National Health Priority Areas Report

Mental health

A REPORT FOCUSING ON DEPRESSION

1998

Commonwealth Department of Health and Aged Care
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Executive summary

The *National Health Priority Areas Report—Mental Health* is one of a series of biennial reports to Australian Health Ministers on each of the five National Health Priority Areas. It is part of a process that involves various levels of government and draws on expert advice from non-government sources, with the primary goal of improving the health of Australians.

This report is designed to give an overview of issues in the mental health priority area for readers who have a general interest in health, but who are not necessarily experts in mental health. The report focuses specifically on depression as, by targeting an area that imposes such high social and financial costs on Australian society, collaborative action can achieve significant and cost-effective advances in improving the mental health status of Australians.

The report provides a description of mental health, followed by a more detailed profile of depression in Australia. The prevention and management of depression, including differences in treatment for different groups, are then discussed. Examples of current Australian initiatives related to depression are described. Lastly, potential opportunities and future directions are given, to provide a basis for future actions that will be taken forward in the proposed National Depression Action Plan. Each major section of the report is outlined below.

Mental health problems and disorders

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 the use of cognitive, affective and relational abilities. However, the measurement of mental health is complex and much more than the absence of illness; even the experts disagree on the best ways to define and measure mental health.

Mental health problems and disorders refer to the spectrum of cognitive, emotional, and behavioural disorders that interfere with the lives and productivity of people. Mental disorders form a substantial part of the disease burden in Australia. It is estimated that one in five individuals will be affected by a mental health problem at some stage in their life. Some of the major mental disorders perceived to be public health problems are schizophrenia, depression, anxiety disorders, dementia and substance use disorders. Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

In the case of depression, it is estimated that it will be the second largest contributor to the world's disease burden by 2020. As depression is associated with other mental disorders and also with many physical disorders, the effective prevention, treatment and management of depression would have a major positive impact on the health and wellbeing of Australians.

Profile of depression in Australia

Depression is often a recurrent disorder, frequently with its first onset in mid-to-late adolescence. During adolescence, the incidence rate for girls is higher than that for boys, and this gender difference persists throughout adulthood. The prevalence of depression declines in older age, except for older people in residential care settings. The experience of depressive symptoms is much more common than

depressive disorders, but also causes considerable disability and distress. Even more disability results when depression is comorbid with another mental or physical disorder. Depression is particularly likely to be comorbid with anxiety.

The 1997 National Survey of Mental Health and Wellbeing reveals that almost six per cent of adults aged 18 years and over suffer from depressive disorders, and the rate is much higher among females than males. The prevalence rate for anxiety disorders is 10 per cent, and again is higher for females than males. In reviewing different rates of depression between males and females we need to consider not just the biological differences that exist but also how male and female gender roles are socially constructed.

Hospital separations for suicide and self-inflicted injury are higher among young people compared with older people and among females compared with males. Suicide rates are higher among males than females by a ratio of almost 6:1 in young people. Suicide rates are higher in rural and remote areas than in metropolitan areas.

Prevention and management of depression

Interventions to impact upon depression are possible across the entire continuum of health care, from promotion, prevention and early intervention through to treatment and maintenance care. While the effectiveness of many promotion and prevention activities is yet to be demonstrated, interventions that improve people's mental health literacy, optimistic outlook, resilience to life stress, and social support appear to be helpful.

Prevention and early intervention activities are particularly relevant for groups that may be at high risk of depressive symptoms and disorders. These groups include mid-to-late adolescents, women in the perinatal period, older people in residential care, children of parents with mental disorders, carers, Aboriginal peoples and Torres Strait Islanders, refugees, and people experiencing adverse life events (such as physical illness and bereavement). Targeted interventions are especially important for these groups.

The treatment of depression occurs through medical and psychological interventions. Of vital importance is the recognition of depressive symptoms, along with comorbid conditions. General practitioners are in a central position to recognise and treat early depressive symptoms and disorders. More severe and complex disorders may require the specialist intervention of a psychiatrist or clinical psychologist. Treatments need to take a biopsychosocial approach, recognising the multiple factors affecting the development and course of depressive disorders. Antidepressant medication has an important role in treatment, particularly for more severe disorders, along with psychosocial interventions that address precipitating and maintaining psychological and social factors. Shared care and good referral networks between primary carers, general practitioners, and specialists are effective models. Training and support in the identification of depressive disorders are particularly important for primary care.

Australia has an active research agenda related to the understanding and treatment of depression, particularly for evaluating pharmacological interventions. In contrast, the evaluation of psychological interventions requires more support to provide a better evidence base.

Barriers to attaining effective treatment include lack of access to specialist services, particularly in rural and remote communities. Furthermore, some groups of people, such as young people, Aboriginal peoples and Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds, require culturally appropriate outreach services. Inadequate funding and lack of ongoing training for practitioners are also barriers to the provision of a pluralistic biopsychosocial approach to treatment.

Current initiatives relating to depression

There are many initiatives relating to depression currently occurring throughout Australia. These cover the entire health care continuum of promotion, prevention and community education; early intervention; management and treatment; and evaluation and monitoring. Within each of these areas, initiatives are occurring in all domains, including Commonwealth government, State and Territory governments, non-government organisations, general practice, as well as other organisations. Future activities need to take advantage of and build upon the vital level of activity underway and widely disseminate outcomes related to current initiatives.

Opportunities and future directions

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 to be mental health promoting include 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. Enable 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.

Introduction

Background

This report on mental health is one of a series of biennial reports to Health Ministers on each of the five National Health Priority Areas (NHPAs)—cancer control, injury prevention and control, cardiovascular health, diabetes mellitus and mental health.

While each report targets a group of discrete diseases or conditions and the recommended strategies for action are often specific in nature, the NHPA initiative recognises the role played by broader population health initiatives in realising improvements to the health status of Australians. Public health strategies and programs that target major risk factors may benefit several priority areas.

This report on mental health is part of an encompassing NHPA process that involves various levels of government and draws on expert advice from non-government organisations, with the primary goal being to improve the mental health of the Australian population. In recognition of the prevalence, associated social, human and economic costs and public health impact of depression in Australia, the National Health Priority Committee (NHPC), in consultation with the National Mental Health Working Group, agreed to focus its initial efforts on depression as the most appropriate area in which to improve mental health nationally.

The National Health Priority Areas initiative

Based on current international comparisons, the health of Australians is among the best in the world and should continue to improve with continued concerted efforts across the nation. The NHPA initiative emphasises collaborative action between Commonwealth and State and Territory governments, the National Health and Medical Research Council (NHMRC), the Australian Institute of Health and Welfare (AIHW), non-government organisations, appropriate experts, clinicians and consumers. It recognises that specific strategies for reducing the burden of illness should be pluralistic, encompassing the continuum of care from prevention through to treatment, management and maintenance and based on appropriate research.

By targeting specific areas that impose high social and financial costs on Australian society, collaborative action can achieve significant and cost-effective advances in improving the health status of Australians. The diseases and conditions targeted through the NHPA process were chosen because these are areas where significant gains in the health of Australia's population can be achieved.

From National Health Goals and Targets to National Health Priority Areas

The World Health Organization (WHO) published the *Global Strategy for Health for All by the Year 2000* in 1981 (WHO 1981). In response to this charter, the *Health for All Australians* report was developed, representing Australia's 'first national attempt to compile goals and targets for improving health and reducing inequalities in health status among population groups' (Health Targets and

Implementation Committee 1988). The 20 goals and 65 targets focused on population groups, major causes of sickness and death, and health risk factors.

A revised set of targets was published in 1993 in the *Goals and Targets for Australia's Health in the Year 2000 and Beyond* report (Nutbeam et al 1993). Goals and targets were established in four main areas—reductions in mortality and morbidity, reductions in health risk factors, improvements in health literacy, and the creation of health-supportive environments. However, this framework was not implemented widely.

The *Better Health Outcomes for Australians* report, released in 1994, refined the National Health Goals and Targets process (DHFS 1994). The focus of goals and targets was shifted to four major areas for action—cancer control, injury prevention and control, cardiovascular health, and mental health. As a corollary to this, Australian Health Ministers also adopted a national health policy, which committed the Commonwealth and State and Territory governments to develop health goals and targets in the priority health areas and reorient the process towards population health.

In 1995, it was recognised that there were a number of fundamental shortcomings of the National Health Goals and Targets process. Principally, there were too many indicators (over 140 across the four disease priority areas), a lack of emphasis on treatment and ongoing management of the disease/condition, and no national reporting requirement. In implementing a goals and targets approach, emphasis was placed on health status measures and risk factor reduction. However, no nationally agreed strategies were developed to promote the change required to reach the targets set.

This led to the establishment of the current NHPA initiative. Health Ministers agreed at their July 1996 meeting that a national report on each priority area be prepared every two years, to give an overview of their impact on the health of Australians. These reports would include a statistical analysis of surveillance data and trends for a set of agreed national indicators. It was also agreed that diabetes mellitus become the fifth NHPA.

A consolidated report on progress in all the priority areas was published in August 1997 (AIHW & DHFS 1997), and reports on injury prevention and control and cancer control were published in 1998 (DHFS & AIHW 1998a, 1998b).

Development of the report

The NHPC developed this report in consultation with the Commonwealth and State and Territory governments, the NHMRC, the AIHW, and a wide range of non-government organisations, consumer groups and professional bodies active in the mental health field. An expert drafting group was established to develop the report. Members included keynote speakers at the National Workshop on Depression held in late 1997, and representatives of consumer interests, Aboriginal peoples and Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds. The national workshop brought together a diverse range of people with relevant expertise in prevention, treatment and management of depression and consumer and carer representatives and its proceedings have provided a basis for the current report.

Data development and statistical analysis by the AIHW, including determination of trends and differentials, form the basis of reporting against a set of depression indicators.

Purpose and structure of the report

This report focuses specifically on depression, which is of major concern both in Australia and internationally, and where significant gains can be achieved through strategic:

- promotion, prevention and community education;
- early intervention;
- management and treatment; and
- research, evaluation and monitoring.

The report is designed to provide an overview of the issues for readers who have a general interest in health, but are not necessarily experts in mental health. It does not provide a systematic review of the evidence and does not attempt to be comprehensive. Specialised reviews of the evidence are cited throughout the report and should be consulted by readers who are interested in a more detailed account.

Chapter 1 presents an overview of mental health in Australia, including a definition of the term 'mental health', an outline of the various mental health conditions, and statistics and trends.

Chapter 2 provides a detailed profile of depression. It examines its definition and diagnosis through a lifespan perspective, considers how it differentially affects particular population groups, and describes known risk and protective factors.

Chapter 3 provides data for the NHPA indicators related to depression.

Chapter 4 looks at issues related to the prevention, management and treatment of depression. It covers the broad range of help-seeking behaviours related to depression, from self-help through to seeking specialist psychiatric help. It considers lifespan issues, promotion and prevention, early intervention, management and treatment, and barriers and gaps in service provision.

Chapter 5 presents examples of current major intervention projects being undertaken or supported by the Commonwealth, States and Territories, non-government organisations and others. These projects are briefly described.

Chapter 6 considers avenues for future development. It highlights issues related to program and infrastructure development, funding levers, intersectoral policy arrangements and links, the value of a public health approach to depression, and presents an outline of the proposed National Depression Action Plan under the renewed strategy of the Second National Mental Health Plan.

Appendix 1 presents the first set of priority depression indicators for Australia, against which future reports will be able to determine progress in improving the population's mental health.

Introduction

Appendix 2 provides an overview of the gaps in national mental health-related data collections, as well as technical information to assist in the interpretation of demographic and statistical methods used in the report.

Appendix 3 shows the framework for a three-year plan developed at the National Workshop on Depression, November 1997.