Reducing the burden of depression: are we making progress in Australia?

A coordinated population health response

Depression is now Australia's most debilitating illness, accounting for 8% of all years lived with disability and over $3 billion annually in direct and indirect costs.[1] Other mood disorders, such as bipolar disorder, add significant additional costs.[2] Unfortunately, mood and anxiety disorders, which typically first become evident in adolescence, often go untreated or only come to attention later in adult life. Thus, people who present for care have recurrent or persistent disorders.[3] Moreover, depressive disorders are frequently complicated by alcohol or other substance misuse,[4] as well as physical health problems.[5] Mental disorders in total now account for 60% of all disability costs in those aged 15–34 years.[1] In a caring society, such statistics should demand an urgent, national and coordinated response.

One aspect of our national response was the establishment in 2000 of *beyondblue: the national depression initiative* by the Australian and Victorian governments.[6] Towards the end of its first phase (2001–2005), it is now time to assess our progress. To reduce the burden of depression, we need an effective combination of

- prevention and early intervention;
- expanded evidence-based treatments (particularly in primary care);
- a reduction of social and economic barriers to full participation, such as exclusion from life insurance or discrimination in the workplace; and
- promotion of research on related health services and suicide prevention.[7]

In this Supplement, evidence is presented either directly from *beyondblue* or from analyses of other available national data sets. Importantly, the early impact of *beyondblue* can be seen in impressive rates of national awareness of the organisation, the number of media contacts, the extent of website utilisation, changing social attitudes to reporting personal experiences of depression, and reduced barriers in access to life insurance and income protection (see Box).[7] However, the personal experiences of those who care for people with depression,[11] and the treatment experiences of those with bipolar disorder,[12] indicate that there is still a great deal of work to be done to reduce stigma and to improve the interaction with healthcare services of people with severe affective disorders.

A novel method for drawing media attention to our national progress, or our progress within target groups of greatest concern (eg, young people, new mothers, Indigenous Australians, small rural communities), is the development of a National Index for Depression.[13] We intend to report this index frequently, so that the general public and the media become as familiar with it as they are with other national measures like the road toll or the annual suicide rate.

Prioritisation of mental health within Australian general practice is critical. *beyondblue* played a key role in advocacy for the $120 million national program *Better Outcomes in Mental Health Care* (BOiMHC) 2001–2004.[14] Others have highlighted the cost-effective health outcomes that could be gained by this type of reform, in that it seeks a better balance of primary and secondary care as well as improved access to specific cognitive-behaviour strategies.[15] The initial impact of BOiMHC is apparent, with 15% of the general practice workforce now participating.[16] If the program continues to promote improved consumer and carer choices and better access to non-pharmacological treatments, then the goals of higher remission rates, prevention of recurrence and delivery of cost-effective treatments may be achieved.

Accompanying the rapid expansion in management of depressive disorders in primary care is the inevitable rise in the level of prescribing of antidepressant medications. Although this increase is associated with clear benefits, most notably a decline in suicide rates in those who access care,[17] the wider community has been quick to question whether this increase is appropriate.[18,19] Mant et al have examined the trends in general practice prescribing and conclude that there is evidence of appropriate restraint in the use of these new antidepressants.[20] Another aspect of primary care management of depression is the common link to life-threatening substance misuse. Burns et al explore what we know about the links between mental health, prescription drug use and heroin overdose.[21] The number of Pharmaceutical Benefits Scheme prescriptions provided has a very strong relationship with overdose, particularly for benzodiazepines, opioids, and tricyclics, but not for the newer antidepressant agents.

Early achievements of *beyondblue: the national depression initiative*

- 27% of Australians in 2002 recognised *"beyondblue"* as the national depression initiative.
- 61% of Australians in 2002 reported that they or someone close to them had experienced depression.
- *beyondblue* generated 1762 unique media stories between 1 April 2001 and 30 June 2004.
- The *beyondblue* website recorded 644 999 visits between 1 April 2001 and 30 June 2004.
- Support for critical changes in primary mental healthcare, introduced under the $120 million *Better Outcomes in Mental Health Care* package.
- Establishment of *blueVoices* as a new national consumer and carer advocacy network.
- Production of new guidelines with the life insurance and income protection industries to ensure equitable access for people with depression.
- Support for large national trials of primary and secondary schools-based, antenatal and community depression prevention and early intervention strategies.[8-10]
- Support for health services research through allocation of large research grants, focusing on the interface of primary and secondary care.

Self-care strategies for depression and anxiety are an increasingly important part of the mix of treatments that need to be available to the wider community. Previously, Jorm et al detailed the evidence for such strategies for treating depression.[22] Here, they set out the current state of knowledge of self-care strategies for anxiety disorders.[23] Anxiety disorders are often either the precursor to depression or a major source of comorbidity.

Although a great deal of concern is expressed about rates of mental disorders in rural and regional Australia, very few systematic data have been available for detailed analysis. Caldwell et al report a most important finding — that an underlying factor relating to increased suicide in young men in rural and regional settings is lower use of services rather than higher rates of mental disorder.[24] This now requires an urgent suicide prevention and health services response.

To date, few countries in the developed world have attempted such a coordinated population health response to the burden of depression. The most recent British initiative achieved limited benefits.[25] Improvements of 5%–10% were reported in terms of more positive attitudes to depression, reported experiences of depression, attitudes to antidepressants and treatment from GPs.[25] Few GPs (11%) had definitely made changes in their management of depression as a result of the campaign.[26] At this early stage, the Australian experience appears to be achieving wider benefits and establishing a broader framework for more sustainable changes in community attitudes and health service reform.

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