

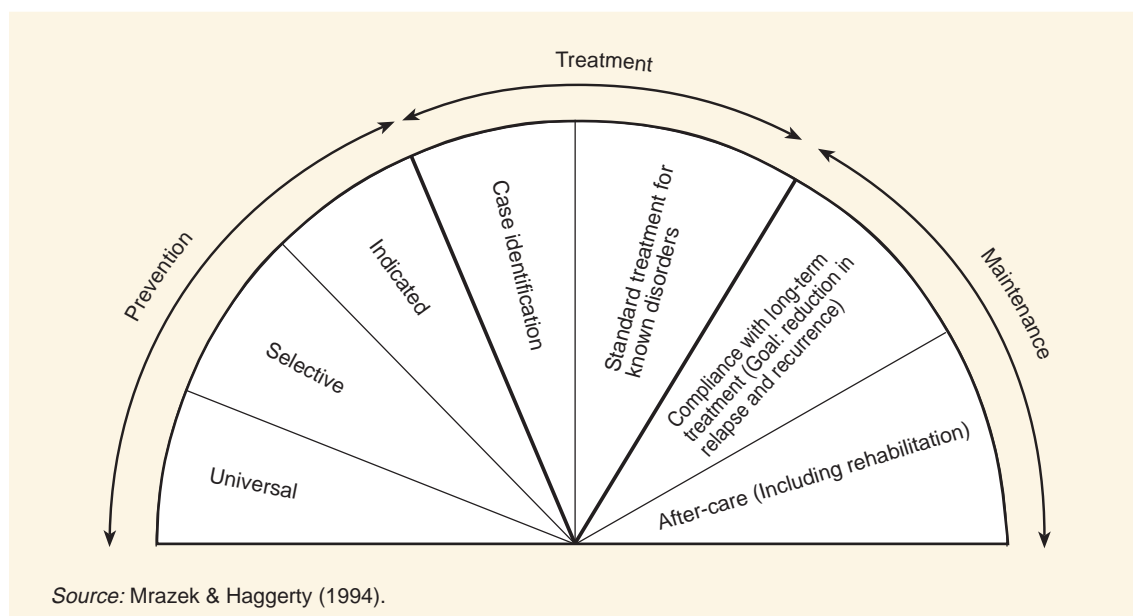
4 Prevention and management of depression

This chapter describes current practice and relevant issues for the prevention, treatment and management of depression in Australia.

The mental health intervention spectrum comprises prevention, early intervention, treatment and maintenance (management) in order to maximise mental health outcomes. Mental health promotion falls outside this spectrum, and aims to protect, support and sustain the mental wellbeing of the population by increasing the protective factors that lead to positive health outcomes.

Interventions able to impact on depression occur at many levels of the community and health sector. This continuum is illustrated in the model presented in Figure 4.1.

Figure 4.1: The mental health intervention spectrum for mental disorders



Prevention and early intervention activities focus primarily on recognition and early management of risk factors that increase people's vulnerability to depression. Depressive symptoms may be averted through recognition and response to the presence of risk factors. Preventive interventions can be targeted universally at the general public, selectively at individuals or subgroups of the population whose risk of developing depressive disorders is significantly higher than average. Specifically indicated interventions can be aimed at high-risk individuals, such as people with existing depressive symptoms (Mrazek & Haggerty 1994).

Early recognition of depressive symptoms and first episodes of disorder and the provision of evidence-based treatments are major issues for treatment interventions. In managing depression, the aim is to provide best practice ongoing treatment and follow-up.

4.1 Promotion, prevention and early intervention

The risk of developing depression over a lifetime is so high that almost the whole population will at some time be affected by it, either directly or indirectly. The entire health workforce, therefore, has multiple roles to play in relation to mental health promotion, prevention and early intervention activities, in addition to treatment delivery.

Relevant health professionals include general practitioners, child and adolescent mental health teams, community nurses, maternal and child health nurses, student welfare personnel in school and tertiary educational settings, as well as youth and social workers who deal with marginalised and disadvantaged groups at high risk for depression. Also relevant are medical and nursing staff providing acute care in hospital settings, aged care assessment services, domestic violence agencies, drug and alcohol services, and counselling services.

The following section outlines some of the roles that health professionals can play in relation to promotion of mental health, prevention of depression and early intervention. Although research into the impact of these activities is still in its infancy, the few studies available to date are encouraging.

Promotion

Mental health promotion contributes generally to improving mental health and wellbeing, and may thereby indirectly prevent depression. Promotion activities improve people's knowledge and skills and strengthen their ability to deal with difficult life situations. Those might include community awareness campaigns related to known risk factors at a community level, such as unemployment, certain types of stress and social isolation.

To have maximum impact, mental health promotion is necessary at all societal levels, from the family to the wider community. Ultimately, the work of mental health promotion takes place in homes, schools, work and social settings and is not the responsibility of the health sector alone. Barriers to optimising mental health need to be identified and appropriate responses integrated into public policy. Supportive environments need to be created and maintained. Health workers have a key role in supporting the development of positive social environments in home, educational and work settings, as well as promoting 'life skills' relevant to dealing with social adversity. Empowering communities to work towards common goals that enhance the wellbeing of their members can occur through strengthening community action. In this sense, the social connectedness of communities may be a powerful, but unrecognised, protective influence on mental health (Leeder 1998).

At the most basic level, the public must have the skills and knowledge that enable them to recognise depression, to undertake appropriate self-care, to utilise informal supports, and to seek effective professional help if necessary. Knowledge of this sort has been termed 'mental health literacy'. A national survey of the Australian general public examined recognition of depression and beliefs about the helpfulness of various professional and non-professional treatments, revealing that only 39 per cent of respondents could recognise depression, but that most respondents believed depression was treatable (Jorm et al 1997a). The mass media has an important role to play in providing timely, accurate and sensitive promotion material.

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A high level of mental health literacy among the public would make it more likely that depression is recognised as early as possible and effective action taken. Within Australia, a great deal has been done to increase public awareness of depression. For example, the *NHMRC Clinical Practice Guidelines* (see Box 4.2) included a brochure to assist young people to understand and identify depression and to find appropriate sources of treatment.

Elsewhere, the United States has a *National Depression Screening Day* during which health care facilities offer free screening and advice (Jacobs 1995). An anonymous automated telephone screening system was also trialled (Baer et al 1995). These events have led large numbers of people to seek screening and have achieved considerable publicity about depression. The success of these activities highlights the importance of mental health promotion to increase public awareness of the nature of depression and its treatment.

Prevention across the lifespan

Recently, attention has turned towards universal, selective or indicated interventions that attempt to divert those at high risk of developing depression and those with current depressive symptoms away from the development of a major depressive disorder. Effective prevention of mental disorder requires:

- identification of risk and protective factors that influence the development of the disorder;
- effective methods of decreasing risk factors and enhancing protective factors;
- identification of those at risk; and
- the availability of funding and systems to enable prevention activities to take place (Spence 1996).

There is substantial literature relating to risk and protective factors for depression, as described in Chapter 2, Section 2.2. Furthermore, research has shown that many of the risk and protective factors are potentially amenable to change, and that screening measures are available to identify individuals at risk. There has been little research to date that directly investigates the effectiveness of prevention and early intervention approaches in reducing the incidence and prevalence of depression. However, the available evidence provides an optimistic picture for the future.

Australia is emerging as a world leader in the prevention of mental health problems in children. Prevention programs are being evaluated in several locations throughout Australia, as outlined below.

Early childhood/preschool

The quality of parenting is a major contributory factor in the development of depression throughout childhood, and the family is a critical setting for preventive interventions. Coercive, aggressive parenting is known to produce high levels of mental health problems in children, particularly conduct disorder, when compared with supportive and nurturing care (Sanders & Markie-Dadd 1996).

The 'Triple P' Positive Parenting for Preschoolers Program aims to enhance parenting skills and deals with marital discord and other risk factors, such as depressive disorder in the mother. It has been shown to be effective in the prevention and early management of conduct and antisocial problems, and is also likely to be helpful for comorbid conditions such as depression and anxiety.

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Primary school aged children

To date, the majority of school-based preventive interventions have aimed to influence general mental health risk factors through programs that build children's skills in social problem solving, optimistic and practical thinking, and handling aggression. One of the longest-running and most extensively evaluated school-based programs is the Primary Mental Health Project (Clarke et al 1993). The implementation of this program in California exposed 47,000 children from 700 schools to screening and short-term (12 contacts) intervention, which substantially reduced levels of emotional disorder associated with acting out, shyness, anxiety and learning problems.

Gillham et al (1995) have reported one of the few studies that focused specifically upon the prevention of depression. Their program represents a selective intervention in which children identified as 'at risk' on the basis of mild symptoms of depression or family problems, received a 12-week intervention that taught them to identify negative thinking patterns and use more optimistic ways of thinking, problem solving skills, assertive strategies, negotiation skills and relaxation techniques. Evaluation at two-year follow-up showed significantly fewer depressive symptoms and a lower level of onset of new depressive symptoms among the intervention compared with the control group. An Australian version of this program, Aussie Optimism, is currently being trialled in Western Australia. It remains to be determined whether prevention programs of this type are better targeted at children who already have mild symptoms of depression or whether they are beneficial when presented more widely to whole classrooms of children.

Adolescence

Researchers have recently started to examine the feasibility of preventing the development of depression in adolescents. Clarke et al (1995) have conducted an indicated prevention program with high school adolescents who were assessed as showing depressive symptoms, but who did not yet meet the criteria for a depressive disorder. These young people were randomly assigned either to a 15-session cognitive group intervention to identify and challenge negative or irrational thoughts or to a 'usual care' control condition. The incidence rate for affective disorders over the next 12 months was 14.5 per cent for the intervention group compared with 25.7 per cent for the control condition. Interestingly, these same researchers failed to find a protective effect for a more universal preventive intervention implemented within the context of the regular classroom. However, this universal intervention lacked a skill-training component to rectify the social skills deficits associated with depression in young people.

In Australia, several programs designed to prevent the onset of depression in young people are being trialed. These include the Gatehouse Project in Melbourne, the Problem Solving for Life Program at the University of Queensland and the Resourceful Adolescent Project at Griffith University. The Gatehouse Project is a school-based program that aims to prevent or delay the onset of depression through enhancement of the emotional wellbeing of young people. This is being done through a comprehensive whole-school strategy to promote social environments in which people feel secure, have a sense of belonging and are positively regarded. The data from this project strongly suggest that this strategy may lead to enhanced emotional health and has indicated great scope for the promotion of security, social connectedness and positive regard as core activities of everyday school life. The Problem Solving for Life Project is also a classroom-based intervention that has prevention and early intervention components. This single-term curriculum is

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designed for administration by teachers and shows young people how to identify their problems, approach them in a constructive and adaptive manner and learn strategies for problem resolution. The results of the Problem Solving for Life projects should be available within the next 12 months.

The Resourceful Adolescent Project also contains prevention and early intervention programs designed for adolescents (RAP-A) and their parents (RAP-P). The adolescent component represents an experiential, resilience-building program designed to promote positive coping abilities in the face of stressful and difficult life circumstances. The parent intervention promotes parental self-esteem and methods for dealing with parent–adolescent conflict. Preliminary findings from this project showed reduced levels of depressive symptoms at post-intervention and 10-month follow-up, particularly for those adolescents who initially show high or moderate levels of depressive symptoms.

Adulthood

In adulthood, preventive approaches to date have been largely selective, focusing primarily on the risk of depression associated with life changes and adverse life experiences. Evidence-based preventive interventions have been shown to lessen vulnerability to depression associated with childbirth, bereavement (Raphael 1977), divorce (Bloom et al 1982, 1985), traumatic experiences, other losses, unemployment (Proudfoot et al 1997), and illness. Further details of these types of interventions are provided in the 'Indicated and early interventions for high-risk situations' section that follows. These interventions can also help children in families experiencing such adverse circumstances.

Older persons

Prevention for older persons may focus on experiences of loss, social isolation, physical disability and organic mental syndromes, such as early dementia, which contribute to depression in old age (Phifer & Murrell 1986). The high prevalence of depressive disorders in older people living in residential care settings needs to be acknowledged and addressed (Ames 1993). Depression in older people is commonly under-diagnosed and under-treated (Snowdon 1998). For older women, enhanced wellbeing and mood may be linked to appropriate hormone replacement therapy (HRT).

Specific preventive programs have also been shown to be effective in preventing stress in carers of people with dementia (Brodaty & Gresham 1989).

Indicated and early interventions for high-risk situations

Postnatal depression

Postnatal depression is a disorder that is likely to recur and may become chronic. It has negative effects on the development of the child, relationships with other children and the marital relationship (Boyce & Stubbs 1994, Boyce 1995). To lessen its impact, an understanding of risk and promotion of good obstetric care are imperative. Screening measures, such as the Edinburgh Post Natal Depression Scale, are useful to predict women at risk of postnatal depression (Boyce 1995). Programs to provide antenatal psychosocial screening as part of routine antenatal care could identify opportunities for prevention or early intervention programs and link women (and their partners and families) to appropriate psychosocial support and, if necessary, prevention, counselling or treatment.

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Brief psychosocial interventions that encompass active listening, providing information, education and support by midwives in the postnatal ward have been shown to be effective in preventing postnatal depression (Boyce et al 1998). Programs need to include appropriate psychosocial interventions to support parenting as well as provide an understanding of infant development. They need to enable the woman to manage her anxiety, talk through the birth experience (especially if traumatic), and deal with the myths of motherhood. Education and support of the partner are also important. Ideally, programs should incorporate the entire childbirth process, from antenatal care to postnatal follow-up, and should integrate the whole spectrum of interventions including prevention, early intervention and treatment (Barnett 1995).

Postnatal depression and risk of child abuse are often strongly associated, and both may be prevented through improved antenatal care, postnatal care and subsequent specialised home visiting and support. Programs that support pre-term infants and high-risk disadvantaged mothers through supportive skilled home visiting have been found to significantly reduce parental abuse of infants (Mrazek & Haggerty 1994, Newpin & Homestart cited in Barnett 1995).

Special recognition and outreach programs in different cultural settings are essential (NSW Health 1996). Cultural understanding of birth practices for Aboriginal and Torres Strait Islander women and migrant and refugee women, and appropriate recognition and provision of these, may also help to prevent postnatal depression and lessen the likelihood of negative developmental outcomes for the child.

Children of parents with a mental illness

Children of parents with mental disorder have been identified as a high-risk group. Programs dealing with parental mental illness, particularly parental depressive disorder or alcoholism, are likely to have positive and possibly preventive benefits for this age group. Along with the prompt recognition and treatment of depression in the parent, the education of the family about related psychological factors is important. Beardslee et al (1992) have reported a specific trial with an educational intervention for adolescents whose parents have mental illness, but the final outcomes of these studies are not yet available.

Carers

Much of the work of caring for people with a disability and chronic illness is carried out by family carers. Around one in 20 Australian households has a family carer, most of whom are middle-aged married women looking after disabled or chronically ill parents, husbands or children (Schofield & Bloch 1998). Although many carers cope well with this work, some develop anxiety and depression symptoms as a result of the demands put on them. Particularly vulnerable are carers who are parents, younger carers, those caring for a person with behavioural problems, and those who have had to give up paid work (Schofield & Bloch 1998). There is evidence that interventions for carers that provide training, support and counselling can reduce symptoms of anxiety and depression and can prevent the placement of the disabled person in residential care (Brodaty & Gresham 1992, Mittelman et al 1996).

Bereavement and other losses

Higher levels of depression and anxiety symptoms have been reported as a consequence of bereavement. Preventive intervention programs for high-risk widowed people have repeatedly demonstrated effectiveness in lessening a range of

morbidity patterns including depression and anxiety symptoms (Raphael 1977). Childhood bereavement interventions can also contribute to prevention of depression and anxiety symptoms (Black & Young 1995). Parents who experience the death of an infant are also at high risk and symptoms of anxiety and depression may be lessened by interventions (Murray et al, 1998).

Relationship and marital problems

Relationship stressors may contribute to the development of depression symptoms. Ideally, the goal is to prevent the onset of relationship difficulties through preparation of couples for successful relationships. Several research trials have now reported convincing evidence of the benefits of behavioural marital preparation programs (Halford 1995, Markman et al 1993).

However, once relationship difficulties become established, interventions are needed to enhance relationship quality or to mitigate the effects of relationship breakdown. Such approaches have a wider protective impact on psychological wellbeing, particularly depression. The preventive benefits, lasting up to four years later, of a divorce intervention program was demonstrated by Bloom et al (1985), particularly for women.

For children and adolescents, parental divorce is one of the most common and serious negative life events confronting them (Hetherington et al 1998). Although the majority of children adjust relatively well following parental separation and divorce, for some children the consequences include depression, anxiety, anger and conduct problems (Amata & Keith 1991, Forehand 1992). The adverse emotional consequences of parental separation and divorce are influenced by the quality of the relationships between family members before, during and after the separation. The negative effects are greatly mitigated when positive relationships between the parents are maintained and the child is able to experience a supportive relationship with the non-custodial parent (Forehand 1992). Several effective programs have been developed to assist children to cope with parental separation and divorce (eg Pedro-Carroll & Cowen 1985, Short 1998), including the Children of Divorce Intervention Project for use on a small-group basis within schools.

Given this evidence, it is important that legislation and procedures relating to separation and divorce are designed to facilitate positive family dynamics in the face of relationship break-up. Procedures and counselling that enable parents to separate amicably and to resolve issues relating to custody, access and property settlement in a harmonious manner will play an important role in facilitating children's adjustment to divorce.

Traumatic and life threatening experiences

Intense, traumatic and life-threatening experiences such as rape, combat, and violent assault are associated with a high risk of PTSD and anxiety and depressive disorders. While initiatives such as debriefing do not prevent these conditions, short-term cognitive behavioural programs lessen trauma-related symptoms and may achieve some prevention outcomes for anxiety and depressive disorders. Positive outcomes have been demonstrated in post-rape, childhood abuse, and other trauma situations (Bryant 1997).

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Physical illness

The relationship between depression and physical illnesses, including cancer and cardiovascular disease, was discussed in Chapter 2. There is evidence that simply asking the question ‘Are you feeling depressed?’ is an adequate screening procedure that can allow detection and appropriate further assessment and management in the case of physical illness comorbidity (Chochinov et al 1994). A preventive program for those who are highly anxious and potentially traumatised by life-threatening illness or treatment may have positive outcomes.

Work and lack of work

Occupational settings provide, largely unacknowledged, opportunities for a preventive mental health approach (Turner et al 1995). Workplaces have much scope to support and enhance the wellbeing of employees through their work practices and social environment. The implementation of family-friendly work practices may be important preventive measures.

In marked contrast, a body of evidence indicates an association between longer-term unemployment and depressive symptoms. The best solution is, no doubt, to alleviate the social and economic conditions that produce long-term unemployment. However, as a palliative measure, a cognitive behavioural therapy program was shown to produce significant positive changes in job seeking, as well as general wellbeing and mental health in a sample of people who were long-term unemployed (Proudfoot et al 1997).

4.2 Management of depressive symptoms and disorders

Depressive symptoms and disorders can be effectively managed if they are recognised and all the relevant issues are taken into account. A biopsychosocial approach that holistically considers all the interacting biological, psychological and social factors that affect the development of depression is important. This section describes the management options currently available for depression. These options include professional health care, which comprises psychological treatments and physiological treatments, as well as self-help strategies. Also covered are issues specific to primary care and across the lifespan and specialist treatments for depressive disorder subtypes. It should be noted that this section is not intended as a comprehensive description of the specialist treatment of depression, as that is a task for specialised clinical guidelines, such as the *NHRMC Clinical Practice Guidelines for Depression in Young People* (see Box 4.2) and the *RANZCP Clinical Practice Guidelines*. Rather, the purpose of this section is to highlight major issues for the management of depressive symptoms and disorders.

A biopsychosocial approach

A biopsychosocial management approach is particularly important for depression. All the contributing factors need to be addressed including, most importantly, the recognition of comorbid conditions and also identification of the associated psychological and social risk factors. This may require response from more than one service.

Management of depressive symptoms and disorders

Most depression treatments can be offered within a primary care setting if the general practitioner is trained in the appropriate psychological and pharmacological approaches. For more complex, severe or chronic cases of depression, the general practitioner or other primary care provider may need to either refer the person to a specialist or work with a psychiatric specialist. People referred to specialist mental health services usually have longer episodes of depression and meet more diagnostic criteria for major depression than those treated in general practice (Sireling et al 1985).

Collaborative models between psychiatrists and general practitioners have been shown to improve outcomes and be more cost-effective compared to conventional primary care (Katon et al 1997, von Korff 1998). An important role for specialists is advising primary carers in their management of people with depressive disorders. There is also potential for self-help to be integrated with primary care (Holdsworth et al 1996). Integrated care models that are best suited to different subtypes of disorder are an area of potential research interest.

Professionals, other than psychiatrists, who provide specialised expertise in the prevention and treatment of depression include clinical psychologists and mental health nurses. In addition, other professionals such as counselling psychologists, social workers, and occupational therapists, who have had subspeciality training and experience in mental health, also contribute. These types of professionals cannot provide pharmacological treatments, but have an important role to play in providing a biopsychosocial approach for people with more complex disorders.

Regardless of the relative importance of antidepressants, treatment should also address depression risk factors and improve general coping skills. Successful management should involve counselling that addresses issues such as the difficulty most people have in coming to terms with having a depressive disorder and taking up problems of stigmatisation when relevant. Assisting the person with relevant social and psychological issues that emerge either at the initial assessment or subsequently is an integral component of good clinical care.

There is currently considerable activity in a number of Australian research centres in evaluating medical and psychological treatments, strategies for preventing relapse and approaches to the prevention of depression. In the last decade, virtually all antidepressant medications and mood-stabilising drugs have been trialled in Australia, allowing local expertise to be developed in relation to the effectiveness and side-effects of such drugs. Other studies have included an evaluation of Transcranial Magnetic Stimulation (TMS) as a possible alternative to electroconvulsive therapy (ECT). Australian researchers have also played a key role in evaluating the effects of psychological treatments such as cognitive and behaviour therapy, and in developing and evaluating psychological approaches for preventing relapse. In addition, studies have recently commenced that assess the benefits of programs that aim to prevent the development of depression among young people.

Self-care

Many people attempt to cope with symptoms of depression without professional help and all such attempts are included under the category of 'self-care' in this report. People may turn to alternative therapies, including naturopathy, exercise, relaxation and meditation. They may also use their social relationships for

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informal 'counselling' and support. There is evidence to suggest that informal sources are a predominant source of help and generally a first step in the help-seeking process (eg Rickwood & Braithwaite 1994). Supportive social relationships are an important protective force generally and also in times of stress (Barnett & Gotlib 1988).

A prominent help-seeking strategy is telephone counselling. Telephone counselling provides anonymity, confidentiality and ensures the caller is in control of the experience. It is generally readily accessible, as neither distance nor transport problems prevent access. It has fewer waiting list delays, is relatively low cost, and is convenient for the caller. Telephone counselling services that are local, state-wide and national exist to respond to a broad range of issues that may contribute to a caller's mental health problems.

Little is known about the effectiveness of the diverse range of self-help strategies that people experiencing depressive symptoms use. Gould and Clum (1993), in a review of the literature, found only three controlled evaluations of self-help treatments for depression and these interventions produced only moderate immediate effects. There were insufficient data to draw conclusions about long-term effectiveness. Some evidence does support the widely held notion that physical exercise is beneficial for depression (Byrne & Byrne 1993, Martinsen 1994).

A meta-analysis has concluded that St John's wort (*Hypericum* extracts) was as effective as standard antidepressants for the treatment of mild and moderately severe depressive disorders, and that both St John's wort and antidepressants are significantly more effective than placebos. Moreover, fewer people experience side-effects using St John's wort than using antidepressants (Linde et al 1996). Further studies of this substance are warranted, given its rapid uptake as a self-help measure in the community.

After, or concomitant with, attempts to deal with depression through self-help or utilising social support networks, professional care may be sought. There is evidence that professional health care treatment is better than no treatment, although many people with depressive disorders do have a spontaneous remission. In the 1997 SMHWB, 56 per cent of persons with an affective disorder (which includes depressive disorders) had used health services for that problem. The great majority (70 per cent) saw a general practitioner. The proportions seeing psychiatrists (15 per cent) and psychologists (11 per cent) were much lower. Rates of health service use for affective disorders were substantially lower in younger age groups compared with older age groups.

Psychological interventions

This section briefly describes the major psychological interventions used for depressive symptoms and disorders and the available evidence of their effectiveness. There is considerable evidence to demonstrate the effectiveness of psychological treatments for depression, with the majority of depressed persons showing long-term, sustained improvements (Brown & Schulberg 1998, Clarkin et al 1996, Jacobson & Hollon 1996). The psychological treatments for which there is the most evidence of effectiveness are cognitive, behavioural and interpersonal psychotherapies.

Management of depressive symptoms and disorders

Cognitive therapy involves teaching individuals to identify their maladaptive and/or irrational patterns of thinking and to challenge these in the light of evidence. The aim is to teach the depressed person to develop a more realistic, positive and adaptive view of the world, themselves and the future (Beck 1967). This approach is based upon evidence that depressed individuals tend to interpret events in an excessively pessimistic way and to hold a variety of distorted patterns of thinking (Seligman 1975). Other cognitive-behavioural techniques that are effective components of the treatment of depression include increasing participation in pleasant events, and training in problem-solving skills, self-monitoring, self-evaluation, self-reinforcement, relaxation, and social skills (Lewisohn 1974, NHMRC 1997). In most instances, treatment involves a combination of these approaches rather than any one element in isolation.

Interpersonal psychotherapy is another treatment that has been found to be effective in the treatment of depression for many people (Frank et al 1991, Elkin et al 1989). This approach involves the therapist helping a person to systematically identify and resolve relationship problems that may contribute to depressive symptoms. It aims to improve the person's relationships and communications with others.

Studies to date have demonstrated minimal difference between cognitive, behavioural and interpersonal psychotherapies (Clarkin et al 1996, Elkin et al 1989, Gloaguen et al 1998). Similarly, there appears to be minimal difference in the effectiveness of these psychological approaches and that of antidepressant medication for less severe depressive disorders (Clarkin et al 1996, Jacobson & Hollon 1996). There is, however, some evidence that relapse and drop-out rates are slightly higher for drug treatments than for psychological treatments (Clarkin et al 1996, Gloaguen et al 1998).

In practice, a variety of other psychological treatment methods, in addition to those outlined above, are used. For example, family and psychodynamic therapies are widely used in clinical practice, although there is little research as yet to determine their long-term effectiveness. Determining which types of psychological therapy are best suited to different subtypes of depression, at different stages of the lifespan, is an area of particular research need. Whatever psychological treatment is used, appropriate training in the technique concerned is essential. Clinical psychologists and psychiatrists receive specialist training in a range of psychotherapies. However, other health professionals, including general practitioners, are increasingly developing basic skills in psychological treatments to enable them to deal with many cases of depression.

Medical interventions

The interventions used to manage depression by medical practitioners include both psychological interventions and medications. Specialist psychiatrists may also provide ECT. The complexity of training may influence the depth of psychological interventions that are provided. Pharmacological interventions are based on the knowledge that depressive disorders are associated with changes in the patterns of brain neurotransmitters. Medications are targeted to address these changes.

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Antidepressant treatment

Antidepressants play an important role in the treatment of depressive disorders. They can be prescribed only by a medical practitioner, usually a general practitioner or psychiatrist. Table 4.1 presents the drugs commonly used to treat depressive disorders.

Tricyclic antidepressants (TCAs) are the most commonly prescribed antidepressants in Australia (Mitchell 1997). There are newer drugs (eg SSRIs) that are safer in relation to risk of overdose, although there is some concern that they may be less effective in the treatment of severe cases of major depressive disorder or disorder with melancholic symptoms (Mitchell 1997).

A major factor to be taken into account is antidepressant choice. When medications are of equivalent efficacy, it is important to prescribe those associated with higher tolerance, lower toxicity and less likelihood of treatment failure and side-effects. The newest antidepressants (such as the SSRIs) may, therefore, be indicated where there is otherwise equal efficacy.

Benzodiazepines (eg diazepam or Valium) are used for the treatment of anxiety. They should not generally be used as antidepressants and, if prescribed, should be used for brief periods only. The benzodiazepines may have some transient effect on depressive symptoms and temporarily relieve anxiety, but they cannot be regarded as true antidepressants. Furthermore, the risk of dependence is extremely high. For persons with depressive disorders that have the capacity to respond to medication, the prescription of an antidepressant is generally preferred. The Gotland study in Sweden focused on changing the custom of general practitioners to prescribe benzodiazepines and replacing such prescriptions with antidepressants. There were positive socioeconomic gains as a result of this change in practice and also a significant, and possibly related, reduction in the suicide rate (Rutz et al 1992).

It is recommended that an antidepressant should be trialled for several weeks before changing to a different treatment. Depressed persons who respond to acute treatment should have that treatment continued for at least four to nine months at the same dose, and long-term treatment should be considered for those with recurrent depression, particularly if it is severe (Mitchell 1997).

There is a strong case for continuing medication in depressed persons who have had at least one episode, where remission has been extremely slow or where the disorder has put them at grave risk of misadventure or self-injury. The dosage of such medications is generally lower than those required during the acute phase to reduce risk of side-effects, but there is evidence to support a maintenance dose akin to the acute treatment dose. When these medications are to be stopped (whether initiated by the treating practitioner or the person themselves), they should be slowly tapered to prevent many severe rebound or withdrawal effects.

A major issue concerning medication as a treatment for depression is its negative perception by the general community (Jorm et al 1997b, 1997c). To be effective, it is important for medication to be taken as prescribed. If the specific effects and purposes of the medication are made clear to the person for whom the medication is being prescribed, compliance with the drug regime is much improved.

Management of depressive symptoms and disorders

Table 4.1: Drugs used in the treatment of depression

Type of drug	Generic name	Brand name	
<i>Selective serotonin reuptake inhibitors (SSRIs)</i>	Fluoxetine hydrochloride	Lovan, Prozac, Erocap, Fluohexal, Lovan, Zactin	
	Paroxetine hydrochloride	Aropax	
	Sertraline hydrochloride	Zoloft	
	Fluvoxamine maleate	Luvox	
	Citalopram hydrobromide	Cipramil	
<i>Serotonin-noradrenaline reuptake inhibitor (SNRI)</i>	Venlafaxine hydrochloride	Efexor	
<i>5-HT₂ antagonist/serotonin reuptake inhibitor</i>	Nefazodone	Serzone	
<i>Tricyclic antidepressants (TCAs)</i>	Amitriptyline hydrochloride	Endep, Tryptine, Tryptanol	
	Clomipramine hydrochloride	Placil, Anafranil	
	Desipramine hydrochloride	Pertrofran	
	Dothiepin hydrochloride	Dothep, Prothiaden	
	Doxepin hydrochloride	Deptran, Sinequan	
	Imipramine hydrochloride	Tofranil, Melipramine	
	Nortriptyline hydrochloride	Allegron	
	Trimipramine maleate	Surmontil	
	Mianserin hydrochloride	Lerivon, Lumin, Tolvon	
<i>Monoamine oxidase inhibitors (MAOIs)</i>	<i>Non-selective</i>	Phenelzine sulphate	Nardil
		Tranylcypromine sulphate	Parnate
	<i>Selective</i>	Moclobemide	Arima, Aurorix
<i>Mood-stabilising drugs</i>	Lithium carbonate	Lithicarb	
	Carbamazepine	Tegretol, Teril	
	Sodium valproate	Epilim, Valpro	

Electroconvulsive therapy

ECT is the passing of electric current through the brain to produce a convulsion. The use of anaesthetics and muscle relaxants considerably modify the effects of the convulsion. ECT is provided by most general psychiatric hospitals, and by some private psychiatric facilities. While it may be administered by any medical practitioner, it is rarely given by other than psychiatry registrars or psychiatrists, and it should only be given by those who have been trained in the technique. The anaesthetic is given by either an anaesthetic registrar or anaesthetist, and nurses are also in attendance. It is a safe and effective treatment for depressive disorder that either fails to respond to antidepressants, or is of delusional intensity. It is occasionally used for manic symptoms that are unresponsive to medications, or where medication is contraindicated during further treatment.

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ECT is usually only applied to the non-dominant hemisphere (one side of the brain—unilateral ECT). Bilateral ECT is often used with people who do not respond adequately to unilateral treatment. The most commonly reported side-effects of ECT are temporary confusion after treatment or memory loss. These side-effects are less likely with unilateral ECT.

The laws regarding administration of ECT vary by State and Territory. However, it is imperative to obtain the person's consent before each treatment. This is particularly important in view of the fact that ECT is a procedure that is not well accepted by the general community. It is more likely to be perceived as harmful than helpful (Jorm et al 1997b).

TMS passes a magnetic field in small, highly focused currents to the outer brain structures. It has been investigated in a number of overseas studies and suggested as an effective treatment for a variety of depressive disorders, including those suspected of having a more biological basis (Kirkcaldie et al 1997). Its suggested effectiveness is extremely important, as ECT causes considerable apprehension to many people. In comparison with ECT, TMS does not necessarily involve an anaesthetic or a convulsion, and short-term memory problems should not develop. An evaluative study has recently been completed at the Mood Disorders Unit, Prince of Wales Hospital, where unilateral TMS was compared to a 'sham' treatment. Both those people receiving TMS and the sham treatment improved in mood over the two-week trial and there was no significant difference between the groups. While the treatment was safe and not associated with any side-effects, there was no significant benefit demonstrated over the sham treatment. This is an important negative finding that requires further study. Currently, the researchers are involved in a new trial, with TMS being given bilaterally in comparison to the unilateral procedure used in the first study.

Issues in primary care

The first level of service providers in the health care system are primary care workers such as general practitioners, community nurses, generalist community health workers, and child and youth health workers. Other community workers, including those providing pastoral care, generalist youth and child services, telephone help-lines, support groups, alternative therapists, counsellors and other community gatekeepers may also be points of first contact. The critical issue for all primary care workers is an ability to recognise depressive symptoms, which comes through an understanding of the nature of depression, and to refer for further assessment or care, when appropriate.

Recognition and response in primary care

Recognition of depression is central to the management of depression in primary care. Some primary care providers, particularly general practitioners, are provided with extensive education programs, particularly through the pharmaceutical industry, and often in partnership with professional and academic bodies, to improve their skills in the recognition of and response to depression. This may help to redress potential inadequacies in their training. A survey of general practitioners has shown that most of the respondents find their undergraduate training in adolescent mental health issues, in particular, is inadequate and 64 per cent find it difficult to obtain advice on complex mental health problems (Veit et al 1996). Furthermore, studies suggest that primary care physicians vary

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considerably in their ability to detect depression, with accuracy rates ranging from 25–75 per cent (Brown & Schulberg 1998).

To detect and appropriately treat depressive symptoms, it is important that the primary care provider obtains a full description of symptoms and associated risk factors. The capacity of the primary care provider to engage the person and to elicit a full description is vital. In the case of depressive disorders, symptoms may cause substantial suffering while also being vague, transient and variable. Depressive symptoms may be attributed by the person experiencing them and their significant others to a number of other causes or dismissed as 'normal', and not be presented to the primary care provider as a clear case of depression.

Consequently, when people seek professional help for a depressive disorder, they often do so in an indirect manner, for example by consulting for a physiological symptom such as pain or tiredness. Depression may also be comorbid with another presenting disorder, such as a physical illness, anxiety or substance use. The symptoms of the comorbid disorder may be more evident and if a thorough assessment is not undertaken the depressive disorder may be missed.

Recognition of depression in high users of health care services, who may have only one or two depressive symptoms, is also critical because of the high costs, poorer functioning and adverse outcomes in this group. Even a few symptoms of depression may be risk factors for the development of a major depressive episode (Judd et al 1997).

Screening for depression can be relatively simple; it has been shown that the question 'Are you feeling depressed?' can be effective in screening medically ill populations for depression (Chochinov et al 1994). Such a question can be used as the first of a two-stage screening process; those identified at higher risk by the screening question can then be followed up by a more detailed assessment.

A number of detailed protocols are available to assist with the assessment of depression in primary care settings. WHO initiatives on primary care psychiatry have developed a screening tool for mental disorders in primary care using a 20-item self-report questionnaire, a primary care version of ICD-10 diagnostic system and relevant education activities (Isaac et al 1995). Other initiatives include PRIME-MD, which is a screening questionnaire and interview for general practice settings, and SPHERE, which is an Australian national depression project developed as a collaboration between academics, clinical psychiatrists and general practitioners. The project is partly supported by a pharmaceutical company. The *NHRMC Clinical Practice Guidelines for Depression in Young People* (see Box 4.2) provide a protocol for recognising depression in young people. There are also numerous depression symptom questionnaires targeted at specific age groups (see Chapter 2, Section 2.1). These protocols and measures assist care by heightening awareness and improving symptom recognition, but need to be supported by appropriate clinical processes (see Box 4.1).

There is clearly a need to ensure that training and continuing education of primary care physicians includes the use of techniques to quickly determine the presence of depressive symptoms and disorder, and also of potential comorbid conditions, particularly anxiety.

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Box 4.1: The use of clinical practice guidelines in general practice

The use of printed guidelines to facilitate general practitioners' decision making about appropriate health care or as a means of updating and educating seems like a simple and efficient way to reach a large number of general practitioners. However, there is little evidence that guidelines alone actually change the practice of physicians (Davis et al 1997, Gupta et al 1998). This ability is enhanced when combined with other educational strategies, such as academic detailing (Davis et al 1997, Davis & Taylor-Vaisey 1997). Recommendations on how guidelines should be formulated make their creation a costly exercise (Rice 1995).

A recent study by Gupta et al (1997) examining Australian general practitioners' views about, and recall of, clinical practice guidelines has shown that, while generally supported, barely half of the physicians report that guidelines have changed their practice. Most question the relevance of guidelines to general practice, believing 'experts' who do not understand general practice created them. Between six and 48 per cent were unaware of the existence of certain guidelines. The credibility of various agencies drafting the guidelines was also shown to vary amongst general practitioners.

There are very few Australian studies measuring the implementation of guidelines in clinical practice (O'Brien 1996, Ward & Holt 1997). A review of international studies on the dissemination and implementation of clinical practice guidelines has shown mixed results (Davis & Taylor-Vaisey 1997). Variables affecting adoption of guidelines included quality of the guidelines, characteristics of the health care professional and the practice setting, incentives, regulation and factors related to presenting persons. Weak implementation occurs with a mail-out alone or with didactic lectures; moderately effective uptake occurs with audit and feedback or opinion leaders; and the strongest uptake occurs with reminder systems, academic detailing or multi-faceted educational interventions.

Treatment in primary care

In primary care a biopsychosocial treatment approach that recognises the multidimensional nature of depressive disorders and the contribution of biological, environmental, social and psychological correlates is required.

Fundamentally, antecedent and coexistent disorders, such as anxiety disorders or substance use disorders, need to be specifically identified and encompassed in the management plan. Addressing a primary anxiety disorder is important because, if its treatment is successful, both current depressive symptoms and the chance of future depressive episodes may be reduced (Parker et al 1997b). It is also critical that potential suicide risk is assessed in all cases because of its high correlation with depressive symptoms, particularly feelings of hopelessness. The WHO has developed a useful educational package for the management of common disorders in primary care, specifically targeting depression and anxiety (Isaac 1995).

The Depression Guideline Panel in the US recently undertook an extensive literature review and meta-analysis and concluded that psychotherapies, such as cognitive behaviour therapy and interpersonal therapy, are slightly more effective than drug treatments for depressive disorder in primary care. Furthermore, drug treatments are associated with greater relapse rates and higher dropout rates (Clarkin et al 1996). However, acknowledging that many primary care physicians do not have adequate training in psychotherapy methods, the guidelines produced by the panel support the use of medications within primary care treatment of depressive disorder.

While there have been a large number of studies examining its efficacy, it is not always clear whether cognitive behaviour therapy (CBT) is generally superior or comparable to antidepressant medication in a primary care setting. An important

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study was undertaken by Blackburn and Moore (1997) who observed a similar pattern of improvement for persons receiving treatment with CBT or antidepressant medication. In addition, maintenance cognitive therapy was shown to be as effective as maintenance medication at two-year follow-up.

Others conclude that people with depressive disorder do best with a combination of antidepressant medication and some form of psychological treatment (Mitchell 1997). A recent large scale study, reported by Thase et al (1997), provides clear evidence that a combined antidepressant plus psychotherapy approach is more effective than psychotherapy alone for people with severe depression. The effectiveness of antidepressants is well established for moderate to severe depression; while psychological treatments alone are most useful with mild to moderate levels of depression (Mitchell 1997). Brown and Schulberg (1998) note that antidepressant treatment outcomes in general practice settings improve if primary care physicians follow standardised treatment protocols that ensure use of appropriate drug dosages, management of side-effects and duration of treatment.

The challenge for primary care clinicians is to identify which treatments will best suit particular individuals. Psychotherapies should be the treatment of choice for depressive symptoms, while antidepressant medication alone, or in combination with psychological treatments, will be likely choices for depressive disorders. The need for combined therapy is indicated by an incomplete response to antidepressants or psychological treatments alone or a poor recovery from symptoms between episodes of depression. Other features that should suggest psychological therapy include chronic psychosocial problems, a previous positive response to psychological treatments, failure to respond to antidepressant treatment, and consumer preference (Mitchell 1997).

To fully treat depressive disorders, assessment of potential risk factors (see Box 2.2) is necessary along with management of the symptoms of the disorder. Relevant risk factors include past depressive disorder episodes, family history of depression or other disorders, recent stressors, environmental factors such as the family context and personality factors. It is also important to consider the children where one or both parents experience depressive disorders. When such risk factors are evident, a pluralistic management plan that incorporates a psychotherapeutic response to the risk factors would comprise best practice.

A paramount issue for primary care providers is their ability to provide such a biopsychosocial approach within their operational constraints. Specifically, the time required to take a full psychosocial history to carefully diagnose any depressive disorder, comorbid disorders and associated risk factors is prohibitive in busy general practice settings. Furthermore, this effort may not be adequately reimbursed by MBS payments. However, a comprehensive review of the structure and remuneration of services in the General Medical Services Table was undertaken by the Medicare Schedule Review Board in August 1997 as part of the joint Government/Australian Medical Association Relative Value Study. A completely new structure for attendance items has been agreed, designed to remove incentives that currently inhibit high quality practice in consultations.

Additionally, in terms of ongoing treatment, a primary care provider may not have either the time or the specific skills to provide both oversight of medications and psychotherapy. It is particularly important to identify methods by which psychotherapies can be made available in primary care settings. In some instances

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this may involve collaboration between mental health specialists and general practitioners. In others, the primary care physician may be trained to conduct brief psychological treatments (Katon et al 1997). For depressed persons requiring specialised psychological treatments, referral to either a psychiatrist or clinical psychologist may be necessary, depending on factors such as individual therapist skill and cost (Mitchell 1997).

Current treatments for depressive disorder subtypes

The previous section covered management issues for depressive disorders generally. This section considers issues that are unique to particular depressive disorder subtypes. These subtypes were defined in Chapter 2 Section 2.1, and a diagnosis of a particular depressive subtype entails consideration of additional management issues as described below.

Unipolar major depressive disorder

For unipolar major depressive disorder, the task for the clinician is to determine the relative contribution of the varying contributing factors and to then attempt to direct therapy at those predisposing or precipitating factors, which include factors such as anxiety, personality and temperament. An approach considering antidepressant treatment only is often, therefore, inappropriate and insufficient.

Many studies and meta-analyses report the superiority over placebo of both antidepressant medications and psychotherapies, alone and in combination (eg Kirsch & Sapirstein 1998). There is some evidence to suggest, however, that antidepressant medication may be the treatment of choice for more severe unipolar major depressive disorder (Elkin et al 1989). In a 16-week study, CBT produced a similar outcome in comparison to antidepressant (imipramine) plus clinical management, placebo plus clinical management or interpersonal psychotherapy when data for the whole sample were analysed. However, for those in whom depression was severe, imipramine produced a superior outcome to all other interventions.

With psychotic symptoms

Meta-analyses indicate that ECT alone and combination antidepressant/antipsychotic medication are the most effective treatments for unipolar depression with psychotic patterns, resolving the depressive disorder in some 80 per cent of cases (Parker et al 1992). Antidepressant medication alone or neuroleptic medication alone is substantially less effective, resolving the depression in 25–40 per cent of instances. Limited studies have been conducted to enable a conclusion about the comparative effectiveness of other combination treatments. There is increasing recognition that for older people, in particular, this condition may take a lengthy period to resolve, and presents a high risk of relapse.

With melancholic symptoms

Melancholic symptoms have been reasonably well established as predicting a 'superior response' to antidepressant medication (Rush & Weissenburger 1994). There is some accruing evidence to suggest that the SSRIs may not be as effective as the tricyclic medications. If tricyclic antidepressant medications fail, another older drug type (the non-selective MAOIs such as phenelzine and tranylcypamine) is often viewed by clinicians as having utility for depressive

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disorder with melancholic symptoms. If such single treatments fail, combination and augmentation treatments are considered by adding drugs such as lithium or thyroid hormone (Silverstone et al 1998). If the antidepressants fail, ECT is a highly effective option.

Bipolar major depressive disorder

In the case of bipolar disorder the person may present in an 'up' (hypomanic or manic) phase or a 'down' depressed phase. If in a depressed phase, there are almost invariably melancholic or psychotic symptoms.

During an acute episode of mania, antipsychotic medication is often prescribed alone or in conjunction with a mood-stabilising medication (eg lithium, carbamazepine, sodium valproate). In addition, benzodiazepines may assist settling the person. ECT is used on rare occasions where it is of benefit to some people with severe manic episodes who do not settle rapidly with medication and who may be at risk of self-injury. During an acute episode of depression, treatment is prescribed according to the presenting symptoms.

When the natural history (and particularly episode frequency) of the disorder is not yet established, the person is presenting for the first time, or the person has had several episodes at rare intervals, treatment may focus on acute and continuation phases. This would mean maintaining some or all of the initial treatments for several months, rather than necessarily commencing with a mood-stabilising drug. Most people with bipolar depressive disorder who have repeated episodes benefit from being placed on mood-stabilising medication. The key issue is careful adherence to the medication regime.

Other depressive disorders

Clear recommendations cannot be made about established treatments for dysthymia and cyclothymia for two main reasons. The first reason relates to the complex nature of these conditions. For example, dysthymia is a mix of chronic mild depression, mixed anxiety and depression, and anxiety states with secondary depression. Secondly, as the suggested existence of these disorders has only been relatively recently described, few definitive treatment studies have been undertaken. The most commonly studied disorder is dysthymia where pharmacological interventions suggest some possible benefit, but not to the degree generally reported for the major depressive disorders.

Relapse and chronic depressive disorder

There is evidence showing that maintenance treatments with both psychological treatment and antidepressant medication reduce the risks of relapse in depressive disorder or, alternatively, increase the amount of time before relapse (Frank et al 1990, Kupfer et al 1992). These studies have shown that the preventive effect of medication is dose related and relapse is delayed if the maintenance drug dose level is high, akin to the acute treatment dose. Relapse is more likely with moderate dose levels and even more likely with the very low maintenance doses. There is also evidence that treatment reduces subsequent social impairments as a result of depressive disorder, though these effects occur well after symptomatic recovery. Relatively few data are currently available on the appropriate use of maintenance treatments in Australian health care settings.

Treatment issues across the lifespan

The management of depression discussed so far has applied generally to depressive disorders and its subtypes in the majority of cases. There are, however, issues specific to the management of depression at different stages of the lifespan.

Children and adolescents

Children, in particular, rarely complain of mental health problems. Rather, their parents, teachers and sometimes their peers complain about their problematic behaviour. There are often, however, prominent signs of mental health problems in children that should be recognised. For example, children who are depressed or anxious have been shown to be almost three times more likely to be performing below their age expectancy at school. They are also five times more likely to have been suspended or expelled from school and 11 times more likely to be reported by their teachers to have frequent problems in getting along with their peers (Zubrick et al 1997). 'Acting out' behaviour in children may, therefore, be an important indicator in the recognition of depressive disorder in children.

Depressive symptoms are frequently neither recognised, nor treated in adolescence. This is partly because adolescent distress may be mistaken as an inevitable part of adolescent development compounded by the fact that young people do not readily access health services. Furthermore, parents are reluctant to have their children labelled with a mental disorder. Depressive symptoms may also be masked by comorbid substance use (NHMRC 1997). The NHMRC clinical practice guidelines provide a comprehensive framework for identifying and treating depressive disorder in this age group (see Box 4.2).

Box 4.2: Clinical Practice Guidelines for Depression in Young People (NHMRC 1997)

These guidelines were developed through an extensive scientific review and consultation process. They describe best practice for the detection and management of depressive disorders in adolescents. There are several components to the guidelines: a scientific report; guidelines for mental health professionals; guidelines for general practitioners; and consumer booklets, one in comic-book style (these latter were carefully focus-tested and evolved in consultation with young people). The guidelines also aim to help prevent suicide in this age group, and are being implemented in association with other initiatives for suicide prevention. The guidelines emphasise the importance of engagement of the young person, appropriate assessment, preference for cognitive behavioural interventions, and the possible use of SSRIs for those most severely affected. The dissemination, implementation and evaluation of these guidelines are currently underway.

The use of antidepressant medication in children and adolescents remains controversial. They and their parents are usually reluctant for medications to be prescribed. There have been few studies of the effectiveness of antidepressant medications with children and younger adolescents and this approach is not the first treatment of choice (NHMRC 1997). In contrast, studies with children and adolescents have suggested that cognitive-behavioural and interpersonal psychotherapies are effective treatment approaches (eg Belsher et al 1995, Kahn et al 1990, Lewinsohn et al 1990, Moreau et al 1991, Mufson et al 1994, Reynolds & Coats 1986, Vostinia & Harrington 1994).

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While it is recognised that the diagnosis of major depressive disorder or dysthymia is relatively infrequent in childhood, but rises in the adolescent years, there is nevertheless a need to ensure that children who have depressive disorders receive appropriate treatment. The appropriate use of antidepressant drugs in such cases requires further research. Treatment recommendation from the NHMRC guidelines for adolescents suggests that SSRIs are the preferable drugs when antidepressants are necessary. In children with a depressive disorder with melancholic symptoms, such a treatment approach may remain the most effective intervention. For those with heterogenous unipolar depressive disorder, clinicians need to prioritise strategies other than antidepressant medications. This is an issue that requires close consideration and further clarification.

Postnatal depression

About half the women suffering postnatal depression do not have their illness recognised. Recognition is aided by routine inquiry about depressive symptoms and screening using a tool such as the Edinburgh Postnatal Depression Scale, along with heightened vigilance for signs of depression (Boyce 1995).

The key component of treatment will be psychosocial intervention including practical support, counselling, supportive psychotherapy and cognitive behaviour therapy. Some women will benefit from the adjunctive use of an antidepressant medication. The indications for medication include a pattern of melancholic symptoms, concomitant panic disorder and failure of psychosocial interventions. Tricyclic antidepressants, in particular dothiepin, remain the first line of treatment for women who continue to breastfeed (Buist & Janson 1995). The newer antidepressants, specifically the SSRIs, have a lower side-effect profile and may be used by women who are not breastfeeding.

As the depression resolves, an assessment should be made of the developing mother–infant bond, the marital relationship and relationships with other children. It may be necessary to intervene with any persisting relationship difficulties to prevent possible negative outcomes for the children.

In the more severe cases of postnatal depression and in post-partum psychosis, inpatient treatment in a mother and baby unit may be a component of care. Both specialised mental health services and specialised motherhood support services (eg Tresillian and Karitane) can provide care.

Older persons

Many depressive symptoms are ‘understandable’ in older persons as reactions to the loss of loved ones and previous physical, mental and social capabilities. However, even ‘understandable’ depressive disorders can be alleviated with treatment (Snowdon 1998). There is a lack of research examining the relative efficacy of different treatments for depression in older persons. At present, appropriate treatment is not substantively different to that for younger adults, although taking into account related environmental and psychosocial factors, is possibly even more imperative. In particular, interventions related to social isolation and physical illness and disability are relevant.

It is also important to separate diagnoses of dementia and depression and to treat both. However, the separation of these disorders is often difficult as they commonly coexist and older people with depression may progress to dementia. Appropriate treatment of older persons requires careful use of antidepressants in order to

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monitor possible drug interactions for persons on multiple medications. This may include the use of lower doses, particularly where comorbidity slows the rate of drug metabolism. An antidepressant with minimal cognitive effects should be chosen; the older tricyclics should be avoided as they affect cognitive function (Simon et al 1996). ECT may be the most effective and safe treatment for some older people with resistant or severe depression.

Psychotherapies, improvement of the social environment, good follow-up and rigorous treatment of relapses and recurrences are required (Flint & Rifat 1997). For older people in residential care who suffer from both multiple physical problems and social isolation, the psychological and social factors contributing to their depressed mood need to be sensitively addressed through the provision of an appropriate physical and social environment within the care facility, along with the provision of appropriate clinical care.

4.3 Issues for prevention and management in special population groups

For some sectors of the Australian community there are unique factors affecting the development and delivery of interventions designed to prevent and manage depression. There are a number of significant barriers that apply to Aboriginal peoples and Torres Strait Islanders, to people from culturally and linguistically diverse backgrounds, and rural and remote communities. In general, more flexible, culturally sensitive and outreaching services need to be developed and delivered to people from different cultural backgrounds and remote populations.

Fundamentally, lack of services and lack of choice of services is characteristic of non-metropolitan areas. Issues related to stigma and discrimination are amplified in areas where help-seeking behaviour is very visible due to limited service provision and insular communities.

Cultural insensitivity can interfere with access to services, communication, the development of social and therapeutic relationships, detection and appropriate interpretation of symptoms, as well as the acceptability of interventions offered by health providers. There is little professional understanding of ethnocentric and alternative healing methods, such as the importance of traditional mourning practices.

Aboriginal peoples and Torres Strait Islanders

A history of dispossession and its impact on emotional and social wellbeing has shaped the relationship between mainstream health services and Aboriginal peoples and Torres Strait Islanders. For example, barriers of distrust, misunderstanding and poor communication may impact on many Aboriginal peoples and Torres Strait Islanders seeking out health care from mainstream providers.

The emotional and social wellbeing of Aboriginal peoples and Torres Strait Islanders must be addressed in a holistic way. This approach requires strategies across the continuum of care from prevention, early intervention, and health promotion to clinical care and management. Strategies to address mental health cannot be developed and delivered in isolation from broader health, primary health, and health-related strategies.

Issues for prevention and management in special population groups

There are now around 100 Aboriginal Community Controlled Health Services (ACCHSs) across Australia that provide a primary health care function consistent with the principles of the Ottawa Charter (Swan & Raphael 1995). The peak body for these services is the National Aboriginal Community Controlled Health Organisation (NACCHO). Services provided range from large multi-functional services employing several medical practitioners and other health professionals to smaller services that rely on a few staff to provide the bulk of primary care services. They provide a range of services covering health promotion, prevention, early intervention and treatment. ACCHSs provide holistic primary health care services to the community in a culturally appropriate setting that ensures that most Aboriginal peoples and Torres Strait Islanders have access to appropriate and timely health care.

While it is crucial for Aboriginal peoples and Torres Strait Islanders to have access to culturally appropriate care through Aboriginal community controlled services, equity of access to specialist mental health care programs is also important. Such programs are identified as a major area of need by Aboriginal peoples and Torres Strait Islanders. The adaptation of psychological treatments to be appropriate for Aboriginal peoples and Torres Strait Islanders (and also for people from culturally and linguistically diverse backgrounds) is an issue of particular concern. Current approaches include adaptations of narrative therapy, the development of culturally relevant models, traditional health practices, and psychodrama.

The issues of language and cultural interpretation can have important implications for the quality of primary health care. For example, a non-Indigenous general practitioner may misinterpret information given by Aboriginal peoples and Torres Strait Islanders during assessment. There is a need for appropriate organisational structures to be in place which recognise the legitimate role of Aboriginal and Torres Strait Islander health workers operating in collaboration with general practitioners to deliver a culturally sensitive service.

Critical issues that are inextricably linked to mental health and disorder by Aboriginal peoples and Torres Strait Islanders include the consequences of trauma, grief, loss, and drug-related harm (Swan & Raphael 1995). Clearly, there need to be specific policies to prevent undue trauma and loss for Aboriginal peoples and Torres Strait Islanders and sensitivity to the high background level of trauma and loss that are part of their experience. In particular, intersectoral and health care system interventions must work towards strengthening families and other social systems to prevent family separations, such as placing children into care and juvenile incarceration, which continue to occur.

People from culturally and linguistically diverse backgrounds

The multiplicity of biopsychosocial causal factors for depression in migrants and refugees highlights the need for early interventions for these groups. Collaborative models of service delivery are currently being implemented in each State and Territory for newly arrived refugees. Community-based services are crucial to promoting access and continuity of care.

The choice of strategies for prevention and intervention needs to be based on a comprehensive analysis of causes and increased understanding of the needs of this population. Interventions that include psycho-education, facilitated access to health services, settlement services, counselling services (including short-term

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counselling), and availability of qualified interpreters has enabled improvements in the physical and psychological health status of migrants.

Adequate support for children, some of whom have also been directly traumatised, is also important. Newly arrived migrant and refugee children and adolescents require support not only from their parents, but also from an educational system that can actively enhance their sense of belonging and accommodate any special needs that arise. Groups conducted in school settings for refugee children have been found to be beneficial for the participant's wellbeing and teachers have reported benefits. This area of work requires more systematic evaluation.

4.4 Barriers to prevention and management

A national survey of the Australian general public revealed that the views of most respondents regarding treatment differed from those of most clinicians (Jorm et al 1999a). General practitioners and counsellors were rated more highly as sources of help than psychiatrists and psychologists. Many standard psychiatric treatments, such as antidepressants, ECT and admission to a psychiatric ward of a hospital, were more often rated as harmful than helpful, while some non-standard treatments were rated highly (eg increased physical or social activity, relaxation and stress management, and reading about people with similar problems). Even vitamins, herbal remedies and special diets were rated more highly than antidepressants. Such differences of opinion between the public and mental health professionals may lead to unwillingness to seek help or comply with treatment.

There are many plausible reasons behind this mismatch of public and professional views. Fear of stigma and labelling, lack of recognition of depressive symptoms, the view that the depression 'will pass' and that 'it is something to be expected', lack of compliance, and fear of dismissal from significant others are all barriers to treatment. For peoples of Aboriginal or Torres Strait Islander descent, cultural factors and lack of access to appropriate services are major barriers. For peoples from culturally and linguistically diverse backgrounds, cultural differences between service users and services providers are also a paramount problem, as is language.

In general, the public are not informed consumers of mental health care services and are unaware of the choice of interventions that may be available to them to treat depressive symptoms and disorders. They may be unaware of the different types of treatments likely to be offered by a general practitioner, a psychiatrist or a psychologist. The Australian Psychological Society (APS) has recognised this problem and is about to undertake an extensive public education program regarding the roles and skills of psychologists.

Consumer choice of mental health treatment should be a collaborative process agreed to by informed choice between the provider and the consumer. However, while it is necessary to raise consumer awareness regarding choice of interventions, it must be realised that such choice is only available to those who can afford it. The cost incurred in many treatments is a major barrier. Counselling and most psychological treatments are not available under MBS or health insurance rebates. As psychotherapy related to a depressive risk factor may be a long-term undertaking, the associated costs are prohibitive for many people. Consequently, the burden of care often rests with general practitioners, as their services are most fully covered by rebates. According to the report of the Joint

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Consultative Committee in Psychiatry (1997) of the RACGP and RANZCP, while there are many enhanced roles available to general practitioners, and that current initiatives under the National Mental Health Strategy and General Practice Strategy are likely to increase opportunities and impetus for general practitioners' involvement in these areas, such conduct is currently not rewarded in terms of appropriate recognition or remuneration. The time taken to provide the full range of care for a complex depressive disorder is still not adequately reimbursed to the general practitioner.

Barriers to recognition and management of depression and other mental disorders by general practitioners cited in published studies (Phongsavan et al 1995, Carr & Reid 1996, Aoun 1997, Aoun et al 1997, Veit et al 1996) include:

- self-perceived lack of skills in the area;
- time pressure in general practice being too great to undertake a counselling role;
- perceived lack of access to or communication difficulties with specialist mental health services for advice and long waiting lists at tertiary services; and
- feelings of discomfort evident by people accessing mental health services.

Assertive marketing and information dissemination of trials using antidepressant medication by pharmaceutical companies, and the comparative lack of assertive demonstration of the established advantages of non-pharmacological treatments, are increasingly leading psychiatrists and general practitioners to judge that 'all depression' should be treated with medication. This is a trend that needs to be carefully considered and evaluated. It will best be addressed by obtaining a clear evidence base that identifies the treatments that are best suited to specific disorders. Lack of awareness of networks or unwillingness to incorporate referral to other care providers for specific types of treatment, and inability to work within a pluralistic approach are also major potential obstacles.

