6 Opportunities and future directions

The pronounced suffering and disability associated with depressive symptoms and disorders could be substantially reduced with concerted efforts across the health care continuum and across sectors of care, communities and governments. Gains in the prevention and treatment of depression would contribute considerably to the wellbeing of Australians. Furthermore, success in relation to depressive disorders would flow on to other mental disorders, general wellbeing, and also to physical disorders, particularly those identified as other NHPAs. This chapter considers opportunities and potential future directions in relation to depression. The boxes highlight the main points that emerge from this report that could be further developed into strategic actions in the proposed National Depression Action Plan. Work on this Plan will commence in 1999 to identify priorities and strategies for national interventions for the years 1999 to 2001 (see Section 6.4).

Concerted action by the health sector, in collaboration with non-health sectors, will be required to bring about the changes needed in the physical, economic and social environmental conditions associated with depressive disorders in Australia. These actions will involve all levels of government, the private sector, and non-government and community organisations. The previous chapter revealed that many important initiatives are currently underway. The proposed National Depression Action Plan will play an integral role in advancing further opportunities for improvement.

In order to discern the best way forward at all levels of the health care continuum, it is necessary to:

- identify current structures and activities that have been shown to be effective;
- address issues related to the prevention and management of depressive disorders;
- determine existing mechanisms that may be able to address these issues; and
- suggest achievable opportunities for the future.

The National Workshop on Depression, held in November 1997, identified five priority areas for strategic intervention. These were: prevention and promotion; early intervention; management and treatment; community education; and evaluation and monitoring. Aboriginal peoples and Torres Strait Islanders were noted as a high priority population group. The following discussion acknowledges and encompasses these priorities.

6.1 Promotion and prevention

Promotion

The principles of the *Ottawa Charter 1986* recognise that a framework for mental health promotion needs to incorporate creating supportive environments, developing personal skills, developing healthy public policy, reorienting health services toward prevention, and strengthening community action. Such initiatives

would impact broadly on all aspects of mental health and wellbeing, and thereby directly and indirectly affect depression.

Opportunity/future direction 1

Identify residential, educational, workplace, community and social environments that enhance mental health, and facilitate their development and adoption.

Identification and development of environments that support mental health and wellbeing are the responsibility of all sectors. Risks for depressive disorder and barriers to mental health span all of life's domains—environmental, social and cultural, socioeconomic, personal and interpersonal. All these domains need to be addressed through broader health, social and economic reform agendas. Examples of commitments to providing mentally healthy workplaces are evident in the provision of parental leave, carer's leave, bereavement leave, and access to high-quality childcare services.

The *Jakarta Declaration 1997* acknowledges the importance of promoting social responsibility for health and improving the community's capacity for developing and sustaining health-enhancing environments. Barriers to the creation of mentally healthy environments need to be identified and eliminated. The development of supportive environments is the responsibility of the entire community. The principles of health promotion highlight the empowerment of the community to enable it to take responsibility for the creation of healthy, sustainable environments. The approach is proactive, ensuring that the community has the knowledge to make appropriate decisions and find solutions to meet its own identified needs.

Opportunity/future direction 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.

At an individual level, people need to be informed about mentally healthy lifestyle choices and provided with knowledge that enables them to know when their mental health is at risk and when it is time to seek help. More evidence is required regarding what comprises mentally healthy lifestyle choices. However, the available evidence suggests that optimistic styles of thinking, coping styles that approach and attempt to resolve problems, having an available and effective social support network, having productive ways in which to fill one's time, and taking adequate physical exercise, are helpful in terms of promoting mental health.

People who are currently experiencing an episode of mental disorder may not make healthy lifestyle choices. To prevent current disorder episodes from having long-term negative effects, support structures need to be put in place. An example of such a support structure is the mutual support group for people experiencing depressive disorders, where they can benefit from ongoing social support.

Opportunity/future direction 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.

More specifically in relation to depression, there is a need for improved community education about depression and its treatment. Research has shown that depression is a condition that is surrounded by misinformation in the community (Jorm et al 1997a). At the most basic level, people need to know how to recognise depressive disorders, and in particular, how to distinguish disorder from normal life problems. People also need to be aware of the types of life events and risk factors that may increase their vulnerability to depression, so that they can take preventive actions.

The community then needs to be informed of effective ways of dealing with life problems in order to reduce their potential to precipitate a depressive response. There is, however, need for a better evidence base regarding the types of actions that are most effective for different types of problems. Better information is required in terms of both self-management strategies and professional help-seeking.

There is a particular need to improve the public's knowledge of the types of treatments offered in specialist care and their efficacy. This may reduce barriers to seeking specialist care, including the stigma attached to undertaking treatment by a specialist. Specifically, the public is not well informed about the range of psychological treatments and their efficacy, and has negative perceptions of pharmacological interventions and ECT, which are treatments that may be life saving in cases of severe depressive disorder. The community is not well informed of the distinct and diverse nature of psychologists and psychiatrists and the services offered by each profession.

For psychotherapies and counselling techniques, the APS has recently developed initiatives to improve the public's knowledge of the role and skills of psychologists. Such activity may go some way toward heightening the public's mental health literacy. The community needs to become more informed about mental health services, knowing the range and cost of health-care actions that are available and the potential outcomes of each.

Opportunity/future direction 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.

The media has a substantial role in informing the community, by providing accurate, informed and non-stigmatising information related to mental health and mental disorders. Care needs to be taken, however, not to trivialise the impact of depression. It is important to get across the message that the development of depressive disorder is not an inevitable response to life's stressors; and that although mild, transitory symptoms of depression are common reactions to adversity, depressive disorders are serious conditions that require treatment.

Opportunities and future directions

Some innovative initiatives have been undertaken in this regard internationally, including depression screening days. Primary care workers, particularly general practitioners, are also well placed to improve the public's mental health literacy, through providing promotion and prevention information.

Overall, information needs to be widely disseminated regarding:

- de-stigmatising depression and associated help-seeking;
- the availability of self-help groups and effectiveness of self-help models for those with known depressive risk factors (eg bereavement, family conflict, drug-related harm);
- effective ways to alleviate depressive symptoms through lifestyle changes (eg physical exercise, social relationships);
- the type, availability, standard and effectiveness of public mental health services, counselling services, psychological services, and specialist psychiatric services available in the local area.

Prevention

Opportunity/future direction 5

Rigorously evaluate and widely disseminate the results of promotion and prevention activities.

Promotion and prevention constitute an area of particular research need, as there is not a solid evidence base on which to advocate particular strategies. It is acknowledged that acquiring such an evidence base is difficult, as these types of activities are not easy to evaluate with rigorous research techniques, such as randomised controlled trials. Consequently, more effort is required to provide much needed research evidence in these areas and to access and disseminate evidence from overseas research. Funding sources also need to be identified to encourage research into promotion and prevention.

Opportunity/future direction 6

Begin prevention activities early in life with programs to encourage positive parenting practices that help to develop optimistic and resilient children.

Opportunity/future direction 7

Identify and widely implement effective school-based programs that enhance children's resilience.

Prevention activities can occur across the lifespan, but are particularly salient early in life. Parenting programs to facilitate positive parenting skills, such as the Positive Parenting for Preschoolers program, recognise the negative impact of poor parenting on mental health later in life. Effective school-based programs that enhance resilience to depression are also available, but need to be rigorously evaluated and widely implemented. Examples of programs currently available

include the Gatehouse project, the Problem Solving for Life Program, Aussie Optimism, and the Resourceful Adolescent Program. These programs promote optimistic thinking, use of social support, and the development of effective coping skills, all of which will better enable young people to cope with life's problems.

Interventions to promote better marital and social relationships, in general, are also needed to improve people's resistance to depression. This recognises the importance of people's close interpersonal relationships and the need to enhance social skills in people of all ages so that they are able to develop and maintain supportive social relationships. More diffuse social ties may also be pertinent to maintaining people's wellbeing and preventing depressive symptoms. Macro reforms that enable communities to promote feelings of social connectedness and hope for the future may also encourage the development of supportive social relationships.

Opportunity/future direction 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.

Determining effective ways to intervene for disabling depressive symptoms, as distinct from depressive disorders, is critical for preventing progression to depressive disorder. Improving public awareness of depressive symptoms is a first step. General promotion activities will contribute, but information also needs to be selectively targeted, possibly through groups where persons at risk might be found, such as drug prevention and treatment services and self and mutual help groups related to life events and risk factors. There also needs to be identification and dissemination of appropriate courses of action and support structures, including self-help strategies. More effective self-help strategies for those with symptoms of depression who do not present for professional treatment need to be identified and disseminated.

Opportunity/future direction 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.

The research evidence shows that there are some stages of life where prevention and early intervention may have an optimal effect, and therefore, a targeted higher risk approach to prevention is warranted. Middle-to-late adolescence is clearly such a time, as many first episodes of depression occur then. Recognition of the risk factors for first episodes of depressive disorder and awareness of the emergence of depressive symptoms are, therefore, important for parents, teachers, youth workers, and others interacting with young people, as well as for the young people themselves. Children of parents with mental disorders are young people who are doubly at risk and who need to be targeted for preventive interventions.

Opportunities and future directions

Another life stage of significance is the childbearing years for women. Childbirth-related services need to promote healthy lifestyle choices and encourage positive parenting practices, as well as screen for postnatal depression. Effective support services need to be identified and put in place for families at risk in the postnatal period. Best practice guidelines and programs need to be developed in collaboration with nursing and mental health providers and widely implemented. Obstetricians, antenatal and postnatal classes, Nursing Mothers Associations and playgroups are some of the avenues for the targeted dissemination of information related to postnatal depression, and these activities need to be supported and encouraged.

Early recognition of depressive symptoms and appropriate responses are required for older people living in residential care settings, and also for older people living within the community with complex health problems and experiencing social isolation. Prevention efforts could be focused around developing and enhancing supportive social relationships for older people and dealing with issues of loss and physical decline. High-quality physical and psychosocial environments that maximise each individual's health and wellbeing are required for residential care. Through the Aged Care Assessment and Home and Community Care programs, at risk older people could be identified and linked with supportive services. The International Year of Older Persons in 1999 provides an opportunity to highlight mental health needs at this time of life.

Supporting the mediation efforts of the Family Court is another potential avenue of prevention. If divorcing couples can be encouraged to resolve their custody, access and property settlements amicably, and to carefully consider the impact of their arrangements and interactions on their children, this may well have positive effects on both the current and future wellbeing of separating parents and their children.

Carers of people with mental or physical disabilities, particularly when there has been a dramatic decline in the condition of the person being cared for, are at risk of developing depressive symptoms if not adequately supported. Identifying these carers and linking them with effective supports may prevent the development of depressive symptoms and disorders. Some of the active organisations that advocate for carers were described in Chapter 5, and these could be encouraged to expand and promote their effective activities.

People who experience adverse life events such as bereavement and job loss may be at higher risk of developing depressive symptoms. Prevention activities need to be selectively targeted at such groups to inform them of their heightened level of risk, and of effective preventive actions to take. These groups need, therefore, to be clearly identified and able to access the strategies developed.

6.2 Early intervention, treatment and management

Recognition of depressive symptoms and disorders in primary care

Opportunity/future direction 10

Support and develop the pivotal role of general practitioners in recognising and treating depression.

Most people suffering from depressive symptoms will come into contact at some time with their general practitioner. A vital function of the general practitioner is, therefore, to recognise the depression and any comorbid conditions and respond appropriately. Strategies to address depressive disorders need to recognise and support the substantial role of general practice. While primary care encompasses a diverse range of services, the general practitioner plays a central role for the treatment of depressive disorders.

Opportunity/future direction 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.

Workers in other types of primary care settings also need to be able to recognise depressive disorders and refer to appropriate follow-up services. Some primary care workers are especially likely to come into contact with people at high risk of depressive symptoms and disorder. These would include Aboriginal health workers, migrant health workers, workers in drug prevention and treatment services, and people providing care services for older people.

Of particular relevance for workers who deal with Aboriginal peoples and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds is cross-cultural awareness and education to ensure identification of symptoms and referral to culturally appropriate treatment.

Recognition of co-existing disorders

Opportunity/future direction 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.

Opportunities and future directions

Related to the importance of recognising depressive disorders is recognition of contributing and pre-existing disorders. One of the most important of these is anxiety, which has been shown to frequently precede or co-occur with depressive disorder. Recognising and treating anxiety symptoms and disorders can have a major impact on the course of depressive disorder.

Collaborative models

Opportunity/future direction 13

Develop and support collaborative models of care, particularly between general practitioners and specialist mental health professionals.

There is potential for cooperation and collaboration between the main professional bodies responsible for the depression workforce—the RANZCP, the College of Clinical Psychologists within the APS, the RACGP, and the Australian and New Zealand College of Mental Health Nurses (ANZCMHN).

Collaboration between specialist mental health services and general practitioners is paramount. A recent example of such collaboration is the report, *Primary Care Psychiatry—The Last Frontier*, produced with National Mental Health Strategy funding by the Joint Consultative Committee in Psychiatry (comprising members of the RACGP and the RANZCP). It reviews the roles of general practitioners in mental health services provision and makes recommendations on their education and training.

There is a particular need to encourage referral networks between general practitioners, psychiatrists, psychologists, mental health nurses and other professionals. The associated professional bodies all have much to offer in terms of facilitating referral. While each of these professions can offer a range of services, they are best placed for the provision of particular types of services. Specifically, general practitioners and other primary care workers are in an ideal position for recognising depressive symptoms and first episodes of depression and for coordinating ongoing management of care. Psychiatrists are best placed to deal with more complex conditions, particularly those with bipolar or psychotic features, and are also needed for ongoing support within primary care. Clinical and counselling psychologists, and other mental health professionals, can provide psychotherapies including CBT, and offer counselling or referral to other services specialising in risk factors for depression. Case conferencing, shared management, coordinated care and fund-holding are all models that could be considered to improve the provision of integrated care that can address the multiple needs of people with depressive symptoms and disorders.

It is also important to ensure effective collaboration between public and private service providers. For example, shared-care approaches to mental health care, involving cooperation between general practitioners and public mental health services, have been applied under General Practice Strategy funding.

Opportunity/future direction 14

Ensure the participation of consumer groups and carers in the development and evaluation of models of care appropriate to specific population groups.

In the development of collaborative models of care, consumers, families and carers need to be active participants in decision making and advocacy. This is all the more important for population groups that are somewhat alienated from mainstream health services, especially Aboriginal peoples and Torres Strait Islanders, refugees, and young people. Associated consumer groups need to be actively sought out and encouraged to participate in the design, development and evaluation of services.

Access to primary and specialist care

Opportunity/future direction 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.

Improved access to services is required by particular groups, specifically those in rural and remote communities and those with cultural barriers to mainstream services, such as Aboriginal peoples and Torres Strait Islanders and those from culturally and linguistically diverse backgrounds. Lack of specialist care and a reluctance to use general practitioners for mental health problems in small communities are major barriers in remote regions. Other types of primary care agencies may be able to offer services to people with depressive disorders to help increase access to appropriate and effective services in these communities.

Opportunity/future direction 16

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

As the vast majority of Aboriginal peoples and Torres Strait Islanders with mental health problems present to primary care services, it is essential that adequate education be provided for all health workers in mental health issues, and that specialised workers in Aboriginal mental health also be available and work through primary health care settings. General practitioners working in areas where there is a significant number of Aboriginal peoples and Torres Strait Islanders also require cross-cultural training.

Strategies to address the emotional and social wellbeing of Aboriginal peoples and Torres Strait Islanders must be a priority. It is evident that the impact of past policies have contributed to the poor health status of Aboriginal peoples and Torres Strait Islanders and a coordinated approach across governments (through

the Framework Agreements[4]) is required in order to achieve the substantial change needed. A number of Aboriginal Health Services provide services in this area. There are benefits to providing emotional and social wellbeing services as a standard component of Aboriginal community controlled (primary) health services.

Aboriginal peoples and Torres Strait Islanders seek not only provision of mental health care in holistic frameworks, but also access to appropriate specialised care. Cross-cultural education is required to ensure that all health professionals have knowledge of the diverse cultural and social frameworks that operate throughout Australia in order to provide the appropriate level of care.

People from culturally and linguistically diverse backgrounds also require culturally sensitive and specific services. The impact of having poor English language skills also needs to be considered, as this may have a major effect on both access to and the effectiveness and appropriateness of mainstream services.

Opportunity/future direction 17

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

Another population requiring better services is young people. Young people have high rates of disorder, but low rates of service utilisation. Young men in particular are reluctant to take depressive symptoms to mainstream medical services. As young men are also at one of the highest levels of risk for suicide, providing services that they feel comfortable approaching is important.

Telephone counselling, drop-in adolescent health centres, and outreach services may be preferred sources of help for young people, and these could be used to disseminate prevention material as well as inform about treatment options. Agencies that are in contact with young people through services related to employment and unemployment, homelessness, drug-related harm, and the criminal justice system could be engaged to promote a better understanding of depression and other mental health issues and their treatment.

Opportunity/future direction 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.

Schools have a pivotal role in providing information and help to children and adolescents. However, intersectoral links need to be built, particularly between school counsellors and mental health providers. There is a need to find ways to

[4] Framework Agreements, based on the principles of collaboration, have been signed in all States and Territories between the Commonwealth Minister for Health and Aged Care, the Chairperson of the Aboriginal and Torres Strait Islander Commission, the State or Territory Health Minister, and the State or Territory-based NACCHO affiliate. For the first time Australian governments have formalised their commitment to a coordinated and collaborative approach to Aboriginal and Torres Strait Islander health that holds all stakeholders accountable for performance.

develop active and positive partnerships between schools, parents, children and service providers so that depressive symptoms are recognised and promptly treated. Schools and education systems have a responsibility to provide an adequate number of school counsellors, ensure that the service they provide is accessible and appropriate to young people and that the confidentiality and sensitivities of young people are respected and supported.

Opportunity/future direction 19

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

There is also an emerging role for technology in enhancing access to health services. This role is particularly evident in the provision of services to remote communities, but also for providing services for those people who prefer a more anonymous and less personal type of interaction. Telephone counselling is already nationally available, but there are also opportunities to use computer services and the Internet to provide promotion, prevention and even management services to remote locations and to targeted groups.

Another major access issue relates to the ability of people to purchase the types of mental health services that they may prefer. In the absence of comprehensive health insurance, psychotherapy may be a long-term and costly commitment that must be funded fully by the individual. Counselling services that address the social and psychological factors that contribute to a person's depression are also not subject to reimbursement through the MBS. Consequently, the full range of services that may potentially alleviate depressive symptoms and disorders are not available to those without the financial means to purchase them.

Best practice evidence-based guidelines, information and training

Opportunity/future direction 20

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

Guidelines and training are relevant within all mental health care settings but particularly within general practice, because of the pivotal role that general practitioners play in relation to the recognition and treatment of depressive disorders. Consequently, the ongoing training of general practitioners needs to ensure that they are vigilant for depressive disorders, particularly for people in high-risk groups. Materials to support general practitioners need to encourage recognition of depressive symptoms and comorbidity, provision of appropriate evidence-based treatments within a biopsychosocial model, and referral to or shared-care with specialists if necessary.

Best practice guidelines for specialist care could also be developed, implemented and supported. Such guidelines need to be based upon the best research and clinical evidence available, and regularly updated. Evaluation of the level of implementation and effectiveness of such guidelines also needs to be put in place.

Opportunities and future directions

The *Clinical Practice Guidelines,* being developed by the RANZCP, are a current initiative in this area.

Guidelines are unlikely to have much impact unless they are provided within a long-term education and support strategy. Furthermore, they need to be developed in collaboration with all the relevant stakeholders, which includes consumers, carers, families, primary care workers, specialist health providers, researchers and training institutions. Guidelines need to be embedded within effective and ongoing structures to educate and support, so that their uptake, rather than their proliferation, is enhanced.

In response to the rapid increase in the prevalence of depression in the adolescent years, the *NHMRC Clinical Practice Guidelines for Depression in Young People* are available specifically for the treatment of young people, and should be the focus for the management of this population group. Importantly, these guidelines inform clinicians that non-pharmacological treatments should be prioritised for adolescents, and that the effects of medications need to be more fully understood for children and adolescents.

Postnatal depression is another major area where general practitioners can have a significant role in the follow-up of mothers and infants in the postnatal period and where guidelines are urgently required. The use of screening measures such as the Edinburgh Postnatal Depression Screening questionnaire is recommended along with the implementation of clinical practice guidelines for the management of women with postnatal depressive symptoms, such as those currently being developed by the NHMRC.

Opportunity/future direction 21

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

The education, training and development of the mental health workforce more broadly is an issue warranting attention. Standards of training need to be developed and applied, and this may be particularly important for workers who are providing counselling services related to depression risk factors. Ongoing professional education and dissemination of up-to-date information need to be monitored and encouraged.

A key priority of the Second National Mental Health Plan is the education, training and professional development of the mental health workforce. The National Mental Health Strategy has supported a series of workshops to address education and training issues for the five mental health disciplines—psychiatrists, psychologists, mental health nurses, social workers and occupational therapists in partnership with consumers and carers. The workshops identified principles of practice that articulate the rights of consumers and carers, and common and discipline-specific values, attitudes and skills that should underpin the practice of those working in mental health and also inform education and training courses.

Funding issues

Opportunity/future direction 22

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

Funding arrangements were identified in Chapter 4 as one of the major barriers to the delivery of best practice collaborative models of care for depressive disorders. The Australian Health Care Agreements 1998–2003 confirm the cooperative relationship between the Commonwealth and the States and Territories in funding and ongoing reform of the delivery of public hospital services and related health services. While the Agreements do not specifically address depression, they have some potential to advance the objectives of the mental health priority area via the Commonwealth's commitment of $300m for the Second National Mental Health Plan and agreements by States and Territories to pursue reform objectives outlined in the Plan. The agreements also commit the Commonwealth and States/Territories to:

- explore options for reform in the integrated delivery and funding of primary care and specialist services for both pharmacological and psychological interventions;
- agree on Commonwealth/State/Territory strategic plans that address ways to reward or promote quality improvement; and
- continue to develop and report against national performance indicators with a particular focus on outcomes.

There may be the possibility of increasing the focus on preventive and psychological activities by including more items of these types in the MBS, and by recognising the increased time required by general practitioners to provide best practice in this area. The Medicare Services Advisory Committee has an important role in this, as it is responsible for advising the Minister for Health and Aged Care on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures and the circumstances under which public funding should be supported. An example of alternative arrangements for the management of people with complex needs is provided by the coordinated care trials that are currently being conducted throughout Australia.

Information, monitoring and surveillance

Opportunity/future direction 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.

Chapter 1 and Appendix 2 clearly highlight the need for better data related to mental health conditions, in terms of both prevalence and service provision. This need is particularly urgent for Aboriginal peoples and Torres Strait Islanders.

Opportunities and future directions

At the most basic level, current service provision data collections could be enhanced to enable the identification of people with depressive disorders. Recording salient features related to the disorder (such as the age of the person and whether the disorder is related to childbirth or another major life event) and the types of service provided are also required. Leginski et al (1989) maintain that mental health data need to provide information on *who receives, what services, from whom, at what cost,* and *to what effect* in order to provide the necessary information for planning and evaluation. Current data related to mental disorder in general, and depressive disorders in particular, are a long way from this ideal.

Mental health data need to be recorded for young people, women after childbirth, older people, those living in rural and remote communities, people from culturally and linguistically diverse backgrounds (particularly refugees), and Aboriginal peoples and Torres Strait Islanders. Where feasible, current data collections need to reliably identify these groups and ensure that measures of mental health status are recorded. There are currently initiatives to improve data availability for some of these groups. A component of the SMHWB is targeting Aboriginal peoples and Torres Strait Islanders and another component has just been completed for children and adolescents. A scoping study on older people and mental disorder has been undertaken by the Department of Health and Aged Care.

Opportunity/future direction 24

Monitor the dissemination, uptake and effectiveness of guidelines.

There is an urgent need for the development of information systems through which to monitor practices and advances related to the treatment of depression. Firstly, the dissemination and uptake of guidelines needs to be known. Currently, uptake of the *NHMRC Guidelines for Depression in Young People* (and also the RANZCP Clinical Practice Guidelines when they are available) need to be determined along with evaluations of their effectiveness.

The four Support and Evaluation Resource Units (SERUs) noted in Chapter 5 have been established to develop program guidelines and protocols for particular projects and activities conducted by Divisions of General Practice. The Divisions have an important role to play in linking their activities to national research and guideline development agendas and involving clinicians in both primary and specialist care.

Opportunity/future direction 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.

Secondly, there is a need to monitor the efficacy of different treatments for subtypes of depression for different types of people. General practitioners may be well placed to provide information on the acceptability and effectiveness of the various treatments that they provide. They may be able to contribute to the development of a reliable database related to depression treatments. Specialist mental health providers could also contribute to such a database.

Qualitative information also has an important role, particularly for acknowledging and informing others about people's personal experiences of depressive disorder. The documentation and dissemination of individual 'success stories' is a valuable resource for people with depressive disorders, their carers, consumer groups, and those providing services.

Qualitative information is particularly relevant for Aboriginal peoples and Torres Strait Islanders, in order to express those aspects of their social and emotional experience that are difficulty to quantify. An important part of building appropriate responses to the emotional and social wellbeing of Aboriginal peoples and Torres Strait Islanders involves assisting community organisations and services to identify and disseminate 'success stories', which may assist other communities to choose responses to similar issues.

6.3 Research issues

Opportunity/future direction 26

Determine ways to fund priority-driven research on depression.

While there is a strong research base in many areas, consultations with stakeholders have identified the following as examples of areas where there is a relative lack of research and research funding support:

- factors and programs for supportive environments to enhance mental health and mentally healthy lifestyle choices;
- potential prevention strategies and their evaluation;
- factors that affect the development of first episodes of depressive disorder in young people;
- the manifestation, prevalence and factors related to depression in Aboriginal peoples and Torres Strait Islanders, including the development of culturally appropriate mental health measurement tools;
- the specific needs of refugees, and the development of validated research instruments;
- depression in older people in residential care;
- the link between depression and suicide in older men;
- the community's knowledge and perception of the mental health workforce;
- the efficacy of self-help treatments, such as support groups and St John's wort;
- potential psychosocial interventions and their evaluation;
- integrated care models best suited to different types of depression;
- treatments for dysthymia and cyclothymia;
- types of psychotherapies best suited to depressive disorders across the lifespan;

Opportunities and future directions

- treatment of depression in young people and also in older persons;
- cultural appropriateness of treatment for Aboriginal peoples and Torres Strait Islanders;
- treatments and interventions that can reach isolated communities;
- relapse prevention and maintenance treatments; and
- people who do not seek professional care.

Australia's existing strengths in depression research need to be nurtured. Past funding of investigator-initiated research on depression has produced some notable achievements and needs continued support. However, the above examples of research issues that stakeholders identify as needing attention highlight the need for additional priority-driven research. The recent report of the Health and Medical Research Strategic Review has also noted that 'Australia needs a well managed, priority-driven program of strategic, development and evaluation research. This program requires explicit funding, national coordination, and a rigorous priority-setting process. Capacity must be built to undertake this research and to facilitate the transfer of research results into policy and practice' (Health and Medical Research Strategic Review 1998, p93). Such a program, which complements the existing funding mechanisms for investigator-initiated research, would help to increase knowledge and improve practice in neglected aspects of depression.

6.4 National Depression Action Plan

The National Workshop on Depression, held in Canberra in late 1997, proposed a framework for a three-year plan of action to improve health care practices and health outcomes for depression, covering the areas of promotion and prevention, early intervention, management and treatment of depression, community education and data needs. For each of these areas the plan identifies goals, strategies, indicators of success, milestones and barriers. The goals for each area are listed in Appendix 3.

Opportunity/future direction 27

The development and implementation of a 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.

This report has explored further the major themes of the National Workshop and provides a knowledge base from which to proceed. The focus on depression will be consolidated in a proposed National Depression Action Plan (NDAP) which will progress the initiatives suggested here into a strategic plan to effect real gains for the Australian community. Its main aim will be to identify priorities and strategies for national interventions for the years 1999 to 2001.

The NDAP will develop initiatives across the entire health care continuum, as outlined in the model presented in Chapter 4. Comprehensive consultations will also be undertaken during the drafting stages and commitment to action sought from key stakeholders prior to its release for implementation. The NDAP is,

therefore, a major and timely national activity that has the potential to make significant improvements to the mental health and wellbeing of the Australian community.

The NDAP will build on the framework proposed by the Depression Workshop, incorporate the issues identified in this report, utilise the Promotion and Prevention Action Plan framework (see Box 6.1), as well as consider current activity and research. This will ensure that previous and current work in the area is built on and that new interventions are integrated within other national mental health activities. It is recognised within the context of broader policy initiatives that depression is a key concern. Examples of health policies that also address depression include the National Strategy Against Drug Abuse, the National Youth Suicide Prevention Strategy and the National Health Policy for Children and Young People. Given that depression is frequently associated with suicide and drug-related harm, and that young people are at particularly high risk, integration into other national strategies is essential.

Box 6.1 Promotion and Prevention Action Plan (PPAP)

The PPAP identifies the following priority groups: peri-natal and infants 0–2 years; toddlers and pre-schoolers 2–4 years; children 5-11 years; young people 12–17 years; young adults 18–24 years; adults in the workplace; older people; communities and families experiencing adverse life events; rural and remote communities; Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; consumers, carers and community agencies; whole of community; media; and health settings, professionals and clinicians. For each of these groups, the PPAP provides information related to national activity in the areas of: priority mental health targets; rationale; evidence base; longer-term outcomes; communities of interest; settings; linked initiatives; national strategies; and process outcomes. It is also intended that indicators will be developed for each of the identified priority groups.

6.5 The next NHPA report on mental health

This report is a positive attempt at building a sound strategic framework to improve the mental health and wellbeing of Australians. The contents will be used to both inform and assist governments and the community in relation to those areas of intervention that will provide most impact in terms of sustainable improvements and outcomes, thus reducing the burden to individuals, families, workplaces and the community. 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. The report builds on those protective factors that are known to work effectively in maintaining mental health as well as identifying areas in need of further action.

Depression was identified as an area where significant gains could be made in both mental and physical health. However, the NHPA initiative is aimed at improving 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.

In the next *NHPA Mental Health Report,* specific gains in the area of depression will be reported, along with updates of indicators more generally related to the mental health status of the Australian population.