National Health Priority Areas

Australian Health Ministers' Conference

Mental Health

A REPORT FOCUSING ON DEPRESSION

Summary

National Health Priority Areas Report

Mental health

A report focusing on depression

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Preface

This is a summary of the National Health Priority Areas (NHPAs) report on mental health. The report is one of a series of biennial reports to Health Ministers on each NHPA—cardiovascular health, cancer control, mental health, injury prevention and control, and diabetes mellitus. These areas all have a significant impact on the health of Australians and offer potential for considerable health gain.

The report is part of an encompassing NHPA process that involves various levels of government, the National Health and Medical Research Council and the Australian Institute of Health and Welfare, and draws on expert advice from the non-government sector.

There is considerable overlap between the priority areas, in terms of factors that contribute to greater risk and barriers to better prevention and care. The NHPA process recognises that broader population health initiatives targeting these risk factors and barriers will bring benefits across priority areas. It also recognises that strategies to reduce the burden of illness should encompass the continuum of care from prevention through to treatment, management and long-term care, supported by appropriate research and monitoring.

Health Ministers agreed in July 1996 that reports should be developed on each of the priority areas. The *First Report on National Health Priority Areas 1996* provided an overview of the five NHPAs and discussed the work program for the initiative. Reports on injury prevention and control and on cancer control were published in July 1998 and have provided a basis for further action in those fields. Reports on cardiovascular health, mental health and diabetes mellitus are being released in July 1999.

The report on mental health was developed through an Expert Drafting Group appointed by the National Health Priority Committee. The process involved consultation with the Commonwealth Government, State and Territory Governments, the Australian Institute of Health and Welfare, and a wide range of those active in the field of mental health, including consumer groups, peak community groups and health care professionals.

This summary aims to present the key messages of the main report, and highlight opportunities for improving the mental health of Australians, particularly in relation to depression. Readers requiring more detail about any of the points in this summary should consult the main report.

Background

Although the health and living conditions of Australians have improved greatly this century, with the notable exception of Aboriginal peoples and Torres Strait Islanders, this has not necessarily been matched by gains in mental health. Efforts to improve mental health and reduce the impact of mental disorders are undergoing a process of significant reform in Australia. Under the National Mental Health Strategy, launched in 1992, there have been major changes in public mental health services that are now extending into the private sector.

Mental disorders are taking a high priority on the health agenda for Australians due to their common prevalence, the level of disability they are associated with, high direct and indirect costs, and the heavy burden of human suffering, including stigmatisation, that they impose.

The importance of depression

The World Bank and World Health Organization have predicted that by the year 2020, the health burden attributable to neuropsychiatric disorders could increase by about 50 per cent, from 10.5 per cent of the total burden in 1990 to almost 15 per cent in 2020. Projections to the year 2020 indicate that depression will contribute the largest share to the burden of disease in the developing world and the second largest worldwide. The economic costs of this increase are likely to be high.

The pronounced suffering and disability associated with depressive symptoms and depressive disorders[1] could be substantially reduced with concerted efforts across the health care continuum and across sectors of care, communities and governments. As many depressive symptoms and disorders are treatable and preventable, improvements in mental health promotion activities, prevention and early intervention efforts, as well as treatment services, are likely to have a major impact on the level of depressive symptoms and disorders in the Australian community.

Furthermore, depressive symptoms and disorders are related to other disorders, both mental and physical. Depressive disorders are more likely to be associated with anxiety than any other mental disorder. Depression is common in people with physical illnesses; the 1997 National Survey of Mental Health and Wellbeing found that nearly half the people with an affective or depressive disorder also had a related physical problem. Preventing and effectively treating depressive disorder is likely to have a much wider impact on people's health by also improving other mental and physical conditions.

1 Chapter 2 of the main report provides definitions of various forms of depressive disorders.

Profile of mental health

Mental health is the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, optimal development, and use of cognitive, affective and relational abilities. It is much more than the absence of mental illness. It is the realisation of one's potential, shaped by factors such as biological make-up, gender roles, family life, human relationships, work opportunities, educational achievements, and a variety of structural and socioeconomic determinants.

At a population level, mental health status highlights several crosscutting themes such as inter-group dynamics, culture and identity, and the overall feeling of positive wellbeing. Both social-emotional ill health and psychiatric disorders can result from oppression, racism, environmental circumstances, economic factors, stress, trauma, grief, loss, cultural genocide, psychological processes and poor physical health. Particularly for Aboriginal peoples and Torres Strait Islanders, mental health must be considered in the wider context of physical, emotional and social wellbeing.

The measurement of mental health is complex, and the term 'mental health' is often used when what is meant is 'mental disorder'. Measured differences in mental health are more often based on the presence of illness than its absence, and generally do not take into account mental health as a positive attribute.

Mental health problems and *mental disorders* refer to the spectrum of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people at school, work and home, and impact upon their interpersonal relationships. The spectrum covers cognitive impairment and disabilities, phobias, panic attacks, drug-related harm, anxiety, post traumatic stress disorder, personality disorders, depressive disorders, schizophrenia and psychoses.

Mental health problems refer to common mental complaints and symptoms, while a *mental disorder* implies the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and interference with personal functions.

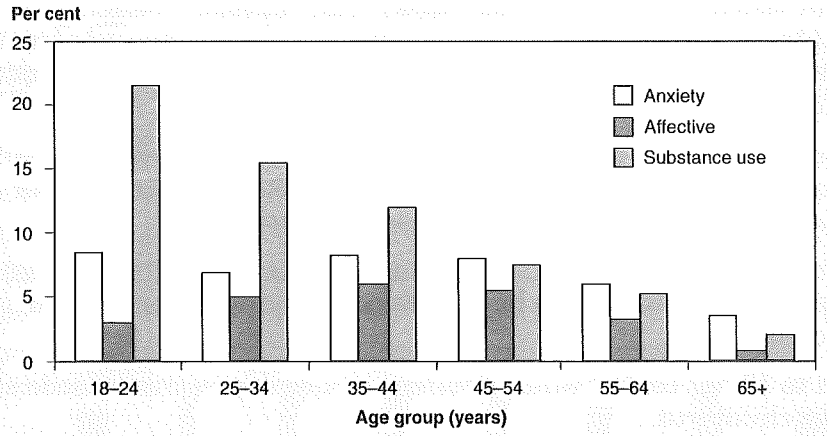
Prevalence of common mental disorders

Over one in six Australian adults reported that they experienced anxiety, affective or substance use disorders at some time during the 12 months before the 1997 National Survey of Mental Health and Wellbeing (SMHWB) conducted by the Australian Bureau of Statistics. Males and females had similar overall prevalence rates, however, females were

more likely to report anxiety and affective disorders and males were more likely to report substance use disorders.

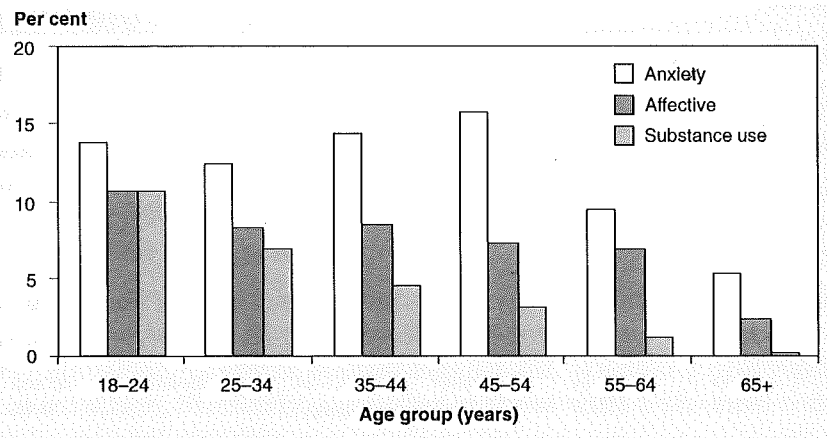
Young persons aged 18–24 years present the highest prevalence of mental disorders, which declined to around six per cent among persons aged 65 years and over (see Figures 1a and 1b). A steady decline with age for substance abuse disorders is evident for both males and females. Anxiety peaks for males in young adulthood and for females in middle age. Conversely, affective disorders peak for males in middle age and for females in young adulthood.

Figure 1a: Age-specific prevalence of common mental disorders/problems among Australian males, 1997



Source: 1997 National Survey of Mental Health and Wellbeing: Adult Component (ABS 1998).

Figure 1b: Age-specific prevalence of common mental disorders/problems among Australian females, 1997



Source: 1997 National Survey of Mental Health and Wellbeing: Adult Component (ABS 1998).

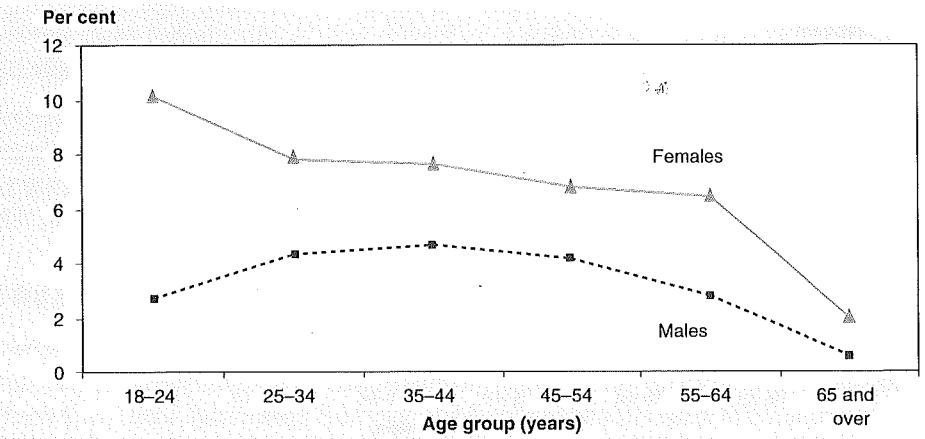
No national estimates of the prevalence of mental disorders among children and adolescents are available. According to the 1993 Western Australian Child Health Survey, nearly one out of six 4–11 year olds and more than one out of five 12–16 year olds have had a mental health problem.

Prevalence of depression

Depression is often a recurrent disorder, although its prevalence generally decreases with age. Depression is more common among females than males at all ages. The prevalence of depression varies across the lifespan as follows:

- Depression and anxiety symptoms occur in about 4–6 per cent of children and are likely to persist with age if not effectively treated. Less than one per cent of pre-pubertal children experience depressive disorder.
- The first onset of depressive disorder often occurs in mid-to-late adolescence and this is the life stage of peak incidence; five per cent of young people suffer from depressive disorder.
- The onset of depressive disorder may also occur for the first time in early adult life and in half these cases there is a prior external stressor.
- Ten to 15 per cent of women suffer a major depressive episode shortly after childbirth.
- Depressive disorder may occur for the first time in later life. This is more likely for older people living in residential care.

Figure 2: Age-specific prevalence of depression, 1997



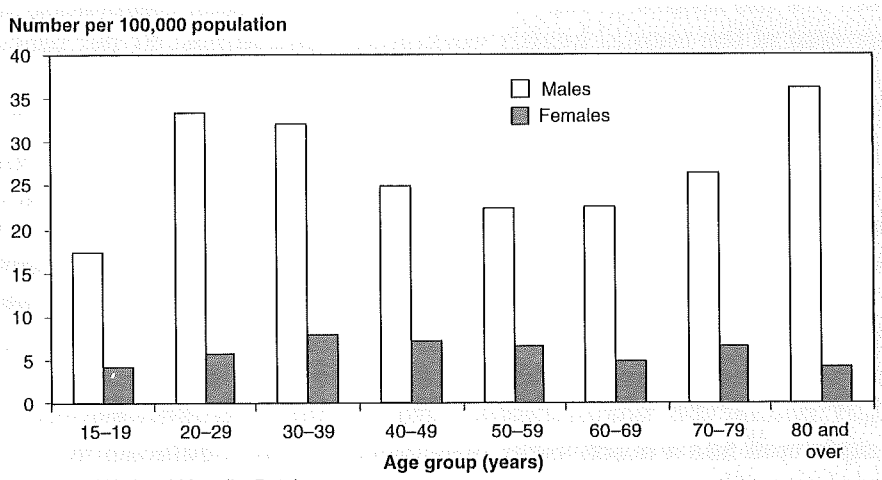
Source: 1997 National Survey of Mental Health and Wellbeing: Adult Component (ABS 1998).

Suicide

Suicide is a leading cause of death in Australia, resulting in 2,393 deaths in 1996. Several factors can contribute to suicide. Mental disorders, specifically depression, consistently emerge as the largest single group of risk factors for suicide and suicidal behaviour.

Males and females are equally likely to attempt suicide, but the male suicide rate is almost five times higher than the rate among females. Suicide rates are relatively stable across the adult lifespan for females, but male suicide rates show two peaks, one in younger males and the other in the oldest age group.

Figure 3: Age-specific suicide rates, by sex, 1996



Source: AIHW National Mortality Database

Comorbidity

Mental disorders are often comorbid with each other, particularly depression and anxiety. The 1997 National Survey of Mental Health and Wellbeing revealed that almost 80 per cent of those with an affective disorder also had an anxiety disorder. More than one in three of those with an anxiety disorder and one in five of those with a substance use disorder also had an affective disorder.

Mental disorders may also contribute to or result from physical conditions and disabilities. Almost 43 per cent of those reporting a mental disorder in the 1997 National Survey of Mental Health and Wellbeing also reported a physical condition. Similarly, a quarter of those with a physical condition reported a mental disorder.

Depressive disorders are particularly likely to be comorbid with physical disorders. Depressive symptoms and disorders have been found for persons with cardiovascular disease, diabetes, cancer, and injury. Untreated depression adversely affects treatment outcomes for these disorders.

Mental health services

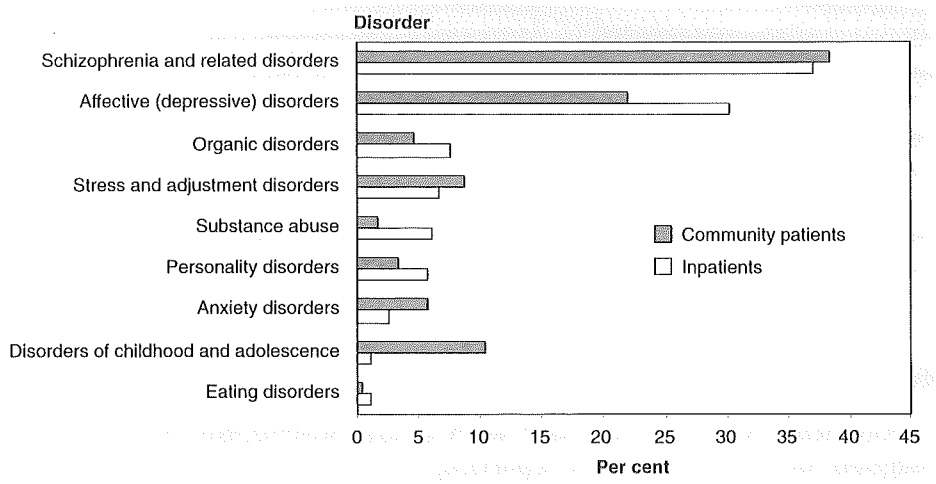
Mental health services in Australia are largely provided through primary health care, private specialist care and community mental health services. Most people with mental disorders are managed outside hospital settings. However, service utilisation data are more readily available for people who have been hospitalised with a mental health problem.

Nurses are the largest group of mental health workers, comprising about 53 per cent of the mental health workforce. Since almost 87 per cent of psychiatrists practise in a capital city, access to private psychiatric services is unevenly distributed throughout Australia.

Limited information has been generated through the 1996 Mental Health Classification and Service Costs project, but it is unknown how well this information generalises to the general Australian population. The main types of disorders for which people received treatment from the mental health services examined in this project were schizophrenia and related psychotic disorders, and mood disorders. These disorders together accounted for 67 per cent of persons treated in inpatient and 60 per cent of persons treated in community settings (see Figure 4).

Schizophrenia has a much lower prevalence in the population in comparison with other mental disorders. However, according to the 1996 Mental Health Classifications and Services Costs study, people with schizophrenia and related disorders used almost 49 per cent of all mental health services. (The onset of schizophrenia often occurs in late adolescence or early adulthood and can result in a high level of disability that persists over the adult lifetime.) Mood disorders accounted for 30 per cent of the services used.

Figure 4: Proportion of people with selected mental disorders (principal diagnosis) treated by mental health services, by patient status, 1996



Source: Mental Health Classification and Services Costs Project (DHFS 1998).

Mental disorders are estimated to be the fourth most expensive disease group, after digestive system diseases, circulatory disorders and musculoskeletal problems.

The total institutional and non-institutional costs of mental disorders have been estimated at $2.58 billion in 1993–94, comprising 8.3 per cent of total health system costs. Self-inflicted injury adds a further $69 million. High cost is partly a consequence of long-term enduring mental disability with relatively low fatality rates.

Current activity and progress

Current initiatives related to depression are many and diverse.[2] Some of these initiatives are supported by the Commonwealth Government, and others primarily by State and Territory governments. Non-government organisations are playing an important role in intervention activities, along with general practitioners, educational institutions, professional bodies, the pharmaceutical industry, and private enterprise. Altogether, there is an impressive level of current activity related to depression interventions, the results of which need to be widely disseminated and built upon.

Measuring progress

A set of priority indicators, each with a standard definition, have been designed for monitoring and reporting on depression The indicators cover the prevalence of anxiety and depression, as well as suicide and self-inflicted injuries. As evident from Table 1, there are data available for reporting against only half of these indicators. Furthermore, as the information reported is based on limited time-series, no clear picture of national trends in depression emerges.

2 Chapter 5 of the main report describes examples of key initiatives that are being undertaken across the nation.

Table 1: NHPA indicators for depression

Indicator		Reported in 1998
1 Prevalence of anxiety and depression		
1.1	Prevalence rates for anxiety and depression symptoms in:	
	a) general population	
	b) children and adolescents	
	c) adults	✗
1.2	Prevalence rates for depressive disorders in:	
	a) general population	
	b) children and adolescents	
	c) adults	✓
1.3	Prevalence rates for anxiety disorders in:	
	a) general population	
	b) children and adolescents	
	c) adults	✓
1.4	Prevalence rates for women who have given birth and who experience post-partum depression over the following year	✗
2 Suicide and self-inflicted injury		
2.1	Hospital separation rates for suicide and self-inflicted injury among:	
	a) young adults, aged 15–24 years	
	b) older people, aged 65 years and over	✓
2.2	Death rates for suicide among:	
	a) young adults, aged 15–24 years	
	b) older people, aged 65 years and over	✓
2.3	Death rates for suicide in rural and remote areas among:	
	a) young adults, aged 15–24 years	
	b) older people, aged 65 years and over	✓
3 Mental health literacy and awareness		
3.1	Proportion of persons in the general community who:	
	a) recognise the symptoms of depressive disorders	
	b) rate treatment of depression as helpful	✗
4 Best practice		
4.1	Proportion of general practitioners who know and apply best practice guidelines for the identification and management of depression	✗
4.2	Proportion of perceived medication needs met among persons:	
	a) with depressive disorders	
	b) without depressive disorders	✗

Notes: ✓ indicates that some data were available for 1998 reporting.
✗ indicates that data were not available for 1998 reporting.

Key issues

High risk groups and risk factors for depression

The aetiology of depression is complex and multifactorial and requires a biopsychosocial approach that takes into account the interaction of many diverse factors. It is, therefore, difficult to determine what risk and protective factors are paramount. Table 2 presents some of the factors widely held to be important, although for many of these supporting evidence is lacking or unclear.

Table 2: Summary of risk and protective factors associated with depression

Risk factors	Protective factors
Environmental and social	
Social disadvantage (eg poverty, unemployment)	Good interpersonal relationships (eg supportive relationship with at least one person/parent, perceived social support)
Family discord (eg relationship break-up, conflict, poor parenting practices)	Family cohesion (eg positive parent–child relations)
Parental mental illness	Social connectedness
Child abuse (eg physical and sexual abuse, neglect)	Academic/sporting achievements
Exposure to adverse life events (eg bereavements, family separation, trauma, family illness)	
Caring for someone with a chronic physical or mental disorder	
For older adults, being in residential care	
Biological and psychological	
Parental mental disorder and family history of depression	Easy-going temperament
Being a female adolescent	Optimistic thought patterns
High trait anxiety and pre-existing anxiety disorders, substance misuse, conduct disorder	Effective coping skills repertoire (eg social skills, problem-solving skills)
Temperament—reacting negatively to stressors, and personality trait of neuroticism	
Negative thought patterns (pessimism, learned helplessness)	
Avoidant coping style	

The experience of depression varies across the lifespan and across population groups. Some population groups are perceived to be at higher risk due to their exposure to risk factors and to the special needs of their members. Groups at particularly high risk of depression include: Aboriginal peoples and Torres Strait Islanders; refugees; people living in rural and remote communities; children of parents with mental disorders; carers; women in the perinatal period; young people; and older people in residential care.

Promotion

Mental Health promotion contributes generally to improving mental health and wellbeing. Promotion activities to enhance people's mental health literacy by improving their knowledge of healthy behaviours and strengthening their ability to deal with difficult life situations are important activities for educational and community media.

Prevention

Prevention activities can be targeted at different sectors of the community (universal, selective or indicated preventions). Prevention activities start in early childhood, where programs to improve the quality of parenting can prevent later depression. School-based interventions are aimed at general mental health risk factors, to improve the resilience of children. In adolescence and adulthood selective and indicated preventive interventions are important for those at increased risk of depressive disorders.

Management

Depressive symptoms and disorders can be effectively managed if they are recognised and all the relevant issues are taken into account. This is best achieved by an approach that acknowledges biological, psychological and social factors that contribute to depression.

Many people attempt to cope with symptoms of depression without professional help. A prominent 'self-care' strategy is telephone counselling. Little is known about the effectiveness of the wide range of self-care strategies, but physical exercise and the herb St John's wort are worthy of further investigation.

Recognising depressive symptoms and disorders is critical to effective management. Notably, only 39 per cent of the Australian general public were able to recognise depression in a national survey.

Primary care workers have a vital role in the detection and appropriate referral of people with depressive symptoms. Screening for depression can be relatively simple. For example, asking 'Are you feeling depressed?' can be effective in screening people who are physically ill. Recognising and treating comorbidity, particularly with anxiety, is also imperative for effective treatment.

There is considerable evidence that psychological interventions are also effective. Studies to date show minimal differences between cognitive, behavioural and interpersonal therapies. Psychological therapies appear to be as effective as antidepressant medication for less severe depressive disorders and are particularly appropriate for adolescents.

More evidence is needed, however, to determine which types of therapy are best suited in different situations. Clinical psychologists and psychiatrists receive specialist training in a range of psychotherapies, although other health professionals, including general practitioners, are developing basic skills in psychological treatments.

Antidepressant treatment is not always well accepted by the general public, yet is an effective and often life-saving intervention in the case of more severe depressive disorders.[3] Antidepressant drugs are not, however, preferred treatments for children and adolescents. Electroconvulsive therapy is another medical treatment that is very effective for depressive disorders that have not responded to other treatments.

An important issue for the effective treatment and maintenance of people with depressive disorders is collaboration among a broad range of service providers. Primary care and general practitioners are often best placed to recognise depression, and general practitioners with appropriate training are able to fully treat many of the people who present with depressive symptoms and disorders. However, extra support in the form of specialist treatment or support from psychologists and psychiatrists, may be required to provide the necessary multifactorial biopsychosocial approach, particularly for complex cases.

Barriers

There are major barriers for some groups in the community that prevent effective depression treatment. In general, the public are not well informed consumers of mental health care services and are unaware of the choice of interventions that may be available to them. The stigma

3 The current medical treatments for depressive disorders are described in Chapter 4 of the main report.

associated with mental illness is another major barrier to effective treatment, along with the pervasive view that depressive symptoms are an inevitable part of life that need to be endured.

Significant barriers apply to Aboriginal peoples and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, and people living in rural and remote communities. Fundamentally, lack of services and/or lack of culturally appropriate and sensitive services prevent access to effective treatment.

Research and information

Australia has a significant history of research on depression and has contributed 2–3 per cent of the world's scientific publications on depression. Major themes have been classification, assessment and diagnosis, depression comorbid with other health problems, causes of depression and biological treatment. However, most published research has been carried out with people receiving specialist treatment for depression. Consequently, there is a need for research based in the community and in primary care, on depression in children and adolescents, and on psychosocial treatments and prevention.

The way forward

Concerted effort by the health sector, in collaboration with non-health sectors, is required to bring about the changes needed in the physical, economic, and social conditions associated with depressive disorders in Australia. Opportunities and future directions to impact on depression include the following:

Promotion

1. Identify residential, educational, workplace, community and social environments that enhance mental health, and facilitate their development and adoption.
2. Develop promotion activities that widely inform and encourage people to adopt mentally healthy lifestyle choices. More evidence is required regarding effective mentally healthy lifestyle choices, but those that appear mentally healthy promote optimistic styles of thinking, coping strategies that enable resilience in the face of life stressors and physical exercise.
3. Improve mental health literacy through promotion activities and community education—specifically, improve recognition of depressive symptoms and disorders and knowledge regarding the availability and efficacy of different treatment options.
4. Encourage the media and primary care workers, particularly general practitioners, to play a major role in disseminating information to improve the community's mental health literacy.

Prevention

5. Rigorously evaluate and widely disseminate the results of promotion and prevention activities.
6. Begin prevention activities early in life with programs to encourage positive parenting practices that help to develop optimistic and resilient children.
7. Identify and widely implement effective school-based programs that enhance children's resilience.
8. Develop prevention activities to inform people of high-risk situations for depressive symptoms, and gather research evidence to determine how best to deal with high-risk situations.

9. Targeted prevention activities are particularly important for the following high-risk groups: mid-to-late adolescents; women approaching and after childbirth; people exposed to major risk factors; older people in residential care; children of parents with mental illness; carers of people with disabilities; and Aboriginal peoples and Torres Strait Islanders. Support is required for the organisations that come into contact with these groups of people (eg schools, community-based organisations) to develop and provide targeted prevention activities.

Recognition of depressive symptoms and disorders in primary care

10. Support and develop the pivotal role of general practitioners in recognising and treating depression.
11. Provide education to primary care workers to improve the recognition of depressive symptoms, particularly in people from high-risk groups, such as adolescents, women after childbirth, older people in residential care, people presenting repeatedly with somatic symptoms, people exposed to major life stressors, and Aboriginal peoples and Torres Strait Islanders.

Recognition of co-existing disorders

12. Treatment requires determining whether the depressive disorder is secondary to another condition, such as anxiety, and encompassing the other condition within the treatment plan.

Collaborative models

13. Develop and support collaborative models of care, particularly between general practitioners and specialist mental health professionals.
14. Ensure the participation of consumer groups and carers in the development and evaluation of models of care appropriate to specific population groups.

Access to primary and specialist care

15. Improve access to appropriate mental health services for young people, Aboriginal peoples and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, and people living in rural and remote communities.

16. Provide culturally appropriate treatment models for Aboriginal peoples and Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds.

17. Target appropriate treatment services at young people, particularly those young people at higher risk through early school leaving, being homeless or unemployed, or having a parent with a mental disorder.

18. Develop the role of schools to have a major role in identifying and supporting young people with current depressive disorders and symptoms, as well as those who are at risk through exposure to life stressors. Improve intersectoral links and partnerships between schools and mental health care.

19. Investigate the use of technology in improving access to mental health services.

Best practice evidence-based guidelines, information and training

20. Develop, implement and support the adoption of best practice, evidence-based guidelines for detection and treatment of depressive disorders.

21. Determine ways to enable the mental health workforce to be well trained and up-to-date with best practice.

Funding issues

22. Consider ways in which funding arrangements can be used to improve the management of depressive disorders.

Information, monitoring and surveillance

23. Improve data regarding depressive disorders for high-risk groups, particularly young people, women after childbirth, older people in residential care, Aboriginal peoples and Torres Strait Islanders, refugees, and people living in rural and remote communities.

24. Monitor the dissemination, uptake and effectiveness of guidelines.

25. Design information systems to inform the planning and development of best practice treatment of depressive symptoms and disorders, and maximise input from all stakeholders.

Research issues

26. Determine ways to fund priority driven research on depression.

National Depression Action Plan

27. The development and implementation of the proposed National Depression Action Plan in the years 1999–2001 is a major opportunity to design strategic actions that will improve the mental health and wellbeing of Australians.

Keeping track

The main report informs Governments and the community about those areas of intervention that will provide most impact in terms of sustainable improvements and outcomes related to depression. It builds on the achievements gained from the implementation of the first National Mental Health Plan and, as part of the Second National Mental Health Plan, continues to implement the National Mental Health Policy and National Mental Health Strategy.

Depression has been identified as an area where significant gains could be made in both mental and physical health. However, the NHPA initiative aims to improve mental health in general in the Australian community. Therefore, while actions specifically related to depression will result from this report, in particular through the proposed National Depression Action Plan, service reform will continue to be a priority for other groups such as those suffering schizophrenia, dementia and drug-related harm.

Major reforms in the areas of service provision, standards, evidence-based practice, workforce design and community integration will continue to be implemented in all areas of mental health. Progress requires collaboration and partnerships across all sectors.

The monitoring of progress and reporting of developments in the mental health area are imperative to inform future strategic directions. Specific gains in the area of depression will be reported in the next *NHPA Mental Health Report*, along with updates of broader indicators related to the mental health status of the Australian population. Monitoring the implementation of the National Depression Action Plan will be a particularly informative process regarding progress in relation to mental health.