highlights the issue of discrimination in the workplace against people with depression[41]. The inability or unwillingness to view depression as an illness has major repercussions in the workplace, resulting in overt and covert discrimination. Disclosure of mental illness to employers often results in an inability to obtain further work, or if in current employment, people being undermined, denied promotional opportunities, and in some cases resulting in demotion or job loss.

Further, *beyondblue's* extensive delivery of workplace programs across a range of organisations indicates that depression and mental health problems are not well managed across organisations. Current management practices (for example, recommending taking time off work or a holiday) often isolate the individual, compound the problem and ultimately increase the degree of disability, resulting in prolonged absenteeism and reducing the likelihood of returning to the workplace.

beyondblue has developed, piloted and evaluated a successful depression in the workplace training program. The program increases the capacity of organisations to recognise and respond to persons who may be indicating signs of psychological illness; responses include providing appropriate referrals and support and keeping the individual connected and productive at work.

This program has proven to be effective in increasing employer and employee knowledge and confidence to engage in a range of appropriate and helpful behaviours and strategies to manage these illnesses in the workplace. It has been successfully implemented in various national settings (e.g. the Australian Taxation Office, Centrelink, the Department of Education and Workplace Relations, Department of Defence and the Reserve Bank of Australia).

beyondblue recommends that a national strategy addressing depression and mental illness in the workplace be developed as an occupational health and safety measure to advance equal employment opportunities for people with mental illness, improve work performance and productivity and to more appropriately respond to the illness.

4.5 Primary health care and allied health

People with depression and anxiety commonly do not present for medical treatment and, of those who do, 75% seek help from their GPs[36]. This demonstrates that GPs are in an excellent position to diagnose a large proportion of all persons who are depressed and to provide appropriate treatment or referral.

A national project conducted in the late 1990s as a collaboration between psychiatrists, psychologists and GPs aimed to scrutinise how well general practice was meeting mental health service needs and to provide GPs with access to support to improve their ability to recognise and manage common mental health disorders. An analysis conducted as part of this project found that there was an under-use of effective treatment strategies for depression in the Australian general practice setting[37]. Also identified was the poor level of support for GPs who take on mental health issues and the dissatisfaction by patients around mental health management in general practice[38].

The Australian Government's Better Outcomes in Mental Health Care (BOiMHC) Initiative introduced in 2001 aims to address these issues. The initiative supports general practitioners by providing them with access to mental health education and training and more support from allied health professionals and psychiatrists. To October 2004, some 4,000 Australian GPs have completed additional training and are registered to deliver the new services. More than one in four general practices now employ a doctor trained and registered with this initiative, rising to nearly 40% of practices in rural areas.

A key component of the BOiMHC Initiative has been the inclusion of the use of screening tools for depression-related illnesses in primary care. The evidence is now in favour of the appropriate use of screening tools in primary care as it has been found to increase the recognition and diagnosis of depression. It is important, however that appropriate services be provided to those who are diagnosed as having depression or a related disorder.

beyondblue is strongly supportive of the BOiMHC Initiative and commends the Australian Government for extending the initiative to 2008. There are some limitations of the Initiative such as the fact that GPs who work in non-accredited practices cannot register for the initiative – this may exclude services in specialist sectors such as Indigenous health. *beyondblue* supports the further extension of the initiative to encourage and support more GPs to become involved, to include psychologists and mental health nurses.

Currently there is very limited inclusion of depression-related disorders in medical degree university curriculum. *beyondblue* has received anecdotal information from medical students and GPs that there is a lack of information and training provided during university education on managing and treating depression in primary care. The 2003 report, *'Out of Hospital, Out of Mind!'* identified a disturbing level of stigma in the health sector. Consumers reported ongoing abuse within hospital care and abuse within emergency departments and other acute care settings of general hospitals[39]. Conversely the issue of burnout of the mental health workforce due to a lack of support and resources was highlighted. Considering the high prevalence and morbidity of depression and the large proportion of people with depression who seek help from their GPs, this must be addressed.

Allied health workers, such as psychologists and counsellors have a crucial role to play in the delivery of mental health care for people with depression. Whilst there have been efforts to make allied health services more accessible, the majority of patients with depression and associated mental health problems are seriously compromised by the cost required to access appropriate services. There is a need to expand the currently restricted access to services under the BOiMHC Initiative.

Many psychologists emerging from university do not pursue a career in mental health and instead engage in other sectors such as human resources. *beyondblue* believes that this is

partly due to stigma. Society's general perception of people with mental illness has implications for the mental health workforce. This stigma has implications for attracting workers into the mental health sector and for retaining them. Many potential employees will hold similar views to those of the general community and, as a consequence, working in the mental health field may not appeal to them. Similarly, people who are working in the sector may feel that their work is not valued by the community and therefore seek employment elsewhere.

The role of psychologists in primary care is vastly under-utilised in Australia and issues around attracting and retaining graduates into the mental health pathways and recognition need to be addressed.

4.6 Consumer and carer involvement and de-stigmatisation

Stigma and discrimination

beyondblue has conducted extensive research into depression, from the perspective of people living with the illness, their carers and the wider community. This research highlights a disturbing level of stigma, discrimination and ignorance in the Australian community regarding depression[40].

People living with depression reported that their experience was compounded by family and friends who did not view their condition as real or serious.

> *"My family and friends didn't understand, or didn't want to know, one or the other."*
>
> *"I wanted my partner to call the doctor but he was embarrassed and said there was nothing he could do."*

The failure to view depression as a health problem is also reflected in the community. When asked to identify the major health problems in Australia, less than 5% of people mentioned depression. Depression will affect one in five Australians at some point in their adult lifetime, however 65% of participants underestimated or did not know that depression was so common.

Many people are not aware of the common signs or symptoms of depression and are therefore unlikely to recognise depression within themselves or others. People are also not aware of what may be helpful or unhelpful to someone experiencing depression. In *beyondblue's* survey, 45% of the respondents believed that, 'keeping out of someone's way and giving them space' would be helpful. In fact this is probably the worst thing that someone could do – it is only likely to compound the sense of isolation and lack of support. Stigma is profound in the community. Over a third of Australians believed that people with severe depression 'should pull themselves together'. Furthermore, 36% indicated that people with depression who worked in high positions of responsibility 'should quit their jobs'.

A key focus of *beyondblue's* work is to raise the awareness of depression to reduce stigma and improve recognition that depression is a serious health problem in Australia. Our research highlights the need to better educate the Australian community, not only about the prevalence, signs and symptoms of depression and getting effective help, but also conveying what it is like for people who may live with depression and their families. *beyondblue's* awareness raising approach through the 'Blue Skies' campaign aims to educate Australian to be more aware and helpful to people with depression.

Gains are being made, with an independent analysis on the Australian public's recognition of depression and beliefs about treatment finding that *beyondblue's* awareness campaign has had a positive effect on some beliefs about depression, treatment and the value of help-seeking[21]. A survey conducted late in 2004 found that depression is being increasingly recognised as the major mental health problem in Australia with the percentage of persons reporting this perception having increased from 39% in 2002 to 45.4%. There is still much to be done, however as we continue to find that the Australian community does not view mental health as one of its major general health issues[21].

Awareness raising and destigmatisation initiatives must be sustained to build on early results. This has been recognised nationally, with the continuation of *beyondblue's* programs and

partnerships however addressing stigma associated with mental illness within the health workforce requires a collective and targeted approach.

Support for people affected by depression and related disorders and their families and carers

Living with a depressive illness not only impacts on the life of the person with the illness, but also on the carer, other family members and workplace colleagues. *beyondblue* has undertaken a wide range of qualitative research that explored the experiences of people with depression-related disorders and the experiences of their carers and families.

People living with depression reported stigma in healthcare settings and in employment. Limited access to high-quality primary care and non pharmacological care was emphasised. Surveys show that people with depression are subject to many of the same attitudes, inadequate healthcare and social barriers reported by people with psychotic disorders[41].

Families and carers have reported that they experience a sense of isolation due to the lack of community awareness about depression and report negative experiences with healthcare providers. Carers and family members are frequently excluded when key decisions are made about treatment and report that emergency services are relatively unresponsive to their concerns.

> *"We are part of a team and I don't care if I am the problem. I would rather they told me 'look you're doing this wrong', it would be better. But don't ignore me. I'm the one she comes home to."*

In contrast, carers of people with depression reported that community agencies are often the sole avenue of support, but these are not as well established as those for people with other mental health disorders such as schizophrenia[42].

Excluding carers from providing or receiving important information, particularly in crisis situations, is likely to lead to adverse outcomes. *beyondblue* supports the legitimate roles of carers and families within our healthcare systems and advocates for the formal recognition and promotion of this important role through its national association, blueVoices, which promotes the interests of people with depression, their carers and families. Other national agencies including the Mental Health Council of Australia with its National Consumer and Carer Forum, SANE Australia and carers also play key roles. The blueVoices network has provided a separate submission to this Inquiry that outlines in detail their specific concerns and recommendations.

Participation rates of consumers and carers in service delivery, policy and planning has increased considerably under the National Mental Health Strategy. However the personal experiences of those who care for people with depression indicate that there is still a great deal of work to be done to reduce stigma and to improve the interaction between healthcare services and consumers and carers.

Discrimination in the insurance industry

There has been a range of concerns expressed that people with mental illness are less able to access the same insurance products as people with physical problems. This is being tackled through the joint efforts of *beyondblue*, the Mental Health Council of Australia, Royal Australian and New Zealand College of Psychiatrists, Royal Australian College of General Practitioners, Australian Psychological Society and the life insurance peak body, the Investment and Financial Services Association. The 'Preventing Insurance Discrimination Agreement' is a memorandum of understanding that outlines principles governing the way the industry treats consumers who have, or have had a mental illness and was recently re-signed for a further two years. It aims to provide people experiencing a mental illness with fair and equitable treatment in dealing with insurance companies, in obtaining appropriate insurance, or in making a claim. Early work is underway but there is still more to be done in tackling discriminatory insurance policies for people with a mental illness.

4.7 Mental health research

An assessment of research activities in the area of mental health published in 2001 found that depression was under-researched, accounting for only 15% of journal publications and 13% of academic grant funding. Very little research was carried out in primary care and in the community. Additionally, evaluations of mental health services, investigations of training and education of the workforce and research on promotion and prevention were poorly represented[43].

Since 2001, *beyondblue* has been funding depression-related research through the *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders and through our own strategic research, with a high proportion of these projects being carried out in a primary care setting or in communities.

While we believe that these efforts have resulted in an increase in targeted research aimed at increasing knowledge about depression, Australia's research investment in depression is low by comparison with other mental health areas. Areas of particular relevance include:

- cost effective community-based and early intervention models
- Indigenous and CALD communities
- e-health interventions
- co-occurring depression and substance misuse
- co-occurring depression and chronic illness
- depression in the elderly

beyondblue supports the establishment of the National Neuroscience Consultative Taskforce and the anticipated establishment of a Brain and Mind Research Alliance[44] as this indicates a new national willingness to develop a research and innovation agenda. However a greater investment in mental health research is required. The National Health and Medical Research Council could play a lead role by increasing applied research into mental health with a focus in regard to high prevalence mental health disorders, with particular investigations into public health innovations and service delivery models.

The National Survey of Mental Health and Wellbeing was established to gather baseline information about the prevalence of mental illness in the Australian population, the amount of associated disablement, and the use of health and other services by people with mental disorders or mental health problems. The National Survey has three components: a household survey of adult Australians aged 18 years and over; a household survey of children and adolescents aged 4-17 years inclusive; and a study of low prevalence disorders covering the age range 15-65 years. Taken together, these three components provided important information about the mental health status and needs of the Australian population. This survey should be conducted on a regular basis (such as every ten years) to ensure that we can monitor prevalence and service utilisation in order to assess how we are progressing in addressing these issues and plan for future improvements.

4.8 Data collection, outcome measures and quality control

A positive aspect of the National Mental Health Strategy has been to introduce outcome measures across private and public clinical practice, rather than relying solely on process measurements such as patients seen, bed days, etc.

There is a need to set new national targets for mental health outcomes around such areas as: proportion of people with mental disorders provided with care; national disability costs attributable to mental disorders; and national suicide rates[4]. This would allow agreed targets to be set and better monitoring of achievements and progress of the National Mental Health Plan.

4.9 E-technology as a mode of delivery of mental health care

The internet is now recognised as a resource to disseminate self-help and treatment interventions for mental health issues. Internet-based programs have a range of advantages in that they:

- provide private, convenient and immediate assistance or advice
- can be responsive and tailored to individual needs
- are particularly useful for people who are disadvantaged by distance or other economic or social barriers
- are cost effective for the individual (the cost of an internet connection) and the health sector as a whole.

There has been a number of research trials conducted evaluating the delivery of CBT using the internet for depression and anxiety which found that both internet-delivered CBT and psychoeducation are effective in reducing symptoms of depression and anxiety[45].

A current *beyondblue*-funded project involves a trial to examine whether MoodGYM (CBT) plus 'Essential GP care' (care given by GPs who have undergone the SPHERE Introductory Training Program) improves depression and/or anxiety outcomes relative to 'Essential GP care' alone. It is anticipated that GPs will be able to provide effective interventions to patients with depression more efficiently and with greater cost-effectiveness, and patients will be able to access effective treatment when and as needed via the Internet.

beyondblue will be undertaking significant work in this area to develop new forms of consumer and carer self-management via electronic prevention and assessment, counselling and treatment options. However this alone will not be enough. It is important that the potential of internet-based mental health care as a health service delivery tool be recognised and investigated more broadly.

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