beyondblue: the national depression initiative 2005-2010

AN INDEPENDENT EVALUATION REPORT

December 2009

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When I reflect on the breadth and volume of beyondblue’s work over the past 10 years, I am truly impressed by how much has been accomplished. It comes as no surprise that this evaluation confirms that beyondblue has established itself as the focal point for depression, anxiety and related disorders in Australia, a major force in shaping public policy and in introducing new programs in mental health.

I am pleased to present this report which represents an independent, objective, scientific evaluation of beyondblue. It builds on an earlier report which evaluated our work from 2000 to 2004, and systematically brings together evidence from a range of sources to assess whether beyondblue has achieved its objectives to date.

Since our last evaluation, community awareness of depression and confidence to seek help has grown enormously Australia-wide. This is, in part, because we have worked hard to promote awareness of the illness, destigmatised people’s experiences, encouraged help seeking, provided support for consumers and carers, and importantly, conducted targeted research, providing the results and evidence for people to access freely. Over the past decade, beyondblue has truly become a national initiative and a well-respected and well-known organisation.

The first few years were spent establishing our base, identifying priorities and objectives, adopting a people-centred focus and diversifying our approach to serve the community. I am proud to say that this evaluation makes it clear that we have been on the right track from day one.

In 10 years, our staff and outcomes have grown ten-fold, our website has been named the most visited health and medical website in the country four times, and our network of consumers and carers who are keen to be involved in our work has now reached 22,000 members and is growing.

We are very pleased with the diversification of our programs over the past six years. With our leadership in the National Perinatal Depression Initiative and the KidsMatter Early Childhood initiative this year, we now have an early intervention and prevention reach across every stage of the lifespan, from birth to older years.

We have over 200 information resources which can be ordered online or via our Infoline, and beyondblue’s fact sheets on depression and anxiety are now available in 26 languages and in braille. Between July 2008 and October 2009, we sent out more than 11 million information materials to meet unprecedented public demand.

One of our most popular resources, the Taking Care of Yourself and Your Family self-help book, is now in its 11th edition. Some 400,000 copies of this guide to good mental health have been sent out free of charge to every corner of the country, in particular, to rural and remote regions.

At the end of 2008, when the Global Financial Crisis hit home, we responded. We recognised that for vulnerable people, retrenchment may contribute to mental health problems. Our Taking Care of Yourself after Retrenchment or Financial Loss booklet is now available free of charge in every Centrelink office in the country. In the first month of its release, more than 160,000 were ordered – a testament to just how many Australian families have been touched by the financial crisis.

It has been particularly gratifying to see the results of beyondblue-funded research translated into practical, early-intervention programs to which governments have committed substantial funding. For example, the National Perinatal Depression Initiative to which the Federal Government has contributed $85 million to roll out throughout the country.

This year, we are proud to release Australia’s first draft clinical practice guidelines for the diagnosis and treatment of depression and related disorders in pregnant women and new mothers, and similarly, guidelines for treating depression in adolescents and young adults. Both sets of guidelines reflect the culmination of many years of research and will be submitted to the National Health and Medical Research Council for approval following the 60-day consultation period.
We are extremely proud that we have brought together the leading experts in their fields to develop these
guidelines which will provide health professionals and the community with the latest international evidence about
treatment of depression and related disorders – this can only be good news for the millions of Australians affected.

As will be seen in the evaluation report, the media has been instrumental in helping us to achieve our goals
of raising awareness of depression and anxiety disorders and reducing the associated stigma Australia-wide.
Coverage increased from around 1,200 articles mentioning beyondblue and depression in 2005, to 12,000
news articles, television and radio broadcasts between July 2008 and October 2009 – a ten-fold increase in less
than four years. We thank all our media partners across the sector, particularly Harold and Stuart Mitchell for
their ongoing support.

My sincere thanks go to the Federal, State and Territory Governments for their vote of confidence in continuing
to fund and support beyondblue. We value the strong bipartisan support they provide and commit to continue
our work in partnership with all tiers of government, the health sector, our corporate and community partners,
and with the media.

Our achievements in destigmatising the illness and increasing help to men across the country have also
been made possible by the generous support of the Movember Foundation and the increasing numbers of
mo-growing men each year. We also thank the thousands of individuals and companies who have voluntarily
donated funds to our cause over the last 10 years.

Late last year, our Board decided to extend beyondblue’s work for a further five-year term to 2015. We look
forward to continuing our work in changing attitudes, reducing stigma and improving services for people with
depression, anxiety and related disorders and their carers throughout Australia.

Overall, the evaluation suggests that since 2004, the health landscape has changed for the better with regard
to depression, anxiety and related disorders in Australia and that beyondblue can claim a good portion of credit
for this – as an independent NGO – and as a keen collaborator with the early Better Outcomes and now Better
Access to Mental Health Initiatives and the promising E-mental health agenda.

Our activities are evenly distributed between innovation (new programs), the expansion of established programs,
targeted research, clinical practice guidelines and support for primary care practitioners, partnerships with
community agencies, and taking awareness raising and destigmatising activities to workplaces and industries
through our National Workplace Program.

It is clear that beyondblue has established itself over the past decade as a major force in shaping public policy
and in introducing new programs in mental health in Australia. This report makes it clear that while we have made
very good progress, it is vital that our work continues. Given the continuing problems with stigmatisation and
discrimination towards people with mental illness, the variable services and health workforce shortages across the
country, and the need for further hospital and health reforms, it is important that we strengthen our efforts.

Finally, a survey has shown that 87 per cent of Australians are aware of the existence of beyondblue and its work.
This is an outstanding result for our organisation that is only 10 years old.

I thank our staff, our partners and supporters, and the media for achieving this wonderful outcome. An outcome that
assists those who suffer a depressive illness, and acts as a preventative measure for those who enjoy good health.

I commend this evaluation report to you.

The Hon. Jeff Kennett AC
Chairman, beyondblue: the national depression initiative
**Executive summary**

**Description of beyondblue: the national depression initiative**

*beyondblue* is an independent national initiative designed to raise awareness, build networks and motivate action in the area of depression prevention. Where possible, it draws on existing expertise, creating collaborations and partnerships. It takes a population health approach to providing a national focus for depression-related activities. More recently, *beyondblue* has added anxiety and related disorders to its remit, therefore, broadening the scope of its activity.

*beyondblue’s* vision is ‘a society that understands and responds to the personal and social impact of depression and anxiety, and works actively to prevent it and improve the quality of life of everyone affected’. In working towards achieving this vision, *beyondblue’s* stated mission is to ‘provide national focus and leadership that increases the capacity of the broader Australian community to prevent depression and anxiety and respond effectively’.

Underpinning *beyondblue’s* mission is a series of five Priority Areas for action:

1. **Community Awareness and Destigmatisation**: to increase community awareness of depression, anxiety and related substance-use disorders and to address the stigma associated with these problems;
2. **Consumer and Carer Participation**: to help consumers and carers living with depression and related disorders understand that information, support and effective treatments are available, as well as promoting their needs and lived experiences with policy makers and service providers in the health care system;
3. **Prevention and Early Intervention**: to develop prevention and early intervention programs around depression and related disorders;
4. **Primary Care**: to improve training and support for GPs and other health care professionals around depression and related disorders;
5. **Targeted Research**: to initiate and support depression-related research.

*beyondblue* was originally funded for five years from July 2000 to June 2005. The initial funding totalled approximately $38 million, $17.5 million from the Commonwealth Government and $17.5 million from the Victorian Government with the balance from other State and Territory Governments. Funding for the current funding period 2005-2010 is approximately $80.2 million, $48.4 million from the Commonwealth Government over five years, $17.5 million from the Victorian Government with the balance from other State and Territory Governments. *beyondblue* also receives financial support, donations and in-kind support from numerous non-government and business organisations and individuals.

**Evaluation design and method**

*beyondblue* was originally evaluated in 2004 by the University of Melbourne’s School of Population Health (Pirkis, 2004). The aim of that evaluation was to consider the extent to which it had achieved its goals of bringing about the structural change and community motivation necessary to prevent depression and minimise its effects. In order to assess this, the evaluation framework clarified the program logic of *beyondblue*, developing a hierarchy of objectives. In the hierarchy of objectives, *beyondblue’s* vision was viewed as equivalent to the highest-level objective, and its mission was seen to equate with the next level objective. Below this, the hierarchy split into five sub-hierarchies, each of which related to one of *beyondblue’s* Priority Areas. The evaluation framework then posed a single evaluation question in relation to each objective in the hierarchy, namely, ‘Was *beyondblue* successful in achieving the given objective?’
The current evaluation draws on data from a range of evaluation components, some internal and some external to beyondblue, to answer this question:

(a) Review of beyondblue program and project documentation
(b) Evaluations of selected beyondblue programs and projects
(c) Monitoring data on beyondblue media coverage, media releases and community service announcements
(d) Data on media coverage of depression and anxiety in general, and beyondblue in particular
(e) Data on the use of beyondblue’s websites
(f) beyondblue’s Depression Monitor data
(g) beyondblue’s consultative processes with consumers and carers
(h) beyondblue National Workplace Program reach (i.e. Sainsbury Centre, UK) and growth
(i) Data from evaluation activities associated with the Better Access/Better Outcomes in Mental Health Care Initiative
(j) Data from the BEACH (Bettering the Evaluation And Care of Health) Project
(k) Additional evaluation evidence
(l) Review of projects contracted by external bodies (e.g. Mental Health Drought Initiative, ACT Health)
(m) Local and national network partnerships
(n) Research investment

The current evaluation builds on the previous one and examines beyondblue’s achievements over the period 2005-2010 and, wherever possible, makes comparison of the achievement in this period with the previous funding period.

It should be noted that the findings reflect the situation in mid 2009 based on the reports and other information provided by beyondblue to the evaluation team. The report is based on a review of the very large number but not every beyondblue program. It is sufficient for the purposes of making an overall assessment of beyondblue’s activities. The purpose of the report is not to make an assessment of individual beyondblue-funded programs except to the extent that they contribute to the assessment of the activities of beyondblue overall.

Key evaluation findings

The key evaluation findings are outlined below, summarised in terms of the extent to which each of the objectives were achieved.

Objectives achieved under Priority Area 1 (Community awareness and destigmatisation)

Many of the key initiatives associated with Priority Area 1 in 2005-2010 continue from the earlier funding period and are now well established, taking the form of a broad range of mass media initiatives (e.g. media exposure; promotional materials; a website; community service announcements; and special supplements on depression in the Medical Journal of Australia) and community activities targeting the broader community and with specific activities focusing on rural communities, youth, older people and men (e.g. Youthbeyondblue; Rotary community forums; training programs and health promotion events).

These key initiatives have led to an increase in the quantity of information available about depression through media and educational sources in comparison with the earlier funding period. Concomitant with the life of beyondblue, there has been increased coverage of depression in print and broadcast media and in specialist professional publications, numerous beyondblue promotional materials have been distributed, the beyondblue website has been much more heavily used, and numerous community awareness-raising activities have taken place. There are good indications that most of this information is of high quality with the beyondblue website having been ranked highly by independent assessors and the specialist publications being peer-reviewed. The only area where the evidence is less clear is that of print and broadcast media, where it is not possible to determine whether the quality of reporting has improved in line with increases in quantity.
The above increase in the quantity and quality of information about depression appears to have been translated into gains in the community’s ‘depression literacy’ compared with the earlier funding period, although there is still room for improvement. Repeated cross-sectional population surveys suggest that there were increases in the community’s awareness and knowledge of depression as well as, to a lesser extent, other mental disorders and improved attitudes towards people experiencing depression and towards help-seeking. However, a high proportion of the population continued to underestimate both the prevalence and the burden of depression. Additionally, whilst recognition of depression appears to have improved over time, there is room for improvement with regard to anxiety, bipolar disorder and postnatal depression.

Less evidence is available to directly determine whether the Australian community has developed an increased understanding of the experiences of people whose lives have been affected by depression. There is some evidence of a further reduction in social distancing and stigma over time and some evidence that this is a result of work by beyondblue.

Likewise, there is insufficient evidence to directly ascertain whether, during the life of beyondblue, there has been a decrease in the levels of stigma and discrimination experienced by people with depression. Results from repeated administrations of surveys suggest that there is an increased acknowledgement by the community of the stigma and discrimination experienced by people with depression and some evidence that this is decreasing as a result of work by beyondblue. However, surveys with consumers and carers indicate that discrimination remains a problem.

Objectives achieved under Priority Area 2 (Consumer and carer participation)

During the current funding period, under Priority Area 2, beyondblue has clearly maintained focus and extended consumer and carer participation through their initiatives. For this, beyondblue has developed new forms of self-management, predominantly involving online strategies, and initiating programs that strengthen beyondblue’s commitment to responding to consumer and carers needs. There is evidence that these initiatives, particularly blueVoices, have led to improved consumer and carer networks. The beyondblue virtual network has grown to 22,000+ members (post 2007) from 9,650 (August 2004) and as of June 2009, blueVoices has over 400 consumers and carers in its membership. It also maintains close links with other relevant organisations such as the Breast Cancer Network of Australia and Multicultural Mental Health Australia. Further, in July 2006, beyondblue also established the ‘Infoline’ which is a telephone helpline that operates twenty-four hours a day, seven days a week. The aim is to provide callers with access to information and referral to relevant services for depression, anxiety and related disorders including bipolar disorder, postnatal depression, related substance misuse and associated issues.

However, the key question remains whether consumers and carers feel more empowered about their situation, and the extent to which they are involved in mental health initiatives targeted at them. Although studies in the previous beyondblue funding period suggested a lack of understanding and awareness by the community and health professionals, to date, there is less evidence-base to suggest that consumers and carers are being consulted at every stage and whether they are satisfied or not with current changes made in mental healthcare. beyondblue has certainly initiated many programs that are aimed at raising community awareness and destigmatisation, and educating health professionals (these are discussed throughout this report); however, further enhancement of the empowerment of consumers and carers would facilitate beyondblue to successfully achieve its objectives under this Priority Area.

Objectives achieved under Priority Area 3 (Prevention and early intervention)

A summary of beyondblue’s achievements considered against this hierarchy of objectives in the current funding period echoes those for the earlier funding period. These are that:

• an impressively diverse group of programs has been put in place covering the principal areas of Prevention and early intervention, both expanding and developing on the programs existing in the earlier funding period;
• there has been an increase in the number and range of programs where the effectiveness (or not) has been more definitively established;
• more systemic change has occurred (though clearly is not complete);
• it is not currently possible to estimate whether there has been an increase in the proportion of people with depression who seek professional help early or whether there has been a reduction in risk factors and promotion of protective factors as a result of the activities of beyondblue.

It is concluded that, as depression prevention programs move from demonstrating efficacy and effectiveness to readiness for dissemination, it is necessary to observe the Standards of the Society for Prevention Research.

It is also concluded that it is now urgent to address the gap in evidence concerning the proportion of people with depression who seek professional help early as this is a key measure of both Priority Areas.

**Objectives achieved under Priority Area 4 (Primary care)**

There has been a considerable expansion of Primary care programs by beyondblue in the current period compared to the previous funding period. The diamond program is particularly notable. Concurrently, there have also been real improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression. In general, there has been a major increase in the availability of primary care services for the treatment and early intervention for depression Australia-wide since the earlier beyondblue 2004 report.

Together, these changes permit this 2009 report to conclude that there has been a sea change in the availability of primary care services for the treatment and early intervention for depression Australia-wide since the earlier 2004 report.

This has occurred most importantly through the establishment of Better Outcomes in Mental Health Care including Access to Allied Psychological Services (ATAPS) that enabled GPs to refer consumers to allied health professionals who delivered focused psychological strategies. This has led on to the establishment of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) Initiative. Together, these programs have been responsible for a significant increase in the management of all psychological problems including depression. This has been associated with an increase in psychological counselling for depression and anxiety management, and a significant increase in the rate at which patients with depression and anxiety problems have been referred to psychologists.

beyondblue was an important advocate for the establishment of Better Outcomes and, subsequent Better Access Initiative. In addition, through the funding of the diamond and Primary care Evidence-based Psychological (PEP) programs, education programs such as Young Minds, and support for the further development of evidence-based guidelines, beyondblue has been able to substantially increase capacity in both depression training and research in primary care.

**Objectives achieved under Priority Area 5 (Targeted research)**

The key initiatives associated with Priority Area 5 are in place, with several funding avenues providing support for research. High quality research is being promoted through the beyondblue Victorian Centre of Excellence in Depression and Related Disorders and through beyondblue’s strategic research initiatives and partnerships. In addition, beyondblue incorporates rigorous evaluations of all its funded programs and projects. beyondblue has supported several supplements in specialist scientific journals (such as the MJA) and has linked with other key research initiatives, such as the establishment of the Depression and Anxiety Consumer Research Unit.

These initiatives appear to have led to an increase in targeted research activities aimed at increasing knowledge about depression. beyondblue funded over 60 studies through the Victorian Centre of Excellence in Depression and Related Disorders over the period 2005-2009 which is more than the 50 projects funded during the earlier funding period. The evidence suggests that this is redressing the imbalance identified by Jorm et al’s (1997) earlier audit of depression-related research activities, conducted prior to the development of beyondblue. Not only has the number of projects increased, but the research now has a more strategic focus and is better aligned with priorities identified by stakeholders.
Many of these projects are now yielding results that are addressing gaps in knowledge about depression (particularly regarding the evidence base for community education, prevention and treatment). Some of these findings have helped shape specific initiatives of beyondblue and have provided some useful information regarding the efficacy of beyondblue’s activities. Other research efforts supported by beyondblue have not yet led to increases in knowledge but have increased research capacity. Whether or not this has led to an increased capacity at community level to prevent and respond effectively to depression is harder to measure, however, it is likely that the progress made in this area over the past few years is certainly a step in the right direction.

Achievement of high-level objectives

It is likely that beyondblue has, at least partially, increased the capacity of the broader Australian community to prevent and respond effectively to depression, for reasons set out below. It is still much too early to assess whether the highest-level objective (Level 7) A society that understands and responds to the personal and social impact of depression, and works actively to prevent it, has been achieved. While it is possible to work towards that goal over time, it is unlikely that situation will ever be achieved without transformative cultural change.

Comparison with previous funding period

Where it was possible to make comparison with the present and previous funding period it is clear that beyondblue has moved on in a number of important ways. These include, for example:

- community awareness and destigmatisation – favourable trends in community awareness and perceptions about depression; substantially more media reports and use of the beyondblue website;
- consumers and carers – substantially higher levels of participation in blueVoices;
- prevention and early intervention – major new initiatives, some of which have attracted Australian Government funding;
- primary care – major new programs and evidence-based guidelines; major new Australian Government initiatives influenced in part by beyondblue;
- targeted research – increase in number of research projects; funded research projects now producing new knowledge about depression and evidence about depression programs.

Conclusion

It can be concluded with confidence, that beyondblue has achieved all of its lower-level Objectives in full, its intermediate Objectives in full or in part (notwithstanding incomplete data in some areas) and one of two higher-order Objectives to some extent. The breadth and depth of its activities across its five Priority Areas is impressive. Its activities are nicely distributed between innovation (funding of new programs), further development of more established programs and preparation for their wider dissemination through planning and workforce development.

beyondblue has a very strong and influential Advisory Board. It also has a number of sources of advice on research matters through individual members of its Board of Directors, through its Research Advisor and through the VCoE Expert Committee. Nevertheless its source of advice on evidence-based medicine, health services research and health economics could be further strengthened. Such a person would bring important insights and skills to the Board and could also act as a Health Services Research Advisor alongside the current Clinical and Research Advisors.

From the above, it is clear that beyondblue has established itself over the past decade as a major force in shaping public policy and in introducing new programs in mental health in Australia. It is true to say that it is the public health face of mental health in the country. Given the well-documented shortfall in mental health services alongside the long-standing problems with stigmatisation and discrimination towards people with mental illness, this is a considerable achievement. It is very important that beyondblue continues to prosper in this role in order that progress continues, new knowledge is created and new initiatives are put in place.
Chapter 1
Background

1.1 An overview of beyondblue: the national depression initiative

beyondblue is an independent national initiative designed to raise awareness, build networks and motivate action in the area of depression prevention. Where possible, it draws on existing expertise, creating collaborations and partnerships. It takes a population health approach to providing a national focus for depression-related activities, supporting programs that are normally located within one of three domains: (a) community awareness, understanding and literacy; (b) preventive programs and research; and (c) training and workforce support, with a particular emphasis on (a) and (b) (beyondblue, 2000).

beyondblue’s vision is ‘a society that understands and responds to the personal and social impact of depression, and works actively to prevent it and improve the quality of life of everyone affected’. In working towards achieving this vision, beyondblue’s stated mission is to ‘provide national focus and leadership that increases the capacity of the broader Australian community to prevent depression and respond effectively’ (beyondblue, 2000). More recently, beyondblue has added anxiety and related disorders to its remit, therefore, broadening the scope of its activity (beyondblue, 2008).

Underpinning beyondblue’s mission is a series of five Priority Areas for action. These were outlined originally in beyondblue’s Strategic Plan (2000) and reiterated more recently in the Strategic Framework for Action 2005-2010. They are as follows:

1. **Community Awareness and Destigmatisation**: to increase community awareness of depression, anxiety and related substance-use disorders and to address the stigma associated with these problems;

2. **Consumer and Carer Participation**: to help consumers and carers living with depression and related disorders understand that information, support and effective treatments are available, as well as promoting their needs and lived experiences with policy makers and service providers in the health care system;

3. **Prevention and Early Intervention**: to develop prevention and early intervention programs around depression and related disorders;

4. **Primary Care**: to improve training and support for GPs and other health care professionals around depression and related disorders;

5. **Targeted Research**: to initiate and support depression-related research.

beyondblue was originally funded for five years from July 2000 to June 2005. The initial funding totalled approximately $38 million, $17.5 million from the Commonwealth Government, and $17.5 million from the Victorian Government with the balance from other State and Territory Governments (beyondblue, 2001; beyondblue, 2002; beyondblue, 2003). Funding for the current funding period 2005-2010 is approximately $80.2 million, $48.4 million from the Commonwealth Government over five years, $17.5 million from the Victorian Government with the balance from other State and Territory Governments. beyondblue also receives financial support, donations and in-kind support from numerous non-government and business organisations and individuals.
Through the new Funding Agreement beyondblue provides:

- a continuation and expansion of beyondblue’s core activities to 30 June 2010;
- an Action Plan for continued activity over the period to 30 June 2010; and
- a revised Evaluation Framework.

1.2 The previous evaluation of beyondblue

beyondblue was originally evaluated in 2004 by Prof Jane Pirkis of the Program Evaluation Unit, the previous title of the Centre for Health Policy, Programs and Economics, within The University of Melbourne’s School of Population Health (Pirkis, 2004). The aim of this evaluation was to consider the extent to which beyondblue had achieved its goals of bringing about the structural change and community motivation necessary to prevent depression and minimise its effects. If beyondblue had fully achieved its goals, the implication was that it should hand back its activities to the community. If it had made no inroads into achieving its goals, it should not continue to be funded. If it had partially achieved its goals, particularly with regard to changes in professional and community attitudes, careful consideration should be given to what action was necessary to foster positive change that would be sustainable to the point that beyondblue no longer needs to exist.

In order to assess this, the evaluation framework clarified the program logic of beyondblue developing a hierarchy of objectives. In the hierarchy of objectives, beyondblue’s vision was viewed as equivalent to the highest-level objective, and its mission was seen to equate with the next level objective. Below this, the hierarchy split into five sub-hierarchies, each of which related to one of beyondblue’s Priority Areas. The evaluation framework then posed a single evaluation question in relation to each objective in the hierarchy, namely, “Was beyondblue successful in achieving the given objective?”

The evaluation drew on data from a range of internal and external evaluation components to answer this question. The results of this evaluation are reported in detail elsewhere (Pirkis et al, 2005). However, in summary, the evaluation reported on beyondblue’s success in establishing the beyondblue brand; engaging the community in public discussion; raising awareness of depression; encouraging positive media coverage of depression; disseminating information; establishing partnerships with mental health agencies; and commissioning and publishing research on depression and related disorders.

The evaluation concluded that by 2004 beyondblue had achieved a significant amount in a relatively short space of time. However, it was emphasised that there was still some way to go and that beyondblue continued to have an important contribution to make, working in concert with Federal, State/Territory and local initiatives. This was recognised by beyondblue in its ‘Way Forward’ document, which outlined a plan for building on its achievements over the subsequent five years (beyondblue, 2004). The evaluation noted that a further five-year funding period would allow many of the partially-achieved objectives of beyondblue to be fully realised, and could maximise Australia’s potential to prevent depression and minimise its effects.

The current evaluation builds on the previous one and examines beyondblue’s achievements over the period 2005-2010.
1.3 Developing an evaluation framework

In its 2005-2010 Strategic Plan, beyondblue anticipated a further evaluation towards the end of its second five-year period (2005-2010 Strategic Framework, December 2005). The current evaluation is modelled on the one conducted previously and again considers the extent to which beyondblue has achieved its goals of bringing about the structural change and community motivation necessary to prevent depression and minimise its effects during this second five-year period.

The Centre for Health Policy, Programs and Economics of The University of Melbourne’s School of Population Health again was commissioned to build on the previous evaluation and to develop an evaluation framework to inform these issues – this time headed by Prof David Dunt, but with input from Prof Jane Pirkis. As was done previously, the evaluation framework explicitly clarifies the program logic of beyondblue, using its stated vision, mission and priorities for action as a starting point, and giving consideration as to how best to determine whether beyondblue has achieved its goals to date. The framework then takes the program logic and formulates a single evaluation question, going on to suggest an evaluation design that can address this question. The design is multifaceted, incorporating a range of different data sources and approaches to analysis.

1.4 Content and structure of the current report

Drawing directly on the evaluation framework document for the period 2005-2010 (beyondblue, December 2005):

- Chapter 2 of this report explicates the program logic of beyondblue, developing a hierarchy of objectives that draws on beyondblue’s vision, mission and priority areas;
- Chapter 3 uses this hierarchy of objectives as the basis for designing the current evaluation framework, considering what the evaluation is asking and how the answers can be determined;
- Chapters 4-8 draw on evidence from the evaluation components to determine the extent to which the objectives associated with beyondblue’s five Priority Areas have been achieved;
- Chapter 9 considers the extent to which the two higher level objectives have been achieved;
- Chapter 10 discusses the findings of the evaluation, providing some interpretation and putting them in the context of the evaluation’s limitations.

On this basis, some key conclusions are drawn.

As previously noted the findings reflect the situation in mid 2009 based on the reports and other information provided by beyondblue to the evaluation team. The report is based on a review of the very large number, but not every beyondblue program. It is sufficient for the purposes of making an overall assessment of beyondblue’s activities. The purpose of the report is not to make an assessment of individual beyondblue-funded programs except to the extent that they contribute to the assessment of the activities of beyondblue overall.

References

beyondblue. beyondblue: Strategic Plan, Melbourne, beyondblue 2000
beyondblue is a major undertaking, which involves a sophisticated set of activities occurring in a complex system. It can be viewed as a process of preventing and minimising the impact of depression, which has many components. Clarifying the causal linkages between these components – or clarifying the program logic of the initiative – was seen as a crucial early step in designing both the original and the current evaluation framework.

2.1 Why clarify a program’s logic?

Clarifying the program logic of a given initiative has clear implications for designing and conducting an evaluation, in that it explicates the way in which the initiative is expected to work, thus enabling the evaluator to test whether in fact the initiative does work in this way. Clarifying the program logic also has benefits for designing and implementing the program, and for developing a shared understanding of the program that can be communicated to others.

Typically, program logic is presented as a matrix. The vertical flow describes the program’s objectives, moving from immediate outputs to short-term impacts and longer-term outcomes. This is often termed the ‘hierarchy of outcomes’ or ‘hierarchy of objectives’. The horizontal flow in a program logic matrix allows closer consideration of each objective in terms of success criteria and relevant data sources (how would the evaluator know if it had been achieved?). Consideration should also be given to the activities and resources (what activities/resources would need to be in place to maximise the chances of the initiative achieving the objective?).

2.2 An hierarchy of objectives for beyondblue

An hierarchy of objectives for beyondblue is shown in Figure 1. Developing this hierarchy, consideration has been given to the vision, mission, and priorities for action of the initiative. The vision was viewed as equivalent to the highest-level objective, and the mission was seen to equate with the next level objective. Below this, the hierarchy splits into five sub-hierarchies, each of which relates to one of beyondblue’s Priority Areas. This step was taken in the interest of simplicity.

It is acknowledged, however, that the relationship between some of the objectives within a given sub-hierarchy is not always linear, and that there are inter-relationships between some of the objectives in different sub-hierarchies. There are also some difficulties in operationalising some of these stages, i.e. specifying objective measures for their achievement. In some cases the empirical data is not available with regard to these measures.

It is worth noting that all of the objectives have been described in terms of achievements, rather than activities. This represents a divergence from the way many of the Priority Areas for action are described in beyondblue’s Strategic Plans (beyondblue, 2000; beyondblue 2005-2010, December 2005) and subsequent Annual Reports (e.g. beyondblue, 2001; beyondblue, 2007; beyondblue, 2008) and is more appropriate for evaluating the extent to which beyondblue has been successful.
It is also worth noting that the highest level objectives reflect beyondblue’s role as a ‘catalyst to action’ (beyondblue, 2002). In addition, factors other than beyondblue are operating that bear on the achievement or otherwise of those objectives. These include, for example, other government mental health initiatives and change in funding arrangements as well as broader societal movements and forces such as the global financial crisis.

The overarching vision of beyondblue is not to eliminate depression or to reduce the suicide rate to nil, but is about mobilising society to better understand and respond to depression.

References

Figure 1: An hierarchy of objectives for beyondblue in relation to depression and related disorders

Objective 7
A society that understands and responds to the personal and social impact of depression*, and works actively to prevent it and improve the quality of life of everyone affected

Objective 6
Increased capacity of the broader Australian community to prevent and respond effectively to depression*

Objective 1.5
Decrease in levels of stigma and discrimination associated with depression*

Objective 4.3
Increase in community education and treatment roles of primary care practitioners

Objective 2.4
Genuine acknowledgement of issues faced by consumers and carers

Objective 5.3
Increase in knowledge about depression*, particularly in terms of the evidence-base for community education, prevention and treatment

Objective 1.4
Increased understanding of experiences of people whose lives have been affected by depression*

Objective 5.2
Increase in targeted research activities aimed at increasing knowledge about depression*

Objective 1.3
Increase in awareness of the prevalence, symptoms, causes, treatments and prognosis of depression*

Objective 3.4
Systematic changes in the health sector and beyond (e.g., in families, schools, workplaces and communities) that support prevention and early intervention efforts

Objective 1.2
Increase in the quantity and quality of information available about depression* through media and educational sources

Objective 4.2
Improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression*

Objective 2.2
Improved consumer and carer networks

Objective 3.3
Increase in the number and range of effective prevention and early intervention initiatives for depression *

Objective 1.1
Key initiatives in place

Objective 5.1
Key initiatives in place

Objective 2.3
Genuine participation by consumers and carers in depression-related initiatives

Objective 3.2
Reduction in risk factors and promotion of protective factors

Objective 3.5
Increase in community education and treatment roles of primary care practitioners

Objective 2.1
Key initiatives in place

Objective 1.4
Genuine acknowledgement of issues faced by consumers and carers

Objective 3.4
Increase in the proportion of people with depression* who seek professional help early

Objective 4.1
Key initiatives in place

Objective 3.1
Key initiatives in place

Objective 7
A society that understands and responds to the personal and social impact of depression*, and works actively to prevent it and improve the quality of life of everyone affected

* Depression, anxiety and related disorders
As with the previous evaluation the current evaluation relies largely on the secondary analysis of existing data, and less on purpose-designed, primary data collection and analysis (Pirkis, 2003).

3.1 Evaluation brief

The independent evaluation will include the following activities:

- Evaluate performance/activity undertaken in the 2005-2010 period;
- Be conducted in accordance with the Evaluation Framework 2005-2010;
- Include a higher level strategic analysis to gauge key Priority Areas to address from 2010.

3.2 Evaluation question

Having developed a hierarchy of objectives for beyondblue, a single key evaluation question emerged in relation to each objective. This was:

- Was beyondblue successful in achieving the given objective?

Consistent with the beyondblue focus on anxiety and related disorders, in addition to depression, over 2005-2010, the current evaluation analysed activities in these areas. This focus is reflected in the Hierarchy of objectives in Figure 1.

3.3 Principles underpinning the evaluation design

Consideration was given to the evaluation components or data sources that could best inform the above evaluation question with regard to each objective. Five principles guided choices regarding the suggested evaluation components:

- Overall evaluation of beyondblue, not evaluation of its individual initiatives: As a general rule, the evaluation design proposed here represents an overall evaluation of beyondblue, not an evaluation of its individual initiatives. It does this through a focus on beyondblue’s five Priority Areas. Within these five areas large programs which are accompanied by evaluation studies, particularly those with robust study designs, are considered more fully than smaller programs without independent evaluation studies. The general rule remains though – no program is separately evaluated.

- Triangulation: A range of evaluation components were used in the evaluation, as it was considered that the evaluation would be strengthened through ‘triangulation’, or the use of a variety of data sources to study the same phenomenon. It was felt that it would be possible to draw conclusions from the evaluation with greater certainty if the findings from all of these data sources began to point in the same direction.

- Attribution of causality: Wherever possible, evaluation components were selected that allow a given situation after the introduction of beyondblue to be compared with the equivalent situation at baseline. Caution should be exercised in attributing any demonstrated improvements over time to beyondblue, since it is difficult to judge whether these changes might have occurred anyway or may have been caused by other factors coinciding with beyondblue. Having said this, assertions about causality can be strengthened by the sound program logic underpinning the program, and by the use of triangulation (described above).
• Recognition of beyondblue’s role as a ‘catalyst to action’: As noted earlier, the role of beyondblue is one of mobilising society to better understand and respond to depression and related disorders, not one of eliminating depression or its associated sequelae, such as suicide. The evaluation reflects this, in that its components were chosen to provide indicators of societal change in attitudes, knowledge and behaviour, rather than indicators of reductions in the prevalence of depression or the cumulative incidence of suicide.

• Reliance on existing data sources: For expediency, information that underpinned the evaluation was largely drawn from secondary sources, rather than from primary data collection exercises.

3.4 Evaluation components

(a) Review of beyondblue program and project documentation

Relevant beyondblue program and project documentation (e.g., beyondblue’s Strategic Plan, Annual Reports, project implementation reports and updates) were retrieved and reviewed (beyondblue, 2000; beyondblue, 2001; beyondblue, 2007; beyondblue, 2008). Information was also sought and synthesised from beyondblue’s website.

(b) Evaluations of selected beyondblue programs and projects

From the outset, beyondblue has had a firm commitment to ‘rigorously evaluate all its programs and interventions’ (beyondblue, 2000). Consequently, most individual initiatives have been evaluated and local evaluation reports exist. As noted earlier, the current evaluation constituted an overall evaluation of beyondblue, rather than an evaluation of the organisation’s individual initiatives. However, findings from selected local evaluation reports were extracted to inform the current evaluation exercise, as relevant. Specific reports were chosen on the basis of their representing evaluations of initiatives that were of particular note, either because of their magnitude or because of their novel approach.

(c) Monitoring data on beyondblue media coverage, media releases and community service announcements

Since January 2001, beyondblue has maintained an internal system for tracking direct media stories, counting the first time a given story occurs on a particular radio or television station, or in a particular newspaper, but not any subsequent occurrences (Hickie, 2004). beyondblue also monitors the number of media releases it issues (Hickie, 2004).

(d) Data on media coverage of depression and anxiety in general, and beyondblue in particular

Quantitative and qualitative data on how Australian newspapers, radio stations and television stations report and portray depression were collected and analysed to inform the evaluation. Supplementary data have been provided in an individual evaluation ‘Monitoring Media Reporting of Depression’ by Dare, Pirkis, Blood and Burgess in 2008. The purpose was to provide a picture of the coverage of depression, anxiety and related disorders in general, and beyondblue specifically, over time.

(e) Data on the use of beyondblue’s websites

Quantitative and qualitative feedback was available on the use of beyondblue’s website. Since beyondblue’s website was launched in April 2001, the independent company (Web Development Group, Melbourne) that hosted the website server monitored the number of ‘hits’ on the site, on a monthly basis (Hickie, 2004). Visitors to the site were offered the opportunity to provide feedback, and selected responses were included in the current evaluation.

(f) beyondblue’s Depression Monitor data

beyondblue conducts cross-sectional telephone surveys biannually examining the community’s awareness and understanding of depression and its treatment. Whilst the surveys focus primarily on depression, questions pertaining to anxiety and related disorders are also asked. The data sets from both 2004/5 and 2007/8 were analysed to measure beyondblue’s impact on these aspects of mental health literacy over time.
(g) **beyondblue**’s consultative processes with consumers and carers

**beyondblue** is responsible for a variety of consultative processes with consumers and carers, including public meetings, focus groups, written feedback, website-based interactions and consultations with consumer and carer organisations. These processes are designed to elicit information from consumers and carers about their experiences with depression, anxiety and bipolar disorder. They, therefore, provide useful background information for the evaluation. Of key importance is **beyondblue**’s consumer and carer network, blueVoices, which brings together people with depression and other disorders and their carers, in a national body to represent their interests. As part of this initiative there are blueVoices e-Groups which comprise of members from around the country on a range of subgroups representing specific areas of focus including:

- Depression
- Anxiety
- Postnatal depression
- Bipolar disorder
- Comorbid substance misuse
- Comorbid chronic physical illness
- Older people’s reference group
- Young people’s reference group.

Data on membership of blueVoices was useful for the evaluation as a measure of the ‘reach’ of the network. Members were also polled to assess the effectiveness of **beyondblue** in engaging consumer and carer participation.

(h) **beyondblue** National Workplace Program reach (i.e. Sainsbury Centre, UK) and growth

In 2005, the National Workplace Program was introduced by **beyondblue** as an initiative to increase awareness of depression, anxiety and related disorders in Australian workplaces, and work actively in preventing these disorders by encouraging staff to understand and address any issues faced by them or by a colleague in their own workplaces. Following its roll-out in Australia, the program was piloted at the Sainsbury Centre in UK, in 2008. This section of evaluation monitored any progress made by the National Workplace Program in terms of number of sessions per annum, client paid sessions, and total number of participants and the feasibility of implementing the program across nations. Thus, the current evaluation explored the growth and reach of the program since its initiation.

(i) Data from evaluation activities associated with the Better Access/Better Outcomes in Mental Health Care Initiative

Evaluation activities associated with the Better Access and Better Outcomes in Mental Health Care Initiative were valuable for the evaluation of **beyondblue**, permitting a description of the extent to which GPs and allied health professionals are providing mental health care for people with depression, anxiety and related disorders, including substance use disorders. Of particular notice is the introduction of new Medicare MBS mental health items and how this has affected service provision by mental health professionals and uptake by patients.

(j) Data from the BEACH (Bettering the Evaluation And Care of Health) Project

The BEACH Project continuously collects information about general practice encounters in Australia, using a design whereby general practitioners collect data on 100 consecutive GP–patient encounters each week. BEACH began in April 1998 and this report used data collected from then to March 2008, covering about 9,900 GP participants and 990,000 GP–patient encounters. Relevant data from the BEACH Project are reported annually by the Australian Institute of Health and Welfare. BEACH data were used in the evaluation to explore changes in depression, anxiety and related disorders, including substance use disorders, managed by GPs over time.
(k) Additional evaluation evidence
Additional data sources were used to evaluate beyondblue activities against objectives as they came to hand, including the development of NHMRC Clinical Practice Guidelines for Depression in Adolescents and Young People and for Perinatal Depression and Allied Disorders.

(l) Review of projects contracted by external bodies (e.g. Mental Health Drought Initiative, ACT Health)
The ACT Health Job Stress and Workplace Mental Health Project, Mental Health Drought Initiative and National Perinatal Depression Initiatives provided an overview of the extent of beyondblue’s involvement in addressing depression, anxiety and related disorders in the community.

(m) Local and national network partnerships
Over the years, beyondblue has both co-sponsored and partnered with many local and national organisations in projects that raises community awareness of depression, anxiety and related disorders. The current evaluation looked into the scope of these activities to provide a balanced outlook of such partnerships.

(n) Research Investment
The current evaluation drew on research initiatives put in place by beyondblue since 2005 to present. Wherever possible the range and number of activities between the 2005-10 and 2000-05 periods were compared.

3.5 Relationship of evaluation components to the hierarchy of objectives
Each of the above evaluation components was used to assess the extent to which one or more of the objectives in the previously-described hierarchy of objectives had been achieved. Sometimes several evaluation components were used to evaluate the achievement of a single objective.

Figure 2 shows the relationship between the evaluation components and the hierarchy of objectives. The specific component or components used to examine the achievement of any given objective are shown in brackets after the statement of the objective. Take, for example, Objective 2.3: Genuine participation by consumers and carers in depression-related initiatives. The achievement of this objective was examined using evaluation components (a) and (e) that is, data from the Review of beyondblue program and project documentation and data from the use of beyondblue’s website respectively.

References
Figure 2: Relationship of evaluation components to the objectives hierarchy for beyondblue

Objective 7
A society that understands and responds to the personal and social impact of depression*, and works actively to prevent it and improve the quality of life of everyone affected*

Objective 6
Increased capacity of the broader Australian community to prevent and respond effectively to depression**

Evaluation component:
(a) Review of beyondblue program and project documentation
(b) Evaluations of selected beyondblue programs and projects
(c) Monitoring data on beyondblue media coverage, media releases and community service
(d) Data on media coverage of depression and anxiety in general, and beyondblue in particular
(e) Data on the use of beyondblue’s website beyondblue’s Depression Monitor data
(g) beyondblue’s consultative processes with consumers and carers
(h) beyondblue National Workplace Program reach, evaluation (i.e. Sainsbury Centre, UK) and growth
(i) Data from evaluation activities associated with the Better Access/ Better Outcomes in Mental Health
(j) Data from the BEACH (Bettering the Evaluation And Care of Health) Project
(k) Additional evaluation evidence, including data on beyondblue research activities, outcomes (if any)
(l) Review of projects contracted by external bodies (e.g. Mental Health Drought Initiative)
(m) Local and national network initiatives
(n) Research investment

* No direct data available
** Depression, anxiety and related disorders
Chapter 4
Objectives achieved under Priority Area 1 (Community awareness and destigmatisation)

Introduction

Wang et al (2008) estimated the percentages of personal stigma by levels of depression literacy and exposure to persons with depression in a population-based survey of 3,047 adults in Alberta, Canada. Over 45% of participants considered that people with depression were unpredictable and over 20% reported that people with depression were dangerous. Other studies similarly report that individuals with depression face a substantial amount of stigma (see Endnote). Lack of public ‘mental health literacy’ contributes both to stigma and to slow problem recognition. It is important, therefore, that beyondblue’s first goal is to increase community awareness of depression, anxiety, substance-use and related disorders and improve understanding of the experiences of persons whose lives are affected.

A bibliography of important studies (meta-analyses, systematic reviews and key articles) including brief descriptions based on edited abstracts is attached in two Endnotes at the end of the main report, the first on Stigma and depression and the second on Community awareness and depression.

Summarising this research:

• individuals with depression face a substantial amount of stigma; even in highly educated populations, the attitudes of considering individuals with depression as being unpredictable and dangerous were prevalent;
• self-stigmatisation as an important mechanism in decreasing the willingness to seek psychiatric help;
• lack of public ‘mental health literacy’ contributes to slow problem recognition. Increasing illness severity eventually facilitates problem recognition and prompts help-seeking. Structural barriers to initial help-seeking are relatively unimportant within the Australian health care system. General practitioners play an important role as gate-keepers to appropriate mental health care;
• there were conflicting reports concerning computer-assisted education in reducing the stigma of depression;
• beyondblue has had a positive effect on some beliefs about depression treatment and has reached a good proportion of Australian young people, and this awareness was associated with better mental health literacy;
• psychological distress was found to have increased in men aged 20-29 years between 2003-2004 in Australia;
• although other countries have previously attempted to address depression literacy, there is little evidence to indicate that those attempts have achieved their aims; the Defeat Depression and Changing Minds Campaigns in the UK reported small effects;
• personal stigma is consistently higher among men, those with less education and those born overseas. It was also associated with greater current psychological distress, lower prior contact with depression and lower depression literacy.
Objective 1.1
Key initiatives in place

A description of the principal programs in Community awareness and destigmatisation funded by beyondblue is attached in Appendix 1. This includes their aims, objectives, activities, outcomes, presence of an external evaluation study and if so, their design, methods, findings, conclusions and recommendations. The principal Community awareness and destigmatisation programs and their aims are set out in Table 4.1.

Mass media initiatives

Soon after it was established, beyondblue held a two-day seminar called Blueprint, designed to engage media professionals in positive, appropriate and responsible reporting of mental health issues. Seventy one mental health and media professionals met to discuss the impact of media reporting on community attitudes, and the consequent need for optimal reporting. This event provided a sound basis for beyondblue to foster ongoing relationships with key media representatives (beyondblue website).

beyondblue has also been an active commentator about depression in print, radio and television media. beyondblue’s Chairman, the Honourable Jeffrey Kennett, former Chief Executive Officer and Clinical Advisor, Professor Ian Hickie, and current Chief Executive Officer, Leonie Young, have been particularly prominent in raising community awareness and educating the public about depression, as well as lobbying for appropriate reporting of depression and related problems in the media (Hickie et al, 2004). An example of this is beyondblue’s recent action against the television documentary “60 Minutes” whereby lobbying by beyondblue, and in particular Mr Kennett, was successful in preventing a story going to air which portrayed the suicides of several young people in Victoria (Herald-Sun website).

As part of its mass media strategy, beyondblue has also disseminated information about depression, anxiety and related disorders through a range of promotional materials. These include brochures, pamphlets, posters and other written materials.

Further information dissemination has occurred through beyondblue’s websites (www.beyondblue.org.au). The website has been updated over time, and includes a clinical section with fact sheets on a wide range of depression and anxiety-related topics, interactive checklists where visitors can conduct online self-assessments to help them understand whether or not they could be experiencing depression, a media centre for journalists, and information on all beyondblue’s programs and partners. It also includes satellite sites for Youthbeyondblue (www.youthbeyondblue.com) (see Chapter 5), the beyondblue National Postnatal Depression Prevention Program (see Chapter 6) and the beyondblue Victorian Centre of Excellence in Depression and Related Disorders (see Chapter 8).

beyondblue has broadcast a range of general television and radio advertisements and community service announcements involving celebrities (e.g. Ms Rachel Griffiths and Mr Garry McDonald) and family doctors (e.g., Dr Rob Walters from Australian Divisions of General Practice) (Hickie et al, 2004). In September 2006, beyondblue launched its second series of national TV, radio and print advertisements. These focused on anxiety, depression in the workplace, bipolar disorder, postnatal depression, depression and drug and alcohol problems, and depression in older people, including a specific advertisement targeting men in rural areas.

In addition beyondblue has been involved in the production of its own television programs which aim to raise awareness and provide information about depression, anxiety and related disorders. For example, in 2005 beyondblue partnered with Schools Television to produce a program presented by television news presenter Jessica Rowe and actor Garry MacDonald who talked openly about their personal experiences with depression. The program was aimed at adults in the school community and was broadcast to approximately 2,000 Secondary and Primary Government, Catholic and Independent schools.
Table 4.1: Principal Community awareness and destigmatisation programs and their Aims

<table>
<thead>
<tr>
<th>Program name</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mass media</strong></td>
<td></td>
</tr>
<tr>
<td>beyondblue’s Depression Monitor data</td>
<td>to monitor public understanding of depression, i.e. survey results to monitor depression awareness, knowledge, attitudes and help-seeking behaviours</td>
</tr>
<tr>
<td>beyondblue Media Releases – February 2008 to July 2009</td>
<td>to provide an overlook of the extent of depression awareness activities beyondblue has been involved in over the period from February 2008 to July 2009</td>
</tr>
<tr>
<td>Media Monitoring (External Media Coverage)</td>
<td>to provide an outlook on the level of media coverage that beyondblue is exposed to</td>
</tr>
<tr>
<td>Hitwise Awards</td>
<td>to demonstrate the efficacy and popularity of the beyondblue website</td>
</tr>
<tr>
<td>Testimonials and Website statistics</td>
<td>to prove the wealth of information accessed by consumers and their testaments on how effective/successful beyondblue resources are to them and to show how people found beyondblue site and how they explored it</td>
</tr>
<tr>
<td><strong>Depression awareness</strong></td>
<td></td>
</tr>
<tr>
<td>Anxiety and Depression Awareness (ADA) Month</td>
<td>to provide an opportunity for workplaces, community groups and individuals to take part in activities to raise awareness of anxiety and depression and help reduce the associated stigma</td>
</tr>
<tr>
<td>National Advertising Campaigns</td>
<td>to develop and implement new advertising and other mass media campaigns with a particular focus on co-existing illnesses including chronic illness and substance use</td>
</tr>
<tr>
<td>beyondblue Community Service Announcements</td>
<td>to raise awareness of depression, anxiety and related problems</td>
</tr>
<tr>
<td>Movember – The Movember Foundation</td>
<td>to raise awareness of depression and anxiety, particularly among men with co-morbid chronic illness, through a national men’s health promotion event</td>
</tr>
<tr>
<td>Find a Doctor/Find a Psychologist/ Mental Health Professional webpage</td>
<td>to provide the public with easily accessible information on available MBS registered practitioners treating depression, anxiety, bipolar and related disorders at locations closest to them</td>
</tr>
<tr>
<td>MHCA Better Access Reports</td>
<td>to analyse the uptake of the new mental health MBS items and some of the trends in service use that have emerged</td>
</tr>
<tr>
<td>beyondblue Better Access Fact Sheet – 24</td>
<td>to provide information regarding Medicare rebates for a range of mental health services, which were previously not subsidised</td>
</tr>
<tr>
<td><strong>Older persons</strong></td>
<td></td>
</tr>
<tr>
<td>Baptcare – maturityBlueprint</td>
<td>to develop a training program for the professional staff at Baptcare Community Aged Care Programs that enables them to recognise and respond to an older person who may be depressed or at risk of depression</td>
</tr>
<tr>
<td>beyondblue’s beyond maturityblues Peer Education Project</td>
<td>to train older people as volunteer educators to deliver information sessions about depression to their peers using the established community networks of each State and Territory COTA in metropolitan, regional and remote settings</td>
</tr>
</tbody>
</table>
### Program name

<table>
<thead>
<tr>
<th>Program name</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indigenous</strong></td>
<td>to develop an understanding of what makes Indigenous men’s spaces safe and healthy for men, and how this might benefit their families and communities</td>
</tr>
<tr>
<td><strong>Rural programs</strong></td>
<td>to raise community awareness, educate and train business and community leaders (by beyondblue), and provision of community outreach and crisis counselling (by Australian General Practice Network)</td>
</tr>
<tr>
<td>Mental Health Drought Initiative – MHDI</td>
<td>to provide rural communities with awareness information, advice on service pathways, community and workplace training, and support for community initiatives to manage the distress of drought at local levels</td>
</tr>
<tr>
<td>Don’t Beat About the Bush! beyondblue Rural Drought Response</td>
<td>to show drought specific support resources available to country people across Australia</td>
</tr>
<tr>
<td>Australian Rural Information Network (ARIN) Map</td>
<td>to provide the public with avenues to raise awareness of depression and destigmatise the illness through Freemasonry</td>
</tr>
<tr>
<td>Freemasons</td>
<td>to raise awareness of depression and anxiety in men with prostate cancer and their partners</td>
</tr>
<tr>
<td>Victorian Bowls</td>
<td>to raise awareness about depression and anxiety in the bowling community</td>
</tr>
<tr>
<td>beyondblue</td>
<td>has engaged in some specialist media activities, which have complemented those aimed at the general community. For example, since the previous evaluation it has supported three special supplements on depression in the Medical Journal of Australia, in an effort to extend its educational efforts to mental health care providers. The first was published in October 2004, the second in June 2008 and the third in April 2009 (in addition there were three previous supplements referenced in the original evaluation – Pirkis, 2004). The articles included in these supplements have covered a broad range of topics within the general area of depression and anxiety (Depression: reducing the burden, 2004; Depression and primary care, 2008; Depression and anxiety with physical illness, 2009).</td>
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</table>

**Community activities**

**Older persons**

During the evaluation period older people have been one of the beyondblue priority groups. An example of this is the beyondblue maturityblues peer education project, the aim of which is to train older people as volunteer educators to deliver information sessions about depression to their peers using established community networks in metropolitan, regional and remote settings. More specifically the objectives are: to increase awareness and understanding among older people of depression; to present strategies to minimise the risk of depression; to increase older people’s knowledge of community services and supports available to help treat depression; and to provide information about the relationship between good general health and good mental health in older people. The project employs a peer educator train-the-trainer model. Training is delivered over one to three days with an average training time of 12 hours.
This project saw the production of a Trainer manual, a Peer Educators resource manual, posters and promotional materials (pamphlet, flyers), as well as fact sheets in an audio CD format for 31 visually impaired groups. 21 project officers underwent training across Australia; 237 Peer Educator resource manuals were developed and distributed nationwide; 35 peer educator training sessions were conducted nationally with 225 volunteers and overall there were 31,327 participants trained at 1,470 community sessions (until March 2009).

The evaluation showed an increase in knowledge about depression as well as increased confidence among state coordinators with regard to delivering the training to peer educators. It also showed overall satisfaction with the relevance of training information, resources and with the training program. 99 % of peer educators indicated that the training and information provided was sufficient to enable them facilitate the beyond maturityblues project. To our knowledge no information is available regarding outcomes among trainees. Although, specific modules on grief and loss have been developed and introduced. Similarly, modules have now been developed for veterans, men, people with chronic illness, and people in rural communities. Further, Culturally and Linguistically Diverse (CALD) beyond maturityblues programs are now in the process of being rolled out; Italian – speaking peer educators have been recruited in five States to deliver an Italian version of the program nationally with Greek, Chinese and Vietnamese versions to follow by late 2010. Future recommendations included the development of programs for Indigenous communities.

A further beyondblue project targeting older people was the development of a training program for the professional staff at Bapcare Community Aged Care Programs to enable them to better recognise and respond to older people who may be depressed or at risk of depression. Additional aims were to increase staff confidence and ability in responding to older people living in their own homes and receiving Community Aged Care Packages and to assist older people to obtain assessment, support and treatment more effectively. This project also employed a train-the-trainer model. Overall 34 staff members received training over four, two-day training sessions. The project evaluation demonstrated generally positive results. In particular the ability of participants to recognise depression as a significant mental health problem increased following training. Similarly, knowledge about depression increased after the training as did confidence responding to clients with depression. Stigma and negative attitudes held by participants reduced after the training.

beyondblue also supported the Seniors Festival Week in Victoria and other States on a number of occasions (Victorian 2009 Seniors Festival Be inspired!, 2009). Moreover, following the successful awareness-raising initiative and Bowls tournament held by the Wangaratta Bowls Club in late 2008, beyondblue began discussions with the Victorian peak Bowls organisations in 2009 towards a more broadly-based community awareness partnership involving Bowls Clubs across Victoria. A partnership agreement was subsequently agreed upon between beyondblue and the Royal Victorian Bowls Association/Victorian Ladies’ Bowling Association and launched in September 2009. The partnership involves Bowls clubs in disseminating information about depression and anxiety to their members and participating in a blue-Pennant round during the month of November 2009, to help raise awareness of depression. It is hoped the partnership will be extended to other States/Territories over time.

Rural programs
The aims of the Don’t Beat About the Bush! campaign are to:

- increase community awareness of depression, anxiety and related substance use disorders and to address associated stigma;
- support depression prevention and early intervention programs;
- increase depression literacy and community awareness of available support services;
- improve access pathways into Primary Care;
- provide training for GPs and allied health professionals on identifying and managing depression; and
- provide Rural Workplace Training to local businesses and other front-line staff who are dealing with increasing levels of distress in their farming clients.
The campaign has led to the development of a wide range of practical resources for people and communities in the rural sector – including the beyondblue rural media campaign and the beyondblue Drought Kit. In addition beyondblue has expanded the chapters on depression and anxiety and widely promoted the free book *Taking Care of Yourself and Your Family* by John Ashfield of which 300,000 copies have been distributed, including one to every doctor who is a member of the Rural Doctors Association.

Other recent community activity has focused on drought affected areas. An example of this is the Commonwealth Mental Health Drought Initiative (MHDI). This was launched in May 2007 and represents a partnership between the Department of Health and Ageing (DoHA), beyondblue, the Australian General Practice Network (AGPN) and the state based Divisions of General Practice (DGPs) as well as other relevant health organisations. The aims are to raise community awareness of depression and related disorders, to contribute to the provision of education and training for business and community leaders and to contribute to the improvement of access to mental health and community support services in drought affected rural and remote areas of Australia.

This initiative has led to partnerships with 45 DGPs. It has also led to the provision of beyondblue’s Frontline Rural Workforce Training, the extension of dissemination of drought resources, and the establishment of beyondblue Information kiosks to all participating DGPs. It has also seen the development of the beyondblue Don’t Beat About the Bush! campaign which has involved the provision of free drought information kits detailing how to recognise and manage depression and other mental health issues, to all participating DGPs. A collaboration with the KidsMatter Initiative and the Community Support Workers engaged by the DGPs led to the development and distribution of drought mental health resources for primary schools in the DGPs, and an expansion of beyondblue’s Rural Information Kit and provision of the kit free of charge at all community awareness rural events, education and training workshops.

Both the MHDI and the Don’t Beat About the Bush! campaigns have received media coverage in the rural regions of every DGP, in particular in communities where the training has been delivered, and has included the promotion of links to the Information kiosks and the DGPs.

Men

Men represent another sector of the community who have received attention from beyondblue in this evaluation period. This is exemplified by beyondblue’s partnership with the Prostate Cancer Foundation of Australia (PCFA), which aims to raise awareness of depression and anxiety in men with prostate cancer, and their partners. The objectives are to provide information on pathways to care and to facilitate prompt help seeking, to provide access to up-to-date health promotion information specific to men’s health and to encourage men to be more proactive about their health. Activity has included the development and dissemination of resources such as the booklet *Maintaining your well-being: information on depression and anxiety for men with prostate cancer and their partners*, a fact sheet on *Prostate cancer and the risk of depression/anxiety*, and a wallet card. In 2008, beyondblue also supported five PCFA-led community forums, which included providing funding support and a speaker to discuss depression and anxiety.

They have also promoted awareness of depression, anxiety and prostate cancer at conferences, workshops, agricultural field days and other community-based activities, provided prostate cancer support group convenors and ambassadors with training on depression and anxiety, supported research investigating effective depression interventions for men with prostate cancer and their partners and supported the development and distribution of the Advanced Prostate Cancer Consumer Guidelines. It has been noted that there is a need for better marketing strategies to attract more people to the forums, especially men of a younger age, and to make sure people are aware that these forums are not just for people with Prostate Cancer, but are valuable for all men.

In tandem, the partnership between PCFA and beyondblue benefit from Movember funding, which draws on the month of November as Movember during which men are encouraged to grow a moustache in order to raise awareness of prostate cancer and of depression, anxiety and related disorders in men. The Movember Foundation was officially launched in 2004 to raise awareness and funds for the PCFA. In 2006, beyondblue was selected as a second charity to be supported by the Foundation. In 2007, Movember committed $6,343,502 each to beyondblue and the PCFA for improving men’s health in rural, remote, regional and metro areas across Australia. In 2008, 124,559 ‘Mo Bros’ registered in Australia and grew moustaches in support of this program.
Indigenous

Another example of beyondblue’s programs for men is the Mibbinbah Indigenous Men’s Sheds/Spaces Pilot Project which aims to develop and strengthen the capacity of Indigenous communities by up-skilling local Indigenous men and providing training in leadership, depression awareness, community communication and media, computer skills and other relevant skills. The project also aims to:

- develop linkages between Indigenous men’s groups and other community organisations;
- maintain and strengthen the Mibbinbah network of Indigenous men;
- use the support of key players to encourage local Indigenous men to become role models/community leaders;
- normalise and de-stigmatise depression by promoting awareness and encouraging help-seeking; and
- develop a ‘safe’ space for Indigenous men where they can speak about depression and anxiety comfortably.

Under the auspices of this project depression awareness training sessions were held in May and October 2008 and were attended by 64 Indigenous men.

Whilst these were not formally evaluated, anecdotal feedback suggests that the training was well received, and the resources were taken by men for use in their respective communities. In addition to the depression awareness training, each project site provided opportunities for local men to share stories that reflect concerns about social and emotional wellbeing, and to refer people to the local information and resources that are available (including beyondblue resources and Mibbinbah website: http://www.mibbinbah.org). These networks accord with the Aboriginal and Torres Strait Islander people’s traditions of yarning and provided the men with a safe space to share their experiences on depression, anxiety and other related disorders. The project also included a mentoring program.

A further outcome has been the development and establishment of Mibbinbah Limited as an independent not-for-profit Indigenous men’s organisation which supports a larger network of men and transfers knowledge about chronic conditions, and social and emotional wellbeing. As noted above this project has not been formally evaluated however it is considered that this pilot project demonstrated the importance of enhancing and strengthening the capacity of Indigenous communities in promoting awareness of depression and anxiety, and encouraging men to seek help. Future recommendations include the development of specific resources and training modules for Indigenous men, the expansion of the networks and the expansion of the mentoring program.

beyondblue also supports National Men’s Health Week each June and in 2009, beyondblue contributed funds to a television advertisement for Men’s Health Week featuring several high-profile men, including Men’s Health Ambassadors Tim Mathieson, Bill Noonan and Dr Rob Walters.

National media releases are also disseminated each year focusing on men’s issues, including men and drinking, men looking out for their mates’ mental health, and men and anxiety disorders.

Community forums

beyondblue has conducted a number of community forums aimed at increasing awareness and decreasing stigma associated with depression and anxiety. During the period October 2008 to March 2009, many forums and events were held which were either hosted by beyondblue or where beyondblue was invited to speak on depression or related disorders. For example, the Victims of Crime Awareness Week (October 2008), Prostate Cancer Forum Queensland (November 2008), 2009 Angus Youth Roundup (January 2009), International Women’s Day Luncheon (March 2009) and Carers Forum (March 2009). beyondblue Deputy Chairman John McGrath presented at four of the five PCFA forums held around Australia.

In addition, beyondblue has conducted a number of community forums with Rotary clubs across Australia, through its partnership with Australian Rotary Health. These forums are designed to bring together consumers and carers, local service providers in mental health and primary care and members of the wider business and professional community. To date, over 400 Rotary community forums have been held, and financially supported by beyondblue, throughout Australia. The forums are designed to increase public awareness and understanding about depression and related mental illnesses, provide insight into the lived experience of mental illness, develop networks of support, and identify local services and agencies in communities to assist individuals and families.
living with a mental illness. The forums are generally chaired by a Rotarian and include guest speakers from beyondblue or relevant academic or healthcare agencies, and consumers and carers whose lives are affected by mental illness. Where possible, service providers are also invited to inform the community about relevant local services (beyondblue website).

**Objective 1.2**

**Increase in the quantity and quality of information available about depression, anxiety and related disorders through media and educational sources**

Data from several sources can be used to ascertain whether the above key initiatives have led to an increase in the quantity and quality of information available about depression through media and educational sources.

**Print and broadcast media**

In terms of quantity of print and broadcast media, beyondblue’s own monitoring systems are informative.

beyondblue has a key group of spokespeople who provide informed comment to the media on depression/ anxiety and related disorders, as well as about beyondblue’s programs and activities. In addition beyondblue stories, information and comment regularly appear nationally in newspapers, magazines, trade magazines, on radio, television and online.

Figure 4.2 shows that between April 2005 and December 2009, 19,677 media stories were recorded that related to beyondblue. This compares to 2,267 between 1 January 2001 and 30 September 2004 (Pirkis, 2004). Whilst there is considerable variability in the number of media stories recorded per month, the trend line indicates that there was a steady increase in the amount of media coverage over time. The highest rating month over this entire period was May 2007 with 1,825 media items being recorded whilst the lowest was December 2005 with 46 items being recorded.

- Coverage in 2005 peaked in May due to extensive reporting on the suicide of Rene Rivkin, which brought depression into the media spotlight.
- There were two major peaks in coverage in 2006. Coverage in October focused on depression in rural communities due to drought, discussing Elmore Field days, an increase in suicide rates among farmers and the Federal Government’s boost to mental health funding. This peak in October also included reports on the resignation of Queensland Attorney-General Linda Lavarch due to depression. November 2006 coverage focused on Movember.
- There were also two significant peaks in 2007 coverage. May coverage discussed concerns that the mother of a baby dumped at Royal Children’s Hospital was suffering from depression, reported on calls for more support for family and friends of those suffering depression, and continued to discuss the impact of drought on farmers’ mental health. October 2007 coverage focused on several initiatives, including Anxiety and Depression Awareness Month and Mental Health Week.
- 2008 had several peaks in coverage, with the media in February focusing on the Victorian Farmers Federation holding community forums to discuss depression in rural areas and on new research that questioned whether anti-depressant drugs work. August coverage discussed the hospitalisation of Tasmanian Minister Paula Wriedt after a suspected suicide attempt, and the suicide of actor Mark Priestly. In December, a new campaign was launched, aimed at those finding it hard to cope with the financial crisis.
- In July 2009, coverage discussed claims that the number of people with depression was rising due to the financial crisis. An increased volume of coverage this month also reported on the suicide of 14-year-old girl after cyber-bullying, with coverage providing advice for parents on how to deal with these issues. October 2009 media coverage again focused on Anxiety and Depression Awareness Month and Mental Health Week. Reports also discussed a program launched to improve the mental health of primary school students. Coverage in November focused on Movember, the announcement from South Australian Treasurer Kevin Foley that he was being treated for depression, and claims that depression is still considered a normal part of pregnancy and motherhood.
Figure 4.2: Media stories about _beyondblue_ by month, January 2005 to December 2009

**Yearly comparison**

**Press**

![Press coverage chart]

Chart 1. Volume of press coverage by month and year

**Radio**

![Radio coverage chart]

Chart 2. Volume of radio coverage by month and year

**Television**

![Television coverage chart]

Chart 3. Volume of television coverage by month and year
On a year-by-year basis starting with 2005, Figure 4.2 shows that media exposure was relatively steady throughout this first year averaging around 100 stories per month with a peak in November. Media exposure increased in 2006 despite a steady decline in the first quarter. Exposure peaked at 1,208 in October and then dropped to 592 in December. 2007 showed a steady increase in exposures early in the year which peaked in May at 1,964 and then decreased to 350 in December. The first quarter of 2008 also showed a steady increase, followed by a decline in the second quarter and a steep increase in September before peaking at 1,470 in October. Data are available for the first quarter of 2009 and show a steady increase in media exposure.

In some instances, the pattern of media reporting can be attributed to specific activities of beyondblue, many of which were promoted by media releases (214 of which were issued during the period under study (http://www.beyondblue.org.au/index.aspx?link_id=9.234). For example, the month with the highest number of media exposures was May 2007, during which there were four media releases as well as four media articles written by beyondblue, in both the print media and on radio. Similarly, October 2008 saw a large number of media stories. During this month there were seven media releases and a further three media articles written by beyondblue. October is also beyondblue Anxiety and Depression Awareness (ADA) Month, which includes Mental Health Week and World Mental Health Day, all of which might contribute to a greater amount of media exposure. In a similar vein November each year attracts a relatively high number of media stories and this may reflect the ‘Movember’ campaign.

Although this demonstrates that beyondblue received a significant amount of media coverage over this period (which is positive in terms of raising awareness of depression and of beyondblue itself), we do not know the content of each story; therefore we cannot be certain that this actually represents an increase in the ‘quantity and quality of information available about depression, anxiety and related disorders’.

However, research funded by beyondblue can provide some insight into both the quantity and quality of media reporting of depression. The aim of the ‘Media Monitoring of depression’ project conducted by Melbourne University was to investigate media reporting prior to beyondblue and the Australian Government beginning their efforts to encourage responsible reporting (01/03/2000-28/02/2001) and to compare it to media reporting after their efforts were well established (01/09/2006-31/08/2007). This project identified all media reports of mental illness, and in particular depression, and rated each for quality and in terms of accuracy of representation of symptoms, causes, treatment and prognosis against standardised criteria. Media items related to mental illnesses were collected from 632 print and broadcast sources, over the two 12-month periods. The findings from this project are detailed in Chapter 8 but the study showed a general improvement in quality of media items about depression with reporting having become more informative and more accurate over time (Dare et al, 2008).

**Promotional materials**

Systematically-collected data is not available on the quantity of the promotional materials distributed by beyondblue, but some idea can be gauged from the number and range of means by which they have been disseminated. Materials have been distributed at:

- beyondblue program launches;
- via website requests;
- schools (via the beyondblue Secondary Schools Program), including all Melbourne secondary schools;
- universities;
- community events (e.g., World Mental Health Days, Melbourne Youth Mental Health Forum);
- Rotary, and other, community forums;
- community groups;
- corporate organisations (through the beyondblue National Depression in the Workplace Program described in Chapter 6);
- via training programs delivered by beyondblue;
- via the 45 Divisions of General Practice that participated in the Mental Health Drought Initiative; and
- General practice clinics, community health centres and other primary care agencies.
In addition, beyondblue has used the core distribution list of the Mental Health Council of Australia to disseminate materials to the mental health community. The core list includes approximately 400 individuals and organisations who, in turn, forward materials to their networks.

The absolute number of promotional materials disseminated by beyondblue has not been collated; however, as an indication over 80,000 items were distributed on World Mental Health Day 2003 in the earlier funding period (Mental Health Council of Australia, 2003) and 11 million resources in 2009 (Annual Report – page 27).

In terms of quality, the content of all of beyondblue’s resource and mass media output is evidence-based, and all materials are reviewed by relevant experts (e.g., clinicians, consumers and carers). This ensures that they work towards decreasing stigma, and do not run any risk of promoting it.

The Internet

In total, 767,059 individuals visited the beyondblue website during the period between 1 April 2001 and 31 August 2004 (Pirkis, 2004). Since April 2008 beyondblue has employed Google Analytics to analyse website usage, tracking how visitors interact with the site, including where they are based, what they did on the site, and in particular whether or not they requested beyondblue resources, whether or not they accessed information on how to identify and help someone experiencing depression and whether or not they requested information about the website and/or beyondblue in general.

During the period 1st July 2008 and 1st July 2009 there were 1.2 million visits to the site, including 860,000 unique visitors. Users viewed approximately 6 pages per visit and spent on average six minutes on the site. The top content viewed was firstly the homepage followed by information regarding signs and symptoms, information on what depression is, treatments available, the depression checklist, how to help yourself, how to get help, information on what puts a person at risk, symptom checklists and finally downloadable beyondblue information resources.

Further testament to the reach and usage of the beyondblue website comes from it having won the Hitwise No. 1 website award in 2004, 2007 and 2008 (e.g. Department of Human Services, 2008). Hitwise provides insights on how Australian Internet users interact with more than one million websites, across more than 165 industries, by collecting aggregate usage statistics from a geographically diverse range of ISP networks in metropolitan and regional areas, which represent all types of Internet usage including home, work, educational and public access.

In July 2005 (before the introduction of Better Access) the ‘Find a Doctor/Find a Psychologist/Mental Health Professional’ page was made available on the beyondblue website; the aim being to provide the public with readily accessible information on practitioners treating depression, anxiety, bipolar and related disorders at locations closest to them. In addition to facilitating access to health practitioners with expertise in mental health, the page is a forum whereby medical or allied health practitioners may register their own details. Practitioners invited to participate in this listing include general practitioners, clinical psychologists, occupational therapists in mental health, and social workers in mental health. All practitioners are required to provide their Medicare Provider number to confirm their eligibility to provide mental health interventions under the Government’s program of better accessing mental health services.

The list can be located at the following link: www.beyondblue.org.au/index.aspx?link_id=107.1007. As of June 2009 there had been 145,000 visits to the site; the number of practitioners listed across Australia is shown in Table 4.3.

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1 Individuals visiting the website more than once are only counted on the first occasion. Counting ‘unique visitors’ in this way is considered more informative than counting the absolute number of visits.
Table 4.3: Number of professionals listed on beyondblue’s ‘Find a Doctor/Find a Psychologist/Mental Health Professional’ webpage (July 2009)

<table>
<thead>
<tr>
<th>Professional</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical psychologists</td>
<td>684</td>
</tr>
<tr>
<td>General practitioners</td>
<td>666</td>
</tr>
<tr>
<td>Psychologists (non-clinical)</td>
<td>576</td>
</tr>
<tr>
<td>Social workers</td>
<td>150</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,097</strong></td>
</tr>
</tbody>
</table>

The list is not a complete directory and practitioners on the list are neither recommended nor endorsed by beyondblue. However, a national consenting practitioners listing (such as this) has long been seen as important and is supported by the mental health sector, including the Better Access in Mental Health Initiative members, the Mental Health Council of Australia, Australian Divisions of General Practice, the Australian Psychological Society, Royal Australian & New Zealand College of Psychiatrists, the Australian Medical Association, and the Royal Australian College of General Practitioners.

The redevelopment of the current IT infrastructure to support an online map version has further enhanced the capacity, speed and usability of this directory, and has recently ‘gone live’.

A further web-based initiative is the ‘Australian Rural Information Network (ARIN) Map’ – formerly known as Rural Assistance Information Network (RAIN) map – (www.beyondblue.org.au/index.aspx?link_id=107.950). This pinpoints services or resources available (such as Centrelink, Rural Financial Counsellors, the Salvation Army, the Australian Red Cross, Divisions of General Practice, and beyondblue Information Kiosks) in a particular area in Australia (by town/city/state/postcode) and its corresponding drought status. Notably however, most of the services are concentrated along the eastern seaboard of Australia (predominantly in Victoria) with fewer services available in the central affected and south-western areas meeting the government’s ‘Exceptional Circumstances’ criteria. By itself, information on the quantity of information being accessed via the Internet only tells part of the story. The quality of this information is clearly crucial in terms of improving the community’s mental health literacy. beyondblue goes to considerable lengths to ensure that the content of the website is of high quality, checking the accuracy and accessibility of information via peer-review processes and recourse to evidence-based literature (Lee, 2004).

Revisions to the website go through extensive user-testing processes, and there are ongoing opportunities for user feedback (Fulcher, 2004). Qualitative information from visitors to the website suggests that they find the information accessible, helpful and relevant (see Table 4.4).
Table 4.4: Feedback from visitors to the beyondblue website

<table>
<thead>
<tr>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Just a short note to say thanks for the fabulous website – beyondblue …… The bottom line is the website was fantastic – I was able to do research to find (general practitioners in my local area which focused on my particular issues (work place bullying/stress/anxiety) and I could go and see whose availability was flexible enough that I could work around my schedule”. (Testimonial 1)</td>
</tr>
<tr>
<td>“I was invited … to come to a rural women’s health talk. The goodie bag they gave out included a beyondblue book... hence this led to my looking at your website and I felt I had hit the jackpot!!” (Testimonial 2)</td>
</tr>
<tr>
<td>“I work as a school psychologist in a high school. I was looking through some of the information about beyondblue on your website a couple of weeks ago and came across the programs for years 8s, 9s and 10s. I sent away for the teacher and student manuals as we are always looking for new ideas and programs to help support our students. They arrived yesterday (with a CD so we can download copies for students) and I would just like to say thank you very much for sending out this package. The resources I received are fantastic and we have started looking at how we can implement them in our school. I also ordered a copy of the book ‘Taking care of yourself and family’ and just like the programs it is a fabulous resource that I can see myself using frequently”. (Testimonial 3)</td>
</tr>
<tr>
<td>“Just want to say thanks for sending out the info I requested via your Web site. Much appreciated. I will take my time to read through it carefully. I am sure it will give me a better understanding of depression and how I can help others who suffer from this debilitating but manageable condition. You’re providing a fabulous service”. (Testimonial 4)</td>
</tr>
</tbody>
</table>

Additional evidence regarding the quality of the beyondblue website comes from the work of Griffiths and Christensen during the earlier funding period. In 2001, these authors identified 15 Australian depression websites, and rated them according to their quality (based on a range of indicators, such as the extent to which they were evidence-based) and their accessibility (based on their relative order of appearance on various search engines). The beyondblue website was rated highly, and ranked among the top four sites (Griffiths & Christensen, 2002).

Likewise, the approval of the beyondblue website as a HealthInsite partner is testament to its standard. HealthInsite acts as a single entry point to quality information to facilitate access to approved websites. Site approval is contingent upon compliance with HealthInsite’s publishing standards, meeting criteria related to quality of information, authority and authentication, disclosure, currency, technical issues, document formats, navigation, aesthetics/design, accessibility and innovation. Sites must also satisfy requirements related to the process of information development (e.g., including a policy that each resource is authored by a person or persons with appropriate qualifications/experience, including a procedure for appropriate attribution of resources, including a review process, detailing the final approval process, addressing conflicts of interest, including a policy on advertising, and including a process for consumer consultation and/or user testing (HealthInsite website). The beyondblue website was approved by HealthInsite in July 2004 during the earlier funding period and met all of the above criteria (Smith, 2004).

In addition, individuals and community groups have developed their own Facebook pages in support of beyondblue with different pages having varying degrees of support. Most notably, one Facebook page had 1,433 members as of 17/08/2009.

Community service announcements

In September 2006, beyondblue launched its second series of national TV, radio and print advertisements with the aim of encouraging viewers to reach out for help and to direct viewers to the beyondblue website and Info line. These have been produced by Frontier Advertising and comprise a series of six separate commercials focusing on anxiety, depression in the workplace, bipolar disorder, postnatal depression, depression and drug and alcohol problems, and depression in older people together with an additional advertisement aimed at rural men, which has been seen in rural areas across Australia. The campaign on Networks Seven, Nine and Ten, as well as SBS and many pay TV channels began in 2006.
All commercial television networks support beyondblue’s community service announcements, providing free prime-time space since July 2004. The campaigns extend through print media, cinema advertising, billboards, public conveniences and posters on public transport and all the major television companies have agreed to provide ongoing support for this campaign.

A selection of beyondblue television, radio and print ads has also been translated into six languages – Vietnamese, Polish, Mandarin, Greek, Italian and Arabic. These have been distributed to relevant media and strategically placed within appropriate ethnic programs and publications, as well as positioned on the beyondblue website with corresponding fact sheets and resources.

Specialist sources
Some indication of whether beyondblue’s activities have increased the quantity of specialist media resources on depression can be gauged from the reach of the Medical Journal of Australia’s supplements on depression. According to the Medical Journal of Australia’s own statistics, it has a circulation of 28,000 (MJA website). This creates the potential for significant numbers of general practitioners, psychiatrists and other mental health care providers to be exposed to information about depression, through the supplements described above.

In terms of quality, all articles in each of the supplements have been peer-reviewed as a check for scientific merit and accuracy.

Community activities
The community activities of beyondblue are many and varied, although only limited data exist to quantify them exactly. Some indication of their reach can be gleaned from specific examples, however. beyondblue has held 475 Rotary community forums to date across Australia attracting around 56,800 people (beyondblue website; Highet, 2004). Similarly information and resources were disseminated via the 45 participating DGPs as part of the Mental Health Drought Initiative which specifically targeted rural and remote areas of Australia, and between October 2008 and March 2009 alone, a range of forums and events were held which were either hosted by beyondblue or where beyondblue was invited to speak on depression or related disorders. Examples include, the Victims of Crime Awareness Week (October 2008), the Prostate Cancer Forum Queensland (November 2008), the 2009 Angus Youth Roundup (January 2009), an International Women’s Day Luncheon (March 2009) and a Carers Forum (March 2009).

Beyond sheer numbers reached, many of the community activities associated with beyondblue have been shown to have an impact in terms of promoting the organisation. For example, Youthbeyondblue is considered to be relatively successful, in terms of ‘hits’ on its new website, an increase in calls to other services (e.g., Kids Help Line, headspace and ReachOut.com), and feedback from involved young people. Similarly high participation rates in community health promotion events give an indication of an awareness of beyondblue as an organisation and of depression and anxiety. For example, research conducted by the Movember Foundation indicates high levels of awareness of beyondblue and depression. A survey of Movember participants conducted in February 2009 revealed that as a result of the campaign; 82% talked about men’s health; 55% conducted their own research into depression/prostate cancer; 12% sought medical advice; and 38% encouraged a friend or family member to seek medical advice.

Another indication of the reach and impact of information about depression and anxiety through education sources comes from community projects with a training focus, such as the beyond maturityblues and Men’s Sheds/Spaces projects. The beyond maturityblues peer education project led to the training of 31,327 participants at 1,470 community training sessions. The program led to an increase in knowledge about depression among state training coordinators. On a smaller scale the Mibbinbah Indigenous Men’s Shed/Spaces project led to the training of 64 Indigenous men from this community receiving training aimed at increasing knowledge and awareness of depression, anxiety and related disorders.
Objective 1.3
Increase in awareness of the prevalence, symptoms, causes, treatments and prognosis of depression, anxiety and related disorders

It can be concluded from the evidence presented in the previous section that there has been an increase in the quantity and quality of information available about depression through media and educational sources since beyondblue’s inception. There is also evidence to indicate that awareness exists among the Australian community of beyondblue itself (Morgan & Jorm, 2007). However, it is important to consider whether these increases have translated into an increase in awareness of the prevalence, symptoms, causes, treatments and prognosis of depression, anxiety and related disorders. In other words, has the ‘depression literacy’ of the Australian community improved as a result of beyondblue’s awareness-raising and educational efforts (Jorm et al, 2007).

Data from the Depression Monitor surveys conducted by beyondblue in 2001 and 2002 (Highet et al, 2002; beyondblue Depression Monitor, unpublished data) and from the 1995 and 2004 Australian National Mental Health Literacy Surveys of Jorm et al (2007) indicated that there were increases in the community’s awareness of depression, and knowledge of its symptomatology, causes and treatment, during the early period of beyondblue and that some of these changes can be attributed (at least to a certain extent) to the work of beyondblue (Jorm et al, 2006). However, there was less of a shift in the population’s recognition of the magnitude of the problem, with a high proportion of the population underestimating both the prevalence and the burden of depression (Pirkis, 2004). Since the previous evaluation beyondblue has conducted two further Depression Monitor surveys, in 2004/5 and 2007/8 which examined public awareness and knowledge of depression, attitudes towards people experiencing depression and help-seeking behaviours (Highet, 2008).

The recent Depression Monitor Surveys (Highet, 2008) found that 6% of the sample spontaneously identified depression – double the 2002 survey result. This figure is significantly lower when compared to awareness levels of other health conditions, for example, obesity. However, depression is readily identified by the Australian public as a mental health problem, with 56% of respondents able to identify it. This compared to 49 % in 2002. This was followed by psychosis which was identified by 24% of respondents, drug and alcohol abuse were identified by 15% and bipolar disorder by 10%. Anxiety was less well recognised with only 7% of respondents identifying it and post natal depression was recognised by only 1% of respondents.

Of the whole sample 45% had looked for information about depression (mainly from the Internet or a General Practitioner) compared to 35% in 04/05. The number of respondents reporting that they would seek information from a mental health service decreased over time (8% to 2%) whilst an increasing number of respondents stated that they would seek help from beyondblue (0%-7%). Overall 76% indicated that they would turn to family and/or friends.

In 2002, 54% of Depression Monitor survey respondents had seen, read or heard something about depression in the media in the previous 12 months (Hickie et al, 2004). By 2004, this figure had risen to 61% in the Australian National Mental Health Literacy Survey (Jorm, 2004). More recent data is not currently available. Significantly, in 2007/8, 76% of Australians were aware of beyondblue compared to 31% in 2002.

Long term counselling, psychological therapy was considered to be helpful in treating depression by 86%, 75% and 70% of respondents respectively. Although antidepressants were considered to be addictive by 56% and tranquilisers even more so, with 73% of respondents expressing this view. The number of people who said antidepressants were harmful has decreased from 21% in 2002 to 16% in 2007/08. In contrast, 93% of respondents identified physical activity, 74% identified change of diet and 65% considered natural remedies to be helpful when treating depression. Both sleeping tablets and occasional use of alcohol were considered to be harmful by 49% and 44% of respondents respectively.

With regard to respondents’ perception of health professionals, confidence in GPs appears to be increasing over time. Around 48% believed that GPs are now more willing to recommend non-pharmacological treatments or to refer to other health professionals (88%). However, despite this 51% reported that GPs do not have enough time to deal with a problem such as depression and 78% reported feeling intimidated when approaching a GP with depression. Overall, 78% of respondents believed people can recover with treatment.
In terms of help-seeking behaviours, 64% had a personal (14% self and 50% family member) experience of depression, 81% received help mainly via their GP (40%), a clinical psychologist (20%), and 18% via other means. The role of counsellors and other mental health professionals is also significant. In the last 12 months of the survey (2007/08 period) 27% indicated that family prompted them to seek help and 16% sought help through self-awareness.

Despite increased media coverage, and favourable trends unwarranted negative perceptions about depression still exist. For example, about one in three people (32%) agree with the statement that people with severe depression are dangerous to others. Half the sample said people with depression are unreliable; however, that figure had dropped from 66% in 2002. In addition, 32% of respondents said that people with depression cannot be trusted in positions of responsibility compared to 36% in 2002, 31% said people with depression should not stand for politics compared to 43% in 2002, and 15% said people with depression who work in high profile jobs, such as pilots, solicitors, doctors, should quit their jobs.

**Objective 1.4**

**Increased understanding of experiences of people whose lives have been affected by depression**

Evidence from the Depression Monitor surveys also informs the question of whether the Australian community has developed an increased understanding of the experiences of people whose lives have been affected by depression over the evaluation period and indeed the data showed that over 80% of the respondents recognised depression as being a genuine and debilitating illness.

In 2001, 56% of Depression Monitor survey respondents indicated that they or someone very close to them had experienced an episode of depression. In 2004, this figure had increased slightly to 61% and in 2007/8 to 64%.

While this does not necessarily translate into increased understanding of the experiences of people with depression, it is a positive finding. The fact that an increasingly high proportion of respondents have directly or indirectly experienced depression augurs well for the community empathising with those affected by the condition, rather than viewing them in a negative light. Likewise, the fact that an increasing number of respondents believe that it is likely that some of those around them will experience depression indicates a growing acceptance that depression can affect anyone.

**Objective 1.5**

**Decrease in levels of stigma and discrimination associated with depression**

The hierarchy of objectives suggests that the increases in awareness, knowledge and understanding of depression on the part of the community should lead to a decrease in the levels of stigma and discrimination experienced by people with depression.

There is certainly an increased acknowledgement of the fact that people with depression experience stigma and discrimination and there is some evidence to suggest that beyondblue has played a role in increasing this awareness (Jorm et al, 2006). For example, 54% of respondents in the 2004 Australian National Mental Health Literacy Survey believed that a person with depression would be discriminated against by others, compared with 48% in 1995 (Jorm et al, 1997; Jorm, 2004). This observed increase in awareness of discrimination was more evident in those states and territories with high exposure to beyondblue (Vic, SA, Tas, Qld) compared to those with low exposure (NSW & WA) (Jorm et al, 2006).
Data from the more recent beyondblue Depression Monitor surveys show a steady reduction in social distancing and stigma over time; although 32% of people surveyed still believe people with severe depression are dangerous to others, 68% reported them as unpredictable, and 52% as unreliable (Highet, 2008). However, there is a distinct lack of data to explicitly test whether people with depression are experiencing a reduction in stigma and discrimination in parallel with the community awareness efforts of beyondblue. Consultations with consumers and carers (described in more detail in Chapter 5) suggest that discrimination remains a problem (McNair et al, 2002; Mental Health Council of Australia, 2003; SANE Australia, 2003).

Summary

Many of the key initiatives associated with Priority Area 1 in 2005-2010 continue from the earlier funding period and are now well established, taking the form of a broad range of mass media initiatives (e.g., media exposure; promotional materials; a website; community service announcements, and special supplements on depression in the Medical Journal of Australia) and community activities targeting the broader community and with specific activities focusing on youth, older people and men (e.g., Youthbeyondblue; Rotary community forums; training programs and health promotion events).

These key initiatives have led to an increase in the quantity of information available about depression through media and educational sources in comparison with the earlier funding period. Concomitant with the life of beyondblue, there has been increased coverage of depression in print and broadcast media and in specialist professional publications, numerous beyondblue promotional materials have been distributed, the beyondblue website has been much more heavily used, and numerous community awareness-raising activities have taken place. There are good indications that most of this information is of high quality, with the beyondblue website having been ranked highly by independent assessors and the specialist publications being peer-reviewed. The only area where the evidence is less clear is that of print and broadcast media, where it is not possible to determine whether the quality of reporting has improved in line with increases in quantity.

The above increase in the quantity and quality of information about depression appears to have translated into gains in the community's 'depression literacy' compared with the earlier funding period, although there is still room for improvement. Repeated cross-sectional population surveys suggest that there were increases in the community's awareness and knowledge of depression as well as to a lesser extent other mental disorders, and improved attitudes towards people experiencing depression and towards help-seeking. However, a high proportion of the population continued to underestimate both the prevalence and the burden of depression. Additionally whilst recognition of depression appears to have improved over time, there is room for improvement with regard to anxiety, bipolar disorder and postnatal depression.

Less evidence is available to directly determine whether the Australian community has developed an increased understanding of the experiences of people whose lives have been affected by depression.

There is some evidence of a further reduction in social distancing and stigma over time and some evidence that this is a result of work by beyondblue.

Likewise, there is insufficient evidence to directly ascertain whether, during the life of beyondblue, there has been a decrease in the levels of stigma and discrimination experienced by people with depression. Results from repeated administrations of surveys suggest that there is an increased acknowledgement by the community of the stigma and discrimination experienced by people with depression and some evidence that this is decreasing as a result of work by beyondblue. However, surveys with consumers and carers indicate that discrimination remains a problem.
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Chapter 5
Objectives achieved under Priority Area 2 (Consumer and carer participation)

Introduction

Until the 1990s, each State and Territory within Australia made its own decisions about mental health care, resulting in a lack of national consistency. In 1992 the National Mental Health Strategy was established. It included the first National Mental Health Policy and Plan put forward by the Commonwealth Government and the Statement of Mental Health Rights and Responsibilities. Each State and Territory agreed to follow the guidelines encompassed in the Strategy to improve the lives of people diagnosed with a mental illness. The Mental Health Statement of Rights and Responsibilities (1991) aimed to ensure that consumers, carers, advocates, service providers and the community were aware of their rights and responsibilities and can be confident in exercising them. A key point made in the Statement refers to the education of people who are likely to provide services to people with mental health problems. For example, it is expected that teachers, police, welfare workers, clergy and other non-health professionals will be sufficiently educated to enable them to recognise and refer people with mental health problems (National Mental Health Strategy, 1991).

Consumer participation in mental health decision-making processes has been welcomed by all States and Territories since the adoption of the National Mental Health Policy (1992). One of the strategies of the first National Mental Health Plan was an agreement to provide for ongoing mechanisms for consumer and carer input into mental health decision-making processes. Each State/Territory establishes and maintains a mental health consumer advisory committee which is representative of the range of mental health consumers and carers. Some States have also developed local mechanisms for involving consumers and carers in the development of services. For example in Queensland, most mental health services have links with local Consumer Advisory Groups which fulfil a role similar to that of the State and national CAGs, except that they are not ministerial advisory committees (Australian Government, undated).

The rising health burden of depression and its projected future impact on the society prompted the Federal and Victorian Governments to develop and roll out a national depression initiative. Another organisation involved was the National Mental Health Consumer and Carer Forum (NMHCCF), the combined national voice for mental health consumers and carers participating in the development of mental health service and sector development in Australia (NMHCCF website). Through its membership, the NMHCCF gives mental health consumers and carers the opportunity to meet, form partnerships and be involved in the development and implementation of mental health reform. Current reports by the NMHCCF show that mental health consumers and carers are still continuing to be marginalised and discriminated against in issues like healthcare benefits and social support, unlike those with physical disabilities.

Likewise, SANE Australia is a national charity working for a better life for people affected by mental illness – through campaigning, education and research (SANE Australia website). SANE conducts programs and campaigns to improve the lives of people living with mental illness, their family and friends. It also operates a Helpline and website, which have thousands of contacts each year from around Australia. A 2007 survey conducted by SANE revealed that despite a plethora of government policies and other mental health initiatives, mental health consumers and their carers still continue to face exclusion and insufficient support from both mental health professionals and mental health services.
Research literature
A bibliography of important studies (meta-analyses, systematic reviews and key articles) including brief descriptions based on edited abstracts is attached in an Endnote at the end of the main report. It indicated little research existed in this area, other than that funded by beyondblue.

Summarising this research there was:

• to some extent a lack of support by other family members or friends which made the carer’s role more difficult;
• adverse experiences with healthcare service providers whereby the carer’s concerns are disregarded by emergency services and they are excluded from key decision-making about the patient;
• people with depression are subject to many of the same attitudes, inadequate healthcare and social barriers reported by people with psychotic disorders;
• signs and symptoms of depression were recognised by carers, generally in hindsight;
• a number of self-help interventions including those on the Internet have promising evidence for reducing sub-threshold depressive symptoms.

Objective 2.1
Key initiatives in place
A description of the principal programs in Consumer and carer participation funded by beyondblue is attached in Appendix 2. This includes their aims, objectivities, activities, outcomes, presence of an external evaluation study and if so, their designs, methods, findings, conclusions and recommendations. The principal Consumer and carer participation programs and their aims are set out in Table 5.1.

Since the 2004 evaluation, beyondblue has worked to further develop their initiatives which are designed to strengthen the roles of consumers and carers in the planning, delivery and evaluation of mental health services, and to reduce the stigma associated with depression and related disorders. Key among these remains the development of blueVoices, a national organisation with consumer and carer membership in each state and territory. blueVoices aims to take forward and represent consumer and carer issues of importance at a national level on relevant committees and government structures. blueVoices also aims to contribute to an improved health service environment through information provision, informing policy and program debates, partnering with other groups in an advocacy role, and providing a network through which members can share experiences and expertise. To achieve its goal, blueVoices has reference groups that focus on specific areas, namely depression, anxiety, postnatal depression, depression in the elderly, bipolar disorder, depression in adolescents and young people, co-morbid substance misuse, and co-morbid chronic physical illness (beyondblue, 2009). blueVoices is well-represented on national committees, providing a consumer and carer perspective that did not previously exist. More recently, it has restructured its e-Groups to include a National Reference Group emphasising its commitment in representing consumer and carer involvement in mental health related activities at national level.

With the establishment of blueVoices, beyondblue has access to a national reference group of people with direct personal experience of depression, anxiety and related disorders. blueVoices also includes people who care for, or directly support, someone with one or more mental health conditions including depression, anxiety disorders or substance use disorder. Since late 2007, communication has been primarily via email and membership is open to anyone in Australia who has had experience of depression, anxiety or related disorders, or their carers or primary support people. More recently, it is being actively promoted through beyondblue’s National Workplace Training programs (NWP).

More recently, self-help accessible via online initiatives is showing promise in encouraging consumers and carers to seek information on depression and related disorders earlier than before, although, many of these programs are in their pilot phases and require rigorous evaluation prior to being judged on their initial outcomes.
E-mental health is a strategically important area for beyondblue in that it offers new ways of both delivering and providing access to mental health services. Mental health interventions delivered ‘electronically’ have been found to be as effective as face-to-face treatment for high-prevalence disorders such as depression and anxiety. E-mental health is currently a priority for Governments and significant funds have been advanced to support research in the field. beyondblue has also supported e-mental health research (see below) and is now working with other key players in the field to help shape Government policy around the development of national e-mental health services.

beyondblue has funded or contributed funding to a significant number of e-mental health research and development projects, including:

- MoodSwings (University of Melbourne)
- Panic Online (Swinburne University)
- Mobile TYPE (Murdoch Children’s Research Institute)
- Rural Carers Online (National Ageing Research Institute)
- e-couch (ANU)
- CyberPsychiatry (Northern Sydney and Central Coast Area Health Service)
- Reach Out Central (Inspire)
- Multicultural Information on Depression Online (Monash University)
- RANZCP Australian Indigenous Mental Health Training Module
- MoodGym (ANU)
- YShareit (University of Tasmania)
- Young Minds (Australian General Practice Network)

A listing of currently available (and future-planned) e-mental health services is now available on beyondblue’s website. This broad and collaborative listing enables consumers to know what e-mental health services are available, and how to access them. E-mental health offers significant potential in terms of cost effectiveness and accessibility, making it an attractive treatment option for groups with limited access to mental health services, for example, in rural and remote areas.

beyondblue is contributing to the development of national policy and strategies around e-mental health through its participation in an Expert Advisory Group (EAG) for Online Interventions. This group formed by invitation from DOHA with the aim of developing a vision for a 10-year national e-mental health plan. The group comprises all key players in e-mental health in Australia (including researchers at ANU, QUT, Black Dog Institute, Swinburne, UNSW, as well as the organisations Lifeline, Inspire, depressioNet and beyondblue).

Further, the EAG has developed its ‘E-mental health: A 2020 Vision and Strategy for Australia’ document, which sets out the rationale for an e-mental health policy, describes the place for e-mental health in traditional health services, and provides recommendations for the future of e-mental health through a set of major strategies. The paper was presented to DOHA in September 2009. It is intended that the paper will both inform and shape the Government’s national e-mental health strategy.

Moreover, e-learning is an integral part of the National Workplace and Social Enterprise (NWSE) business plan given its potential to expand beyondblue’s reach into organisations which, for reasons of size, location, or preference, make face-to-face programs inappropriate. The NWSE team is currently exploring the development of an e-learning pilot program with PricewaterhouseCoopers for use within their organisation and beyond.
beyondblue has also been central in involving consumers and carers in policy and planning by promoting their representation in various organisations. For example, blueVoices members are an integral part of the Mental Health Professionals Network Advisory Committee, the National Mental Health Consumer and Carer Forum, the Private Mental Health Consumer and Carer National Committee and the Mental Health Council of Australia Members Policy Forum. The National Consumer and Carer Forum, auspiced by the Mental Health Council of Australia, enable consumers and carers to meet on a regular basis. beyondblue has also continued to support the participation of consumers and carers through funding a range of self-management projects that explore the lived experiences of consumers and carers. These include the Ambassadors Program, e-health research projects such as e-couch, MiDOnline and Panic Online. Further, the National Workplace Program (NWP) and the Mental Health First Aid course incorporated into some of beyondblue’s initiatives actively empower and provide knowledge about mental health issues.

The Ambassador Program is an essential component of beyondblue’s Consumer and Carer portfolio. It has three arms, namely High Profile Ambassadors (with personal experience), Consumer and Carer Ambassadors (blueVoices members), and Health Professional Ambassadors (currently under development, in conjunction with NWP). This program has created a powerful tool of sharing personal experiences by building a pool of trained speakers in every State and Territory. Together with the projected nationwide dissemination of the Carer Information Kit, this will be a significant achievement on behalf of beyondblue’s role towards improving consumer and carer participation. Notably, the Carer’s Information Kit produced by beyondblue contains a Guide for Carers that was developed by carers for carers with inputs and quotes from carers. The Guide not only provides information on wellbeing, support services and resources for those cared for, but also for carers themselves.

Furthermore, beyondblue has also acknowledged and extended its reach to involve consumers and carers with co-morbid chronic illness through its various partnerships. For example, partnerships with the Australian Centre for Posttraumatic Mental Health, Breast Cancer Network of Australia, and The Prostate Cancer Foundation has resulted in the co-badging and launching of fact sheets and other relevant information for consumers and carers with depression and a co-morbid illness.

**Objective 2.2**

**Improved consumer and carer networks**

**Partnerships and networks**

beyondblue has, over the years, collaborated with key organisations to form partnerships that support consumer and carer networks. The Multicultural Mental Health Australia (MMHA) partnership which addresses the mental health and wellbeing of the Culturally and Linguistically Diverse (CALD) community in Australia is of key note. Working in collaboration with beyondblue through its auspice Sydney West Area Health Service, MMHA consumers are included in the beyondblue “Hope and Recovery” DVD and in the beyondblue pilot Ambassador Training Program. Further, both beyondblue and MMHA fact sheets have been translated to cater for the diversity in consumers and carers accessing information on depression and related disorders. These fact sheets have also been printed for distribution across the country and are available on both these websites.
<table>
<thead>
<tr>
<th>Program name</th>
<th>Aim</th>
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<tbody>
<tr>
<td><strong>Partnerships</strong></td>
<td></td>
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<tr>
<td>Australian Centre for Posttraumatic Mental Health – ACPMH</td>
<td>to address issues/concerns related to mental health of people following a traumatic experience/event</td>
</tr>
<tr>
<td>Multicultural Mental Health Australia – MMHA</td>
<td>to address the mental health and wellbeing of the Culturally and Linguistically Diverse (CALD) community in Australia</td>
</tr>
<tr>
<td>PricewaterhouseCoopers – PwC</td>
<td>to address the mental health and wellbeing of staff at the PricewaterhouseCoopers workplace and the wider corporate sector as part of the National Workplace (National Workplace and Social Enterprise) Program</td>
</tr>
<tr>
<td><strong>Self-help (Online therapy)</strong></td>
<td></td>
</tr>
<tr>
<td>beyondblue e-network</td>
<td>to provide people across Australia and the world the opportunity to be informed with the latest research and information related to depression, anxiety and related disorders, via the internet</td>
</tr>
<tr>
<td>e-couch Project</td>
<td>to develop a web-based interactive program on depression</td>
</tr>
<tr>
<td>Multicultural Information on Depression – MIDonline</td>
<td>to improve depression literacy and assist in pathways to mental health care for people of CALD backgrounds living in Australia</td>
</tr>
<tr>
<td>Panic Online – PO</td>
<td>to investigate the effectiveness of PO with face-to-face assistance provided by a GP (PO-GP) compared to PO with email assistance from a psychologist (PO-P), for treating panic disorder (PD) with or without agoraphobia</td>
</tr>
<tr>
<td><strong>Networks</strong></td>
<td></td>
</tr>
<tr>
<td>Ambassador Program</td>
<td>to raise depression awareness across Australia and reduce the stigma associated through the powerful tool of sharing personal experiences in media and public settings by building a pool of trained speakers in every State/Territory</td>
</tr>
<tr>
<td>blueVoices</td>
<td>to take forward and represent the consumer and carer issues of importance at a national level on relevant committees and government structures</td>
</tr>
<tr>
<td>beyondblue Bulletin Board (BB) &amp; Share Your Story (SYS) web pages</td>
<td>BB: to provide a forum for people affected by depression, anxiety and related disorders to share their own personal experiences of the illness</td>
</tr>
<tr>
<td></td>
<td>SYS: to provide an outlet for people affected by depression, anxiety and related disorders to let others know about their own personal experiences</td>
</tr>
<tr>
<td><strong>Enhanced consumer and carer choice</strong></td>
<td></td>
</tr>
<tr>
<td>beyondblue Infoline</td>
<td>to provide callers access to information and referral to relevant services for depression and related disorders including anxiety, bipolar, postnatal depression, related substance misuse and associated issues</td>
</tr>
<tr>
<td>Mental Health &amp; Insurance Discrimination Project – MHID</td>
<td>to ensure mental health conditions are fully understood by the insurance industry and are treated no differently from comparable physical conditions</td>
</tr>
</tbody>
</table>
Steady progress by blueVoices is indicative of improved consumer and carer networks since its establishment in 2002. There is evidence that the establishment of blueVoices has led to improved consumer and carer networks creating opportunities for information and experience sharing that did not previously exist. beyondblue’s e-network was at 9,650 (as at August 2004) and post 2007, this virtual network has grown to 22,000+ members. Further, as of June 2009, blueVoices has over 400 consumers and carers in its membership. E-network members regularly receive information, with many using beyondblue to communicate directly with the organisation, share information and their stories and raise awareness about depression, anxiety and related disorders. This includes up-to-date information and developments in the areas of depression and beyondblue related to research, programs, resources and events. Members include people with a mental health condition and other interested people including health professionals.

Enhanced consumer and carer choice

In July 2006, beyondblue established an ‘Infoline’ which is a telephone helpline that operates 24 hours a day, seven days a week. The aim is to provide callers with access to information and referral to relevant services for depression, anxiety and related disorders including bipolar disorder, postnatal depression, related substance misuse and associated issues. The service specifically aims to assist callers who experience barriers to accessing information and referrals, for example due to geographic isolation and it has a mandate to follow up callers at particular risk for whom a duty of care obligation has been identified by the Infoline staff. Referrals are made to services with expertise in the treatment of mental health concerns (GPs, psychologists, primary care providers and crisis services).

Infoline staff refer to various service providers with appropriate expertise in support and/or information provision, in areas such as carer support services, government assistance and counselling. Callers ring for information on a range of mental health conditions including depression, anxiety, bipolar disorder, related substance-use disorders, postnatal depression, and eating disorders. The Infoline is advertised on all beyondblue material, including fact sheets, posters, DVDs, booklets, flyers, flipper cards, wallet-sized cards, the drought kit and public forum guide.

The beyondblue Bulletin Board and Share Your Story web pages provide a forum for people affected by depression, anxiety and related disorders to share their own personal experiences of the illness and respond to those of others. beyondblue has received overwhelmingly positive feedback that the Bulletin Board plays a critical role in assisting people affected by depression and anxiety through the giving and receiving of support and by actively participating in the recovery of other people.

Numerous community activities and education campaigns have also occurred through beyondblue. A key activity over this evaluation period has been the rebranding of Ybblue into Youthbeyondblue. Of significance is that this campaign was developed in close consultation with, and featuring young people, including consumers of mental health services, from a range of ethnically diverse backgrounds. An evaluation will be conducted later in 2010 to judge the efficacy and reach of the poster component of this campaign. The target audience for Youthbeyondblue is young people aged 12-25 as well as their friends, parents and families. The aims of Youthbeyondblue are to raise awareness of the signs and symptoms of depression and anxiety specifically in young people, to provide information regarding how and where to seek help and to direct people to the website www.youthbeyondblue.com and the beyondblue Info line 1300 22 4636, in addition to other youth-friendly services such as headspace, Kids Helpline and ReachOut.com. The campaign has also included three television advertisements, three radio advertisements, print ads suitable for newspapers, magazines, posters in public spaces and for use on billboards, plus advertisements for the Internet and the cinema.
Objective 2.3  
Genuine participation by consumers and carers in depression-related initiatives

As indicated by the initiatives described above, beyondblue has a strong consumer and carer arm, with a number of major activities that are led by, or conducted in close collaboration with, consumers and carers. This focus on involving consumers and carers in meaningful collaborations extends beyond the activities classified as being within the consumer and carer Priority Area, and permeates all of the initiatives of beyondblue.

Notably, one of its key achievements in this regard is the Mental Health and Insurance Discrimination Project which resulted in the world’s first Memorandum of Understanding (MoU) signed between the life insurance industry (IFSA) and the Mental Health Sector Stakeholders (MHSS) in 2003. The MoU between the mental health sector and the insurance industry has significantly enhanced the insurance outcomes for people with a past or current history of mental illness. The success of the MoU to date demonstrates the value of a collaborative approach and the challenge is to continue to build on this success. The MoU signatories and the Steering Group participants are committed to working together on this challenge and firmly believe the work plan for the 2008 – 2010 MoU will further improve the life insurance outcomes for those with mental illnesses and their carers.

The beyondblue Infoline provided information, referral and general assistance to 73,129 callers between July 2007 and December 2008. Attempted calls to the beyondblue Infoline have increased substantially since the inception of the service, from 791 calls in July 2006 to 6,755 calls in June 2009. Over the life of the service, calls have increased at an average rate of 150 calls per month. The Infoline continues to be well-utilised with over 6000 calls answered on average every month. Callers are grouped into three categories: a consumer (45%); a third party, e.g. relative or friend (36%); and professionals seeking information (15%). Almost half the callers (44%) ringing with concerns about their own mental health are male. Over 25% of the callers are from regional or remote areas. The service is staffed by designated beyondblue Infoline operators daily from 7:00 a.m. to 22:30 p.m. Monday to Friday and 10:00 a.m. to 22:30 p.m. Saturday and Sunday. Other suitably qualified telephone counselling staff take calls outside of these hours. Review and expansion of service referral information, and options to enhance consumer and carer choice has also occurred.

In addition, the Find a Doctor/Find a Psychologist/Mental Health Professional webpage provides consumers and carers with easily accessible information on available practitioners treating depression, anxiety, bipolar and related disorders at locations closest to them (see Chapter 1). Although beyondblue does not endorse individual practitioners in the list, a national consenting practitioners listing has long been seen as important and is supported by the mental health sector, including the Better Access in Mental Health Initiative members, the Mental Health Council of Australia, Australian Divisions of General Practice, the Australian Psychological Society, Royal Australian & New Zealand College of Psychiatrists, the Australian Medical Association, and the Royal Australian College of General Practitioners. The usefulness and genuine participation of consumers and carers in depression-related initiatives is attested by consumer and carer testimonials and website statistics which prove the wealth of information accessed by them and their testaments on how effective beyondblue resources are to them (refer to chapter 4).
Objective 2.4
Genuine acknowledgement of issues faced by consumers and carers

McNair et al (2002) highlighted key issues in consumer and carer participation in mental health. Of note, the role of GPs in mental healthcare, exclusion in insurance, lack of understanding by health providers and discrimination at workplace were key themes raised. Over time, these issues are being addressed and efforts are in place (some of which are discussed throughout this report) to efficiently and effectively resolve such concerns. The authors also suggested that many of those experiencing depression and anxiety had their basic needs met by health providers, based on the 1997 Australian National Survey of Mental Health and Wellbeing (SMHWB) – also see Chapter 6 (Australian Bureau of Statistics, 1997). Interestingly, the 2007 SMHWB revealed that 2.1 million people of the 3.2 million people with a 12-month mental disorder did not use services for mental health problems but perceived that they had an unmet need, of these, the highest unmet need was for counselling (10%). However, it is worth noting that it is not possible to compare the two surveys due to the different methodologies used in both periods.

Furthermore, the world's first Mental Health First Aid (MHFA) course developed by Kitchener and Jorm (2002) which is being actively supported in many of beyondblue’s current initiatives, has been subject to an intense consensus study with consumers, carers and clinicians (Langlands et al, 2008). This has resulted in the refinement of the MHFA in aiding carers to provide the best possible support to those experiencing depression and facilitate help-seeking behaviours. Several trials have been carried out to evaluate the efficacy of the MHFA course to date. Results showed that the course improved recognition of mental disorders, changes in attitudes and beliefs, and increased confidence in helping someone with a mental disorder. Of significance is the shift in recognising mental ‘disorder’ as opposed to mental ‘illness’ which has contributed immensely to the improved understanding of consumers and carers in mental health. MHFA course success has seen it being widely disseminated across Australia as well as adapted overseas in countries like the UK, Canada and Singapore.

Summary

During the current funding period, under Priority Area 2, beyondblue has clearly maintained focus and extended consumer and carer participation through their initiatives. For this, beyondblue has developed new forms of self-management, predominantly involving online strategies, and initiating programs that strengthen beyondblue’s commitment to responding to consumer and carers needs. There is evidence that these initiatives, particularly blueVoices and the e-network, have led to improved consumer and carer networks. beyondblue e-network currently boasts a membership of 22,000+ post 2007, a growth from 9,650 (as at August 2004), and maintains close links with other relevant organisations such as the Breast Cancer Council Network of Australia and Multicultural Mental Health Australia.

Research in the last funding period showed that quite often the sole support for consumers and carers and their families was provided by community agencies such as beyondblue, the Mental Health Council of Australia (MHCA), with its National Consumer and Carer Forum, and SANE Australia (Highet et al, 2004). In its response to this perceived lack of national coordination, the blueVoices network which promotes the interests of consumers with depression and carers and their families was established by beyondblue. blueVoices is continuing to be highly successful in its accomplishments as a national network for depression and related disorders for consumers and carers since its initiation in the last funding period.

However, the key question remains whether consumers and carers feel more empowered about their situation, and the extent to which they are involved in mental health initiatives targeted at them. Although studies in the previous beyondblue funding period suggested a lack of understanding and awareness by the community and health professionals, to date there is less evidence-base to suggest that consumers and carers are being consulted at every stage and whether they are satisfied or not with current changes made in mental healthcare. beyondblue has certainly initiated many programs that are aimed at raising community awareness and destigmatisation, and educating the health professionals (these are discussed throughout this report); however, empowerment of consumers and carers needs to be further emphasised if beyondblue is to successfully achieve its objectives under this Priority Area.
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Introduction

A good starting point for assessing the impact of beyondblue on programs of Prevention and early intervention is to consider the Standards suggested by the Society for Prevention Research for identifying effective prevention programs and policies (Flay et al, 2005). This involved assessing their efficacy, their effectiveness and their readiness for dissemination. The Society recognised that interventions that are ready for dissemination are a subset of effective programs and policies, and these in turn are a subset of interventions, that are efficacious.

Under these Standards, an efficacious intervention must have been tested in at least two rigorous trials that involved defined samples from defined populations that used psychometrically sound measures and data collection procedures that analysed their data with rigorous statistical approaches. They needed to show consistent positive effects (without serious iatrogenic effects) and report at least one significant long-term follow-up.

An effective intervention needed not only to meet all standards for efficacious interventions, they needed also to have been evaluated under real-world conditions in studies that included sound measurement of the level of implementation and engagement of the target audience (in both the intervention and control conditions). They needed to have manuals, appropriate training, and technical support available to allow third parties to adopt and implement the intervention and to indicate the practical importance of intervention outcome effects and clearly demonstrate to which population groups intervention findings can be generalised.

An intervention that was ready for broad dissemination must meet all standards for efficacious and effective interventions, but must also provide evidence of the ability to be rolled out, together with clear information about what this might cost and be able to make available monitoring and evaluation tools so that adopting agencies can assess how well the intervention works in their settings.

On this basis beyondblue’s funding for Prevention and early intervention programs can be assessed on scientific and policy grounds. On scientific grounds this will be to what extent beyondblue funds studies of programs that demonstrates (or otherwise) their efficacy and effectiveness. On policy grounds, beyondblue’s funding for Prevention and early intervention programs can be assessed on the basis that they promote the delivery of programs that are efficacious, effective and ready for dissemination.

To assist in making this assessment, a bibliography of important studies (meta-analyses, systematic reviews and key articles) including brief descriptions based on edited abstracts is attached in an Endnote at the end of the main report. While many of the areas for Prevention and early intervention funded by beyondblue and identified in the literature are similar, there are some differences. There are many studies in the research literature focusing on depression prevention in primary care including for the Elderly and Internet and self-help.2 There is to date limited research on Young children and Youth outside of schools and Indigenous youth. This reflects in part the focus of beyondblue to include a range of different population groups defined both by stage of life and socio-demographic characteristic.

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2 Depression prevention in primary care including for the Elderly and Internet and self-help projects are largely considered under Primary care in Chapter 7.
Summarising this research:

- preventing depression (considered globally across all settings and stages of life) can be considered to be effective with important reductions in depressive symptoms and depression. There was some difference in the effectiveness of different types of depression prevention programs;
- it is time to start disseminating depression prevention programs, albeit cautiously as many research questions remain unanswered. It is advisable to start with pilot projects for dissemination, combined with research on the effectiveness;
- both selective and indicated school-based prevention programs were more effective than universal programs with small to moderate effects in the short to medium term with longer-term effects being less clearly demonstrated. However, even well established programs require further evaluation to establish readiness for broad dissemination as outlined in the Standards of the Society for Prevention Research;
- primary care patients with sub-threshold depression benefited from minimal contact psychotherapy as a basis for depression prevention and is cost-effective;
- psychological treatment of depression was found to be effective in primary care, especially when GPs refer patients with depression for treatment. There is a range of cost-effective interventions for episodes of major depression which are currently underutilized;
- routinely administered case finding/screening questionnaires for depression in medical practice have minimal impact on the detection, management or outcome of depression by clinicians;
- stepped-care prevention of depression and anxiety in elderly individuals is effective in reducing the risk of onset of these disorders and is valuable as seen from the public health perspective;
- diverse psychosocial or psychological interventions do not significantly reduce the number of women who develop postnatal depression. The most promising intervention is the provision of intensive, professionally based postpartum support. There are no antenatal screening tools that have been shown to be of benefit in predicting postnatal depression. The Edinburgh Postnatal Depression Scale is widely used in the postnatal period to screen for depression. Individualised psychosocial interventions aimed at the at-risk populations and initiated in the postnatal period appear to have some benefit in preventing postnatal depression; evidence of longer-term success is limited;
- a broad range of workplace health promotion interventions appear to be effective, although the effect is small (NWSE has reached only 0.4% of the Australian labourforce);
- self-help interventions, including Internet-guided therapy, for depression and anxiety disorders have medium to large effect sizes.
### Objective 3.1
#### Key initiatives in place

A description of the principal programs in Prevention and early intervention funded by beyondblue is attached in Appendix 3. This includes their aims, objectives, activities, outcomes, presence of an external evaluation study and if so, their designs, methods, findings, conclusions and recommendations. The principal Prevention and early intervention programs and their aims are set out in Table 6.1.

#### Table 6.1: Principal Prevention and early intervention programs and their Aims

<table>
<thead>
<tr>
<th>Program name</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workplace</strong></td>
<td></td>
</tr>
<tr>
<td>National Workplace &amp; Social Enterprise – NWSE</td>
<td>to increase the capacity of Australian workplaces and other identified groups to understand the impacts of depression, anxiety and related disorders, and work actively to prevent these disorders and improve the quality of life of everyone affected, building on National Workplace Program’s (NWP) beyondblue vision</td>
</tr>
<tr>
<td>– Evaluation of NWP</td>
<td></td>
</tr>
<tr>
<td>– National Award</td>
<td></td>
</tr>
<tr>
<td>– Sainsbury Centre of Mental Health UK Pilot</td>
<td></td>
</tr>
<tr>
<td>– Program Session – numbers</td>
<td></td>
</tr>
<tr>
<td>ACT Health Job Stress and Workplace Mental Health Project</td>
<td>to design, develop, deliver and evaluate a workplace mental health promotion program for businesses and other workplaces in the ACT</td>
</tr>
<tr>
<td><strong>Youth in sporting clubs</strong></td>
<td></td>
</tr>
<tr>
<td>Build Your Game (formerly Good Sports Good Mental Health)</td>
<td>to implement structural change within sporting clubs in order to reduce the incidence of alcohol-related problems and to raise awareness of depression and anxiety and available support</td>
</tr>
<tr>
<td>Coach the Coach – CTC</td>
<td>to train key sporting club identities in Mental Health First Aid (MHFA) to support club members and the sporting community to identify and respond to mental health issues early and effectively and to boost awareness and knowledge of mental health issues in general and depression in particular</td>
</tr>
<tr>
<td>Netball Australia</td>
<td>to raise awareness of depression and anxiety in Australia’s netball community and encourage people to seek help early</td>
</tr>
<tr>
<td><strong>Youth in schools</strong></td>
<td></td>
</tr>
<tr>
<td>Secondary Schools Research Initiative – SSRI</td>
<td>to examine how school communities can prevent depression in young people and to alter adolescents’ individual and environmental risk and protective factors to build their resilience, and to reduce depressive symptoms amongst adolescents</td>
</tr>
<tr>
<td>Stay on Track – SOT (Internet-based)</td>
<td>to increase the knowledge of students about how to identify people around them who are suffering from depression and how to respond accordingly, using an interactive and engaging format</td>
</tr>
<tr>
<td>ReachOut Central – ROC</td>
<td>to assist young people in identifying and developing practical coping skills for dealing with life stressors that may be precursors to mental health problems including depression, anxiety and substance use issues through adapting a cognitive behavioural theory for a web-based interactive environment</td>
</tr>
<tr>
<td>Red Frogs Schools Program</td>
<td>to educate young people on the importance of looking after yourself and your friends by supporting the development of a strong sense of self</td>
</tr>
<tr>
<td>Program name</td>
<td>Aim</td>
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<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Red Frogs University Program</td>
<td>to provide alternative activities from the typical drinking culture to young people within the university setting and support them through this transition period with a focus on depression awareness and promotion of help seeking</td>
</tr>
<tr>
<td>Streetsmart</td>
<td>to distribute to all final years high school students a handbook with a focus on depression and a chapter on healthy mind</td>
</tr>
<tr>
<td><strong>Youth – other</strong></td>
<td></td>
</tr>
<tr>
<td>Youthbeyondblue youth training (May 2009)</td>
<td>to provide information of youth mental health, in particular, depression and anxiety to people working within the youth sector</td>
</tr>
<tr>
<td>Phunktional</td>
<td>to engage young people in two different locations in a creative arts program which aims to explore issues and support resilience, confidence and cooperation</td>
</tr>
<tr>
<td>Save A Mate Talk Out Loud – SAM TOL</td>
<td>to provide information sessions to young people to increase awareness of youth mental health, in particular, depression and anxiety and promote discussing and help-seeking around these issues</td>
</tr>
<tr>
<td><strong>Indigenous youth</strong></td>
<td></td>
</tr>
<tr>
<td>Save A Mate Our Way – SAM Our Way</td>
<td>to increase rural and remote Indigenous community capacity to respond to youth social and emotional wellbeing</td>
</tr>
<tr>
<td>Indigenous Hip Hop Projects – IHHP</td>
<td>to facilitate interactive workshops in hip hop dance and music targeting Indigenous youth by engaging participants in positive exercises whilst actively raising awareness and promoting the key messages of Youthbeyondblue – Look, Listen, Talk and Seek Help</td>
</tr>
<tr>
<td><strong>Young children</strong></td>
<td></td>
</tr>
<tr>
<td>Every Family</td>
<td>to prevent/reduce severe behavioural, emotional and developmental problems in children making transition to school by enhancing the knowledge, skills and confidence in parents (based on Triple P – Positive Parenting Program)</td>
</tr>
<tr>
<td>KidsMatter Primary Schools</td>
<td>to improve the mental health and wellbeing of primary school students and to reduce mental health problems amongst students to achieve greater support for students experiencing mental health problems</td>
</tr>
<tr>
<td>Children of a Parent with Mental Illness (COPMI)</td>
<td>(Paying Attention to Self (PATS) – to provide young people (12 – 18 years) who have parents with mental illness the opportunity to share their experiences, be supported, and reduce their risk of developing mental health difficulties</td>
</tr>
<tr>
<td>– Paying Attention to Self (PATS)</td>
<td>(VicChamps) – to provide children (5 – 12 years) who have parents with mental illness the opportunity to share their experiences, be supported, and reduce their risk of developing mental health difficulties</td>
</tr>
<tr>
<td>– VicChamps</td>
<td></td>
</tr>
<tr>
<td><strong>Perinatal</strong></td>
<td></td>
</tr>
<tr>
<td>a) National Postnatal Depression Program – PND (2001-05)</td>
<td>to bring about change in healthcare for women with perinatal depression, to improve outcomes for them and their families, in order to reduce the potentially devastating consequences on current and future generations</td>
</tr>
<tr>
<td>b) National Perinatal Initiative (2008/9-2012/13)</td>
<td>to improve the early detection and prevention of perinatal depression (PD) and to provide better care, support and treatment for expectant and new mothers experiencing depression</td>
</tr>
</tbody>
</table>
Description of some notable well-established and more recent programs

For example, the Secondary Schools Research Initiative had a number of objectives – to reduce levels of depression experienced by young people; to engage whole school communities to promote emotional wellbeing and social connectedness; to increase awareness and understanding of adolescent depression and its impact, including the management of pathways for care; and to increase the capacity of school communities to adapt, implement and evaluate interventions relevant to the prevention of depression.

There were four components for participating schools (25 intervention schools and 25 control schools). These were a community forum, input into the classroom curriculum, supportive environments and pathways for care and education. School Action Teams developed and implemented Action Plans at the start of 2005. Newsletters were published biannually. There were 30 session class curriculum program (10 sessions per year over three years); delivered to the same students in 2003 (Year 8), 2004 (Year 9) and 2005 (Year 10).

Children of a Parent with Mental Illness (COPMI) – Paying Attention to Self (PATS) and VicChamps – aims to provide young people (PATS 12 – 18 years and 5 – 12 years) who have parents with mental health issues the opportunity to share their experiences, be supported, and reduce their risk of developing mental health difficulties. PATS offer peer support groups, co-leadership, leadership training and advocacy, and social events. VicChamps offers programs for children 8-12 years old and 5-7 years old, workforce development (e.g. Getting There Together program), program facilitator networks and network development, family care plans, community education and Supporting Kids in Primary Schools pamphlets and a website.

The evaluation of PATS concluded that it provided a form of early intervention in a model that engages COPMI, provided emotional and practical support, and equipped participants with help-seeking knowledge and skills that built on their strengths. The evaluation of VicChamps concluded that interagency partnerships had been central to the development and running of these activities. Including younger children with their older siblings in the 8-12 year old program had been one successful strategy in attracting children to VicChamps programs. Further, achievements of this program had contributed to the development of the Victorian Government’s 2006 state-wide strategy to support families where a parent had a mental illness.

ReachOut Central aimed to assist young people in identifying and developing practical coping skills for dealing with life stressors that may be precursors to mental health problems including depression, anxiety and substance use issues through adapting a cognitive behavioural theory for a web-based interactive environment. Its activities have included the development of mental health content and ReachOut storylines, development of series of score metres to accompany the mood metre, production of a CD for use in education and clinical settings, ROC awareness campaign and an external evaluation.

Some outcomes for the program include that since September 2007, there have been 121,998 visits to the website. It has 18,818 members, 45% of whom are males. It is acknowledged both nationally and internationally as an innovator in serious gaming. The ReachOut Central curriculum resource was distributed to participating secondary school teachers in the ReachOut.com Teachers’ Network. Ten pilot professional development workshops were conducted in NSW to up-skill teachers in 2008. Three thousand CDs were produced, with 1,532 teachers receiving the resource. ReachOut! Pro, ROC for use with mental health professionals has been launched. An awareness campaign included youth websites, bus/tram interiors, youth magazines, an online competition to win PS3, posters/postcards, media releases and interviews have all been conducted.
While a number of beyondblue programs continue from the earlier funding period, a number of other projects are new and include:

- ACT Health Job Stress and Workplace Mental Health Project;
- the three youth sporting clubs projects (Build Your Game Program, Coach the Coach and Netball Australia);
- the two new Indigenous projects (Save A Mate Our Way – SAM Our Way and Indigenous Hip Hop Projects – IHHP);
- KidsMatter Primary Schools.

For example, the Build Your Game Program aimed to enhance a club’s capacity to promote the health and wellbeing of all members, players and supporters; to use the existing national sporting clubs infrastructure to deliver combined drug and alcohol and mental health interventions; to use the Good Sports program as a vehicle to pilot a project for the promotion of mental health, specifically addressing depression and anxiety and alcohol misuse; to examine to what extent the Good Sports alcohol program, in itself, “passively” enhances the mental health of club members; and to examine whether the Good Sports infrastructure, and the existing community partnerships, could be used to “actively” promote the mental health of club members.

Activities included a three-level accreditation process through which it usually takes 3–5 years to reach Level 3. Two research studies were conducted to address the aims and objectives. Study 1 which was quantitative in nature evaluated the extent to which the Good Sports alcohol program improved the mental health of sports club members and Study 2 made a more qualitative evaluation of mental health interventions within Good Sports clubs. Two thousand three hundred and twelve community sports clubs were involved in the program across Australia, with 1,312 clubs registered in Victoria. There were significantly lower levels of anxiety and stress (but not depression), compared to individuals who belonged to clubs that did not adopt the program. There was evidence of reduced alcohol consumption. In metropolitan communities, increased awareness of mental health was evident among committee members who were actively engaged with the pilot project, but not among the general members, members of the community who attended stress management workshop and women’s tennis program, and members of sports clubs who attended the Club Networks’ Healthy People, Healthy Clubs seminar. In metropolitan communities, there was an increased awareness of mental health among members of both sports clubs.

Assessment: These projects are of different scales and relate to different Standards of the Society for Prevention Research (efficacy, effectiveness and readiness for dissemination). At one end of the spectrum, the Youth in sporting clubs and Indigenous youth are examples of interventions for which evidence is being sought mainly on their efficacy at this stage. At the other end of the spectrum, Every Family was more focussed at studying the level of success of a limited dissemination and its suitability for wide dissemination. The National Postnatal Depression Prevention Program has progressed one further step and is now being disseminated nationally with funding from both Australian and State/Territory Governments, having moved through earlier effectiveness and limited dissemination stages funded by beyondblue.

There can always be debate as to why one project was selected for funding and another not. Every Family illustrates this point well. This project trials a program that addresses an important social problem that is, the deleterious effects of poor parenting skills on early childhood health and development. These skills are associated with maternal mental health. The conduct and study design of Every Family were exemplary including a focus on readiness for dissemination rather than effectiveness, for which there is much evidence in support. On the other hand its focus is only secondarily on depression.

Considered together however, an impressively diverse group of programs has been put in place, covering the principal areas of Prevention and early intervention.³

³ As noted, depression prevention in primary care including for the Elderly and Internet and self-help projects are largely considered under Primary care in Chapter 7.
Objective 3.2
Increase in the number and range of effective prevention and early intervention initiatives for depression

There appeared to be an increase in the number and range of projects funded in this 2005-2010 funding period compared to the earlier 2000-4 period.

Considering effectiveness, this will depend firstly, on the level of evidence in support of these programs as revealed by the research literature. Some programs (e.g. School-based programs) have yet to demonstrate convincing longer-term effects. This will also depend secondly, on the level of research and evaluation accompanying the programs. The majority of these have been funded by beyondblue at a level so as to make possible their evaluation. The level of robustness of the study designs has varied somewhat reflecting to some extent the scope and type of the program being studied. For example, the Secondary Schools Research Initiative and Every Family (as noted) were accompanied by very robust methodologies. Others had substantial, but arguably not the most robust study design possible. This will also reflect funding constraints on beyondblue as often the most robust designs are more expensive. The evaluation of the National Workplace and Social Enterprise Program consisted of a business analysis so as to identify a future sustainable model and method of operations. It did not constitute an evaluation as commonly understood and could be regarded as a missed opportunity. This could perhaps be attributed to the fact that the NWSE is the only beyondblue program that works on a cost recovery basis, and hence, its focus is on a business model. It should also be noted that a key strategy within the business plan for 2009/2010 and beyond is to review evaluation and effectiveness of the program. Further, the National Workplace Program works closely with the beyondblue Employment and Workplace Program which has a complementary focus on research, policy and best practice. The ACT Health Job Stress and Workplace Mental Health Project gave very proper attention to research and evaluation.

In summary then, there has been an increase in the number and range of studies with due regard to their known effectiveness or where this is not known with due regard to establishing this.

Objective 3.3
Systemic changes in the health sector and beyond (e.g., in families, schools, workplaces and communities) that support prevention and early intervention efforts

Systemic changes in the health sector and beyond will reflect many things. It will reflect the extent of the achievement of beyondblue but also other agencies that are also seeking this objective. Given that the provision of programs here is quite small currently, it is possible that these systemic changes could occur in the short-term at least through the establishment of new programs funded by these agencies. For the longer-term it is more likely to require that beyondblue (and others) are successful as advocates to governments and they commit funding for the expansion of these programs.

It will also depend on the state of the evidence on the efficacy and effectiveness of depression prevention programs. For example, School-based programs have yet to demonstrate convincing longer-term effects, as noted and are not yet at a stage where they are suitable for wider dissemination. However, the KidsMatter Primary Schools evaluation is promising: a pilot phase was trialled in 100 schools across Australia during 2007-2008. Fifty of the schools ran KidsMatter during the 2007 and 2008 school years. The remaining schools undertook KidsMatter during the 2008 school year. A consortium based in the Centre for Analysis of Educational Futures at Flinders University undertook an evaluation of the two-year trial. (Slee et al, 2009)

Findings were that statistical and practically significant improvement had occurred across all four components of the KidsMatter framework. There had been practically significant improvement in students’ measured mental health, in terms of both reduced mental health difficulties and increased mental health strengths. The impact was more apparent for students who were rated as having higher levels of mental health difficulties at the start of the trial.
There was substantial similarity in the findings for schools formally involved in KidsMatter for one year and for schools formally involved over two years. However, there were some measures that showed stronger effects in the schools involved for two years.

The study concluded that KidsMatter appeared to have had an impact on and changed schools in multiple ways. These included holistic changes associated with school culture and approaches to mental health difficulties, as well as serving to strengthen protective factors within the school, family and child. Importantly, KM was associated with improvements in students measured mental health, especially for students with higher existing levels of mental health difficulties. The evaluation findings showed that the KM trial was associated with a systematic pattern of changes to schools, teachers, parents and students. The outcomes of the KM trial are consistent with an emerging body of national and international literature that a ‘whole school’ approach can be protective for students, promoting mental health and helping to enhance academic and social competencies.

The study recommended that:

- the broad framework, processes and resources of KidsMatter be maintained as the basis for a national roll-out;
- additional support be provided for school communities to consolidate and develop the four components, with a particular emphasis on Components 3 and 4: Parent support and education and Early intervention for students who are experiencing mental health difficulties;
- guidelines be provided regarding strategies to enhance the quality of the KidsMatter implementation, and attention be given to the role of leadership in developing and sustaining KidsMatter, because effective leadership provides the foundation for the school and its staff to fulfil the potential of KidsMatter.

Through beyondblue’s funding capacity it has been able to fund a diverse range of Prevention and early intervention programs and through these alone it has been able to produce systemic change. In addition, beyondblue has been able to exercise a key role as an advocate in the decision of the Federal and State Governments to allocate substantial funds in this area, e.g. the National Postnatal Depression Prevention Program. This is a considerable policy achievement for beyondblue, bearing in mind that the Program progressed through earlier effectiveness and limited dissemination stages funded by beyondblue which has also supported the funding of a number of research projects on postnatal depression.²

There is, however, one caveat, that is the move to national rollout could be argued to be premature. This is because postnatal depression prevention programs do not as yet satisfy the Standards of the Society for Prevention Research as being ready for widespread dissemination. It will be important therefore that both beyondblue and the participating governments retain a research interest in the program (as is intended) to support the knowledge base concerning their effectiveness.

In broad though, the objective of producing systemic changes can be regarded as having been achieved.

**Objective 3.4**

**Increase in the proportion of people with depression who seek professional help early**

This will clearly be affected not only by the achievements of beyondblue but other events such as a change in fees and co-payments on Medicare payments. Nevertheless it is important that it be measured because it is such a key measure of both this Priority Area (3) Prevention and early intervention but also Priority Area 1 Community awareness and destigmatisation.

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² A similar sort of progression has occurred with KidsMatter for which the Commonwealth Minister for Health and Ageing announced $18.7 million additional funding on 6 October 2009 which will allow quadrupling of the KidsMatter program.
Jorm et al (2005) have reported changes in beliefs about some treatments for depression, particularly counselling and medication, the benefits of help-seeking in general as well as recognition of depression. These changes were also generally greater in those Australian States with greater exposure to beyondblue. Thus, in a case vignette presented to samples of the Australian population in 1995 and 2003-4, there was a change of 31% in the recognition of depression from 37% to 68% in high exposure States and change of 25% from 42% to 67% in low exposure States. This is supportive of the notion that a higher proportion of people with depression will seek professional help early. It does not however constitute good evidence that this has in fact happened.

The only source of data relevant to this are the National Survey of Mental Health and Wellbeing: Summary of Results, 2007 and the Mental Health and Wellbeing: Profile of Adults, Australia 1997. Tables are presented for service use (by type of service) for persons with affective disorders in both reports. In general, the ABS counsels caution in comparing results in the two reports due to the differences in data collection methodology in the two surveys.

In summary then it is difficult to estimate whether there has been an increase in the proportion of people with depression who seek professional help early due to a gap in evidence as well as in difficulties in interpreting the data. This gap is significant as it is therefore impossible to assess whether such a key measure of both this Priority Area 3. Prevention and early intervention but also Priority Area 1 Community awareness and destigmatisation has been achieved.

Objective 3.5  
Reduction in risk factors and promotion of protective factors

While this is a valid higher-order objective for assessing beyondblue’s achievement, it is not really possible to operationalise this objective so as to isolate beyondblue’s contribution compared with the large number of other factors such as the Global Financial Crisis which did not exist at the beginning of this funding period.

In summary, it is not possible to assess whether there has been a reduction in risk factors and promotion of protective factors as a result of the activities of beyondblue.

Summary

A summary of beyondblue’s achievements considered against this hierarchy of objectives in the current funding period echoes those for the earlier funding period. These are that:

- an impressively diverse group of programs has been put in place, covering the principal areas of Prevention and early intervention both expanding and developing on the programs existing in the earlier funding period;
- there has been an increase in the number and range of programs where the effectiveness (or not) has been more definitively established;
- more systemic change has occurred (though clearly is not complete);
- it is not currently possible to estimate whether there has been an increase in the proportion of people with depression who seek professional help early or whether there has been a reduction in risk factors and promotion of protective factors as a result of the activities of beyondblue.

In addition it is also concluded that, as depression prevention programs move from demonstrating efficacy, effectiveness to readiness for dissemination, it is necessary to observe the Standards of the Society for Prevention Research.

It is also concluded that it is now urgent to close the gap in evidence concerning the proportion of people with depression who seek professional help early as this is a key measure of both Priority Area 3 Prevention and early intervention but also Priority Area 1 Community awareness and destigmatisation.
References


Chapter 7
Objectives achieved under Priority Area 4 (Primary care)

Introduction
A good starting point for assessing the impact of beyondblue in Primary care is again the Standards suggested by the Society for Prevention Research (Flay et al, 2005). While primary care involves treatment even more than prevention, the same need to assess the efficacy, effectiveness of a program and its readiness for dissemination still apply. A bibliography of important studies (meta-analyses, systematic reviews and key articles) including brief descriptions based on edited abstracts is attached in an Endnote at the end of the main report as well as for preventing depression in general practice in the Endnote to Prevention and early intervention.

Summarising this research:
• psychological treatment of depression was found to be effective in primary care, especially when GPs refer patients with depression for treatment;
• in moderately severe depression, all recognised antidepressants, cognitive behavioural therapy and interpersonal psychotherapy are equally effective. Its cost-effectiveness for moderate depression is more uncertain from current evidence;
• in severe depression, antidepressant treatment should precede psychological therapy. For depression with psychosis, electroconvulsive therapy (ECT) or a tricyclic combined with an antipsychotic are equally helpful; Combination therapy (antidepressants and psychological therapy) is likely to be a cost-effective first-line secondary care treatment for severe depression;
• depression has a high rate of recurrence and efforts to reduce this are crucial.

Objective 4.1
Key initiatives in place
A description of the principal programs in Primary care funded by beyondblue is attached in Appendix 4. This includes their aims, objectives, activities, outcomes, presence of an external evaluation study and if so, their designs, methods, findings, conclusions and recommendations. The principal Primary care programs and their aims are set out in Table 7.1.

Description of some well established and more recent notable programs
For example, the objectives of the Aboriginal Mental Health Worker Program were to train, mentor and provide ongoing support to Aboriginal Mental Health Workers (AMHWs), to develop a role for AMHWs and integrate them into clinical practice as members of a community-based mental health team, to provide effective health care practices through application of local cultural knowledge and expertise of AMHWs and to improve the level and quality of mental health care services assessed by participating community members. A series of ‘Learning Both Ways’ workshops for AMHWs, GPs and mental health staff were delivered at the Batchelor Institute of Indigenous Tertiary Education in 2000. Six participating communities established AMHW programs and three AMHWs have also graduated with Certificate III in Community Health (Non-Clinical) and enrolled in Certificate IV.
While a number of programs continue from the earlier funding period, a number of other projects are new, these include:

- Aboriginal Mental Health Worker Program
- Mental Health Aptitudes into Practice (MAP) Training Program (not included in Table 7.1)
- diamond Project (funded 2003/4)
- Primary Care Evidence-based Psychological Interventions – PEP study (funded 2003/4)
- RANZCP Australian Indigenous Mental Health Website
- AGPN Primary Care Youth Mental Health Initiative (Young Minds Training Program)

For example, the diamond Project has as its aim to raise the profile of primary care depression research and draw together researchers, practitioners, consumer groups and Divisions of General Practice who shared this research interest.

Table 7.1: Principal Primary care programs and their Aims

<table>
<thead>
<tr>
<th>Program name</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of treatment</strong></td>
<td></td>
</tr>
<tr>
<td>NHMRC Depression in Adolescents and Young Adults Clinical Practice Guidelines</td>
<td>to develop current clinical practice guidelines for depression in adolescents and young adults based on new data, burgeoning research in the area and changes in community awareness, policy and services over the last decade</td>
</tr>
<tr>
<td>NHMRC Perinatal Depression and Related Disorders Clinical Practice Guidelines</td>
<td>to assist in improving prevention and early detection of antenatal and postnatal depression (perinatal depression) and related disorders and improve the support treatment for expectant and new mothers experiencing depression, anxiety, puerperal psychosis and bipolar disorder</td>
</tr>
<tr>
<td><strong>Depression innovations and the primary care system</strong></td>
<td></td>
</tr>
<tr>
<td>RANZCP Australian Indigenous Mental Health Website</td>
<td>to achieve better health outcomes for the Aboriginal and Torres Strait Islander community through supporting health professionals in improving knowledge and understanding of Aboriginal and Torres Strait Islander mental health issues</td>
</tr>
<tr>
<td>Aboriginal Mental Health Worker Program</td>
<td>to empower Aboriginal mental health workers in order to improve the quality of mental health care services in remote Indigenous communities</td>
</tr>
<tr>
<td>AGPN Primary Care Youth Mental Health Initiative</td>
<td>to develop a training program for GPs, practice staff and allied health professionals focusing on skills development in the diagnosis, management and treatment of high prevalence mental health disorders commonly occurring in young people</td>
</tr>
<tr>
<td><strong>Depression research in primary care</strong></td>
<td></td>
</tr>
<tr>
<td>National Heart Foundation Strategic Research Partnership</td>
<td>to build research capacity and to contribute to better understanding of the links between depression and cardiovascular disease</td>
</tr>
<tr>
<td>diamond Project</td>
<td>to raise the profile of primary care depression research and draw together researchers, practitioners, consumer groups and Division of General Practice who shared this research interest</td>
</tr>
<tr>
<td>Primary Care Evidence-based Psychological Interventions – PEP study</td>
<td>to evaluate the impact of general practitioner (GP) training in Cognitive Behavioural Therapy (CBT) skills using randomised controlled design</td>
</tr>
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The diamond Consortium activities have focused on four key areas: communication strategy, research program, seed funding and capacity building.

The communication strategy has consisted of the development of Consortium website, circulation of newsletters Australia-wide and internationally, dissemination of information via radio interviews, articles published in primary care and local newspapers, presentations at forums, conferences and meetings nationally and internationally and policy input.

The research program resulted from the 2003 diamond pilot study which acted as a catalyst for the development of further research projects and research capacity building in mental health and depression research in primary care. Success of the pilot enabled to secure successful NHMRC grant and beyondblue VCoE applications. The diamond study findings are being used to inform the development of general practice based models for depression care that suit the Australian health care setting through the re-order study. Seed funding was awarded to seven projects.

The diamond Consortium has built research capacity in primary care mental health by supporting the careers of early career researchers, young researchers and research students. On the whole, the diamond Consortium has enabled the development of a comprehensive program of primary care mental health research and has increased the research capacity for this work in Victoria.

The Primary Care Evidence-based Psychological Interventions program aimed to evaluate the impact of general practitioner (GP) training in CBT skills using a RCT design. This was assessed by increased GP knowledge, efficacy, practice and quality of CBT as well as improved clinical outcomes and consumer satisfaction for patients. The main findings were that GP confidence and skills had increased substantially. However, patients of intervention GPs improved no more than those of control GPs, and both groups still had significant depressive symptoms at three months. Patient interviews suggested that though they were satisfied with their experiences of care, they supported the idea that GPs work collaboratively with specialist mental health providers.

The National Heart Foundation/beyondblue Strategic Research Partnership as well as the beyondblue Research Report: 2001 – 2007 are discussed further in Chapter 8 (Objective 5.1). Bettering the Evaluation And Care of Health Project – BEACH is also discussed further in Chapter 8 (Objective 5.3).

Assessment: There has been a considerable expansion of Primary care programs in the current period compared to the previous funding period. The diamond program is particularly notable.

**Objective 4.2**

**Improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression**

This expansion has been associated with an expansion in research and evaluation relating to primary care and clinical care relating to disease groups more generally. These include the National Heart Foundation Strategic Research Partnership, the Priority-driven Collaborative Cancer Research Scheme as well as partnerships with the Prostate Cancer Foundation of Australia and Breast Cancer Network of Australia.

The evaluation activities have been very important in establishing how effective the programs are, whether they should continue in the future and if so, how they might be improved. The increase in capacity of practitioners and researchers depression prevention and treatment in primary care in the diamond program is significant. It is an important (though disappointing) advance to have evidence that, despite increases in GP confidence and skills in CBT, there have been to date no improvements in depressive symptoms of patients of GPs at three months in the PEP study. It will clarify, all else being equal, how programs must need to change in the future to produce improvements in patients’ conditions.

Assessment: It is therefore possible to conclude that there have been real ‘improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression.’
Objective 4.3
Increase in community education and treatment roles of primary care practitioners

The 2004 evaluation report noted that beyondblue had also supported the primary care initiatives of the Australian Government in mental health. Most prominent then was the Better Outcomes in Mental Health Care (BOIMHC) (Australian Government, 2009a). The program has two principal components – Access to Allied Psychological Services (ATAPS) that enables GPs to refer consumers to allied health professionals who deliver focused psychological strategies and GP Psych Support which provides GPs with access to patient management advice from psychiatrists.

Access to Allied Psychological Services (ATAPS) include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications. Through ATAPS, patients are eligible for a maximum of twelve sessions per calendar year – six time-limited sessions with an option for a further six sessions following a mental health review by the referring GP. Sessions can be individual and/or group therapy sessions. ATAPS aims to provide patients with assistance for short-term intervention. Divisions of General Practice act as fund holders in this component of the BOIMHC program. Appropriate mental health training can help GPs to further develop and improve their skills in diagnosing, treating and referring patients with mental disorders to appropriate services. It is strongly recommended that GPs participate in appropriate mental health training, such as that accredited by the General Practice Mental Health Standards Collaboration.

Fletcher et al (2009) have evaluated ATAPS. The program has established itself over time as a cornerstone of mental health service provision in Australia. It attracts substantial numbers of general practitioners and allied health professionals and delivers services to significant numbers of consumers, the majority being women with high prevalence disorders who may have had difficulty accessing mental health care in the past.

beyondblue acted as a catalyst for the BOIMHC in a number of ways. The organisation sensitised the community to the significance of depression and anxiety as public health problems, drew together the evidence in a coherent manner, developed a high profile and was able to be a vocal advocate having a lead role in meetings at Parliament House in Canberra. Finally, beyondblue brought to bear a multidisciplinary perspective that was important for decision makers.

The interim evaluation of the BOIMHC showed that in the early months of its existence there had been considerable activity both by large numbers of participating GPs (the three-step mental health processes and sessions of focused psychological strategies defined under the scheme at this time) as well as by the allied health professionals associated with the initiative (Hickie et al, 2004).

Nevertheless the latest data available to the 2004 report from the Bettering the Evaluation and Care of Health (BEACH) Project, which collects annual data on general practice encounters did not indicate any change in GP management of depression (Australian Institute of Health and Welfare, 2004). Depression in 2004 was managed in 3.5% of all general practice encounters in 2002-2003, a level that has remained stable since 1998-1999, when the BEACH Project commenced. The 2004 report noted that these proportions will increase as the BEACH data ‘catch up’ to the Better Outcomes in Mental Health Care data.

Two developments since 2004 are important here. First, the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative has been established (Australian Government, 2009a). It complements BOIMHC which continues in the modified form, set out above. Medicare rebates are available for general practitioners (GPs) to provide early intervention, assessment and management of patients with mental disorders, as part of a GP Mental Health Care Plan. A GP Mental Health Consultation item plus review item are available for general practitioners to provide continuing management of patients with mental disorders.
Medicare rebates are also available for up to twelve individual and twelve group allied mental health services per calendar year to patients with an assessed mental disorder who are referred by designated medical practitioners. Allied mental health services under this initiative include psychological assessment and therapy provided by eligible clinical psychologists, and focussed psychological strategies provided by eligible psychologists, social workers and occupational therapists.

Second, the low proportion of cases of depression managed by GPs, noted in the 2004 reports has well and truly ‘caught up’ with the Better Outcomes in Mental Health Care data, which should now be understood to include activity under the Better Access program. During the 2008/09 financial year, around 2.7 million Better Access Medicare subsidised mental health services were accessed by Australians living with mental illness.

As measured by BEACH, this has led to a significant increase in the management of all psychological problems between 2002–03 and 2007–08, after the introduction of the 2002 BOIMHC initiative and the subsequent 2006 Better Access initiative:

- a significant increase in the management rate of depression from 1998–99 to 2007–08;
- a significant increase in the rate of psychological counselling for depression management between 1998–99 and 2001–02 and for anxiety management between 1998–99 and 2002–03;
- a significant decrease in the use of clinical treatments (apart from psychological counselling) after 2004–05;
- a significant increase in the rate at which patients with depression and anxiety problems were referred, with a significant shift in referral patterns for patients with depression from psychiatrists to psychologists associated with the introduction of the MBS items for psychologist services.

Furthermore, encounters involving the management of depression, anxiety and drug and alcohol problems are, on average, longer than those where they are not managed. There was no difference between patients from major cities and those from outside major cities in the proportion of psychological encounters covered by either the BOIMHC or Better Access item numbers, nor was there a difference between them in the proportion referred to a psychologist before or after the Better Access Initiative was introduced. No difference was found between patients from disadvantaged areas and advantaged areas in the proportion of psychological encounters that were covered by BOIMHC or Better Access Initiative item numbers.

There have also been other significant developments during the current funding period with the production of NHMRC evidence-based guidelines on depression. Beyondblue has been influential in the development of the NHMRC Clinical Practice Guidelines for Depression in Adolescents and Young Adults and for Perinatal Depression and Related Disorders. For example, it formed two committees of experts to update these NHMRC Clinical Practice Guidelines for Depression. These build on the earlier evidence-based guidelines on depression in primary care commissioned by Beyondblue (Ellis, Smith, 2002).

Assessment: there has been a major increase in the availability of primary care services for the treatment and early intervention for depression Australia-wide since the earlier 2004 report.

Summary

There has been a considerable expansion of Primary care programs in the current compared to the previous funding period. The diamond program is particularly notable. There have also been real ‘improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression’. There has been a major increase in the availability of primary care services for the treatment and early intervention for depression Australia-wide since the earlier 2004 report. There have also been other significant developments during the current funding period with the production of NHMRC evidence-based guidelines on depression that were initiated by Beyondblue.

Together, these changes permit this 2009 report to conclude that there has been a sea change in the availability of primary care services for the treatment and early intervention for depression Australia-wide since the earlier 2004 report.
This has occurred through the establishment of Better Outcomes in Mental Health Care including Access to Allied Psychological Services (ATAPS) that enabled GPs to refer consumers to allied health professionals who delivered focused psychological strategies. A few years on this led on to the establishment of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) Initiative. Together, these programs have been responsible for a significant increase in the management of all psychological problems including depression. This has been associated with an increase in psychological counselling for depression and anxiety management which in turn has led to a significant decrease in the use of clinical treatments (apart from psychological counselling) and a significant increase in the rate at which patients with depression and anxiety problems have been referred to psychologists.

 beyondblue has been an important advocate for the establishment of Better Outcomes and Better Access. In addition, through the funding of the diamond and PEP programs, and similar programs as well as support for the further development of evidence-based guidelines, beyondblue have been able to substantially increase capacity in both depression training and research in primary care.

References


Introduction

Jorm et al (2001) reviewed research activities in the area of mental health in the period prior to the establishment of beyondblue. They concluded that depression was under-researched, accounting for only 15% of journal publications and 13% of academic grant funding, yet it contributes the highest disease burden and was consistently rated as a priority by stakeholders. In addition, very little research was carried out in primary care or in the community, despite these settings being viewed as more appropriate for such research than specialist settings. Similarly, research on prevention and promotion, evaluations of mental health services, and investigations of training and education of mental health professionals were poorly represented in terms of publications and grants, but were viewed as high priorities by stakeholders.

It is important therefore that beyondblue accords high priority to conducting quality research to address gaps in knowledge about depression, anxiety and related substance use disorders. The beyondblue Victorian Centre of Excellence in Depression and Related Disorders is a joint initiative of the Victorian Government and beyondblue. Many beyondblue programs have a strong research and evaluation component.

Objective 5.1
Key initiatives in place

A description of the principal programs in Targeted research funded by beyondblue is attached in Appendix 5. This includes their aims, objectives, activities, outcomes, presence of an external evaluation study and if so, their design, methods, findings, conclusions and recommendations. The principal Targeted research programs and their aims are set out in Table 8.1.

An ongoing commitment to supporting the development of evidence-based practice in Australia and advancing knowledge about depression is included in the remit of beyondblue. As a result, beyondblue has supported a range of research initiatives and partnerships. These are detailed in the beyondblue Research report 2001-2007 but several warrant particular mention here (beyondblue, 2008).

beyondblue auspices the Victorian Centre of Excellence in Depression and Related Disorders (bbVCoE), which is funded as part of the Victorian Government’s contribution of $3.5 million per annum to beyondblue. Launched in 2002, the Centre supports innovative, high quality research across disciplines to improve prevention and treatment of depression, anxiety and related disorders, thereby enhancing Victoria’s research base and reputation. It supports three types of grant funding: (a) consortia grants of up to $500,000 per annum to undertake research in Victoria on issues of national significance; (b) large grants of more than $100,000 per year, which can be offered for up to three years; and (c) small grants of up to $100,000, awarded for an initial 12-month period, which may be renewable (beyondblue website).
Research supported via the bbVCoE during this evaluation period has been funded via a series of annual funding rounds and falls into the following categories: Depression and Chronic Illness; Depression in Primary Care Settings; Depression and Youth; Depression and Substance Use Disorders; Depression and Older People; Depression and Intellectual Disability; Bipolar Disorder; Depression in Culturally and Linguistically Diverse Communities; Postnatal Depression; Depression in Rural and Remote Communities; Mental Health and E-health; Indigenous Communities and Depression; Consumer and Carer Experiences of Depression; and Depression in Men. As of March 2009, 103 projects had been funded, of which 53 were complete (beyondblue website; beyondblue, 2008).

beyondblue also supports research partnerships such as the Cancer Australia Partnership which aims to fund strategic research into Cancer and Depression through the Priority-driven Collaborative Cancer Research Scheme. Two funding rounds have been conducted under the auspices of this partnership, the first in 2008 and the second in 2009. At the time of writing applications under the 2009 scheme were being assessed but examples of successful applicants in 2008 include:

- Improving the Psychosocial Health of People with Cancer and their Carers: A Community-Based Approach;
- Understanding the psychosocial consequences of surviving testicular cancer;
- Psychological morbidity, unmet needs, quality of life and patterns of care in migrant cancer patients: The first year; and
- A web-based intervention to reduce distress and improve quality of life among younger women with breast cancer: A Randomised-controlled Trial.

Another key partnership is between beyondblue and the National Heart Foundation: a Strategic Research Partnership through which research is funded up to the value of $5 million in the area of depression and cardiovascular disease (CVD). As above, two funding rounds have been conducted and examples of projects funded include:

- A randomised-controlled trial of a web-based intervention to improve depression, cognitive function and adherence in people with CVD;
- A longitudinal study of dietary risk factors for CVD (metabolic syndrome) and depression in adolescence;
- A study of the acceptability and effectiveness of a system based approach to reducing CV risk, including depression and lifestyle risk factors in rural and remote general practices – A Randomised Controlled Trial; and
- A study of Depression and CVD in a cohort of middle aged Australian women.

Since the previous evaluation beyondblue has supported two further supplements in the Medical Journal of Australia with the aim of highlighting Australian research into depression and related disorders. In October 2004, beyondblue supported a supplement entitled Depression: Reducing the Burden; in June 2008, it supported a supplement entitled Depression and Primary Care and in April 2009, it supported a supplement entitled Depression and Anxiety with Physical Illness (see also Chapter 4).

In addition to the above, beyondblue conducts some of its own research, and requires all of its funded programs and projects to devote a significant proportion of their budgets to detailed evaluations (beyondblue website).
Objective 5.2  
Increase in targeted research activities aimed at increasing knowledge about depression

As noted by the previous evaluation (Pirkis, 2004), Jorm et al (2001) provide useful baseline information against which to assess whether the above initiatives have led to an increase in targeted research activities aimed at increasing knowledge about depression. These authors reviewed research activities in the area of mental health in the period prior to the establishment of beyondblue. They concluded that depression was under-researched, accounting for only 15% of journal publications and 13% of academic grant funding, yet it contributes the highest disease burden and was consistently rated as a priority by stakeholders. In addition, very little research was carried out in primary care (3% of publications and 10% of grant funding) or in the community (30% of publications and 21% of grant funding), despite these settings being viewed as more appropriate for such research than specialist settings. Similarly, research on prevention and promotion, evaluations of mental health services, and investigations of training and education of mental health professionals were poorly represented in terms of publications and grants, but were viewed as high priorities by stakeholders.

Ideally, the current evaluation would have repeated this exercise in order to ascertain whether there has been an increase in targeted research activities aimed at increasing knowledge about depression since the establishment of beyondblue. However, as previously this was beyond its scope, but it was possible to quantify the research projects that have received direct support from beyondblue (as well as some that have received indirect support).

Table 8.1 shows the research that has been funded by beyondblue through the bbVCoE between 2005 and 2008. Additional funding rounds were conducted in 2009 but at the time of writing the outcomes of these rounds are not known. This table indicates that between 2005 and 2009 the bbVCoE has funded 63 research studies in the area of depression and related disorders via annual funding rounds which is more than the fifty projects funded during the earlier funding period. This figure is an underestimate of all beyondblue research as it does not include the evaluations of beyondblue funded projects or projects conducted as part of core work programs some of which have a strong research focus, such as the beyondblue Postnatal Depression Program, the Every Family Initiative, the beyondblue National Workplace Program and the beyondblue Schools Research Initiative.

Each of these studies has gone through a rigorous selection process, involving a review of its feasibility, scientific merit and ‘fit’ with beyondblue’s priorities. The magnitude of this research output is impressive, and it is reasonable to assume that it equates to an increase in targeted research activities aimed at increasing knowledge about depression. Even if there has been some decrease in funding for depression-related studies by other bodies (e.g., the National Health and Medical Research Council, the Australian Research Council, the Australian Rotary Health Research Fund), it is likely that there has been a net gain in terms of aspects of depression that are the focus of beyondblue’s interest; and indeed there has been an increase of effort since the previous evaluation was conducted.

Beyond merely quantifying the number of projects, it is also possible to consider the nature of these projects, and whether their profile matches the priorities previously identified by Jorm et al (2001). The previous evaluation identified that a large number of projects funded between 2002 and 2004 was being carried out in a primary care setting or in specific communities; many had a focus on prevention and promotion and/or on evaluations of mental health services, and a number involved investigations of training and education of mental health professionals. Many of these projects are now completed and their findings published.
It is noted that the VPHREC Population Health Committee’s earlier review was critical of beyondblue’s program of research, describing it as lacking strategic direction (Population Health Committee, 2003). It observed that ‘an investigator-led grants program does not represent an effective public health strategy … [and] … consideration should be given to the commissioning of research in identified Priority Areas of both prevention and treatment coupled with a carefully developed plan of capacity building …’ (Population Health Committee, 2003). Since then beyondblue appears to have developed a more strategic focus in its approach to funding research with the development of strategic partnerships (see above) and designated funding rounds on specific Priority Areas. For example, 2008 and 2009 saw funding rounds specifically targeting one of beyondblue’s Priority Areas – depression and chronic illness with funding rounds seeking projects about depression and cancer and depression and cardiovascular disease.

The review of the Victorian Centre of Excellence in Depression and Related Disorders by Plexus Consulting 2005 concluded that:

• The beyondblue Victorian Centre of Excellence for Depression and Related Disorders in a short period has stimulated a large amount of activity in research into depression and related disorders. It devised a multi-tiered system of grants which allowed funding of a number of significant major projects, but also made provision for the funding of a wide diversity of researchers and programs for developmental or seeding activities. This strategy has been successful and is widely supported by grant recipients. One indicator of its success is the large proportion of researchers who have received seeding or development funding that have gone on to attract other, larger grants.

Up until now, VCoE processes however have been more oriented to the management of individual contracts than to capturing and driving an overall program of work. The review recommended:

• Proactive, systematic capacity building [that is, to expand the range of participating researchers], their ability to conduct quality research, and their connections with other researchers, and to increase the ability of organisations to develop integrated and developing research programs

• Management of a research agenda including integration of knowledge and support for utilisation [that is, actively developing programs of research based on a clear identification of knowledge gaps and policy needs], and supporting the systematic integration of research findings to meet policy needs and to guide the future development of the research program.
### Table 8.1: Research funding through the *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders (2005 to 2008 funding rounds)

#### Grant round 2005
- **beyondblue** VCoE Research Project: The *beyondblue* training program for professional carers in recognising late-life depression
- Consumer Evaluation of Intervention Guidelines for Intimate Partner Abuse and Depression in General Practice
- Depression in People with Intellectual Disability
- A preliminary investigation into the validity of techniques aimed at the therapeutic amelioration of post stroke depression
- Time for a future: Effective treatment of depressed youth in urban and rural primary care settings
- Rural carers on line: A feasibility study
- Toward Parenthood: An Antenatal Self-Help Intervention for Depression, Anxiety & Parenting Difficulties
- Optimising emotional health during pregnancy and early parenthood
- A Randomised Controlled Trial of a Letter Intervention in Primary Care Patients to Improve Depression and Anxiety Disorders
- Regenerate: A strength-training program to enhance the physical and mental health of chronic post stroke patients with depression
- A pragmatic trial of a ‘stepped care’ intervention for people with depression and cardiac failure
- Extending the Emotional and Lifestyle Impact of Type 2 Diabetes Pilot Project
- Treatment for depression: A qualitative exploration of the experiences of alcohol and drug users
- An inter-professional intervention to detect and manage postnatal depression among drug-dependant, pregnant women
- Automated longitudinal monitoring to predict and counter relapse in Bipolar Disorder
- Effective management of school refusal and childhood anxiety as a community based early intervention to prevent subsequent depression
- A 3-8 year follow-up of adolescents treated for depression and their families: Predictors of treatment outcome
- Multicultural Information on Depression online (MiDonline): Development of an IT resource to improve depression literacy and assist in pathways to mental health care for people of CALD backgrounds
- Re-orientating general practice towards preventative mental health care for adolescents, utilizing the practice nurse: A pilot study
- Novel ways of capturing adolescent depression.

#### Grant round 2006
- **MoodSwings**: An online intervention program for bipolar affective disorder
- The impact of antidepressants on men and their partner's sexual desire, sexual functioning and intimate relationship
- Ensuring best practice in terms of maintaining and seeking employment for people with depression and related disorders: An evaluation of the Disability Open Employment Services program
- Development of depression first aid standards for indigenous Australians
- Helping smokers with a history of depression quit smoking safely: Depression and smoking cessation outcomes among clients of a tailored Quitline call-back service offering doctor-Quitline co-management of smoking cessation and depression
- Problem gambling and depression: a prevalence study
- Toward the identification and minimisation of depression and psychological distress in family caregivers of people receiving palliative care
- Specialist mental health consultation in the treatment of depression in nursing home residents with dementia
- Reducing suicide risk in men through general practice (the SiM Study)
- Evaluation of a best practice integrated intervention for regular methamphetamine users with co-morbid depression
- Determining the effectiveness of a new model of care for young people with substance misuse disorder
- Does Interpersonal Psychotherapy improve clinical care for adolescents with depression attending a rural child and adolescent mental health service?
- Evaluating evidence-based treatment of depression in adolescents using Acceptance and Commitment Therapy (ACT) delivered in rural/regional services.
Grant round 2007

• Improving Inter-Personal Communication as a means of Reducing Post-Stroke Depression in Patients Living in the Community
• An investigation into the effectiveness of CBT Group on anxiety and depression in a disease specific versus a generic chronic disease management model
• MoodSwings: an online intervention for bipolar affective disorder. (Extension of 2006 Grant).
• An investigation of levels of psychological distress (depression and anxiety) and unmet needs amongst people diagnosed with head and neck cancer
• Motivational Interviewing based Health Coaching as an Early Intervention for the Prevention of Depression in Type II Diabetes in an Australian Regional and Rural population
• Type 1 diabetes as a risk factor for depression and other adverse outcomes for young people in rural Australia
• Screening and Management of depression in cardiac settings: An examination of clinical practice and a National study of prevalence of screening for depression by cardiologists and their beliefs regarding screening and management
• A Program for Prevention and treatment of depression in people with intellectual disability: an extension and evaluation of a roll out into the community. (Extension of 2005 Grant).
• Development of alcohol misuse first aid guidelines for Indigenous Australians
• A Nurse-Assisted Screening and Referral Program for Depression among Survivors of Cancer.
• Cognitive behaviour therapy for co-morbid chronic headache and depression
• A randomised, controlled, final stage evaluation of the beyondblue depression training program for aged care staff: Impact on the delivery of health care services for older people with depression. (Extension of 2004 Grant)
• Evaluation of Heart Health Online: A program to assist GPs to manage depression and related illnesses in patients with coronary heart disease
• Identifying Depression in people with vision impairment and developing pathways to care
• Improving the engagement detection and management of adolescent depression: Applying the mobile type program to general practice settings. (Extension of 2005 Grant)
• Looking beyond dual diagnosis: young people speak out
• Investigating the interaction between depression, tobacco and alcohol use in teenage Australians – can we identify a high risk group for poor outcome? A longitudinal study.

Grant round 2008

• Recognition of depression in patients with chronic obstructive pulmonary disease in Victoria
• A pilot study of the use of Magnetic Seizure Therapy for Treatment Resistant Depression
• “Healthy Mind, Healthy Heart”: Assessment of depression and related psychosocial factors in CALD people with CHD
• Development of drug misuse first aid guidelines for Aboriginal and Torres Strait Islander people
• Evaluating the impact of a psychosocial intervention (Optimal Health Program) on anxiety, depression and quality of life for people with chronic kidney disease who are commencing dialysis (a pilot study)
• A randomised controlled trial of enhanced cognitive therapy and family education for youth depression, anxiety and substance use
• Improving Self Efficacy: better outcomes for youth with depressive disorders
• Development and pilot of e-PACT: a psychological treatment of depression in people with spinal cord injury
• Experiences and needs of cardiac patients with depression in regional and rural Victoria: a qualitative study
• Improving Community Coordination, Access and Networks (I-CCaN): primary care for depression, anxiety and related disorders with co-morbid chronic physical illness
• Improving pathways of care for individuals with a dual diagnosis: implementing an early identification model at an integrated primary care and community health setting
• Is acculturation the nexus between chronic physical disease and depression and anxiety in a culturally and linguistically diverse population?
• Improving depression and anxiety screening of patients with heart disease: implementing a multidisciplinary clinical pathway.

Source: beyondblue website, 2009
Objective 5.3
Increase in knowledge about depression, particularly the evidence base for community education, prevention and treatment

Some of the above-mentioned research activities are beginning to produce data that can help address gaps in knowledge about depression, particularly regarding the evidence base for community education, prevention and treatment and pathways through care. These findings are of significance in the Australian context, and also have relevance for an international audience.

One example is the Bettering the Evaluation And Care of Health (BEACH) Project (see also Chapter 7), the aim of which is to examine changes in the clinical activities of General Practice in Australia between April 1998 and March 2008 across eight health conditions corresponding to the National Health Priority Areas, and including depression. A complete list of publications arising from this project can be found at: www.fmrc.org.au/publications.

However key findings demonstrate a significant increase in the management of all psychological problems, including depression, between 2002–03 and 2007–08, following the introduction of the 2002 Better Outcomes in Mental Health Care Initiative and the subsequent 2006 Better Access Initiative. The implications of these findings are discussed elsewhere in the report (Chapter 7).

In addition to research conducted in Primary Care settings, another priority area of the Victorian Centre of Excellence in Depression and Related Disorders is research into Depression and Substance–use Disorders. An example of a piece of related research is Treatment for Depression: a qualitative exploration of the experiences of alcohol and drug users. This study was completed in 2006 and was supported by a $44,000 grant from the beyondblue Victorian Centre of Excellence. This study used in-depth semi-structured interviews to examine the experiences of people with substance use and depression and to identify specific barriers to help-seeking among this population.

Key findings included that participants’ experiences of depression treatment were generally negative and medication compliance was extremely poor. Counselling was viewed more favourably than pharmacological treatment, although this was still variable. In addition, despite the availability of health promotion information regarding access to services, most alcohol and drug users were not aware of how and where to access treatment for depression. Lessons learned from this study have implications for policy and practice and for beyondblue itself. In particular, despite an increase in health promotion and educational messages over the lifespan of beyondblue, there are some sectors of society whom these messages are still not reaching and who require further attention (beyondblue 2008).

beyondblue has drawn on new knowledge from research that it has funded or conducted, in order to inform its own programs and evaluate its activities. For example, beyondblue supported an investigation into the Awareness of beyondblue in Australian young people (Morgan & Jorm, 2007). This study was completed in 2007 and measured the awareness of beyondblue and Ybblue (previously the youth program of beyondblue) and the associations between awareness and mental health literacy.

This study found that there was an overall awareness of beyondblue among 45% of young people; females were more likely than males to be aware of beyondblue as were young people from rural or regional areas. Those who were aware of beyondblue generally demonstrated better mental health literacy, that is, they were better able to recognise depression in others and were less likely to believe that it is helpful to deal with depression alone. Awareness of beyondblue was lower in younger adolescents and increased with age. These findings demonstrated a continued need to specifically target young people in relation to information around mental health. They have also had a direct effect on the structure and messaging for young people from beyondblue and likely contributed to the subsequent re-branding of Ybblue into Youthbeyondblue.
The aim of the ‘Media Monitoring’ project conducted by Melbourne University has been to investigate media reporting prior to beyondblue and the Australian Government beginning their efforts to encourage responsible reporting (01/03/2000-28/02/2001) and to compare it to media reporting after their efforts were well established (01/09/2006-31/08/2007) (Dare et al, 2008). This project identified all media reports of mental illness, and in particular depression, and rated each for quality and in terms of accuracy of representation of symptoms, causes, treatment and prognosis against standardised criteria. Media items related to mental illnesses were collected from 632 print and broadcast sources, over the two twelve-month periods. In both study years, media items in which the main focus was depression accounted for around 20% of all items on mental illness and were more common than items about any other specific mental illness. In terms of content, depression-related items showed an increased focus on individuals’ experiences (24.2% in 2000/01 versus 45.3% in 2006/07). They also showed a significant improvement in quality over the study period. There was a greater tendency for depression-related items to include detail about the symptoms, causes and treatment of depression in 2006/07 than previously; but by contrast, these items were less likely to discuss the prognosis of depression in the latter period. The accuracy of these descriptions was quite high in the earlier period and remained at the same level or improved still further, although causes of depression proved the exception to the rule. Reference was made to beyondblue in nearly 20% of all depression-related items in 2006/07; although comparative data from 2000/01 were not available. In general reporting of depression largely changed for the better and whilst this finding is extremely positive, the investigators noted that there is still room for improvement in media reporting. Given that raising public awareness of depression is a key goal of beyondblue this increase in both quality and quantity of media reporting of depression is highly positive.

Other research efforts supported by beyondblue have not only led to increases in knowledge, but, perhaps equally as importantly, have also increased research capacity. This is important, as it lays the foundation for future discoveries that can help reduce the impact of depression and related disorders. The PEP and diamond collaborations were cited as research projects funded by the bbVCoE in the previous evaluation and provide good examples of this. Both began as beyondblue Victorian Centre of Excellence project grants, involving specific studies; both were subsequently provided with further funding, through beyondblue Victorian Centre of Excellence consortium grants, and have since joined forces to strengthen primary mental health care research.

The PEP study (a randomised controlled trial exploring the effect of training GPs in psychological skills and the effect of GP-provided psychological care on consumers’ experience of care and clinical outcomes) was in its early stages at the time of the previous evaluation and was subsequently completed in 2007. Its key findings are described in Chapter 7.

The diamond study is a longitudinal project examining the diagnosis, management and outcomes of depression in primary care. Again this was in its early stages when the previous evaluation was conducted and was subsequently completed in January 2008. During this study seven hundred and ninety-one people with depressive symptoms who had attended the GP in the previous twelve months were surveyed three, six, nine, twelve and twenty-four months following recruitment. Outcome data from this study were not available at the time of writing however the study is expected to provide a comprehensive picture of the experience of people living with depression in the community, in particular with regard to their interaction with the health system (beyondblue, 2008).

Summary

The key initiatives associated with Priority Area 5 are in place, with several funding avenues providing support for research. High quality research is being promoted through the beyondblue Victorian Centre of Excellence in Depression and Related Disorders and beyondblue’s strategic research initiatives and partnerships. In addition, beyondblue encourages rigorous evaluations of all its funded programs and projects. beyondblue has supported several supplements in specialist scientific journals (such as the MJA) and has linked with other key research initiatives, such as earlier, the establishment of the Depression and Anxiety Consumer Research Unit.
These initiatives appear to have led to an increase in targeted research activities aimed at increasing knowledge about depression. The beyondblue Victorian Centre of Excellence in Depression and Related Disorders has supported over 60 studies over the period 2005-2009 which is more than the fifty projects funded during the earlier funding period. The evidence suggests that this is redressing the imbalance identified by Jorm et al’s earlier audit of depression-related research activities, conducted prior to the development of beyondblue. Not only has the number of projects increased, but the research now has a more strategic focus and is better aligned with priorities identified by stakeholders.

Many of these projects are now yielding results that are addressing gaps in knowledge about depression (particularly regarding the evidence base for community education, prevention and treatment). Some of these findings have helped shape specific initiatives of beyondblue and have provided some useful information regarding the efficacy of beyondblue’s activities. Other research efforts supported by beyondblue have not yet led to increases in knowledge but have increased research capacity. Whether or not this has led to an increased capacity at community level to prevent and respond effectively to depression is harder to measure however it is likely that the progress made in this area over the past few years is significant, evidenced by the investment in research.

References

Chapter 9
Achievement of high level objectives

Objective 6
Increased capacity of the broader Australian community to prevent and respond effectively to depression

It is likely that beyondblue has, at least partially, increased the capacity of the broader Australian community to prevent and respond effectively to depression, for reasons set out below. Yet, it is highly doubtful that Australia currently understands and responds to the personal and social impact of depression, and works actively to prevent it and improve the quality of life of those affected. To achieve this requires substantial effort and is unlikely to be achieved even within the 10 year funding period from 2000-2010.

The increases in awareness, knowledge and understanding of depression that have been demonstrated to have occurred in the Australian community should lead to a decrease in the levels of stigma and discrimination experienced by people with depression and beyondblue has played a role in increasing this awareness. It is unlikely though that Australia is now a society that understands and responds to the personal and social impact of depression, and works actively to prevent it and improve the quality of life of everyone affected, given that 32% of people surveyed in the Depression Monitor still believe people with severe depression are dangerous to others, 68% reported them as unpredictable, and 52% as unreliable (Highet, 2008).

Most importantly, there are distinct lack of current studies designed to explicitly test whether or not people with depression themselves are experiencing a reduction in stigma and discrimination in parallel with the community awareness efforts of beyondblue.

During the current funding period, beyondblue has clearly extended Consumer and carer participation through promoting online strategies and improved consumer and carer networks particularly through blueVoices. However, the key question remains whether consumers and carers feel more empowered about their situation, and the extent to which they are involved in mental health initiatives targeted at them. Although studies in the previous beyondblue funding period suggested a lack of understanding and awareness by the community and health professionals (e.g. McNair et al, 2002), there is limited evidence to suggest whether consumers and carers themselves feel more empowered, are being consulted more frequently and whether they are satisfied or not with current changes made in mental health care.

Regarding Prevention and early intervention, it is not possible to estimate whether there has been an increase in the proportion of people with depression who seek professional help early due to a gap in evidence as well as in difficulties in interpreting the data. During the 2007/08 financial year, nearly 3.8 million Better Access Medicare subsidised mental health services were accessed by Australians living with mental illness.

Unfortunately, it is not possible to compare service usage levels in people with depression using data from the National Survey of Mental Health and Wellbeing: Summary of Results, 2007 and the Mental Health and Wellbeing: Profile of Adults, Australia 1997 as their methodologies were not commensurate. Jorm et al (2005) reported changes in beliefs about some treatments for depression, particularly counselling and medication, the benefits of help-seeking in general as well as recognition of depression. This is supportive of the notion that a higher proportion of people with depression will seek professional help early. It does not however constitute good evidence that this has in fact happened as it is not based on a self-report of the people themselves with depression. For similar reasons, it is also difficult to estimate if there has been a reduction in risk factors and promotion of protective factors for depression.
It is now urgent to address the gap in evidence concerning the proportion of people with depression who seek professional help early as this is a key measure of both Priority Area 3 Prevention and early intervention but also Priority Area 1 Community awareness and destigmatisation. In doing so it is important to appreciate that beyondblue’s contribution cannot be isolated from a large number of other factors of which the Global Financial Crisis would be most important.

The situation in primary care is, however, quite different. beyondblue has been a major supporter of the primary care initiatives of the Australian Government in mental health, particularly, the Better Outcomes in Mental Health Care (BOMHHC) and as a flow-on effect, the Better Access program. There is now good evidence that as a result there has been, for example, a significant increase in the GP management rate of depression, a significant increase in the rate of psychological counselling for depression and anxiety management and a significant increase in the rate at which patients with depression and anxiety problems were referred to psychologists. There have also been other significant developments with the production of NHMRC evidence-based guidelines on depression with which beyondblue has played a major developmental role.

beyondblue’s extensive funding for research and evaluation in depression are significant both in Australia and internationally. These initiatives have led to an increase in targeted research activities aimed at increasing knowledge about depression. The beyondblue Victorian Centre of Excellence in Depression and Related Disorders has supported over 60 studies during the period 2005-2009. The evidence suggests that this is redressing the imbalance identified by Jorm et al’s earlier audit of depression-related research activities, conducted prior to the development of beyondblue. Not only has the number of projects increased, but the research now has a more strategic focus and is better aligned with priorities identified by stakeholders.

Many of these projects are now yielding results that are addressing gaps in knowledge about depression (particularly regarding the evidence base for community education, prevention and treatment). It is too early to assess whether this has led to an increased capacity at community level to prevent and respond effectively to depression is harder to measure.

**Objective 7**

**A society that understands and responds to the personal and social impact of depression, and works actively to prevent it and improve the quality of life of everyone affected**

It is still much too early to assess whether the highest-level objective (Level 7) A society that understands and responds to the personal and social impact of depression, and works actively to prevent it, has been achieved. While it is possible to work towards that goal over time, it is unlikely that situation will ever be achieved without transformative cultural change.
Overview of findings

Figure 10.1 provides an overview of the findings of the current evaluation. Specifically, it describes, in broad terms, whether the individual objectives in beyondblue’s hierarchy of objectives have been fully achieved, have been partially achieved, achieved to some extent, not achieved or not known.

The lower-level objectives (Levels 1 and 2) of beyondblue have been completely achieved. It has key initiatives in place across all five of its Priority Areas, and these have variously led to increases in the quantity and quality of information available about depression, improved consumer and carer networks, systemic improvements that support primary care practitioners to prevent and treat depression, and increases in targeted research activities.

The intermediate (Level 3) Objectives have been largely achieved. These are typically expressed in terms of increases in change or improvement that extend beyond the beyondblue programs to programs more generally. In judging whether these changes or improvement in programs can be regarded as being fully or largely achieved for the intermediate Objectives, it is necessary to judge how substantial the change or improvement has been and requires a subjective judgement.

It is more difficult to make a judgement about the intermediate (Level 4) objectives as these require that there is an impact of beyondblue programs or programs influenced by beyondblue leading to a changed situation in the target population for that particular Priority Area. For three of the Priority Areas it is not possible to arrive at a conclusion due to an absence of data.

We do not know whether there has been:

- a decrease in levels of stigma and discrimination associated with depression (Priority Area 1); this is notwithstanding the information about trends in community perceptions about stigma and discrimination derived from successive Depression Monitor surveys;
- a genuine acknowledgement of issues from society faced by consumers and carers (Priority Area 2);
- an increase in the proportion of people with depression who seek professional help early (Priority Area 3); and
- a reduction in risk factors and promotion of protective factors (Priority Area 3).

For the other two Priority Areas it is different. In Priority Area 4 (Primary care) beyondblue programs and the major government programs, influenced by beyondblue have quite clearly had a major impact and led to a changed situation in the target population. The prevention and management of depression of primary care in Australia has undergone a sea change.

In Priority Area 5 (Targeted research) the scale of research funded by beyondblue has been substantial and resulted in an increase in knowledge about depression, particularly with regard to the evidence-base for community education, prevention and treatment. There remains much to learn judged by Jorm et al (2001) who concluded that depression was under-researched, particularly in primary care, the community, prevention and promotion, evaluations of mental health services and investigations of training and education of mental health professionals.
Figure 10.1: Relationship of evaluation components to the objectives hierarchy for beyondblue

Objective 7
A society that understands and responds to the personal and social impact of depression, and works actively to prevent it and improve the quality of life of everyone affected

Objective 6
Increased capacity of the broader Australian community to prevent and respond effectively to depression

Objective 1.5
Decrease in levels of stigma and discrimination associated with depression

Objective 1.4
Increased understanding of experiences of people whose lives have been affected by depression

Objective 1.3
Increase in awareness of the prevalence, symptoms, causes, treatments and prognosis of depression

Objective 1.2
Increase in the quantity and quality of information available about depression through media and educational sources

Objective 1.1
Key initiatives in place

Objective 2.4
Genuine acknowledgment of issues faced by consumers and carers

Objective 2.3
Genuine participation by consumers and carers in depression-related initiatives

Objective 2.2
Improved consumer and carer networks

Objective 2.1
Key initiatives in place

Objective 3.4
Increase in the proportion of people with depression who seek professional help early

Objective 3.3
Systemic changes in the health sector and beyond (e.g., in families, schools, workplaces and communities) that support prevention and early intervention efforts

Objective 3.2
Increase in the number and range of effective prevention and early intervention initiatives for depression

Objective 3.1
Key initiatives in place

Objective 4.3
Increase in community education and treatment roles of primary care practitioners

Objective 4.2
Improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression

Objective 4.1
Key initiatives in place

Objective 5.3
Increase in knowledge about depression, particularly the evidence-base for community education, prevention and treatment

Objective 5.2
Increase in targeted research activities aimed at increasing knowledge about depression

Objective 5.1
Key initiatives in place

Objective 4.3
Increase in knowledge about depression

Objective 4.2
Increase in community education and treatment roles of primary care practitioners

Objective 4.1
Key initiatives in place

Objective 3.5
Reduction in risk factors and promotion of protective factors

Objective 3.4
Increase in the proportion of people with depression who seek professional help early

Objective 3.3
Systemic changes in the health sector and beyond (e.g., in families, schools, workplaces and communities) that support prevention and early intervention efforts

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Increase in the number and range of effective prevention and early intervention initiatives for depression

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Objective 2.1
Key initiatives in place

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Increase in awareness of the prevalence, symptoms, causes, treatments and prognosis of depression

Objective 1.2
Increase in the quantity and quality of information available about depression through media and educational sources

Objective 1.1
Key initiatives in place

Objective 6
Increased capacity of the broader Australian community to prevent and respond effectively to depression

Objective 5
Increased knowledge about depression, particularly the evidence-base for community education, prevention and treatment

Objective 4
Improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression

 Objective 3
Increase in the number and range of effective prevention and early intervention initiatives for depression

Objective 2
Improved consumer and carer networks

Objective 1
Key initiatives in place

Objective 7
A society that understands and responds to the personal and social impact of depression, and works actively to prevent it and improve the quality of life of everyone affected

Objective 6
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Increase in the number and range of effective prevention and early intervention initiatives for depression

Objective 2
Improved consumer and carer networks

Objective 1
Key initiatives in place
Given these major successes, it is possible to make the judgement that with regard to the high-level objective (Level 6) there has been some increased capacity of the broader Australian community to prevent and respond effectively to depression. This would have been much easier to judge if the evidence-base was better. As noted, it is still too early to assess whether the highest-level objective (Level 7) A society that understands and responds to the personal and social impact of depression, and works actively to prevent it, has been achieved. While it is possible to work towards that goal over time, it is unlikely that situation will ever be achieved without transformative cultural change.

Where it was possible to make comparison with the present and previous funding period it is clear that beyondblue has made further achievements in a number of important ways. These include for example:

- community awareness and stigma – favourable trends in community awareness and perceptions about depression; substantially more media reports and use of the beyondblue website;
- consumers and carers – substantially higher levels of participation in blueVoices;
- prevention and early intervention – major new initiatives some of which have attracted Australian Government funding;
- primary care – major new programs and evidence-based guidelines; major new Australian Government initiatives influenced in part by beyondblue;
- targeted research – increase in number of research projects; funded research projects now producing new knowledge about depression and evidence about depression programs.

It can be concluded with confidence therefore that beyondblue has achieved all of its lower-level Objectives in whole, its intermediate Objectives in full or in part (notwithstanding incomplete data in some areas) and one of two higher-order Objectives to some extent. The breadth and depth of its activities across its five Priority Areas is impressive. Its activities are nicely distributed between innovation (funding of new programs), further development of more established programs and preparation for their wider dissemination through planning and workforce development.

Pirkis (2004) in her earlier evaluation report noted that beyondblue fared well in comparison with depression initiatives in other countries. Parslow and Jorm (2002) systematically reviewed these initiatives in terms of improved mental health literacy. These were the Defeat Depression Campaign (United Kingdom), the Changing Minds Campaign (United Kingdom), the Depression Awareness, Recognition and Treatment Program (United States) and the National Depression Screening Day (United States). They concluded that the Defeat Depression Campaign was the only initiative that demonstrated impacts in this area, noting that it achieved attitudinal improvements of 5-10%. The other campaigns were either not evaluated, or were subject to evaluations that did not consider improvements in mental health literacy. In 2006 New Zealand established a National Depression Initiative and is receives around NZ $10 million. Like beyondblue, its goal is to reduce the impact of depression on the lives of New Zealanders with the objectives of strengthening individual, family and social factors that protect against depression and improving community and professional responsiveness to depression. It is too early to assess its impact.

Not only has beyondblue had a significant impact on mental health literacy in Australia, it has programs having effects on consumer and carer participation, prevention and early intervention, primary care and targeted research.

**Limitations of the study**

For reasons of time and resource constraints, the current evaluation relied almost exclusively on secondary analysis of existing data and information, with no additional primary data collection and analysis. It is possible nevertheless to come to confident conclusions about beyondblue’s activities for the period 2005-2010 since a broad range of data sources were used to do this. The perspective derived from these data sources will be broadened by the strategic review of key stakeholders which is to follow. It should be acknowledged that wider and more direct input from consumers and carers would have extended and deepened the review process and brought to light any unintended (positive or negative) consequences.
There are also some limitations in the program logic model used as it was not possible in some instances to operationalise some Objectives. On some occasions empirical data relevant to testing whether the Objective had been met or not, were not available.

It is also not possible to estimate the significance of influence of beyondblue on government decisions to fund programs aimed at depression. In some situations, information was available to assist in this assessment. However there were many other contemporaneous influences on government. For example, successive National Mental Health Plans had standing in their own right (Australian Health Ministers, 2003). They have focused the attention of the National Mental Health Strategy on to high prevalence disorders such as depression. There have been other State/Territory agencies such as the Black Dog Institute in New South Wales as an educational, research and clinical facility offering specialist expertise in mood disorders (Black Dog website). There are also other peak mental health bodies such as SANE and the Mental Health Council of Australia. It is nevertheless clear beyondblue has been a major influence on government in mental health.

Finally, it is not possible to comment on the likely sustainability of beyondblue’s achievement. However, given that much of beyondblue’s work is based on fostering partnerships within the mental health sector and beyond, it is likely that many of its achievements will have medium to long-term effects.

Need for further development

There is one area where beyondblue could develop further. This is in the funding of audits that directly inform the extent to which beyondblue is over time moving to achieve its higher-level Objectives. As discussed above, these involve the first three Priority Areas – Community awareness and destigmatisation, Consumers and carers, Prevention and early intervention. It could also extend to Priority Area 4, Primary care with ongoing audits of numbers, education levels and current practices of primary care practitioners with regard to depression care and prevention.

This would require the repeated application of these audits over time using purpose-designed, data collection methodologies. The repeated application of the Depression Monitor, the depression literacy surveys of Jorm et al (2006) and the media monitoring exercises of Blood et al (2003) are good examples of where this sort of audit is occurring already. As noted already e.g. Objective 3.5 in Chapter 6, it would be necessary to interpret beyondblue’s achievements using these audits of higher-order Objectives as factors other than beyondblue will impact on their attainment.

It should be noted that these observations have been made before. The earlier evaluation report made this point in its Chapter 10 under Implications for future evaluation efforts. In addition, as noted in Chapter 8, the VPHREC Population Health Committee’s earlier review commented that beyondblue’s program of research lacked strategic direction (Population Health Committee, 2003).

Since then beyondblue has developed a more strategic focus in its approach to funding research with the development of strategic partnerships and designated funding rounds on specific Priority Areas. Nevertheless the strategic focus should be further strengthened. This is necessary because the community will wish to be assured that beyondblue is achieving its higher order Objectives. Governments will wish to know that progress is being made in moving toward these. It is very much in beyondblue’s interests to be able to report on these as progress towards achieving these higher-order Objectives, while challenging, should be achievable.

It is also important that beyondblue is able to recommend to government when innovative programs are ready for funding and rollout. An excellent evidence-based starting point for this, as noted in Chapters 6 and 7, is the Standards of the Society for Prevention Research for judging the efficacy and effectiveness of a program as well as its readiness for dissemination.

Another area of strategic focus should be to strengthen the evidence-base with regard to those Prevention and early intervention programs that a number of reviewers have queried do not yet meet the Standards of the Society for Prevention Research particularly in regard to medium and longer-term effects. These include both post natal and school-based depression prevention programs.
beyondblue has a number of roles. Two very important ones in relation to government are to be the principal advocate for people with depression and related disorders as well as to be the best source of advice on the efficacy, effectiveness readiness for dissemination of a program. Reconciling these two roles is not straightforward.

beyondblue has a very strong and influential Advisory Board. It also has a number of sources of advice on research matters through individual members of its Board of Directors, through its Research Advisor and through the VCoE Expert Committee. Nevertheless its source of advice on evidence-based medicine, health services research and health economics could be further strengthened. Such a person would bring important insights and skills to the Board and could also act as a Health Services Research Advisor alongside the current Clinical and Research Advisors.

Concluding remarks

From the above, it is clear that beyondblue has established itself over the past decade as a major force in shaping public policy and in introducing new programs in mental health in Australia. It is true to say that it is the public health face of mental health in the country. Given the well-documented shortfall in mental health services alongside the long-standing problems with stigmatisation and discrimination towards people with mental illness, this is a considerable achievement. It is very important that beyondblue continues to prosper in this role in order that progress continues, new knowledge is created and new initiatives are put in place.

References


Schomerus et al (2009) examined two aspects of stigma related to seeing a psychiatrist and their association with help-seeking intentions for depression: anticipated discrimination by others when seeking help and desire for social distance from those seeking help. They used a representative population survey in Germany. Contrary to expectations, anticipated discrimination from others was unrelated to help-seeking intentions, while personal discriminatory attitudes seem to hinder help-seeking. Our findings point to self-stigmatization as an important mechanism decreasing the willingness to seek psychiatric help.


Peluso & Blay (2009) assessed public stigma in relation to individuals with depression and possible factors associated with this phenomenon using a cross-sectional study in Sao Paulo. They concluded that individuals with depression face a substantial amount of stigma, pointing to the need to gain in-depth knowledge about its impact on the experiences of these individuals, as well as to implement anti-stigma programs that focus on this disorder in the Brazilian context.


Wang (2007) sought to identify gender specific demographic, clinical, knowledge and attitudinal factors associated with stigma related to depression using a population-based survey in Alberta. They concluded that improving mental health literacy may be one of the promising ways to reduce stigma associated with depression. Personal contacts with individuals with depression may have positive effects on stigma in women. Mental health education and promotion should clarify misconceptions about causes, treatments and risk factors for depression. Gender differences related to stigma should be considered in stigma reduction initiatives.


Finkelstein & Lapshin (2007) investigated the efficacy and feasibility of a web-based depression stigma education tool for healthcare professionals. They concluded that computer-assisted education was effective in reducing the stigma of depression and increasing knowledge about depressive disorder. A web-based intervention has the potential to be used for educating graduate students and university staff about depression and for reducing depression stigmata. Healthcare professionals interacting with people with stigmatizing conditions can benefit from web-based computer education.


Eaton (2009) reported that an £18m campaign to tackle the discrimination and stigma that surrounds mental health appeared on television screens and in newspapers in England on Wednesday. Its aim was to tell the public that it is no longer acceptable to discriminate against people with a mental illness. The campaign included an advertisement on the prime time television, during *Coronation Street* for three weeks. A series of press advertisements involving celebrities who have experienced mental illness are also part of the campaign. They include the former aide to the prime minister, Alistair Campbell, the television host Ruby Wax, and the actor Stephen Fry. The campaign’s website gives details of what can be done to help people with a mental illness and how to run a local campaign.

Klap (2009) examined the long-term impact on stigma concerns of two quality improvement (QI) interventions for depression in primary care in a group-level randomized trial comparing patients enrolled in interventions with enhanced resources for therapy or medication management with those in usual care. They concluded that Quality improvement programs for depression can raise or lower stigma concerns, depending on program design and resources for specific treatments.


O’Kearney et al (2006) evaluated the effectiveness of a cognitive behaviour therapy Internet program (MoodGYM) for depressive symptoms, attributional style, self-esteem and beliefs about depression, and on depression and depression-vulnerable status in male youth. A total of 78 boys age 15 and 16 years were allocated to either undertake MoodGYM or to standard personal development activities. Outcomes were measured before commencement, post-program and 16 weeks post-program. There were no significant between-group differences in change scores pre- to post- or pre- to follow-up. For boys completing 3 or more modules there were small relative benefits of MoodGYM for depressive symptoms. While the numbers are small, there was a reduction (that was not sustained) in the risk of being depressed in the MoodGYM group of 9% at post-treatment compared with a slightly increased risk for the control group. The limitations of the study highlight several important challenges for MoodGYM and other self-directed Internet cognitive behaviour therapy programs.


Wang, et al (2008) estimated and compared the percentages of personal stigma by levels of depression literacy and exposure to persons with depression, overall and by gender using a population-based survey of 3047 adults in Alberta. Over 45% of participants considered that people with depression were unpredictable and over 20% reported that people with depression were dangerous. However, the percentages did not differ by levels of depression literacy and whether having a family/friend with depression. There were gender differences. They concluded that in the highly educated population, the attitudes of considering individuals with depression as being unpredictable and dangerous were prevalent. Educational campaigns may have some positive effects on stigma against depression, but should be carefully designed and pay attention on the target populations.
Endnote

Bibliography of meta-analyses, systematic reviews and key articles on Community awareness in depression

These consist of edited versions of the abstracts of the relevant papers.


Jorm et al (2005) evaluated whether a campaign to increase public knowledge about depression (beyondblue: the national depression initiative) has influenced the Australian public’s ability to recognise depression and their beliefs about treatments using national surveys of mental health literacy in 1995 and 2003-04. They investigated if States and Territories which funded beyondblue (the high exposure states) had greater change than those that did not (the low exposure states). Using the low-exposure states as a control, the high-exposure states had greater change in beliefs about some treatments, particularly counselling and medication, and about the benefits of help-seeking in general. Recognition of depression improved greatly at a national level, but slightly more so in the high-exposure states. Results were deemed to be consistent with beyondblue having had a positive effect on some beliefs about depression treatment.


Morgan & Jorm (2007) measured awareness of beyondblue: the national depression initiative and Ybblue (the youth program of beyondblue) in Australian young people using a national telephone survey of mental health literacy. They concluded that beyondblue: the national depression initiative had reached a good proportion of Australian young people, and awareness was associated with better mental health literacy. Males and younger adolescents could be targeted for improvements in awareness.


Jorm et al (2006) assessed whether psychological distress has changed in the Australian population using household surveys of Australian adults in 1995 and 2003-2004. Psychological distress was found to have increased in men aged 20-29 years. This change was observed even when the same cohorts were compared. No change was found in women or in other male age groups. They concluded that there is a need for routine population monitoring of mental health to determine subgroups requiring priority action.


Paykel et al (1998) reported that the aims of the Defeat Depression Campaign in the UK between 1991 and 1996 included the reduction of stigma associated with depression, education of the public about the disorder and its treatment and encouragement of earlier treatment-seeking. Newspaper and magazine articles, radio and television programs and other media activities were employed. Three surveys of public attitudes were conducted over 6 years as well as structured interviews. There were significant positive changes regarding attitudes to depression, reported experience of it, attitudes to antidepressants, and less consistently, to treatment from GPs. Changes were of the order of 5-10%. Throughout, attitudes to depression and to treatment by counselling were very favourable, whereas antidepressants were regarded as addictive and less effective.
Crisp et al. (2005) investigated the impact of the Changing Minds campaign based on baseline and follow-up surveys. There were reductions in the percentages of all stigmatizing opinions albeit often small, apart from reported opinions concerning treatment and outcome. The greatest proportion of negative opinions was in the 16-19 year age group, and respondents with higher education were less likely than the rest to express such views. The authors concluded that stigmatizing opinions are frequent in the community but the various disorders are not stigmatized in the same way. Campaigns to reduce stigma should take account of these differences, and of the need to address young people.

Griffiths et al. (2008) investigated and compared the predictors of personal and perceived stigma associated with depression using three samples: a national sample of Australian adults, a local ACT sample; and a psychologically distressed subset of the latter. Personal stigma was consistently higher among men, those with less education and those born overseas. It was also associated with greater current psychological distress, lower prior contact with depression, not having heard of a national awareness raising initiative, and lower depression literacy. These findings differed from those for perceived stigma except for psychological distress which was associated with both higher personal and higher perceived stigma.

Parslow et al. (2002) identified the goals of an effective depression literacy campaign and a range of educational strategies for achieving change in each of these areas. Applying these strategies may give a stronger basis for improving depression literacy than previous initiatives.

Thompson et al. (2004) examined the barriers to initial help-seeking and factors that facilitate help-seeking for anxiety and depression based on a help-seeking history from patients at a specialist anxiety clinic, all of whom had delayed seeking professional treatment for at least one month. The authors concluded that lack of public ‘mental health literacy’ contributes to slow problem recognition. Increasing illness severity eventually facilitates problem recognition and prompts help-seeking. Structural barriers to initial help-seeking are relatively unimportant within the Australian health care system. General practitioners play an important role as gatekeepers to appropriate mental health care.
Endnote

Bibliography of meta-analyses, systemic reviews and key articles on Consumer and carer participation in mental health

These consist of edited versions of the abstracts of the relevant papers.


Highet et al (2004a) conducted focus groups and in-depth interviews with people with documented bipolar disorder who frequent mental health services in Australia in order to explore their experiences with the healthcare system. Participants were recruited via contact with the beyondblue website, and/or participation in local illness support groups. Of key significance was the lack of understanding and awareness about bipolar disorder within the Australian community. This is exacerbated by barriers faced with timely and appropriate diagnosis, and hence, optimal treatment. Further, the healthcare system was considered inadequate with frequent discontinuation of its services and exclusion of consumers and carers from management of decisions. Such barriers were considered to worsen the social, interpersonal and economic aspects of this illness. Of note is the focus of the healthcare system in relation to mental health problems; i.e. the focus is predominantly directed at people with chronic psychotic conditions and less on those with episodic conditions such as bipolar disorder or severe depression.


Highet et al (2004b) conducted structured focus groups to explore the experiences of carers and families of people with depression. Participants were recruited via prior written contact with beyondblue, contact with beyondblue website, and/or in other current Australian consumer or carer organisations for people with mental disorders. The study highlighted the lack of community awareness of depression and to some extent, the lack of support by other family members or friends which made the carer’s role more difficult. This is further exacerbated by the adverse experiences with healthcare service providers whereby the carer’s concerns are disregarded by emergency services and they are excluded from key decision-making about the patient. On the contrary, community support agencies were considered to be more supportive as it provided a sense of inclusion and common purpose. Thus, the study concluded that the experiences of carers and families of people with depression highlight the urgent need for more extensive community education about depression and more productive partnerships within the healthcare system.

Hickie IB. Responding to the Australian experience of depression.

Although depression is recognised as a major public health issue in Australia, lack of community awareness and stigmatisation continues to exist within the community. Following the Federal and Victorian Governments’ decision, beyondblue was implemented as a national depression initiative aimed at increasing community depression awareness and reducing stigma associated with mental disorders. For this, beyondblue should seek to develop evidence-base guidelines and introduce non-traditional therapies such as self-help (online) with a focus on promoting the voice of the consumer and carer. Provision of authoritative and detailed information about depression to those affected, and educating the mental health professionals to utilise their leadership roles towards destigmatisation is another aspect that beyondblue should aim to target. Over time, it is crucial to monitor and evaluate beyondblue initiatives with regards to community recognition of depression, impact of this recognition, and the extent of personal and social barriers to full social participation.

The extent to which the role of consumers and their participation occurs has considerably changed following the widespread changes to the structure and delivery of mental health services. The view of consumers as passive recipients of care and treatment is gradually undergoing a significant shift following the establishment of mechanisms that allow the inclusion of consumers in service and program delivery. However, although consumer participation is broadly reflected in government policy, the extent to which this is realised in practice remains to be seen. This research study highlighted that there are no clear pathways which convey the experiences of consumers, which needs to be rectified if consumer participation is to be promoted. One of the major barriers considered was the lack of acceptance and attitudes of service providers to consumer participation. Thus, the challenge remains the facilitation and development of genuine partnerships of health professionals with consumers of mental health services.


The objective of this research was to clarify the meaning of consumer and carer participation in mental health services, to identify reasons why consumer participation is important both to consumers and to services, and to discuss barriers to participation and ways of overcoming these barriers. The research concluded that consumer and carer participation has been promoted as part of the National Mental Health Strategy and has the potential to empower consumers and carers and to improve mental health services. Barriers to consumer participation include professional staff attitudes and resource allocation. Guidelines are provided to assist services to address these barriers and increase the level of consumer and carer participation in both clinical decision-making and service development. As recipients of mental health services, consumers can contribute uniquely towards the improvement of mental health services which stems from the expertise they have gained. Their contribution should be reinforced positively in areas of program development, policy formulation, program evaluation, research, quality assurance, and education and training of mental health services staff.

McNair BG, Highet NJ, Hickie IB et al. Exploring the perspectives of people whose lives have been affected by depression. Med J Aust 2002; 176: S69-S76.

The key objective of this study was to describe the experience of people whose lives have been affected by depression by measuring the barriers to social participation, and interactions with the healthcare system. Methodology included thematic review of data collected from 21 community meetings and focus groups held nationally, and written feedback and website-based interactions with beyondblue. The results evidenced increased experience of stigma in healthcare settings and barriers in social participation, particularly at the workplace. Further, inadequacies of primary care and specialist treatments were also highlighted with emphasise on limited access to high-quality primary care and non-pharmacological care. The stigmatising attitudes of many healthcare providers were also notable. Lack of access to knowledge and self-care or mutual support services were also evident within the society. Further, lack of support both from and for people in caring roles was identified. Thus, the study concluded that people with depression are subject to many of the same attitudes, inadequate healthcare and social barriers reported by people with psychotic disorders. Consumers and carers prioritise certain notions of illness, recovery and quality of health care, and expect health care providers to respond to these concerns.

Current research activity has not focused adequately upon the experience of caring for a person with depression. This study aimed to explore the carer’s experience of living with a person with clinical depression. Specific focus was given to the detection and recognition of the disorder. A series of focus groups and in-depth interviews was conducted with carers living with a person with clinical depression in rural and metropolitan Australia. Results of the study indicated signs and symptoms of depression were recognised by carers, generally in hindsight. Barriers to early detection were identified by carers and these were likely to contribute to the psychological reaction of carers and to the eventual diagnosis of the care recipient. This research has important implications for clinical practice and health policy, which must evolve to facilitate early detection and intervention, and to address the experience and needs of carers.


The authors conducted a systematic review of 13 meta-analyses on the efficacy of self-help interventions, including internet-guided therapy, for depression and anxiety disorders. All reported medium to large effect sizes for self-help interventions. Most found relatively large effect sizes for self-help treatments, independent of the type of self-help, and comparable to effect sizes for face-to-face treatments. Further research is needed to optimize the use of self-help methods.


Christensen & Griffiths (2002) reported that there are no published randomised controlled trials of the effectiveness of the Internet in delivering depression prevention programs. The feasibility and potential effectiveness of the Internet is indicated by a range of research Possible limitations to public health interventions using the Internet include selective access, the inability to promote the sites to potential users and the issue of uptake once users access the sites. Randomised controlled trials of CBT delivered by the Internet are required.


Morgan & Jorm (2008) conducted a systematic review of 38 RCTs investigating self-help interventions for depressive disorders or depressive symptoms. The majority of interventions searched had no relevant evidence to review. Interventions with the best evidence of efficacy in depressive disorders were for S-adenosylmethionine, St John’s wort, bibliotherapy, computerised interventions, distraction, relaxation training, exercise, pleasant activities, sleep deprivation, and light therapy. The authors concluded that a number of self-help interventions have promising evidence for reducing sub threshold depressive symptoms. Other forms of evidence such as expert consensus may be more appropriate for interventions that are not feasible to evaluate in randomised controlled trials. There needs to be evaluation of whether promotion to the public of effective self-help strategies for sub threshold depressive symptoms could have any undesirable outcomes such as harmful use of substances.
Endnote

Bibliography of meta-analyses, systematic reviews and key articles on Prevention and early intervention in depression

These consist of edited versions of the abstracts of the relevant papers.

Standards of evidence for dissemination


Flay et al (2005) reported that the Society for Prevention Research sought to establish standards for identifying effective prevention programs and policies. Recognizing that interventions that are ready for dissemination are a subset of effective programs and policies, and that effective programs and policies are a subset of efficacious interventions, SPR’s Standards Committee developed overlapping sets of standards.

Under these Standards, an efficacious intervention will have been tested in at least two rigorous trials that (1) involved defined samples from defined populations, (2) used psychometrically sound measures and data collection procedures; (3) analysed their data with rigorous statistical approaches; (4) showed consistent positive effects (without serious iatrogenic effects); and (5) reported at least one significant long-term follow-up.

An effective intervention under these Standards will not only meet all standards for efficacious interventions, but also will have (1) manuals, appropriate training, and technical support available to allow third parties to adopt and implement the intervention; (2) been evaluated under real-world conditions in studies that included sound measurement of the level of implementation and engagement of the target audience (in both the intervention and control conditions); (3) indicated the practical importance of intervention outcome effects; and (4) clearly demonstrated to whom intervention findings can be generalized.

An intervention recognised as ready for broad dissemination under these Standards will not only meet all standards for efficacious and effective interventions, but will also provide (1) evidence of the ability to “go to scale”; (2) clear cost information; and (3) monitoring and evaluation tools so that adopting agencies can monitor or evaluate how well the intervention works in their settings.

Global depression prevention


Jane-Llopis et al (2003) aimed to identify potential predictors of effect in prevention programmes (reduction of depression or depressive symptoms) employing a meta-analysis of 69 programmes. There was an 11% improvement in depressive symptoms that can be achieved through prevention programmes. Effectiveness was demonstrated for different age groups and different levels of risk, and in reducing risk factors and depressive or psychiatric symptoms. Programmes with larger effect sizes were multi-component, included competence techniques, had more than eight sessions, had sessions 60-90 minutes long, had a high quality of research design and were delivered by a health care provider in targeted programmes. Older people benefited from social support, whereas behavioural methods were detrimental.


Cuijpers et al (2008a) conducted a meta-analysis involving 19 suitable studies. There was a 22% reduction of the incidence of depressive disorders. This means that it will be necessary to treat 22 patients to prevent one case of depressive disorder. There were no systematic differences between target populations or types
of prevention (universal, selective, or indicated). The data included indications that prevention based on interpersonal psychotherapy may be more effective than prevention based on CBT. The authors concluded that prevention of new cases of depressive disorders seems to be possible. Prevention may become an important way, in addition to treatment, to reduce the enormous public health burden of depression in the coming years.


Barrera et al (2007) reviewed US and international studies that attempted to reduce the incidence of Major Depressive Episodes (MDEs), either to prevent onset in populations of children and adults (including women during the postpartum period) not currently meeting diagnostic criteria for depression, or to prevent a new episode in individuals who have recovered after treatment through protective, but not prophylactic interventions. They identified 12 RCTs that focused on preventing the onset of major depression, 5 randomized controlled trials focusing on preventing relapse, and no randomized controlled trials focused exclusively on preventing recurrent episodes through protective interventions. The review was limited in scope given that depression prevention trials focused on infants, young children, and older adults were not included in the review. The research to date suggested that the prevention of major depression is a feasible goal for the 21st century.


Chisholm et al (2004) aimed to estimate the population-level cost-effectiveness of evidence-based depression interventions (not necessarily prevention) and their contribution towards reducing current burden. Evaluated interventions had the potential to reduce the current burden of depression by 10-30%. Pharmacotherapy with older antidepressant drugs, with or without proactive collaborative care, are currently more cost-effective strategies than those using newer antidepressants, particularly in lower-income subregions. The authors concluded that even in resource-poor regions, each DALY averted by efficient depression treatments in primary care costs less than 1 year of average per capita income, making such interventions a cost-effective use of health resources. However, current levels of burden can only be reduced significantly if there is a substantial increase in treatment coverage.


Cuijpers (2008b) considered the results of the meta-analysis of Cuijpers (2008a) which showed that it was possible to prevent the incidence of depressive disorders. It is now necessary to examine how this knowledge can be applied in routine practice. In the Netherlands, for example, preventive services for depression are already offered on a regular basis in most mental health services through the Coping with Depression course. This is a preventive intervention aimed at persons with sub threshold depression, and is currently available for 80% of the general population in the Netherlands.

At the same time, it is necessary to be cautious about starting to disseminate preventive interventions. As indicated, many research questions still have to be answered. In the meta-analysis interventions in each of the various settings were not equally effective. Only when we pooled all studies together the results were statistically significant. So, it seems to be advisable to start with pilot projects for dissemination, combined with research on the effectiveness in routine practice settings.

School-based


Horowitz et al (2006) conducted a meta-analysis of 30 suitable studies. It indicated that selective prevention programs were more effective than universal programs immediately following intervention. Both selective and indicated prevention programs were more effective than universal programs at follow-up. Effect sizes for selective and indicated prevention programs tended to be small to moderate, both immediately post-intervention and at an average follow-up of 6 months. Most effective interventions are more accurately described as treatment rather than prevention.

Neil et al (2007) studied 24 efficacy or effectiveness trials of 9 intervention programs to determine the nature and efficacy of Australian school-based prevention and early intervention programs for anxiety and depression. Most were associated with short-term improvements or symptom reduction at follow-up. The authors concluded that a number of schools programs produced positive outcomes. However, even well established programs require further evaluation to establish readiness for broad dissemination as outlined in the standards of the Society for Prevention Research.

Spence SH, Shortt AL. Can we justify the widespread dissemination of universal, school-based interventions for the prevention of depression among children and adolescents? J Child Psychol Psychiatry 2007; 48(6); 526-42.

Spence et al (2007) studied the efficacy and effectiveness of universal, school-based interventions designed to prevent the development of depression in children and adolescents. It evaluated the outcomes of research in relation to standards of evidence specified by the Society for Prevention Research (Flay et al., 2005). The limited evidence available brings into doubt the efficacy and effectiveness of current universal school-based approaches to the prevention of depression, suggesting that the widespread dissemination of such interventions would be premature. Relatively brief programs, which focus specifically on enhancing individual skills and characteristics of the individual in the absence of environmental change, may be insufficient to produce lasting effects in the prevention of depression among children and adolescents.


Sutton et al (2007) conducted a qualitative review identifying significant programmatic and methodological issues in youth-based depression programs. They reported that meta-analyses of preventive interventions have consistently yielded small but significant effect sizes in the short-term prevention of depression. However, the maintenance of intervention effects over extended follow-ups ranging from 6 months to 3 years has not been consistently demonstrated. Programmatic issues include the implementation of booster sessions, augmentation of protective factors and exploration of mediators and moderators of intervention effects. Methodological issues include appropriate statistical analyses and examination of multiple outcome variables.


Bond et al (2004) examined the effectiveness of a multilevel school based intervention on adolescents’ emotional wellbeing and health risk behaviours using a school based cluster RCT. There were no significant effect of the intervention on depressive symptoms, and social and school relationships. The authors concluded that a focus on general cognitive skills and positive changes to the social environment of the school can have a substantial impact on important health risk behaviours relating to smoking and alcohol use.


Merry et al (2004a) conducted a meta-analysis to determine whether psychological and/or educational interventions (both universal and targeted) were effective in reducing risk of depressive disorder in children and adolescents over the next one to three years. They reported that psychological interventions were effective compared with non-intervention immediately after the programmes were delivered. While small effect sizes were reported, these were associated with a significant reduction in depressive episodes. The overall risk difference after intervention translates to “numbers needed to treat” (NNT) of 10. There was no evidence of effectiveness for educational interventions. The authors concluded that although there is insufficient evidence to warrant the introduction of depression prevention programmes currently, results to date indicate that further study would be worthwhile.

Merry et al (2004b) conducted a randomized placebo-controlled study of the effectiveness of a universal school-based depression prevention program. The intervention was an 11-session manual-based program derived from CBT. The placebo was similar but with cognitive components removed. Immediately after the intervention, depression scores were reduced significantly with the “number needed to treat” for short-term benefit of 33. Group differences in depression scores averaged across time to 18 months were significant on one depression index but not another. Confirmation of effectiveness measuring episodes of depressive illness and broader measures of adjustment is warranted.


Merry (2007) concluded that despite early promise, there is little evidence that prevention of depression is a practical possibility at this stage. There is no clear evidence of effectiveness for universal programmes. Targeted programmes are more promising, with evidence of short-term reduction in depressive symptoms, and there are a few studies in which there is evidence of a reduced incidence of disorder. There are promising developments in efforts to screen for disorder, although there is a requirement for more effective therapy. Potential cost-savings are considerable, so it is imperative that the search continues for effective interventions for depression in young people. Attention to wider social issues that impact on mental health is also needed. The reviewer concluded that developing preventive services for depression is premature at this stage. There is evidence to support screening for depression and providing early intervention, but current treatments have limited effectiveness. There is a compelling need for further research in this area.


Cuijpers et al (2006) conducted a meta-analysis of 8 suitable studies in which students were screened for depression, and those with depressive symptoms were treated with a psychological intervention. The ‘numbers-needed-to-screen’ was 31. Although the number of studies is small and their quality is limited, screening and early intervention at schools may be an effective strategy to reduce the burden of disease from depression in children and adolescents.


Williams et al (2009) aimed to assess the health effects of routine primary care screening for major depressive disorder among children and adolescents aged 7 to 18 years. The authors concluded that ‘primary care-feasible screening tools may accurately identify depressed adolescents and treatment can improve depression outcomes.’


Barrett et al (2006) evaluated the long-term effectiveness of the FRIENDS Program in reducing anxiety and depression in a sample of children from Grade 6 and Grade 9 in comparison to a control condition. The intervention maintained earlier reported reductions in anxiety. Girls in the intervention group reported significantly lower anxiety at 12-month and 24-month follow-up but not at 36-month follow-up. Results demonstrated a prevention effect with significantly fewer high-risk students at 36-month follow-up.
Clinical populations


Cuijpers et al (2009) conducted a meta-analysis of the 25 RCTs of the “Coping with Depression” course (CWD), a highly structured CBT intervention. The six studies aimed at the prevention of new cases of major depression were found to result in a reduced risk of getting major depression of 38%. The authors concluded that CWD has contributed considerably to the development and innovation of prevention and treatment of depression in many target populations.


Smit et al (2006) studied the cost-effectiveness of care as usual plus minimal contact psychotherapy relative to usual care alone in preventing depressive disorder. Primary care patients with sub-threshold depression benefited from minimal contact psychotherapy as it reduced the risk of developing a full-blown depressive disorder from 18% to 12%. In addition, this intervention had a 70% probability of being more cost-effective than usual care alone. A sensitivity analysis indicated the robustness of these results. The authors concluded that this intervention is therefore superior to usual care alone in terms of cost-effectiveness.


Gilbody et al (2005) aimed to determine the clinical and cost effectiveness of screening and case finding instruments in: improving the recognition of depression, improving the management of depression, and improving the outcome of depression. The authors concluded that ‘there is substantial evidence that routinely administered case finding/screening questionnaires for depression have minimal impact on the detection, management or outcome of depression by clinicians. Practice guidelines and recommendations to adopt this strategy, in isolation, in order to improve the quality of healthcare should be resisted.’

Clinical populations – the Elderly


van’t Veer-Tazelaar et al (2009) conducted an RCT to determine the effectiveness of an indicated stepped-care prevention program for depression and anxiety disorders in the elderly. Stepped-care participants sequentially received a watchful waiting approach, CBT-based bibliotherapy, CBT-based problem-solving treatment, and referral to primary care for medication, if required. The intervention halved the 12-month incidence of depressive and anxiety disorders in the usual care group. The authors concluded that indicated stepped-care prevention of depression and anxiety in elderly individuals is effective in reducing the risk of onset of these disorders and is valuable as seen from the public health perspective.


The authors conducted a meta-analysis of 25 suitable RCTs on psychological treatments for depression in older adults. The authors concluded that although the quality of many studies was not optimal, the results of this meta-analysis support the results of earlier meta-analyses, which also included non-randomized studies. Psychological treatments are effective in the treatment of depression in older adults.

Postnatal


Dennis (2005) systematically reviewed the effects of psychosocial and psychological interventions compared with usual ante partum, intrapartum, or postpartum care on the risk of postnatal depression in 15 suitable studies. Although there was no overall statistically significant effect on the prevention of postnatal depression in the meta-analysis of all types of interventions, these results suggest a potential reduction in postnatal depression. The only intervention
to have a clear preventive effect was intensive postpartum support provided by a health professional. Identifying women “at risk” assisted in the prevention of postnatal depression. Interventions with only a postnatal component were more beneficial than interventions that incorporated an antenatal component. In addition, individually based interventions were more effective than group based interventions. The author concluded that diverse psychosocial or psychological interventions do not significantly reduce the number of women who develop postnatal depression. The most promising intervention is the provision of intensive, professionally based postpartum support.


Chabrol & Callahan (2007) critically reviewed pharmacological, psychological and psychosocial approaches of prevention and treatment for postnatal depression. They concluded that there is little evidence of short-term success for preventive interventions and some evidence of short-term success for treatment interventions. No preventive or therapeutic studies, however, have provided evidence for long-term success. There is a need for future research into the prevention and treatment of postnatal depression including the assessment of long-term effects on the child’s development as well as feasibility in relation to cost-effectiveness.


Boath et al (2005) systematically reviewed the success of 21 suitable RCTs of preventative interventions for postnatal depression (PND). Nine of these trials demonstrated short-term preventative success (seven psychological and supportive interventions, one unpublished antidepressant trial and a calcium carbonate trial) but none provided any evidence of long-term success. Furthermore, the results of three of the psychological intervention trials should be viewed with caution due to a lack of methodological rigour.


There are no antenatal screening tools that have been shown to be of benefit in predicting postnatal depression. Edinburgh Postnatal Depression Scale is widely used in the postnatal period to screen for depression. The psychosocial interventions to prevent postnatal depression have not been shown to be beneficial and there is a dearth of psychopharmacological trials to make firm conclusions about their efficacy in preventing postnatal depression. Individualised psychosocial interventions aimed at the at-risk populations and initiated in the postnatal period appear to have some benefit in preventing postnatal depression.


Austin (2003) reviewed the efficacy of antenatal group interventions aimed at reducing postnatal depression (PND) in ‘at risk’ women. All five studies reviewed suffer from substantial methodological problems. The authors concluded that there is currently little evidence from RCTs to support the implementation of antenatal group interventions to reduce PND in ‘at risk’ women.


Lumley et al (2006) evaluated a primary care and community-based strategies embedded in existing services using a cluster-randomised trial involving 16 rural and metropolitan communities, pair-matched in Victoria. Women’s mental and physical health scores were not significantly different in the intervention arm and the comparison arm. The authors concluded that combined community and primary care interventions were not effective in reducing depression, or in improving the physical health of mothers six months after birth.
Workplace


Martin et al (2009) conducted a meta-analysis of 17 suitable studies. The results indicated small, but positive overall effects of the interventions with respect to symptoms of depression and anxiety but no effect on composite mental health measures. The interventions that included a direct focus on mental health had a comparable effect on depression and anxiety symptoms, as did the interventions with an indirect focus on risk factors. The authors concluded that a broad range of health promotion interventions appear to be effective, although the effect is small.


Couser (2008) conducted a literature review concerning workplace factors and interventions in preventing depression in the workplace. Employees can help prevent depression by building protective factors such as better coping and stress management skills. Employees may be candidates for depression screening if they have certain risk factors such as performance concerns. Organisational interventions such as improving mental health literacy and focusing on work-life balance may help prevent depression in the workplace but deserve further study. The author concluded that a strategy to prevent depression in the workplace can include developing individual resilience, screening high-risk individuals and reducing that risk, improving organisational literacy, and integrating workplace and health care systems to allow access to proactive quality interventions.

Self-help


The authors conducted a systematic review of 13 meta-analyses on the efficacy of self-help interventions, including internet-guided therapy, for depression and anxiety disorders. All reported medium to large effect sizes for self-help interventions. Most found relatively large effect sizes for self-help treatments, independent of the type of self-help, and comparable to effect sizes for face-to-face treatments. Further research is needed to optimize the use of self-help methods.


Christensen & Griffiths (2002) reported that there are no published randomised controlled trials of the effectiveness of the Internet in delivering depression prevention programs. The feasibility and potential effectiveness of the Internet is indicated by a range of research Possible limitations to public health interventions using the Internet include selective access, the inability to promote the sites to potential users and the issue of uptake once users access the sites. Randomised controlled trials of CBT delivered by the Internet are required.


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Endnote

Bibliography of meta-analyses, systematic reviews and key articles on treatment of depression in primary care settings

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Effectiveness of treatment


Cuijpers et al (2009b) conducted a meta-analysis of psychological treatment of depression in adults in primary care, and to compare these results to psychological treatments in other settings. The authors concluded that although the number of studies was relatively low and the quality varied, psychological treatment of depression was found to be effective in primary care, especially when GPs refer patients with depression for treatment.


The CPG team (2004) reviewed the treatment outcome literature, consulted with practitioners and patients and conducted meta-analyses of outcome research. They recommended that it was necessary to establish an effective therapeutic relationship and to provide the patient with information about the condition, the rationale for treatment, the likelihood of a positive response and the expected timeframe; consider the patient’s strengths, life stresses and supports. Treatment choice depends on the clinician’s skills and the patient’s circumstances and preferences, and should be guided but not determined by these guidelines. In moderately severe depression, all recognised antidepressants, cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT) are equally effective; clinicians should consider treatment burdens as well as benefits, including side-effects and toxicity. In severe depression, antidepressant treatment should precede psychological therapy. For depression with psychosis, electroconvulsive therapy (ECT) or a tricyclic combined with an antipsychotic are equally helpful. If response to an adequate trial of a first-line treatment is poor, another evidence-based treatment should be used. Second opinions are useful. Depression has a high rate of recurrence and efforts to reduce this are crucial.


Simon et al (2006) conducted systematic literature reviews to develop cost-effective clinical guidelines for treatment options for depression include antidepressants, psychological therapy and a combination of the two. They concluded that combination therapy is likely to be a cost-effective first-line secondary care treatment for severe depression. Its cost-effectiveness for moderate depression is more uncertain from current evidence. Targeted combination therapy could improve resource utilisation.


Ward et al (2000) compared the clinical effectiveness of general practitioner care and two general practice based psychological therapies (up to 12 sessions of non-directive counselling or CBT provided by therapists) compared with usual general practitioner care. They concluded that psychological therapy was a more effective treatment for depression than usual general practitioner care in the short term, but after one year there was no difference in outcome.
Cost-effectiveness of treatment


Chisholm et al (2004) aimed to estimate the population-level cost-effectiveness of evidence-based depression interventions (not necessarily prevention) and their contribution towards reducing current burden. Evaluated interventions had the potential to reduce the current burden of depression by 10-30%. Pharmacotherapy with older antidepressant drugs, with or without proactive collaborative care, are currently more cost-effective strategies than those using newer antidepressants, particularly in lower-income subregions. The authors concluded that even in resource-poor regions, each DALY averted by efficient depression treatments in primary care costs less than 1 year of average per capita income, making such interventions a cost-effective use of health resources. However, current levels of burden can only be reduced significantly if there is a substantial increase in treatment coverage.


Mihalopoulos et al (2005) evaluated an internet-based psychological intervention supported by either general practitioners or psychologists (Panic Online), and a Primary-care Evidence-based Psychological-interventions (PEP) strategy which involves training GPs to deliver specific psychological interventions. Economic modelling suggests that Panic Online is cost-effective when supported by either GPs or psychologists. Threshold analysis of the psychological training of GPs suggests that a modest effect size for clinical benefit would be sufficient to provide an acceptable cost-effectiveness ratio. The sustainability of these approaches depends on a range of factors, including funding, workforce availability, and acceptability to consumers and health care providers.


Vos et al (2005a) evaluated the available evidence on costs and benefits of CBT and drugs in the episodic and maintenance treatment of major depression. The authors concluded that a range of cost-effective interventions for episodes of major depression existed and are currently underutilized. Maintenance treatment strategies are required to significantly reduce the burden of depression, but the cost of long-term drug treatment for the large number of depressed people is high if SSRIs are the drug of choice. Key policy issues with regard to expanded provision of CBT concerned the availability of suitably trained providers and the funding mechanisms for therapy in primary care.


Vos et al (2005b) assessed, from a health sector perspective, options for change that could improve the efficiency of Australia's current mental health services by directing available resources toward ‘best practice’ cost-effective services. There are cost-effective treatment options for mental disorders that are currently underutilized (e.g. CBT for depression and anxiety, bibliotherapy for depression, as well as other interventions for other diseases). The biggest hurdle to implementation of more efficient mental health services is that this change would require reallocation of funds between interventions, between disorders and between service providers with different funding mechanisms.

Depression innovations and the primary care system


Gilbody et al (2003) conducted a systematic review of 21 suitable studies of the effectiveness of organisational and educational interventions to improve the management of depression in primary care settings. Strategies effective in improving patient outcome generally were those with complex interventions that incorporated clinician education, an enhanced role of the nurse (nurse case management), and a greater degree of integration between primary and secondary care (consultation-liaison). Telephone medication counselling delivered by
practice nurses or trained counsellors was also effective. The authors concluded that there is substantial potential to improve the management of depression in primary care. Commonly used guidelines and educational strategies are likely to be ineffective. The implementation of the findings from this research will require substantial investment in primary care services and a major shift in the organisation and provision of care.


Hickie et al (2004) examined the uptake by general practitioners (GPs) of the five key components of the Better Outcomes in Mental Health Care (BOiMHC) initiative: education and training for GPs; the three-step mental health process; focussed psychological strategies; access to allied health services; and access to psychiatrist support. The authors concluded that the level of uptake of the main components of the BOiMHC initiative has expanded the national capacity to respond to the needs of people with common mental disorders, such as depression and anxiety.


King et al (2002) assessed the effectiveness of teaching general practitioners skills in brief CBT based on a cluster RCT of an educational package on CBT. The main results were that doctors’ knowledge of depression and attitudes towards its treatment showed no major difference between intervention and control groups after 6 months. The training had no discernible impact on patients’ outcomes. They concluded that general practitioners may require more training and support than a basic educational package on brief cognitive behaviour therapy to acquire skills to help patients with depression.


Hegarty et al (2009) assessed national guidelines on general practice management of depression using two complementary approaches to identify specific ways in which guidance could be made more relevant and applicable to the nature of general practice and the patients who seek help in this context. The quantitative assessment highlights that most of the guidelines fail to meet the criteria on rigour of development, applicability, and editorial independence. The qualitative assessment shows that the majority of guidelines do not address associated risk factors sufficiently and the dilemma of diagnostic uncertainty flows over into management recommendations. Moreover, the guidelines in the main fail to acknowledge individual patient circumstances, in particular the influence on response to treatment of social issues such as adverse life events or social support.


Whitty & Gilbody (2000) examined whether the NICE guidelines will lead to this improvement in outcomes for people with depression? They concluded that will not do so unless organisational support in primary care for treating the vast majority of people is considerably extended, which includes enhancing the working relationship between primary and secondary care.


The depression initiative has been launched to integrate treatment for depressive disorder on a nationwide level according to the principles of disease management. First, Thirteen depression breakthrough collaborative teams consisting of a general practitioner (GP) and a multidisciplinary team from a Mental Health Institution seek to attain goals in implementation that were chosen by the teams. The second is collaborative care involving at least two out of three professionals in the primary care setting, namely the GP, the care manager and the consultant psychiatrist. Both efforts can facilitate implementation of integrated care. They seek a link between professionals and patients in the primary care setting. Also, all professionals involved in both projects are enthusiastic about collaboration with the depression initiative. Furthermore, the use of a web based algorithm is widely accepted in the collaborative care project. However, for both projects, limitations for the implementation of integrated care were found as well.
Appendix 1

*beyondblue*-funded Community awareness and destigmatisation programs and associated research

Depression awareness

4.1 Anxiety and Depression Awareness (ADA) Month

**Aims**
- to provide an opportunity for workplaces, community groups and individuals to take part in activities to raise awareness of anxiety and depression and help reduce the associated stigma

**Objectives**
- to give *beyondblue* the opportunity to keep the focus on mental health nationally for a month
- to work with partner organisations to step up awareness-raising activities throughout the month, particularly in workplaces and with the media

**Activities**

*beyondblue* Anxiety and Depression Awareness (ADA) Month during October, which includes Mental Health Week and World Mental Health Day encourages activities including:
- holding a morning tea to raise awareness in workplaces
- distributing *beyondblue* anxiety and depression-awareness information materials to colleagues, family and friends
- nominating a *wear blue* day at work
- displaying *beyondblue* posters in the workplace or community space
- wearing a *beyondblue* wristband for the month
- encouraging work colleagues or community group to participate in regular physical activity for ADA month

**Outcomes**
- in its inaugural year 2007, *beyondblue* distributed 30,000 ADA Month depression information resource kits
- more than 100,000 *beyondblue* ADA Month kits and materials were distributed nationally to individuals and organisations in 2008
- *beyondblue* distributed the *beyondblue* Stories of Hope and Recovery DVD as part of ADA Month
- National Australia Bank (NAB) participated in ADA Month by distributing *beyondblue* materials to thousands of staff, hosting information stalls in key buildings and featuring interviews on NAB TV
- *beyondblue* worked with Victoria Police to promote ADA Month and Mental Health Week by producing a co-badged information card and ADA Month kits for every police station in Victoria
- Barry Plant Real Estate included *beyondblue* ads and article in its magazine, provided community notice boards and promoted ADA Month in a letter box drop to over 900,000 Victorian households

**Evaluation** – NO
Conclusions – demand in ADA Month 2008 grew significantly with over 100,000 ADA kits ordered by organisations, businesses and individuals from every state and territory in Australia. In 2007 and 2008, beyondblue participated and promoted Mental Health Week (5-11 October) and World Mental Health Day (10 October) during ADA Month by supporting events in each State and providing thousands of information resources to give away to the community. The beyondblue Communications Team sent ADA month information and display kits to more than 400 radio stations across Australia. This awareness-raising exercise produced a great result, with many radio stations taking up the cause by promoting ADA month on-air, playing beyondblue Community Service Announcements and airing interviews on depression and anxiety with beyondblue ambassadors. Many newspapers including The Age, The Sydney Morning Herald, The Mercury, The Canberra Times, The Northern Territory News, MX and Leader Community newspapers ran beyondblue’s ads free of charge.

Recommendations – N/A

4.2 National Advertising Campaigns

Aims
– to develop and implement new advertising and other mass media campaigns

Objectives
– to use advertisements to raise awareness of depression, anxiety and related disorders

Activities
– APN Outdoor: the advertising agency ran beyondblue campaigns over a three-year partnership
– Barry Plant Real Estate: promoting the beyondblue website and Infoline on Barry Plant letterbox drop cards; making beyondblue information available in their offices; links from the Barry Plant website to beyondblue
– Convenience Advertising: supporting beyondblue in promoting its key messages
– Mitchell and Partners: Mitchell and Partners is Australia’s leading media buyer and a long-term beyondblue supporter

Outcomes
– APN Outdoor: beyondblue’s messages appear on billboards, buses, trams and railway stations in Melbourne, Sydney, Brisbane, Adelaide and Perth
– Barry Plant Real Estate: regular free advertisements in Imagine magazine; community real estate boards during Anxiety and Depression Awareness Month in October; newsletter articles; promoting the beyondblue AFL Cup each July through Barry Plant networks
– Convenience Advertising: through their support beyondblue advertisements have appeared in public bathrooms across Australia, including shopping centres, airports, hotels and bars
– Mitchell and Partners: Harold Mitchell of Mitchell and Partners long term beyondblue supporter enlisted the support of major media outlets including television, radio, cinema and print to support the Youthbeyondblue campaign with free airtime and ad space from 18 May 2009

Evaluation – NO

Conclusions – Pro bono partners APN, Mitchells, Convenience Advertising, and Barry Plant collectively and significantly assist beyondblue in raising awareness of depression amongst their staff and through promotion and advertising to clients and the general public.

Recommendations – N/A
4.3 *beyondblue* Community Service Announcements

**Aims**
- to raise awareness of depression, anxiety and related problems

**Objectives**
- to encourage viewers to reach out and seek help and information on depression, anxiety and related disorders
- to provide support for people who are exhibiting signs of depression
- to direct viewers to the *beyondblue* website and info line for information

**Activities**
- separate commercials focusing on anxiety, depression in the workplace, bipolar disorder, postnatal depression, depression and drug and alcohol problems, and depression in young people, older people and rural men
- translation of community service announcements

**Outcomes**
- in September 2006, *beyondblue* launched its second series of national TV, radio and print advertisements
- commercials are produced by Frontier Advertising in close association with *beyondblue*
- six TV commercials in the series and an additional advertisement aimed at rural men, which has been seen in rural areas across Australia
- the message is: “Helping someone with depression isn’t beyond you. For more information visit www.beyondblue.org.au or call the beyondblue info line 1300 22 4636 (local call)”
- the campaign is currently shown on Networks Seven, Nine and Ten, as well as SBS and many pay TV channels
- a selection of *beyondblue* television, radio and print ads has been translated into six languages – *Vietnamese, Polish, Mandarin, Greek (bipolar disorder), Italian (alcohol) and Arabic (older person and depression)*; these have been distributed to relevant media and strategically placed within relevant ethnic programs and publications as well as positioned on the *beyondblue* website with fact sheets and resources in the corresponding language

**Evaluation** – NO

**Conclusions** – each commercial provides a candid insight into the experiences of people with these conditions and how they hide their symptoms from friends, families and work colleagues. All commercial television networks support *beyondblue’s* national advertising campaigns, providing free prime-time space since July 2004 for *beyondblue* community service announcements. The campaigns extend through print media, cinema advertising, billboards, public conveniences and posters on public transport. All the major television companies have unanimously agreed to provide generous and ongoing support for this important community service campaign.

**Recommendations** – N/A

4.4 Find a Doctor/Find a Psychologist/Mental Health Professional webpage

**Aims**
- to provide the public with easily accessible information on available practitioners treating depression, anxiety, bipolar and related disorders at locations closest to them

**Objectives**
- to be a source of information and a guide to access treatment to health practitioners who have completed additional post graduate professional development in mental health
- to provide a means whereby medical or allied health practitioners may register their details and have their details removed or edited at any time
Activities
- practitioners invited to participate in this listing include general practitioners, clinical psychologists, psychologists, occupational therapists in mental health, and social workers in mental health
- all practitioners are required to provide their Medicare Provider number to confirm their eligibility to provide mental health interventions under the Government’s program of accessing better mental health services

Outcomes
- listing was made available on the beyondblue website, in July 2005
- the list can be located at the following link, www.beyondblue.org.au/index.aspx?link_id=107.1007
- June 2009 count showed the following practitioners now listed across Australia: general practitioners – 666; clinical psychologists – 684; psychologists – 576; occupational therapists in mental health – 21; social workers in mental health – 150; a total of 2,097 practitioners
- 145,000 webpage views

Evaluation – NO

Conclusions – the list is not a complete directory and practitioners on the list are not recommended or endorsed by beyondblue. Although, a national consenting practitioners listing has long been seen as important and is supported by the mental health sector, including the Better Access in Mental Health Initiative members, the Mental Health Council of Australia, Australian Divisions of General Practice, the Australian Psychological Society, Royal Australian & New Zealand College of Psychiatrists, the Australian Medical Association, and the Royal Australian College of General Practitioners.

Recommendations – N/A

4.5 beyondblue Better Access Fact Sheet – 24

Aims
- to provide information regarding Medicare rebates for a range of mental health services, which were previously not subsidised

Objectives
- to provide information on who is eligible for Medicare rebates under the Better Access initiative
- to provide information on what type of treatment is available and who provides it

Activities
- under the Better Access initiative services include: GP mental health care, psychological treatment, focused psychological strategies, and other services for which new Medicare rebates are available
- fact sheet provides information on: service costs and rebates, how often can a person have psychological treatment and qualify for a Medicare rebate, how does a person access treatment, should family members/friends be involved

Outcomes
- produced beyondblue Fact Sheet 24 on ‘Help for depression, anxiety and related disorders under Medicare – Better Access to Mental Health Care Initiative’
- GP Mental Health Care Plan – up to 12 (or 18) individual consultations in one calendar year
- review of a GP Mental Health Care Plan – after each block of six sessions with a mental health professional
- GP Mental Health Care Consultation – a GP can now provide a long consultation under Medicare (at least 20 minutes) for a person with a mental disorder
- Psychological Therapy, which includes Psycho-education, Cognitive Behaviour Therapy (CBT), and Interpersonal Therapy (IPT)
– Focused Psychological Strategies includes relaxation strategies and skills training
– other services available are initial consultation with a psychiatrist, assessment and management plan with a psychiatrist, and review of management plan with a psychiatrist

**Evaluation** – NO

**Conclusions** – it is important to note that while the rebate (the amount a person can claim from Medicare) is standard, the amount the provider actually charges can vary from one mental health professional to another.

**Recommendations** – N/A

**OLDER PERSONS**

**4.6 Baptcare – maturityBlueprint**

**Aims**
– to develop a training program for the professional staff at Baptcare Community Aged Care Programs that enables them to recognise and respond to an older person who may be depressed or at risk of depression

**Objectives**
– to provide staff with the information and skills necessary to be able to recognise depressions and the possible risk factors for depression for their client group
– to increase staff confidence and ability to be able to respond to those older people living in their own homes and receiving Community Aged Care Packages
– to assist older people more effectively to obtain assessment, support and treatment as necessary

**Activities**
– consultation process involving three parts: literature review, Depression Monitor data analysis, assessing training needs of Baptcare staff
– training program for the Baptcare staff through Train the Trainer sessions
– research conducted to determine the degree of change, if any, in knowledge/attitudes/comfort level when dealing with clients with depression, after the program
– focus group consultations (two) with Victoria-wide Baptcare staff, individual interviews (16) with carers and care recipients, one focus group with staff and Certificate IV students (eight) from Nextt Health (registered training organisation that provides brokered staff)

**Outcomes**
– initial training session was attended by 10 people from throughout VIC, in Melbourne
– three extra sessions added on demand (2 in Melbourne and 1 in Morwell); 7 attended the first session although only 5 completed the course, and 8 attended the second and 9 in Morwell
– outcomes from the focus groups informed the content and design of the training program
– overwhelming consensus that training be delivered to Care Managers and Supervisors first, and then to brokered staff and carers in the future
– interviews with carers and care recipient pointed out that attitudes of staff was very important
– Next Health focus group reported that recruitment and retention of brokered staff, and the personal attributes of all staff including care managers and brokerage as essential
– DVD which includes training materials and video clips, printed resources for the training program, background articles, participant registration forms, training assessment forms, and research questionnaire provided to each person completing the training program

**Evaluation** – YES (training and research components)
Evaluation design – qualitative

Methods
– pre and post training questionnaire (for all participants), then 3 and 6 months later
– evaluation rated relevance of training information, change in depression awareness/understanding/recognition, confidence levels, recommending program to others

Findings
– overall, evaluation results were positive
– depression nominated as the most important mental health problem (55.6% pre and 70% post)
– knowledge of depression rose from 50% pre to 80% post, to 100% at final follow up
– responding to clients and colleagues, i.e. confidence and comfort levels increased from 40% to 90%
– stigma and attitudes of participants receiving training data towards people experiencing depression decreased from 30.4% to 4.5%

Conclusions – low follow up rates from participants renders it difficult to ascertain the effectiveness of the training. Despite positive evaluation results, Baptcare has not conducted any maturityBlueprint training within their organisation in the eight months since the Train the Trainer sessions. The project shows that training frontline staff enhances the recognition of depression and improves the interventions for older people with depression.

Recommendations – further implementation of the program will ensure value for the money invested in the development of the program, ensure continuity and longevity of the program and improve staff capacity to assist their clients.

4.7 beyondblue beyond maturityblues Peer Education Project

Aims
– to train older people as volunteer educators to deliver information sessions about depression to their peers using the established community networks of each State and Territory COTA in metropolitan, regional and remote settings

Objectives
– to increase awareness and understanding among older people of depression in the older person
– to present strategies to minimise the risk of depression among participating older people, including how to discuss issues related to their physical and mental health with their own health professionals
– to increase older people’s knowledge of community services and supports available to provide them with help in addressing or treating depression
– to provide information to older people on the link between good general health and good mental health in older people

Activities
– peer education sessions presented to seniors groups and clubs across Australia
– peer educator training conducted over one to three days (average training time = 12 hours)
– media and promotional activities presented at: e.g. church and religious groups, chronic illness and other support groups, local government, multicultural/Indigenous groups/organisations
– community sessions across all states and territories; regional/metropolitan/remote areas
– COTA staff training: Train the Trainer model of induction for all coordinators over two-days (two group training sessions conducted)
– WA nominated and finalist for ‘Community Services Industry Awards 2008’ for this project
Outcomes
- developed Trainers manual, Peer Educators resource manual, posters, promotional materials (pamphlet, flyers)
- 21 project officers underwent training during the project, Australia-wide
- 237 Peer Educator resource manuals developed and distributed nationwide
- 35 peer educator training sessions conducted nationally with 225 volunteers of which 146 continued into Stage two of the project; average retention rate was 71.4% nationally
- all states and territories contributed to and distributed the Peer Educators Network News to peer educators by four per annum during the course of the project
- 31,327 participants overall at 1,470 community sessions, until 31 March 2009
- fact sheets in an audio CD format produced for visually impaired groups (n=31)
- developed modules for veterans, men, people with chronic illness and people in rural communities
- 5 Italian speaking peer educators recruited in five States to deliver Italian version of the program, nationally

Evaluation – YES

Evaluation design – qualitative, formal, cross-sectional

Methods
- feedback collected at completion of training (from state coordinators)
- peer educators completed a COTA training evaluation form at completion of training
- feedback forms completed at end of each community session

Findings
- increase in depression knowledge/confidence of state coordinators to present the training to peer educators; satisfaction with relevance of training information/resources and overall training
- 98.95% peer educators indicated training and information provided was sufficient to enable them to facilitate the beyondblue maturityblues project
- community sessions identified issues on depression and chronic disease, stigma, lack of communication and loneliness, cost of counselling, death and dying, retrenchment, unemployment and financial crisis, lack of services and supports particularly in rural and regional centres

Conclusions – specific modules on grief and loss have been developed and introduced. Further, CALD beyondblue maturityblues programs are now in the process of being rolled out; Italian speaking peer educators have been recruited in five States to deliver an Italian version of the program nationally with Greek, Chinese and Vietnamese versions to follow by late 2010. There is ongoing partnership with a range of community organisations to promote the sessions, such as St Vincent’s Housing Program to present sessions on a regular basis as part of its outreach service.

Recommendations – development of fact sheets relevant to Indigenous community would be useful. Training around appropriate support and referral, in dealing with issues of grief and loss in a community setting is also recommended.
INDIGENOUS

4.8 Mibbinbah Indigenous Men’s Sheds/Spaces Pilot Project

Aims
– to develop an understanding of what makes Indigenous men’s spaces safe and healthy for men, and how this might benefit their families and communities

Objectives
– to develop and strengthen the capacity of Indigenous communities through:
  – upskilling local Indigenous men; training in leadership, depression awareness, community communication and media, computer skills and other relevant skills to support them become skilled community leaders
  – to develop linkages between Indigenous men’s groups and community organisations
  – to maintain and strengthen the Mibbinbah network of Indigenous men
  – to use the support of key players to encourage local Indigenous men to become role models/community leaders
  – to normalise and de-stigmatise depression by promoting awareness and encouraging help-seeking by Indigenous men
  – to develop a ‘safe’ space for Indigenous men where they can speak about depression and anxiety

Activities
– depression awareness training – held in May and October 2008 with 26 Indigenous men in the first session and 38 in the second session, respectively. A beyondblue appointed facilitator was actively involved throughout these sessions
  – development of networks – a Mibbinbah network module consisting of primary and secondary networks within each participating site was established. The primary network consists of CEO of Indigenous organisation, project associate, mentor, and coordinator. A champion outside the immediate primary network advocates for the program both within the organisation and in the community. The secondary network is established when the primary network develops linkages with other sites
  – raising awareness of depression within local communities – each project site provide opportunities to share stories that reflect concerns about social and emotional wellbeing, and to refer people to the local information and resources that are available (including beyondblue resources and Mibbinbah website)
  – development of a mentoring program – project associates as mentors provide training sessions to Indigenous men and encourage meeting, sharing experiences and learning from each other through networking and capacity building.

Outcomes
– anecdotal feedback suggests that the training was well received, and the resources were taken by men for use in their respective communities
  – the networks accord with the Aboriginal and Torres Strait Islander people’s traditions of yarning and provided the men with a safe space to share their experiences on depression, anxiety and other related disorders
  – the project has been a learning process whereby Indigenous men open up and learn about depression and anxiety – a process of normalising and de-stigmatising depression and anxiety
  – development and establishment of Mibbinbah Limited as an independent not-for-profit Indigenous men’s organisation which supports a larger network of men and transfers knowledge about chronic conditions, and social and emotional wellbeing.

Evaluation – NO
Conclusion – the Men’s Spaces pilot project demonstrated that enhancing and strengthening the capacity of Indigenous communities is a vital step in promoting awareness of depression and anxiety, and encouraging men to seek help. Mibbinbah has the potential to develop and maintain a support network infrastructure for Indigenous men that will strengthen their capacity to become community leaders. Such a community capacity building model will promote health and wellbeing within the Indigenous community, and it will provide an excellent opportunity for beyondblue to promote awareness of depression and anxiety through Indigenous networks.

Recommendations – beyondblue and Mibbinbah to develop specific and tailored training modules on depression and anxiety for Indigenous men, informed by the work undertaken as part of this pilot study; beyondblue and Mibbinbah partner to continue to strengthen and expand the Mibbinbah network; beyondblue and Mibbinbah continue to disseminate information and resources on depression and anxiety through the Mibbinbah network, and to consider the development of tailored resources for Indigenous communities; beyondblue to support Mibbinbah to continue to strengthen and expand the mentoring program.

RURAL PROGRAMS

4.9 Mental Health Drought Initiative – MHDI

Aims
- to raise community awareness, educate and train business and community leaders (by beyondblue), and provision of community outreach and crisis counselling (by Australian General Practice Network)

Objectives
- to provide activities to raise community awareness of depression and related disorders
- to contribute to the provision of education and training for business and community leaders
- to contribute to improving access to mental health services in drought affected rural and remote areas of Australia

Activities
- beyondblue collaboration with the AGPN to develop linkages with State-based Divisions of General Practice (DGPs) and relevant health organisations
- participation in the proposed National Divisional Workshop convened by AGPN, February 2008
- beyondblue MHDI Plan identified four Strategic Targets: Collaboration and Partnership, Communications and Awareness, Community Development, and Rural and Remote Access
- beyondblue has identified five Action Areas in which the Strategic Targets will be delivered: National Divisional Workshop, Communication, consultation and liaison, beyondblue Don’t Beat About the Bush! information campaign, including resource development and distribution, Frontline Rural Workforce Training (RWT), and Evaluation and Reporting

Outcomes (NB: July 2008 – June 2009)
- collaboration and Partnership: collaborative and consistent approach with AGPN and DGPs (45) on building mental health capacity in drought-affected communities
- Communications and Awareness: media coverage in every DGP, specifically in communities where the RWT is delivered, and promotion of links to Information kiosks and DGPs
- Community Development: provision of remaining RWT, overall review and evaluation of RWT workshops
- Rural and Remote Access: extension of dissemination of drought resources to and through the 43 DGPs, and establishment of Information kiosks in all 43 DGPs
- National Divisional Workshop: AGPN National Coordinator for the MHDI is convening a workshop for all 45 DGP coordinators and beyondblue to coordinate planning for the implementation of the MHDI
Communication, consultation and liaison: beyondblue will collaborate and liaise with all tiers of AGPN drought management for the MHDI, and with other key stakeholders and AGPN officers (e.g. Centre for Rural and Remote Mental Health NSW, NSW, SA, VIC and QLD farmers associations, Centrelink and drought bus services).

beyondblue Don’t Beat About the Bush! (refer item 7.3): provide free of charge to all 45 DGPs a drought information kit about how to recognise and manage depression and other mental health issues, collaborate with the KidsMatter Initiative and the Community Support Workers engaged by the 45 DGPs to develop and distribute drought mental health resources for primary schools in the DGPs, expand beyondblue’s Rural Information Kit and provide the Kit free of charge at all community awareness rural events, education and training workshops.

Frontline Rural Workforce Training: list details of Frontline training schedules on the beyondblue website Drought page.

Evaluation and Reporting: the evaluation of beyondblue’s performance on this Plan will be on the four Strategic Targets and five Action Areas.

Evaluation – YES – The project has been evaluated independently by DoHA (report pending)

Conclusions – beyondblue’s participation in the Commonwealth Mental Health Support for Drought Affected Communities Initiative was announced in the Australian Government May 2007 Budget. The contracted funding period ceases on 30 September 2009. The effective timeframe for beyondblue’s activity, which includes early planning and consultation with drought-affected communities, began on 1 July 2007. Extended by DoHA to 30 June 2010.

Recommendations – N/A

4.10 Don’t Beat About the Bush! beyondblue Rural Drought Response

Aims
- to provide rural communities with awareness information, advice on service pathways, community and workplace training, and support for community initiatives to manage the distress of drought at local levels

Objectives
- increasing community awareness of depression, anxiety and related substance use disorders and addressing associated stigma
- supporting depression prevention and early intervention programs
- researching development and information provision to increase depression literacy and awareness of support services
- improving access pathways to Primary Care
- training GPs and allied health professionals on depression
- providing Rural Workplace Training to local business and other front-line staff who, increasingly, are dealing with major distress in their farmer customers and clients

Activities
- partnership and action with Australian and all State and Territory Governments; the beyondblue Rural Drought Response is a national, across-government strategy
- beyondblue works on the ground with Rural Financial Counsellors and other support services through state and territory partnerships
- promoting phone support services such as the Rural Financial Counsellors Line 1800 026 222 and the Centrelink Drought Assistance Line 13 23 16
- beyondblue Infoline (1300 22 4636) and beyondblue website are widely promoted as one-stop information portals to a comprehensive range of support services for people in need across drought-affected areas
- beyondblue Don’t Beat About the Bush! community awareness campaign
- Don’t Beat About the Bush – communications strategy
Outcomes
- In partnership with governments and rural industry, beyondblue has developed a wide range of practical resources for people and communities in the rural sector, including the beyondblue rural media campaign and beyondblue Drought Kit
- beyondblue has widely promoted through the media the free book “Taking care of yourself and your family” by John Ashfield – 300,000 copies have been distributed
- Every doctor who is a member of the Rural Doctors Association has received a free copy
- beyondblue in association with the Rural Doctors Association produced a TV commercial in 2006 (the ad received widespread exposure and is still being played by networks – at no cost)
- Men’s Health Week in June – in 2009, beyondblue contributed funds to a TV ad (NB: ads shown at no charge by TV networks) ad for Men’s Health Week featuring several high-profile men, including Men’s Health Ambassadors Tim Mathieson, Bill Noonan, and Dr Rob Walters
- beyondblue also promotes on an ongoing basis to local media in specific regions, the Rural Workforce depression-awareness training programs which are being conducted in partnership with the Australian General Practice Network under the banner of the federally funded Mental Health Drought initiative (see item 3.2)

Evaluation – NO

Conclusions – beyondblue’s ‘Don’t Beat About the Bush’ Drought Response is a co-ordinated and comprehensive mental health strategy involving existing beyondblue programs, all tiers of government and community and corporate sector programs aiming to strengthen community and regional infrastructure and enhance community resilience. beyondblue has the capacity to resource and support Australian Government (DPI, DAFF and Centrelink) programs such as the EC Drought Package, the Centrelink Drought Bus, emergency individual and community grants (CWA administered), the communication campaign on farmer assistance and also on monitoring and evaluation strategies. National media releases are disseminated every year focusing on men’s issues – men and drinking, men looking out for their mates’ mental health issues, and men and anxiety disorders, and gives rise to dozens of stories particularly in rural and regional papers.

Recommendations – N/A

4.11 Australian Rural Information Network (ARIN) Map

Aims & Objectives
- To show rural specific resources available to country people in across Australia
- An online directory to organisations and agencies with links to mental health information and support available to country people in rural, specifically drought and disaster affected communities across Australia

Activities
- Websites provide information on resources including Centrelink, Rural Financial Counsellors, Salvation Army, Drought Support Workers, St Vincent De Paul, RSL and Rotary clubs, Country Women’s Association, Rural Financial Counsellors, Divisions of General Practice, and beyondblue Information sites
- The Federal Government has deemed geographically defined areas as eligible for extra support and assistance due to the effects of the prolonged drought; i.e. Exceptional Circumstances (EC) – brown areas on the map
- Prima Facie areas have the potential to become EC areas and remain under scrutiny. Should conditions deteriorate due to the drought the status of these areas will be upgraded to EC declared. Should this happen people living in these areas will become eligible for further support and assistance – yellow areas on the map

Outcomes
- 9,000 page views to date
- There are 3500 organisations and agencies listed on the ARIN map.
The ARIN map shows Information sites which are local businesses and organisations in 250 rural and remote localities where beyondblue and local mental health information is available to the community.

Evaluation – NO

Conclusions – the ARIN Map shows (pinpoints) services available in particular areas in Australia (by town/city/state/postcode). Interestingly, most of the services are concentrated in the eastern border of Australia (predominantly in VIC). beyondblue information sites are located across Australia, mostly concentrated in VIC and QLD

Recommendations – N/A

COLLABORATIONS

4.12 Freemasons Men’s Health – No More Secrets

Aims
– to provide the public with a new avenue to information on depression and anxiety

Objectives
– to make men aware of the need to be more responsible about their health through attending awareness seminars organised by their local Masonic lodges around Australia.

Activities
– media coverage which included a full page stories in the Financial Review and the Adelaide Advertiser, as well as some 400 articles in suburban weeklies and regional dailies
– events and seminars: several across Australia and New Zealand, 2006
– brand awareness of Freemasons Australasia
– collaboration between peak bodies associated with men’s health in a co-operative effort for the first time: beyondblue, Andrology Australia, the Prostate Cancer Foundation of Australia, Foundation 49, the Cancer Council of Australia, and the Heart Foundation

Outcomes
– Men’s Health – No More Secrets campaign ran from September to November 2006, with events planned by Freemasons under the umbrella of Men’s Health
– first time the six Grand Lodges of NSW, ACT, New Zealand, QLD, SA, NT, Tasmania, VIC and WA worked together on the one project
– a distinctive branding strategy and brand livery was developed and produced
– some 30,000 people attended 251 men’s health events throughout Australasia
– almost $400,000 worth of positive publicity was generated for men’s health
– many new community links were formed for Men’s Health organisations throughout Australasia
– continuing demand for Men’s Health information material prepared for the campaign
– attendance by Federal Health Minister Tony Abbott at his first men’s health event, by the State Ministers for Health at functions in South Australia and Tasmania, and by local members of parliament and local government representatives at many seminars around Australasia
– in February 2007, the National Campaign Chairman and the chairman of beyondblue made a National Press Club televised address on men’s health, which revitalised the campaign’s public awareness, presenting Men’s Health and Freemasonry to a national audience
– in Victoria, some 6,000 people received Men’s Health information kits at the “Tan Walk”, a men’s health display day held at Melbourne’s Botanical Gardens; some 300 Freemasons turned up to support representatives from 12 other organisations that support Men’s Health
Evaluation – YES, the project was evaluated by the Freemasons

Conclusions – Freemasonry Australasia gained recognition as the first community group to run a national, structured series of Men’s Health seminars, a major logistical event which harnessed the capabilities of the six groups which administer the movement in Australia and New Zealand. Although the campaign confirmed anecdotal evidence of a high level of apathy amongst Brethren at all levels in most jurisdictions, however, many Lodges and organisers report positive anecdotal responses to the initiative from participants and local communities. SA and NT reported that beyondblue meant little to them as their events were well organised before beyondblue’s involvement could be positively confirmed. However, wherever possible they did encourage depression to be included in the presentations. A national approach to this (the men’s health campaign) was attempted but was not universally applied across the jurisdictions.

Recommendations – N/A

4.13 Prostate Cancer Foundation of Australia – PCFA

Aims
– to raise awareness of depression and anxiety in men with prostate cancer and their partners

Objectives
– to provide information on pathways to care and prompt help seeking
– to provide access to factual and current health promotion information related to men
– to increase knowledge of the need for men to be proactive about their health

Activities
– beyondblue is partnering with the PCFA
– developing and distributing resources
– hosting community forums (e.g. Men’s Health Promotion Forum Perth, 2008) and promoting awareness of depression, anxiety and prostate cancer at conferences, workshops, agricultural field days and other community-based activities
– providing prostate cancer support group convenors and prostate cancer ambassadors with training on depression and anxiety.
– supporting research investigating effective depression interventions for men with prostate cancer and their partners
– supporting the development and distribution of the Advanced Prostate Cancer Consumer Guidelines

Outcomes
– beyondblue and PCFA have signed a two-year MoU to guide their partnership
– produced a booklet on Maintaining your well-being: information on depression and anxiety for men with prostate cancer and their partners, a fact sheet on Prostate cancer and the risk of depression/anxiety, and a wallet card
– in 2008 beyondblue supported five PCFA-led community forums; this included providing $15,000 per forum and a speaker to discuss depression and anxiety

Evaluation – NO

Conclusions – beyondblue and PCFA have joint ambassadors, who promote awareness of depression and anxiety in men with prostate cancer and their partners. Continue to promote awareness of depression and anxiety through PCFA events and communication channels.

Recommendations – N/A
**MEDIA**

**4.14 beyondblue’s Depression Monitor Data**

**Aims & Objectives**
- to monitor public understanding of depression, i.e. survey results to monitor depression awareness, knowledge, attitudes and help-seeking behaviours

**Activities**
- longitudinal results of national telephone survey for periods 2001/02, 2004/05, 2007/08, conducted in October across all States in Australia
- analysis categories: awareness, perceptions/knowledge/understanding, assistive behaviours, attitudes/stigma, help-seeking behaviour, knowledge/attitudes of treatments, awareness of beyondblue, anxiety disorders, pre and postnatal depression, bipolar disorder
- sample selection controlled for gender, age, State and region
- response rate in 07/08: only 10.2% contact interviews, with over 54% no contact, over 6% out of scope and over 28% refusals (n=31,327)
- sample n=3,200 of which males 49%, females 51%, 40% within the age groups 25-34 (20%) and 35-44 (20%), education level Year 12/13 or Certificate/Diploma (21 – 25%)
- survey conducted predominantly in VIC (34 – 40%), metro regions (65%), NESB (18%), ATSI (1%)
- experience of depression (07/08) self only (9%), family member (32%) and both 23%
- Clinical Distress scale reported 97% yes and 2% no (n=3,200)
- health training 20% and mental health training 9% (steady increase by 1% each year since 2001)
- awareness of beyondblue: steady increase from 22% (2001) to 76% (2007/08)

**Outcomes**
- depression is still not recognised as a major health problem, although understanding has increased slightly (3% – 2001 to 6% – 2007/08), many competing health issues overshadows it
- depression is strongly identified as a mental health problem (56%), followed by psychosis (24%), drug/alcohol abuse (15%) and bipolar disorder (10%); however, postnatal depression (PND) is quite poorly recognised (1%) and limited awareness of anxiety (7%)
- 58% of the population still underestimate both the prevalence of depression and likelihood of contact
- there is a growing recognition that depression is debilitating (over 80%), and many (78%) agree that they can recover with treatment
- psychological therapy (75%), antidepressants (70%), long term counselling (86%), physical activity (93%) were considered helpful in treating depression; although, antidepressants were considered addictive (56%) and tranquillizers even more addictive (73%), change in diet (74%) and natural remedies (65%) were considered helpful, however, sleeping tablets (49%) and occasional alcohol (44%) was considered harmful
- steady but consistent reduction in social distancing and stigma over time; although 32% still believe people with severe depression are dangerous to others, 68% reporting them as unpredictable, and 52% as unreliable
- although perceptions/confidence of GP is steadily improving over time, 51% still feel that GPs spend less time with the problem; however, GPs are more willing now to provide/recommend non-drug treatments (58%) or refer to other health professionals (88%). Notably, 78% of people with depression feel intimidated to approach the GP regarding their problem
- depression information is predominantly sought from the internet (49%), whilst asking a GP or doctor (combined 44%), contacting a mental health organisation decreased over time (from 8% to 2%), contacting beyondblue risen from 0% to 7%
– however, actual information seeking behaviour was 41% of which 44% from internet, 35% from GP/doctor, and only 3% from beyondblue
– 76% indicated that they would turn to family/friends, 28% to GPs; reduction in % who indicated they wouldn’t seek help or don’t know
– 64% had experience depression (direct/indirect), 81% received help predominantly through GPs and other health professionals, 27% indicated that family prompted to seek help and 16% self awareness
– 77% aware of depression in the media in the last 12 months, 60% heard of depression-related organisations of which 74% recognised beyondblue (44% unaided; 29% with beyondblue prompt, 3% with JGK prompt)

Evaluation – NO

Conclusions – awareness of depression and related disorders is increasing steadily over time.

Recommendations – specific focus needs to be placed on PND, anxiety and bipolar disorder.

4.15 beyondblue Media Releases – February 2008 to July 2009

Aims & Objectives
– to provide an overview of the extent of depression awareness activities beyondblue has been involved in over the period from February 2008 to July 2009

Activities

Outcomes (few examples)
– February 2008: www.beyondblue.org.au wins Hitwise Website Award (beyondblue’s website was announced as the most-visited site in the Health and Medical – Organisations Category in the Hitwise Online Performance Awards for 2007), free Mental Health DVDs available from NSW video/DVD stores (co-badged media release with the Mental Health Association of NSW prompted several mentions in suburban newspapers)
– March 2008: beyondblue and AGPN – $10m – tackling drought and depression in rural communities (co-badged media release (bb and AGPN) was issued to promote the first workshop of the Mental Health Support for Drought-affected Communities Initiative), Spreading the word… in languages other than English (launching of the multilingual resources at The Diversity in Health 2008, Strengths and Sustainable Solutions Conference at Darling Harbour)
– April 2008: National Youth Week, April 5-13 (a national media release was sent out to promote beyondblue’s involvement in National Youth Week with Government media releases in TAS, NT, VIC, ACT and NSW which featured quotes from beyondblue CEO Leonie Young and media kits containing bb info and youth statistics)
– June 2008: Look out for your mates in Men’s Health Week (June 9-15) – by A/Prof Michael Baigent
– July 2008: beyondblue/Heart Foundation – research funding awarded for depression and heart disease
– August 2008: Hip Hop Dance Workshops tackle depression in young people (promoting beyondblue’s Kempsey Deadly Styles project at the International Unity in Diversity Conference and Cultural Fest in Townsville and workshops/performances by Indigenous Hip Hop Projects
– September 2008: beyondblue exports depression awareness program to UK (announcing beyondblue’s National Workplace Program to be trialled in the UK by Sainsbury Centre)
– October 2008: Seniors Festival Week in Victoria Oct 5-12
– November 2008: Raising awareness of depression and prostate cancer on the Gold Coast
– December 2008: Taking care of yourself after retrenchment or financial loss
- January 2009: SA Grade Cricket clubs go into bat for depression awareness during Febuary (promoting launch of Febuary Campaign at the Adelaide Oval)
- February 2009: beyondblue announced as L’Oreal Melbourne Fashion Festival Charity for 2009
- March 2009: National Youth Week (Mar 28 – April 5)
- April 2009: Out of the Blue Gala Dinner to raise awareness of depression (Tasmania) to promote dinner being held in Ulverstone to raise community awareness of depression and anxiety
- May 2009: New program for GPs to help young people with depression/anxiety (media release to promote the launch of Young Minds: Treating Depression and Anxiety in Young People)
- June 2008 to May 2009: Raising awareness of depression (promoting beyondblue Rural Workforce Training (RWT) workshops and establishment of beyondblue info kiosks to local media; media releases relating to over 35 RWT workshops that have taken place, sometimes simultaneously, across Australia

Evaluation – NO

Conclusions – N/A

Recommendations – N/A

4.16 Media Monitoring (External Media Coverage)

Aims & Objectives
- to provide an outlook on the level of media coverage that beyondblue is exposed to

Activities
- beyondblue subscribes to a media monitoring service and media interviews/mentions are tracked and logged
- beyondblue has a key group of spokespeople who provide informed comment to the media on depression/ anxiety and related disorders, and beyondblue’s programs and activities
- beyondblue fields calls from the media on a daily basis, assisting journalists with information and facilitating interviews with beyondblue experts who provide informed comment when appropriate
- beyondblue stories, information and comment appear nationally in newspapers, magazines, trade magazines, on radio, TV and online on a regular basis

Outcomes (NB: beyondblue media exposure provided for periods January 2005 to May 2009)
- 2005: exposure has been relatively steady throughout, averaging around 100 exposures/month and peaking in November
- 2006: although higher level of media exposure than 2005, there is a steady decline in the first quarter, followed by fluctuations and then peaking at 1208 exposures in October followed by steep decline to 592 exposures in December
- 2007: steady increase in exposure peaking at 1964 in May, then followed by fluctuations, again peaking at 1300 in October followed by steep decline to 350 exposures in December
- 2008: steady increase in the first quarter, followed by steady decline in the second quarter, and steep increase in September, peaking at 1470 in October, followed by fluctuations
- 2009: steady increase in media exposure in the first quarter (i.e. till May)

Evaluation – NO

Conclusions – N/A

Recommendations – N/A
4.17 Hitwise Awards

Aims
– to demonstrate the efficacy and popularity of the beyondblue website

Objectives
– to showcase the reach of beyondblue website
– to enable the most efficient way of monitoring of how more people visit more websites than any other way of measuring Internet usage
– to provide detailed insights into the search terms used to find thousands of sites as well as a range of click stream reports, analysing the movements of visitors between sites

Activities
– the anonymous data sent to Hitwise from the ISPs include a range of industry standard metrics relating to the viewing of websites including page requests, visits and average visit length
– Hitwise collects aggregate usage statistics from a geographically diverse range of ISP networks in metropolitan and regional areas, representing all types of Internet usage including home, work, educational and public access
– to ensure the ISP and opt-in data is accurate and representative, it is weighted to estimates in each market
– Hitwise enables an efficient way of monitoring of how people visit websites.

Outcomes
– beyondblue has won the annual Hitwise No. 1 website award in 2004, 2007 and 2008
– Hitwise provides insights on how 3 million Australian Internet users interact with more than 1 million websites, across 165+ industries

Evaluation – NO

Conclusions – twice a year, Hitwise awards the 10 most popular websites across each of 160+ categories. Each winner is presented with a Hitwise Top 10 award. Companies are not required to be a Hitwise client to qualify for the Hitwise Top 10 Award program. Top 10 Website Awards are based on popularity according to the market share of user visits a website receives compared to other websites in their industry.

Recommendations – N/A

4.18 Testimonials and Website statistics

Aims & Objectives
– to prove the wealth of information accessed by consumers and their testaments on how effective/successful beyondblue resources are to them
– to show how people found beyondblue site and how they explored it

Activities
– beyondblue currently uses Google Analytics to analyse website usage; it tracks how visitors interact with a website, including where they are located, what they did on a site, and whether they completed any of the site’s goals
– sending out free beyondblue resources to teachers, school psychologists, etc on request via the beyondblue website
– providing information on the website on how to identify and help someone experiencing depression
– including information about the website in ‘info bag’ at community health talks
Outcomes
– of the four testimonials provided by beyondblue, it is clear that those people were highly satisfied with beyondblue resources received/accessed via the website and its usefulness in providing mental health information and further links to upcoming mental health events and services, with confirmation on continued use of beyondblue services/website

Evaluation – NO

Conclusions – Google Analytics data on beyondblue usage is only available from 19 April 2008. Should data prior to this date be required for the evaluation, beyondblue is able to request raw usage logs from their website hosting provider NextDigital. This raw data, however, has been collected in a different manner to Google Analytics and therefore, is not directly comparable to the results provided by Google Analytics.

Recommendations – N/A
Appendix 2

*beyondblue*-funded Consumer and carer programs and associated research

PARTNERSHIPS

5.1 Australian Centre for Posttraumatic Mental Health – ACPMH

Aims
- to address issues/concerns related to mental health of people following a traumatic experience/event

Objectives
- to encourage people to seek information and support on mental health and wellbeing following a traumatic experience/event
- to work in partnership with key organisations to collaborate on mental health issues following traumatic events

Activities
- working in collaboration with *beyondblue*, Red Cross, Centre for Grief and Bereavement, and National Workplace and Social Enterprise (NWSE)

Outcomes
- MoU signed between ACPMH and *beyondblue*
- co-wrote and branded *beyondblue*’s new Post Traumatic Stress Disorder Factsheet
- drafting of booklet for adults following natural disaster to be published in the second half of 2009
- contracted by DoHA to develop materials for the Community Support Training Project for bushfire recovery training

Evaluation – NO

Conclusions – ACPMH will be on the expert advisory group for the above mentioned training project (managed through *beyondblue* National Workplace & Social Enterprise Program).

Recommendations – N/A

5.2 Multicultural Mental Health Australia – MMHA

Aims
- to address the mental health and wellbeing of the Culturally and Linguistically Diverse (CALD) community in Australia

Objectives
- to support the development of initiatives increasing access and awareness of mental health, with a focus on depression anxiety and related disorders, amongst the CALD community in Australia

Activities
- working in collaboration with *beyondblue* through its auspice Sydney West Area Health Service
- translation of both *beyondblue* and MMHA fact sheets which are available on both websites and have been printed for distribution across the country
– inclusion of a MMHA consumer in the beyondblue “Hope and Recovery” DVD
– involvement of a MMHA consumer in the beyondblue pilot Ambassador Training Program

Outcomes
– MoU signed between MMHA and beyondblue
– dissemination has included large mail outs and advertising in MMHA and Federation of Ethnic Communities Councils of Australia (FECCA) newsletters
– co-launching multilingual fact sheets, television and radio advertisements and posters
– presentation of programs and services at key multicultural conferences (FECCA Women’s Conference, Unity in Diversity Conference and the MMHA Diversity Conference)

Evaluation – NO

Conclusions – N/A

Recommendations – N/A

5.3 PricewaterhouseCoopers – PwC

Aims
– to address the mental health and wellbeing of staff at the PricewaterhouseCoopers workplace as part of the National Workplace Program

Objectives
– to collaborate with beyondblue’s National Workplace and Social Enterprise (NWSE)
– to train PwC staff under beyondblue’s NWSE guidelines
– to develop an e-learning module for PwC and beyondblue

Activities
– workplace presentation by Senior Program Manager from NWSE, to PwC leadership group
– discussions between PwC and beyondblue to support capacity building to assist with the scoping for SCMH partnership
– review of pricing and business model of the workplace program
– discussions to deliver beyondblue’s program as a pilot to relationship managers in PwC

Outcomes
– workplace trainers delivered NWP info sessions (12) as part of PwC foundation weeks 2006 – 2008
– presentation to a work team in Melbourne as part of their team building day
– beyondblue program to PwC relationship managers
– training for PwC relationship managers in all offices (9), August 2008
– Leonie Young presented to the PwC Foundation Council 2008
– Mark Higgins, partner at PwC who led beyondblue’s National Workplace Program review, was invited and joined the Board sub-committee on NWSE in 2009.

Evaluation – NO

Conclusions – PwC Foundation and beyondblue progressing e-learning options

Recommendations – N/A
SELF-HELP (ONLINE THERAPY)

5.4 beyondblue e-network

Aims
– to provide people across Australia the opportunity to be informed with the latest research and information related to depression, anxiety and related disorders, via the internet

Objectives
– to encourage people to seek information on mental health and wellbeing
– to engage in proactive communication through sharing of information

Activities
– free to join email database via beyondblue website
– subscribers receive beyondblue newsletter in either print or email formats
– beyondblue newsletter provides up-to-date information about beyondblue programs and projects

Outcomes
– established beyondblue virtual network with 10,000+ members as at 2005
– beyondblue virtual network with 22,000+ members post 2007

Evaluation – NO

Conclusions – e-members regularly receive information, with many using the service to communicate directly with the organisation, share information and their stories and raise awareness about depression, anxiety and related disorders. Members include people with a mental health condition and other interested people including health professionals. This includes up-to-date information and developments in the areas of depression and beyondblue related to research, programs, resources and events.

Recommendations – N/A

5.5 e-couch Project

Aims
– to develop a web-based interactive program on depression

Objectives
– to test the public release of the e-couch web program

Activities
– Centre for Mental Health Research (CMHR) team worked towards the public deployment of e-couch project
– internal testing of the system to the level required for deployment of the program to the public by CMHR

Outcomes
– users register with username and password to access the site
– program includes an assessment stream, a depression literacy section, and four evidence-based interventions – CBT, Interpersonal Psychotherapy, Relaxation Therapy and Physical Activity
– program also includes interactive exercises and a personalised workbook
– site functionality is complete and tested
– program provides approximately 6 – 8 hours of ‘online experience’ for the typical user
Evaluation – YES, e-couch has been subjected to a randomised controlled trial evaluation, results having been presented at the 1st International e-mental health summit in Amsterdam, Netherlands in October, 2009. It was reported to be effective in reducing depressive symptoms post intervention.

Conclusions – CMHR has a strong track record of consistent delivery of online public mental health interventions over the last six years. Its team will apply its experience and expertise to ensure the ongoing success of the site including protection of privacy and confidentiality of data, relevance of content, server security and program functionality. CMHR intends to independently continue development of e-couch, beyond the scope of its agreement with beyondblue; which has been evident in the addition of an anxiety stream along with a social anxiety program.

Recommendations – beyondblue agreement stipulates that a complete copy of the project material must be deliverable to beyondblue; however, e-couch is a web-based program driven by a database and is only recognisable through web delivery via browser. Therefore, alternative arrangements have been preferred by CMHR. Monitoring of the site to ensure that any problems or potential issues are dealt with in a timely and appropriate manner is to be taken on by the CMHR team. The team is also to measure the effectiveness of the site using repeated online measures and to modify content or functionality as required to test specific research hypotheses.

5.6 Multicultural Information on Depression – MIDonline

Aims
– to improve depression literacy and assist in pathways to mental health care for people of CALD backgrounds living in Australia

Objectives
– to examine levels of depression literacy and depression related stigma in mid to older aged Greek and Italian people
– to develop and evaluate a depression-specific internet based information resource, MIDonline, specifically targeted at mid to older CALD communities in Australia
– to examine whether viewing the website results in changes in the levels of depression, anxiety, depression and anxiety symptomatology
– to examine beliefs that Greek and Italian born people have on the causes, symptoms, course, consequences and treatment of depression
– to investigate the effects of a multilingual depression specific internet based information resource on the levels of depression literacy and depression related stigma in Greek-born and Italian-born immigrants living in Melbourne

Activities
– linking with ethno-specific organisations such as AGWS and CoAsIt to advertise the research project and website
– MIDonline website is planned to be added as a link on various other mental health related websites
– results of the study is planned to be advertised through ethno-specific radio and media print

Outcomes
– evaluation of the consumer section of MIDonline project
– two manuscripts have been intended for submission to peer reviewed journals for publication
– translation of the MIDonline consumer section into Chinese and Spanish through academic staff at the School of Languages, Cultures and Linguistics, Monash University

Evaluation – YES; consumer section only

Evaluation design – randomised control trial
Methods
– a sample of 202, 65 year olds (mean age) were randomly allocated to MiDonline (intervention n=110) and depression interview (control n=92) groups
– levels of depression and anxiety, depression literacy, personal stigma and perceived stigma were assessed before and after, and again at one week follow up

Findings
– depression literacy significantly increased in intervention group at post and one week follow up relative to control group
– significantly reduced levels in personal stigma related to depression in intervention group at post and one week follow up
– significantly reduced levels in depression in intervention group at post and one week follow up
– significantly reduced levels in anxiety in intervention group at post and one week follow up
– no difference between intervention and control groups on perceived stigma levels related to depression

Conclusions – MiDonline is the first study to develop and evaluate a multilingual depression specific website to increase knowledge of depression, decrease self and perceived depression related stigma, and assist in pathways to mental health care in mid to older aged members of the CALD communities. MiDonline has demonstrated that the internet may be an effective and accessible medium for depression literacy and depression stigma reduction programs targeting mid to older CALD populations. MiDonline has filled the current gap in Australian mental health system by providing culturally appropriate mental health information and resources for CALD consumers and carers, and mental health professionals.

Recommendations – MiDonline can be utilised to facilitate pathways to professional mental health care for CALD communities. Further research into accessibility to internet based program by older aged CALD people is needed. Also, further research is required to determine what information and messages are most effective in reducing stigmatising attitudes in CALD communities. Further research is also needed into the evaluation of the use mental health information interventions, such as MiDonline, by mental health professionals when managing CALD people.

5.7 Panic Online – PO
Aims
– to investigate the effectiveness of PO with face-to-face assistance provided by a GP (PO-GP) compared to PO with email assistance from a psychologist (PO-P), for treating panic disorder (PD) with or without agoraphobia

Objectives
– to directly compare two different ways of delivering an internet-based treatment program for clinical mental health disorder
– to provide new information about the effectiveness of an internet-based mental health intervention applied to a primary care setting

Activities
– study advertised via Australian mental health websites, local and national media
– interested individuals directed to PO website, www.med.monash.edu/mentalhealth/paniconline, to self register for the study
– promotion of study to GPs (Focused Psychological Strategies trained – FPS) via several BOiMHC accredited mental health training programs in Victoria and SA
– interested GPs were contacted by telephone and registered for study; then, given access to PO website and sent written materials about the study
– research officer (registered psychologist) either met or via telephone discussed study with GPs
– potential patients registering online (PO-P group) or referred via GP (PO-GP group) were screened (via telephone) for PD; once recruited they completed a set of online questionnaires prior to beginning treatment
– initial PO use training for GPs provided by first and second authors followed by consultative support via telephone and email

Outcomes
– PO study investigators produced two peer-reviewed publications and six conference presentations
– 65 individuals with PD participated (PO-GP n=34; PO-P n=31); NB: 18 in PO-GP and 12 in PO-P groups were taking medications for depression and/or anxiety during the period of participation
– 132 GPs from Victoria and SA registered for the PO-GP group (37 actively referred and treated participants in the study)
– seven psychologists recruited as therapists for the PO-P group
– PO comprised of an introductory, four learning, a relapse prevention modules and stress management program with six learning modules (standardised non-varying information)

Evaluation – YES

Evaluation design – a natural groups design

Methods
– clinical interviews administered by a psychologist over telephone and self-administered online questionnaires: Anxiety Disorders Interview Schedule – IV (ADIS-IV), Panic Disorder Severity Scale (PDSS), Anxiety Sensitivity Profile (ASP), Depressions Anxiety Stress Scales (DASS), Treatment Credibility Scale-Modified (TCS-M), WHO Quality of Life – brief (WHOQoL-brief)
– post treatment assessments at the end of 12 weeks included ADIS-IV interview via telephone and same set of online questionnaires

Findings
– PDSS and DASS: reduction in mean scores for both groups
– ASP: marginally higher pre-treatment scores for PO-P than PO-GP and lower post-treatment scores for PO-P than PO-GP
– WHOQoL: increase in mean scores for both groups
– ADIS: PD clinical change was not statistically significant between both groups
– panic free and end state functioning: high end functioning achieved was not statistically significant between both groups at post treatment

Conclusions – PO study suggests that accredited GPs, when provided with validated online treatment protocols, can achieve patient outcomes comparable to that provided by clinical psychologists. It demonstrated that internet-based CBT with GP support produced clinically significant improvements in PD symptomology, quality of life and end-state functioning. Further, PO provides an innovative opportunity to relieve some of the pressures on the GP workforce.

Recommendations – to ensure that programs like PO are integrated into existing models of primary care to increase availability and accessibility of evidence-based treatments and potential sustainability beyond research setting. Future research should investigate the use of internet-based mental health initiatives delivered by GPs without FPS skills training. It also investigates whether the frequency of GPs visits, in which supportive therapy is provided to patients undergoing internet-based treatment, affects patient outcomes. Future research is also needed to isolate the mechanisms of change in CBT and internet-based treatment for PD, with a view to more closely targeting these mechanisms in future interventions.
5.8 Ambassador Program

Aims
– to raise depression awareness across Australia and reduce the stigma associated through the powerful tool of sharing personal experiences in media and public settings by building a pool of trained speakers in every State/Territory

Objectives
– to raise community awareness about depression and related disorders and to decrease the associated stigma through publicly sharing personal experiences
– to encourage community members to seek help for themselves and others
– to promote beyondblue’s key messages through the sharing of personal experiences

Activities
– ambassadors to speak about their experience to the media, at community forums, events, conferences and workplace briefings
– ambassadors to appear in beyondblue advertising and awareness campaigns (TV, print and radio ads, printed resources and DVDs) which tackle stigma and discrimination
– ambassadors to share their story on beyondblue website
– briefing and debriefing pre and post events and media interviews; i.e. ongoing communication and support for Ambassadors
– one-on-one induction session provided by senior beyondblue staff
– blueVoices members are invited to participate

Outcomes
– full day face-to-face training provided for selected Ambassadors
– training covers role of Ambassadors, introduction to beyondblue, public speaking and presentation skills, beyondblue event management process and working with media
– ambassadors are provided with a beyondblue information pack as part of training
– 8 High Profile Ambassadors and 10 Consumer and Carer Ambassadors from blueVoices selected
– ambassador pilot training conducted on June 29, 2009

Evaluation – YES

Conclusions – The Ambassador Program is a part of beyondblue’s Consumer and Carer portfolio. It has three arms, namely High Profile Ambassadors (with personal experience), Consumer and Carer Ambassadors (all blueVoices members), and Health Professional Ambassadors (currently under development, in conjunction with NWP). Clinical input is included in the structure of the face-to-face training and the ongoing support offered to beyondblue Ambassadors. Feedback from the many events that beyondblue has been involved in reflects that the personal stories presented by someone who has experienced depression, or a carer, was often the most powerful, and most remembered part of the event.

Recommendations – Following the evaluation of the above pilot of the Ambassador program for blueVoices members, it is anticipated that the program will be rolled out to more members across Australia.
5.9 blueVoices

**Aims**
– to take forward the lived experience of depression and anxiety and represent the consumer and carer issues of importance at a national level for *beyondblue* on relevant committees and government structures

**Objectives**
– to lead the nation in rewriting how the Australian community views people living with depression, anxiety and related disorders
– to educate and empower the community to support, accept and encourage those affected by these illnesses to participate in a full and rich life

**Activities**
– provides consumer and carer input into all *beyondblue* materials (Fact sheets and Resources) and activities
– provides ongoing consultation for the national awareness campaigns, including focus group consultation
– identifies and informs *beyondblue* of the needs and experiences of consumers and carers
– promotes personal experience of caring and carer perspectives to the media, through representation on committees (e.g., guidelines, research), and at forums and conferences

**Outcomes**
– established blueVoices Management Committee (2002 – 2007)
– established blueVoices Sub-Committees, with reps from all state and territories, comprised of Bright blueVoices, Beyond babyblues, Beyond maturityblues, Youthbeyondblue and Blueboffins
– re-structure of blueVoices e-groups to include a National Reference Group
– email correspondences with blueVoices members in many mental health related sub-groups
– as of June 2009, blueVoices has over 400 consumers and carers in its membership

**Evaluation** – NO

**Conclusions** – With the establishment of blueVoices, *beyondblue* has access to a national reference group of people with direct personal experience of depression, anxiety and related disorders. blueVoices also includes people who care for, or directly support, someone with one or more mental health conditions including depression, anxiety disorders or substance use disorder. Since late 2007, communication has been primarily via email and membership is open to anyone in Australia who has had experience of depression, anxiety or related disorders, or their carers or primary support people.

**Recommendations** – N/A

5.10 *beyondblue* Bulletin Board (BB) Summary and Share Your Story (SYS) web pages

**Aims**
– BB: to provide a forum for people affected by depression, anxiety and related disorders to share their own personal experiences of the illness and respond to those of others
– SYS: to provide an outlet for people affected by depression, anxiety and related disorders to let others know about their own personal experiences and to help each other

**Objectives**
– to support each other through the diagnosis, treatment and recovery phases of illness and gain an understanding that they are not alone
– to provide an opportunity for consumers and carers to utilise their lived experience to actively participate in other peoples’ journey towards recovery
– to actively participate in providing other people with the first-hand knowledge of the personal challenges and triumphs associated with depression, anxiety or related disorders

**Activities**

– BB and SYS web pages are accessed via the Youthbeyondblue website
– rigorous and timely moderation for every web posting/submission, by a qualified mental health professional
– review process underpinned by set of criteria that govern what should and should not be posted

**Outcomes**

– number of people completing posts has almost doubled from 740 posting in the first half of 2008 to 1,180 posting in the first half of 2009
– since May 2007, the beyondblue BB has been viewed by around 130,000 people
– number of people completing posts has more than tripled from 79 posting in the first half of 2008 to 247 posting in the first half of 2009
– in the last two years there have been around 250,000 visits to beyondblue’s SYS web pages

**Evaluation** – NO

**Conclusions** – beyondblue has received overwhelmingly positive feedback that the Bulletin Board plays a critical role is assisting people affected by depression and anxiety through the giving and receiving of support and by actively participating in the recovery of other people. Likewise, the beyondblue Share Your Story web pages are increasingly being utilised and accessed.

**Recommendations** – N/A

### 5.11 Youthbeyondblue

**Aims**

– to work in partnership with key youth and mental health organisations and the community to raise awareness of depression, anxiety and related disorders and support community awareness and destigmatisation, and prevention and early intervention programs focussing on young people aged 12 -25 years

**Objectives**

– to highlight the call to action of ‘Look (for the signs of depression), Listen (to what the person is saying), Talk (about what’s going on) and Seek Help Together’ and promote the development of those skills for all young people
– to raise awareness of the signs and symptoms of depression and anxiety in young people
– to raise awareness of where to get help
– to direct people to the website www.youthbeyondblue.com and the info line 1300 22 4636 (1300 bb info)
– to direct young people to services e.g. headspace, Kids Helpline, ReachOut.com
– to target not only young people, but their friends, parents and families

**Activities**

– target audience, young people 12 – 25 years
– production process in association with Frontier Advertising, Zealot Films and beyondblue Community Awareness, Communications and Youth teams, and clinical advisers
– ads for TV, the web and cinemas, radio ads, CSAs, print ads
– casting ads with young people
– final scripts/language used in ads consulted for acceptability and believability by an adolescent psychologist; words described were actual words used by real people to describe their feelings
– focus testing of finished TV and proposed print ads
– re-developing Youthbeyondblue website

Outcomes
– call to action icons and text have been created and incorporated across the youth-focused advertising campaign
– three TV ads (Community Service Announcements), three radio CSAs, print ads
– the call to action message is: “You can help someone find a way back from anxiety and depression. Find out where to get help at Youthbeyondblue.com or call 1300 22 4636”
– radio ads have been produced with similar scripts and the same message as the TV ads
– print ads suitable for use in newspapers, magazines, posters in public spaces and on billboards, have been developed
– three different groups of young people viewed the print and TV ads; group of young women mainly tertiary students aged 18 – 20 years; group of young men mainly university students 18 – 22 years; group of young consumers, who had been involved in the script development, aged 17- 19 years
– website redeveloped to include an improved design, easier navigation, updated content – refreshed and relevant, and new youth fact sheets incorporating the images from the ad campaign
– Convenience Advertising is currently displaying print ads featuring the Look, Listen, Talk and Seek Help messages in toilets/bathrooms on university and TAFE campuses around Australia

Evaluation – NO

Conclusions – beyondblue has re-branded its youth arm from Ybble (a brand transferred in 2002 from a Queensland-based private hospital initiative related specifically to youth suicide) to Youthbeyondblue after a study showed that young people had a reasonable knowledge of the brand beyondblue, but a very poor knowledge of the brand Ybble. Four website design options were developed and focus-tested with young people and the final design selected according to their preferences. An evaluation will be conducted later in 2009 to judge the efficacy and reach of this poster campaign. Most of the advertising space and time is donated to beyondblue free of charge. Overall, the ads were well-received.

Recommendations – N/A

ENHANCED CONSUMER AND CARER CHOICE

5.12 Mental Health & Insurance Discrimination Project – MHID

Aims
– to ensure mental health conditions are fully understood by the insurance industry and are treated no differently from comparable physical conditions

Objectives
– to recognise the issues faced by people with a mental health condition and the difficulties they faced in obtaining life insurance
– to improve the industry’s understanding of mental health conditions and their risk management practices
– to improve the life insurance outcomes for Australians with mental health conditions

Activities
– first MoU (world first) signed between the life insurance industry (IFSA) and the Mental Health Sector Stakeholders (MHSS), March 2003
Management of MoU by Steering Committee comprises of key stakeholders including Mental Health Signatories, Life Insurance Signatories, additional mental health stakeholders (carer and consumer representatives), and additional life insurance stakeholders

underwriting and claims surveys, three since 2003

Mental Health Council of Australia/beyondblue qualitative study Mental Health and Insurance Discrimination Project, on consumer experience.

Outcomes

in September 2003, IFSA published developed new industry-wide guidelines on underwriting and claims treatment in respect of mental health conditions

in June 2006, IFSA published a report by Professor Gavin Andrews which analysed the recurrence, severity and duration of disability resulting from mental health conditions with a view to determining the appropriateness of current rating and underwriting practices in Australia

new processes have been developed and implemented providing the means for more people with a mental illness to receive an appropriately-modified insurance policy, rather than being declined access to cover

annual data collection and reporting from IFSA members on current practises in insurance applications and determinations in Australia has taken place

a mechanism has been introduced to address complaints about underwriting in respect of mental health conditions, and industry complaints guideline and consumer fact sheets on the process have been developed

the MoU stakeholders have prepared information sheets to assist the community in understanding the implications of applying for insurance products and the importance of making accurate statements about their health

formal communication with the General Practice community has started on life insurance/mental health

stakeholder relationships have been broadened in order to develop education and training programs for underwriters and claims assessors about mental health and the experiences of persons with a mental health problem

Evaluation – NO

Conclusions – The MoU between the mental health sector and the insurance industry has significantly enhanced the insurance outcomes for people with a past or current history of mental illness. The success of the MoU to date demonstrates the value of a collaborative approach and the challenge is to continue to build on this success. The MoU signatories and the Steering Group participants are committed to working together on this challenge and the work plan for the 2008 – 2010 MoU aims to further improve the life insurance outcomes for those with mental illnesses and their carers. Through effective monitoring and setting clear measures, the success of the fourth MoU will be assessed in 2010, when it is hoped that the commitment by all parties will see the fifth signing of the MoU.

Recommendations – The re-signing of the MoU (Oct 2008) will see the Life Insurance Industry and Mental Health Stakeholders continue their partnership approach between 2008 and 2010. The commitment is to undertake streams of work in the following areas:

1. Simplification (of insurance forms and procedures for applicants);
2. Information, Education and Awareness (training for underwriting and claims professionals, raising community awareness of insurance issues and the MoU, information for financial planners);
3. Complaints Processing and Monitoring;
5.13 beyondblue Infoline

Aims
- to provide callers with access to information and referral to relevant services for depression and related disorders including anxiety, bipolar, postnatal depression, related substance misuse and associated issues

Objectives
- to assist callers who experience particular barriers to accessing referrals, such as geographic isolation
- to follow up callers for whom a duty of care obligation has been identified by the Infoline staff

Activities
- providing information about: beyondblue, depression and related disorders, mental health resources, research, policies, available treatments and management strategies, services and service pathways
- referrals are made to services with expertise in the treatment of mental health concerns (GPs, psychologists, primary care providers and crisis services)
- Infoline staff refer to various service providers with appropriate expertise in support and/or information provision, in areas such as carer support services, government assistance and counselling

Outcomes
- the beyondblue Infoline was established in July 2006
- this service operates 24-hours a day, seven days a week; designated beyondblue
- Infoline operators are available daily from 7:00 to 22:30 Monday to Friday and 10:00 to 22:30 Saturday and Sunday and other suitably qualified, Crisis Support Services, telephone counselling staff take calls outside of these hours
- the beyondblue Infoline provided information, referral and general assistance to 73,129 callers between July 2007 and December 2008

Evaluation – NO – Planned early 2010

Conclusions – attempted calls to the beyondblue Infoline have increased substantially since the inception of the service, from 791 calls in July 2006 to 6,755 calls in June 2009. Over the life of the service, calls have increased at an average rate of 150 calls per month.

Recommendations – N/A
Appendix 3
*beyondblue*-funded Prevention and early intervention programs and associated research

**WORKPLACE PROGRAMS**

**6.1 National Workplace & Social Enterprise – NWSE**

**Aims**
- to increase the capacity of Australian workplaces and other identified groups to understand the impacts of depression, anxiety and related disorders, and work actively to prevent these disorders and improve the quality of life of everyone affected, building on National Workplace Program’s (NWP) beyondblue vision

**Objectives**
- to achieve its aims through the use of an evidence-based and collaborative approach, on a cost-recovery basis
- to implement a new business model based on sustainable growth
- the NWP break-even annual volume must exceed 1,267 sessions, based on average pricing, variable and fixed costs for 2009/2010
- proactively targeting large organisations
- develop and market new products for past and present clients
- leverage beyondblue networks
- to trial key initiatives such as e-learning and consultancy (to be rolled out in 2010/2011)
- licensing elements of the NWSE portfolio both in Australia and overseas (2011 and beyond)

**Activities (projected)**
- current service offering supplemented and integrated into a total solution for promoting mental health in the workplace, including e-learning, consultancy and other beyondblue activities
- incremental increases in people, process, technology infrastructure
- discount policy determined by contracted booking volume and pro bono work

**Outcomes**
- NWP changed its organisational name to NWSE, in April 2009, to include a social enterprise model and reflect the breadth of work covered outside the workplace
- demand for NWSE has grown significantly with a CAGR of 46% from 2005/06 to 2008/09 with sessions numbers projected to increase by 38% on the previous year
- the top 5 ANZSIC/ABS industry groups provide 56% of the total number of sessions
- Government and allied services provide 39% of NWSE’s clients
- targeted positions have been recruited and roles clarified
- an interim solution (booking and customer system) developed on MS Access and implemented, beyondblue’s new core IT system will be implemented in 2009/10
– projected growth based on operational capacity;
– exporting NWP to the Sainsbury Centre of Mental Health in the UK

Evaluation – YES (NB: PwC evaluated the original NWP in Jan 2008)

Conclusions – there are 10.8 million Australian employees and NWSE has reached 40,000; therefore, 99.6% of the market remains untapped. After 10 years, based on CAGR of 46% for the past four years, NWSE will reach only 2.9%. Therefore, on the current model beyondblue may not be able to take a significant share of the addressable market of Australian employees. Nevertheless, beyondblue will operate beyond 2010 and incorporate NWSE as a strategic business unit of the organisation. Overall, NWSE is a niche player that provides depth in a specific area of mental health in the workplace value chain as opposed to mental health being one aspect of a broader health and wellbeing value chain; hence, its value proposition is strong. Key drivers of business value (sustainability, evidence-based, expanding reach, agile: responsive and proactive, professional/high standards, builds reputation) which provide criteria for evaluating suitability of strategies to most effectively reach the vision of NWSE has been met. NB: The National Professional Sports Program and the Rural Workforce Program are existing programs within the NWSE portfolio as external clients.

Recommendations – NWSE model requires high quality governance and accountability to maintain reputation and public trust, as it manages entrepreneurial initiatives and risks whilst sustaining core values. Hence, it is vital to maintain an appropriate balance between social and enterprise goals.

6.2 PricewaterhouseCoopers’ NWP evaluation summary

Aims & Objectives – refer to item 6.1

Activities & Outcomes – refer to Item 6.1

Evaluation – YES

Evaluation design – quantitative, economic evaluation

Methods
– overall financial performance
– overall demand,
– customer demand by segment,
– session type demand by segment,
– market analysis of NWP segment breakdown (Federal, State and local governments, professionals services, education and agribusiness),
– competitors and comparable programs,
– value chain analysis,
– return on investment, and
– price volume analysis

Findings
– demand for beyondblue’s NWP services has grown significantly (CAGR 45%) from Jan’06 to Dec’07
– government segments consistently exhibit the highest overall demand whilst other segments experienced significant demand fluctuations which are primarily event driven
– beyondblue only serves about 1% of each addressable industry market
– various Employee Assistance Program (EAP) providers service the corporate world with differing offers and pricing structures
**Conclusions** – NWSE has continued to grow rapidly and has met all recommendations including:

- Doubled in size of sessions
- Improving its financial position:

But to achieve a goal of reaching all Australian workplace even after 10 years, based on the current compound annual growth rate of 46% for the past four years, beyondblue may not be able to take a significant share of the addressable industry markets. There are 10.8 million Australian employees and NWSE has reached 40,000, therefore 99.6% of the market remains untapped.

**Recommendations**

- Building on the beyondblue vision, the vision for NWSE is for all Australian workplaces and other identified groups to understand the impacts of depression, anxiety and related disorders, and work actively to prevent these disorders and improve the quality of life of everyone affected.
- The current face to face approach cannot alone achieve this due to logistics and costs. Increasing reach, using scalable technology such as e-learning and partnerships to increase capacity through licensing and in-company workplace-based facilitators will be key.
- As NWSE is operating on a social enterprise model, it needs to manage entrepreneurial initiatives and risks whilst sustaining core values. High quality governance and accountability to maintain reputation and public trust will underpin this business plan.

**6.3 Australian Institute of Training and Development (AITD) National Award to NWP**

**Aims**

- to recognise outstanding practice in learning and development and in organisational development

**Objectives**

- to celebrate those who have made a significant contribution to organisational performance through learning and development

**Activities**

- four AITD awards were presented in Business Strategy, Excellence in Design, E-learning Achievement and Excellence in a Learning Resource, April 2008

**Outcomes**

- Business Strategy awarded to Foster’s Group, Excellence in Design awarded to Sensis, E-learning Achievement awarded to Money 101 and Excellence in a Learning Resource awarded to beyondblue for the resource ‘Tackling Depression and Related Disorders in the AFL.

**Conclusions** – the NWP resource used a range of tools and support options to present comprehensive and informative approach to the need it was addressing by excellent adaptation of an existing resource, targeting a specific market and basing the customisation on survey data.

**Recommendations** – N/A
6.4 Tackling Depression and Related Disorders in the AFL

Aims
– to raise awareness about depression among AFL players

Objectives
– to help the AFL directly by supporting affected players
– to help de-stigmatize depression and related disorders within the broader Australian community

Activities
– resource was developed and informed by a survey screening process undertaken by AFLPA
– AFL Program and Resource developed by various beyondblue staff and adapted from beyondblue National Workplace Program
– AFL Resource information disseminated to players, coaches, umpires, support and administrative staff across the country in conjunction with workshops
– media launch of the AFL Resource, April 2007
– development interviews filmed with well-known Australian footballers and athletes describing their experience of depression and recovery

Outcomes
– the Australian Football League (AFL) and AFL Players’ Association collaborated with beyondblue to create the National Professional Sports Program (part of National Workplace Program)
– 48 workshops held in two stages delivered to 1,096 participants by beyondblue NWP team members or beyondblue Accredited Trainers; stage 1 – for players and stage 2 – for those working in supporting roles within the industry
– resources included production of DVD, development of website, co-branded AFL-specific information sheets, and development of an engaging and interactive training session

Evaluation – YES

Evaluation design – quantitative and qualitative analysis

Methods – handouts provided in conjunction with a 1 – 2 hour training session

Findings
– high levels of satisfaction with quality of presenter, support materials and resources
– high relevance of workshop content reported by participants
– increased awareness and knowledge about depression, and greater confidence to assist someone with depression
– 87.4% of AFL participants reported that they would recommend the workshop to others

Conclusions – the program has been successful and is being rolled out in other professional sports contexts. The program was also significant because AFL players are inspirational role models for many people.

Recommendations – N/A
6.5 Sainsbury Centre NWP UK Pilot

Aims
- to make widely available high quality, affordable and evidence-based training for employers

Objectives
- explore the extent to which the program can be applied in the UK context, and how it compares to evaluations of the program in Australia
- identify the impact the training has on managers’ awareness and understanding of depression
- investigate whether the training helps managers feel more confident at approaching and supporting colleagues who may be experiencing depression
- understand whether the level of impact of the training varies dependent on the type of organisation
- assess how feasible it was to deliver the programme at ‘arms length’ from beyondblue through a partnership with the Sainsbury Centre

Activities
- between October and November 2008, the Sainsbury Centre piloted one of beyondblue’s NWP training sessions ‘A Management Response to the most common mental health problems’; a 3 hour session, specifically aimed at managers
- University of Nottingham commissioned to undertake an independent evaluation of the program which supported the impact and effectiveness of the beyondblue program
- beyondblue and SC entered an exclusive licensing agreement for the UK to pilot the program for one year, ending on 30 April 2009, since extended to February 2010

Outcomes
- four trainers delivered 17 sessions over six weeks, to 266 managers from seven different businesses from across the public and private sectors
- discussion group after last session with all four trainers

Evaluation – YES

Evaluation design – before and after design

Methods
- pre and post training questionnaires, and anonymous feedback sheet completed by all managers who attended the training
- 14 telephone interviews with a purposeful sample of managers who attended the training
- feedback sheets completed by a key contact (HR or Training Manager or OH specialist) from all participating companies

Findings
- managers’ feedback sheets showed a very high level of satisfaction with the training; over 90% found the program relevant and 97% indicated that they would recommend the workshop
- feedback from participating organisations was positive, with key contacts at companies praising the training for its effectiveness
- the findings from the pre and post-training questionnaires completed by managers showed an increase in knowledge with a significant change from 44% to 95% about the prevalence of depression
- manager’s awareness increased as a result of the training (statistically significant); similarly, more managers after the training disagreed with a list of prejudiced statements about people with depression
– the training also significantly influenced manager’s confidence and they were clearer on what behaviours would be helpful and unhelpful
– the questionnaire findings showed that this confidence had increased across all participating organisations to a large extent; whereas changes in attitudes and stigma did not increase so uniformly, or to such a large degree, across all the companies

Conclusions – It is possible to deliver the NWP, with minor adaptations for the UK context, at arm’s length from the beyondblue NWP. Although guidance and training was essential in order to plan and set up the pilot, ongoing input from the beyondblue NWP was not required once delivery commenced. Throughout the delivery of the UK Pilot, the quality of the NWP was maintained and the beyondblue NWP’s quality control and monitoring processes were adhered to. The collaboration between the Sainsbury Centre and beyondblue was excellent at all levels, particularly service development, operations and on-going communication.

Recommendations – The messages of the training can be enhanced when undertaken in conjunction with anti-stigma campaigns both at the national, regional and workplace level. The training can be enhanced when it is backed up by support from within the organisation (through the company’s policies/procedures). Managers need clear guidelines and follow up on what they are expected and allowed to do. Sainsbury Centre is recommending that the beyondblue NWP be made available across the UK. Priorities for any national roll-out need to be: maintaining the high quality of delivery achieved in the pilot, adherence to beyondblue’s NWP operational standards and branding, and ensuring the program is affordable and accessible for any workplace in the UK.

6.6 Workplace Program Sessions

Aims & Objectives – refer to item 6.1

Activities & Outcomes
– NWP sessions participants across financial years:
  – 2005/2006 – total sessions 161; total participants = 2620; peaks in May’06 (4th qtr)
  – 2006/2007 – total sessions 265; total participants = 5395; peaks in Oct’06 (2nd qtr)
  – 2007/2008 – total sessions 529; total participants = 14190; peaks in Oct’07 (2nd qtr)
  – 2008/2009 – total sessions 745; total participants = 22885; peaks in Oct’08 (2nd qtr)
  – 2009/2010 (current/projected) – sessions 32; peaks in Oct’09 (2nd qtr)
  – sessions per annum – steady increase shown from 2005/2006 (n=161) to 2008/2009 (n=745)

Conclusions – beyondblue’s National Workplace Program has shown steady progress in terms of number of sessions per annum, and total number of participants. Interestingly, across the financial years from 2005/2006 to 2009/2010, NWP sessions show a peak during the month of October. This can be attributed to events and initiatives such as the World Mental Health Day, Mental Health Week, beyondblue’s Movember and Anxiety and Depression Awareness (ADA) Month falling in October.

Recommendations – N/A
6.7 ACT Health Job Stress and Workplace Mental Health Project

Aims
- to design, develop, deliver and evaluate a workplace mental health promotion program for businesses and other workplaces in the ACT

Objectives
- to integrate the existing beyondblue early intervention NWP and the McCaughey Centre’s (at The University of Melbourne) job stress intervention

Activities
- as at March 2009: tailoring of beyondblue training sessions (each worksite was invited to request tailoring of the materials to address specific issues in their workplace, to date no worksites have taken up this invitation)
- delivery of beyondblue training sessions
- analysis of baseline survey data
- provide advice and consultation to worksites

Outcomes
- standard beyondblue training presentation and materials have been tailored for use in the ACT Health project
- delivery of beyondblue training sessions for general staff (2hr sessions) and managers (3hour sessions) in each of the participating worksites
- preparation of baseline measures for analysis against final (to be collected July 2009) as part of effectiveness evaluation
- ongoing advice and consultation provided to each of the worksites on request; progress meetings have been carried out with seven of the nine worksites

Evaluation – YES (ongoing)

Evaluation design – quantitative effectiveness evaluation, quantitative process/implementation evaluation, qualitative case study evaluation

Methods
- a census survey will be conducted with all employees in each organisation or business unit enrolled in the study before and after receiving the intervention
- measures on baseline survey, final survey, and 6-month follow up
- notes and observations collected in the Future Inquiry workshops (these will take place at start of intervention period) as well as semi-structured interviews (conducted in person or by telephone) with 2-4 respondents
- future inquiry workshops, one per site at baseline
- key informants interviews (up to 4 per site; i.e. 2 from management and 2 from other employees) at baseline, midpoint and final

Findings
- preliminary descriptive analysis of responses to the pre and post training surveys:
- an increased knowledge about depression (e.g. prior to training, 67.2% of respondents correctly identified that one in five Australians will experience depression, compared to 95.3% after training)
- an increased recognition of the link between depression and stress (e.g. prior to training, 54.7% of respondents agreed that having a stressful job increases your likelihood of developing depression, compared to 77.1% after training)
– an increased ability to identify strategies to help someone at work who may be experiencing depression (e.g. prior to training, 23.8% of respondents said it would be unhelpful to encourage someone with depression to take time off work or a holiday, this increased to 39.6% after training)

– 89% of respondents reported that the session provided relevant information and 96.9% rated the presenter as ‘good’ or ‘excellent’

– 100% of respondents said that they would recommend the session to others.

Conclusions – the key messages from the study (i.e. that exposure to job stress leaves employees vulnerable to developing depression and that a systems approach is the best way to address this issue) have been incorporated into standard material where appropriate/relevant. For example, beyondblue Fact Sheet 3, standard workplace training packages and key messages communicated in conference presentations and media interviews on depression in the workplace. A number of presentations at research, policy, and practice conferences and workshops delivered have provided an overview of the ACT Health Project, the rationale for integrating intervention on job stress with beyondblue’s workplace program, and progress to date.

Recommendations – N/A

YOUTH IN SPORTING CLUBS

6.8 Build Your Game Program – formerly known as Good Sports Good Mental Health Program

Aims
– to implement structural change within sporting clubs in order to improve the knowledge and mental health of members

Objectives
– to enhance a club’s capacity to promote the health and wellbeing of all members, players and supporters
– to use the existing national sporting clubs infrastructure to deliver combined drug and alcohol and mental healthy interventions
– to use the Good Sports program as a vehicle to pilot a project for the promotion of mental health, specifically addressing depression and anxiety and alcohol misuse
– to examine to what extent the Good Sports alcohol program, in itself, “passively” enhances the mental health of club members
– to examine whether the Good Sports infrastructure, and the existing community partnerships, can be used to “actively” promote the mental health of club members

Activities
– three-level accreditation process which usually takes 3 – 5 years to reach Level 3
– two research studies conducted to address aims and objectives (aforementioned):
  Study 1 (quantitative) Evaluation of the extent to which the Good Sports alcohol program improves the mental health of sports club members, and Study 2 (qualitative) Trial evaluation of mental health interventions within Good Sports clubs

Outcomes
– 2,312 community sports clubs involved in the program across Australia, with 1,312 clubs registered in VIC
– findings from both studies were used to propose a series of models for the future development and implementation of mental health interventions within community sports clubs
– the program changed its name from Good Sports Good Mental Health to Build Your Game in 2009 to reflect its inclusion of a mental health component

Evaluation – YES
Evaluation design – quantitative multilevel modelling (Study 1), qualitative action research pilot (Study 2)

Methods

- **Study 1**: 102 football and 68 cricket clubs with varying SES invited to participate, each club sent 50 surveys (8,500 surveys in total) – clubs provided with incentives to participate
  - Onyx and Bullen social capital instrument modified to suit the setting of sports clubs piloted before use in this study
  - Mental health measured with DASS21
- **Study 2**: pilot implemented in two communities – Metropolitan regional (Comm. A) managed by Regional Sports Assembly and Rural (Comm. B) by Community Health Service
  - Two sports clubs in each community participated: Comm. A – tennis and bowling clubs, Comm. B – football and netball clubs
  - Formal process evaluation after each mental health intervention (completed short questionnaire or marked a ‘thermometer’) – Comm. A
  - Informal observational methods during project activities – Comm. B
  - Summation evaluation (interviews) conducted in December 2007 (Comm. B) and March 2008 (Comm. A)

Findings

- **Study 1**: significantly lower levels of anxiety and stress, compared to individuals who belong to clubs that do not adopt the program (78% of respondents were males)
  - Average reported stress and anxiety levels for participants in both Good Sports and non-Good Sports clubs fall into the normal range
  - The Good Sports program does not seem to have the same effect on reported levels of depression
  - While social capital levels were predictive of stress and anxiety, the level of social capital in a club was not related to accreditation level
- **Study 2**: In Comm. A, increased awareness of mental health was evident among committee members who actively engaged with the pilot project, but not among the general members, members of the community who attended stress management workshop (61) and women's tennis program, and members of sports clubs who attended the Club Networks’ Healthy People, Healthy Clubs seminar
  - In Comm. B, there was an increased awareness of mental health among members of both sports clubs
  - The pilot project was discussed openly in footy records, club newsletters and flyers, and show bags with additional information
  - Some people were observed wearing the beyondblue blue armbands at the end of the footy season

Conclusions – the alcohol and mental health program in addition to reducing alcohol consumption, reduced stress and anxiety levels in club members. The project infrastructure, through the strong relationships between community partners and sport clubs, offers a unique opportunity to coordinate the implementation of community mental health interventions. The implementation of mental health interventions in sport clubs can increase the awareness of the mental health among community sport clubs members and the wider community.

Recommendations – ensure that community partners/project teams have well-established relationships with participating sports clubs prior to implementing mental health interventions. Establish a selection process to identify clubs that are ready, willing and able to engage with the mental health project. Continue to fund Good Sports Promoting Good Mental Health as a cost-free program for sports clubs. Provide ongoing education about mental health promotion principles to project officers, volunteers and club members. Develop and implement strategies to engage sports club members in project planning and design to ensure shared ownership of the mental health project. Engage in capacity building with community partners and clubs to ensure sustainability of mental health activities. Finally, any future work needs to build in process evaluations to ensure ongoing constructive feedback and opportunities for reflection.
6.9 Coach the Coach – CTC

Aims
– to train key sporting club identities in Mental Health First Aid (MHFA) to support club members and the sporting community to identify and respond to mental health issues early and effectively and to boost awareness and knowledge of mental health issues in general and depression in particular

Objectives
– to encourage early help-seeking behaviour in its target group, young rural males, linked to football clubs;
– to provide mental health training using the Mental Health First Aid (MHFA) program to football club leaders;
– to empower football club members to seek early help with mental health concerns by providing a readily identifiable easily accessible source of help

Activities
– a project officer engaged by the CTC underwent training as a MHFA presenter; actively involved with ongoing support for clubs to coordinate progress, provide information, and develop networking. Also, to maintain awareness of mental health issues through informal contacts with participating clubs
– MHFA training offered to coaches and team captains of 12 Goulburn Valley Football League (GVFL) clubs; 3 x 4 hour sessions (3 separate blocks at 3 geographically spread locations for four clubs each)
– leaders (36) were recruited from these 12 clubs and presented to club members and community at a meeting in the first half of the progress
– a series (8) of evening information sessions (“road-show events”) mainly focused on destigmatising depression and encourage seeking help for oneself or a friend if depression was a concern
– local media coverage of the project, including a formal project launch by the Victorian Minister for Mental Health in Shepparton on 9th May 2007

Evaluation – YES

Evaluation design – mixed methods

Methods
– liaison with key organisations and informal data collection; at project planning stage, throughout project, post-intervention interviews with stakeholders
– questionnaire of club leaders; pre-training and post-training using a 110 item self-report survey tool
– questionnaire of club players; initial and follow-up using a limited questionnaire
– questionnaire of players from another football league; comparison group using the same follow-up questionnaire as used for GVFL
– focus group interviews (FGIs); 2 sessions with randomly selected group of coaches, captains, trainers from GVFL (four months post-training with 11 participants from 7 of the 12 GVFL clubs)

Findings
– the role of the project officer was seen as crucial in drawing together in a practical way all 12 participating GVFL clubs
– a dedicated website has been developed; available at http://www.coachthecoach.net.au/index.php
– questionnaires of club leaders were administered immediately before the initial training session and six months post-training, and indicated markedly increase in confidence in providing help to someone experiencing a mental health problem and changes in views on treatment modalities in line with evidence-based content
– FGIs concluded that training resulted in early development of knowledge and confidence related to mental health issues
questionnaires of club players administered pre- and 6-8 months post-training indicated positive findings in terms of young peoples’ attitudes to those experiencing depression. 36% of players completing the initial questionnaire also completed the follow-up questionnaire; comparison group showed no or insignificant differences

interviews with key stake holders indicated recognition on the role of football community leaders as key mediators in the project. The road-show events were seen as a valuable component as it formally acknowledged and introduced the MHFA trained leaders. It was considered to have the potential for other non-mental health initiatives to be included with the support/involvement of local health professionals. It was considered to target clubs that are structurally strong with a cohesive organisation to maximally utilise the limited resources available for the project. Collaborating with NGOs involved in a similar area of work was considered beneficial. Time constraints, attracting adequate funding and retaining the interests of participants throughout the training sessions were other concerns raised.

Conclusions – the project context was seen as vital in the success of the project as it was implemented from within a rural community setting and utilised existing social cohesion structures (i.e. local football clubs). Identification and support of key individuals (community leaders/organisations) was regarded an important factor for the success of the project. Football clubs were not homogenous in terms of organisational strength; hence, did not reflect the effectiveness of the project based on its on-field performances. Role of the project officer identified as a vital component for the success achieved within the limited timeframe of the project. Utilising an established tool (MHFA) as opposed to developing a new training program was seen as more time and cost efficient. FGIs were considered as sources of valuable data and insights not readily available from questionnaire derived data. Road show events facilitated recognition of the MHFA trained members and promoted mental health awareness to those not directly linked with football clubs. Overall, the CTC project was successful in achieving its aim in raising mental health awareness and confidence in both MHFA trained and other players, as well as those in the wider community. It is suggested that CTC model be utilised in future similar rural mental health initiatives using existing structures.

Recommendations – it is recommended the aforementioned (conclusions) be incorporated as key recommendations for future similar projects. Targeted assistance that caters to the variations in the organisational structure of football clubs needs to be taken into consideration for participating clubs.

6.10 Netball Australia

Aims
- to raise awareness of depression in Australia’s netball community and encourage people to seek help early

Objectives
- to focus on awareness raising activity
- to distribute depression information to women and girls in the netball community
- to provide depression awareness training for players and staff

Activities
- beyondblue and Netball Australia working together (three-year partnership from June 2008)
- letter to State netball organisations with information about the partnership and sample materials
- netballers across Australia encouraged to ‘Turn blue in June’
- beyondblue provided free kit of materials for community awareness raising activities

Outcomes
- development of netball-specific co-branded materials including a poster, postcard and wallet card
- ANZ Festival of Stars celebrity game, June 2009, broadcast on Channel 10 where beyondblue was a beneficiary with National Breast Cancer Foundation (NBCF)
- articles in the Netball Australia newsletter and website

Evaluation – NO

Recommendations – N/A
YOUTH IN SCHOOLS

6.11 Secondary Schools Research Initiative – SSRI

**Aims**
- to examine how school communities can prevent depression in young people and to alter adolescents’ individual and environmental risk and protective factors to build their resilience, and to reduce depressive symptoms amongst adolescents

**Objectives**
- to reduce levels of depression experienced by young people
- to engage whole school communities to promote emotional wellbeing and social connectedness
- to increase awareness and understanding of adolescent depression and its impact, including the management of pathways for care
- to increase the capacity of school communities to adapt, implement and evaluate interventions relevant to the prevention of depression
- to encourage and build partnerships between school systems, local communities, the health sector and academics

**Activities**
- recruitment of 25 intervention schools and 25 control schools
- development of four SSRI components for participating schools (community forum, classroom curriculum, supportive environments, pathways for care and education)
- development of protocols by beyondblue research teams to maximise uniformity between schools
- administration of questionnaires by beyondblue facilitator/school staff during single lesson period
- school Action Teams developed and implemented Action Plans at the start of 2005

**Outcomes**
- community forum held by all 50 participating schools
- 30 session class curriculum program (10 sessions per year over three years); delivered to same adolescents in 2003 (Year 8), 2004 (Year 9) and 2005 (Year 10)
- beyondblue SSRI newsletters published biannually
- intervention schools completed Action Plans showing high level of school engagement

**Evaluation** – YES

**Evaluation design** – randomised control trial, qualitative analysis

**Methods**
- 25 intervention schools (completed all four SSRI components) and 25 control schools (completed only community forum component)
- two schools were paired (‘school pairs’ 8 in VIC, 5 in SA, 9 in Queensland) based on similarities in SES and total enrolment size, then randomly allocated into intervention and control groups
- self-report questionnaire to assess adolescents in mental health outcomes, experience of individual-level risk and protective factors, and experience of environmental-level risk and protective factors
- assessments conducted in 2003 pre-intervention (Year 8), 2004 (Year 9) and 2005 (Year 10)
Findings

- 5634 (n=3037 intervention; n=2597 control) Year 8 adolescents from 50 schools completed beyondblue self-report questionnaire (63%), in 2003
- Dropout rate 10% (between 1st and 2nd assessment), and 20% (by 3rd assessment); but, no significant difference between intervention and control groups although depression was rated higher in those who dropped out than in those who remained in the study for the three years
- Constructive problem solving, interpersonal competence, and optimistic thinking style declined, and negative problem solving increased in a similar way in both groups
- Support from family/friends/schools, sense of belonging to schools, level of participation in school activities, and experience of bullying were considered less in a similar way in both groups
- Higher rates of depressive symptoms, emotional symptoms, conduct problems, peer problems and anxiety in intervention group across the three study years

Conclusions

- SSRI results showed that the intervention did not have any significant impact during the first three years. However, SSRI showed possibility to develop and implement innovative classroom curriculum in many schools. SSRI highlighted the difficulty of enrolling and maintaining the involvement of a large proportion of students in school-based interventions. Further, SSRI provided information relating to depression and other mental health problems experienced by adolescents. The national profile of beyondblue greatly facilitated implementation of SSRI. Overall, SSRI showed that beyondblue has the capacity to build and maintain over several years a large collaborative research team from multiple universities, education and non-government sectors.

Recommendations

- Compromises are necessary between what would be ideally offered and what is practical in a busy school environment. It is essential that key components of SSRI are clearly described and correctly employed in any other school-based interventions. Funding and infrastructure support, ongoing evaluation, strong relationships with service providers, and sustainability are key factors required to develop effective and efficient prevention programs for child and adolescent mental health problems.

6.12 Stay on Track – SOT

Aims

- To increase the knowledge of students about how to identify people around them who are suffering from depression and how to respond accordingly, using an interactive and engaging format

Objectives

- To develop an educational program about depression that is delivered by young people
- To build trust between students and facilitator
- To train peer educators with the support of program coordinator and project officer

Activities

- SOT was based on the National On Track Leadership Project – 2003, and involved 12 young people collaborating with Glenorchy City Council staff to develop the educational package and pilot the program
- Consultation with local community to identify major concerns/issues for young people
- Pilot phase of program trialled in a local high school with two groups of grade nine students
- Pilot phase evaluated by teachers, students and SOT facilitators
- SOT implemented in 11 schools and evaluated following which the education package was further developed
- SOT run by peer educators as a five-week program with one class being offered per week

Outcomes

- 13 SOT programs offered during 2007-2008; 1450 program contact hours provided to students
- SOT educational sessions provided to 290 (54% males: 46% females) grade 9 and grade 10 students in ten high schools, in 2007-2008
- promoting the program through emails to all grade 9 Coordinators and using the InfoStream Department of Education communication system
- SOT offered to both whole class and targeted groups
- facilitators Training Package – two day training (5 hours per day) provided for nine peer educators as initial induction, then followed up with further training sessions (five sessions). Four x 4 hour sessions planned for 2008/2009 financial year
- program Coordinator has been changed several times hindering consistency in data collection and evaluation of the program

Evaluation – YES

Evaluation design – qualitative methods

Methods
- pre and post participant evaluation forms
- peer educators feedback forms
- teacher feedback forms
- targeted interviews with other stakeholders (schools’ principals, peer educators)

Findings
- students who have been less engaged in other classes have demonstrated a high level of engagement with SOT
- student feedback indicates that the majority of participants say they now know more about depression (75.7%), how to recognise it (80%) and how to talk to someone who is suffering with depression
- 87.8% of participants said that their knowledge of depression had changed as a result of participating in SOT
- 77.3% said that they now know what to do or say if a friend was seriously depressed (compared to 58.2% prior to undertaking the program)
- a larger proportion (78.8%) said that they would talk to someone if they were feeling down or depressed by the end of the program compared to at the start (23.3%)
- prior to starting the program just under one third of the participants thought that depression had significant impacts on the lives of the person experiencing it or the people around them. By the end of the program this figure had almost doubled to 61.9%
- school staff were generally complimentary about SOT, although teachers felt less enthusiastic

Conclusions – SOT has been successful in school settings because of its different approach where students work with older peer educators, as opposed to teachers. This approach, therefore, is more engaging as the program not only enhances peer support within the group but also delivers useful practical information on mental health, in an interactive way for students to use in their own lives. SOT is now being offered in a growing number of schools in Tasmania with 25 programs scheduled for the next financial year. It has the potential to be used as model for implementation in other Australian States.

Recommendations – Funding is required to support ongoing development and updating to ensure that the resources are ‘current’ and the program style continues to engage young people in new and interesting ways. A proactive approach to schools liaison is also required so that the potential is fully embraced by schools and is not overlooked in busy schedules. Further evaluation work can be done to assess the sustainability of outcomes. There is also a need to further develop the internal capacity of program staff to report on the outcomes on a regular basis.
6.13 ReachOut Central – ROC

Aims
- to assist young people in identifying and developing practical coping skills for dealing with life stressors that may be precursors to mental health problems including depression, anxiety and substance use issues through adapting a cognitive behavioural theory for a web-based interactive environment

Objectives
- to improve the mental health literacy and coping skills of young people, specifically young men
- to increase the likelihood that young people will seek help when experiencing depression and other mental disorders
- to provide an additional interactive tool for mental health professionals to use when helping young people to develop cognitive behavioural skills

Activities
- development of mental health content and ROC storylines
- development of series of score metres to accompany the mood metre
- production of a CD for use in education and clinical settings
- ROC awareness campaign
- external evaluation conducted by Swinburne University

Outcomes
- 1st online module of ROC launched November 2005, advanced version in September 2007, www.reachout.com; since September '07 121,998 visited the site, has 18,818 members (45% males)
- ROC acknowledged both nationally and internationally as an innovator in serious gaming
- ROC curriculum resource (ROC CD, manual, lesson plans) distributed to participating secondary school teachers in the ReachOut.com Teachers’ Network, February 2008
- 10 pilot professional development workshops in NSW to up skill teachers, September/October 2008
- 3000 CDs produced with 1,532 teachers receiving the resource; remaining as new teachers join
- ReachOut.com Pro, ROC for use with mental health professionals, launched in June 2008
- awareness campaign included youth websites, bus/tram interiors, youth magazines, online competition to win PS3, posters/postcards, media release and interviews
- online advertising delivered 49% of website visits to the ROC game landing page; 19% of all visits to the member sign-up page

Evaluation – YES

Evaluation design – single group, quasi-experimental open trial design using repeated measures

Methods
- 595 registered for evaluation, but 329 did not meet the inclusion criteria; hence, 266 (176 females, 88 males) young people took part in the evaluation
- at post-program and follow up respectively, 154 (116 females, 38 males) and 100 (78 females, 22 males)
- participants completed three sets of online surveys at pre- and post-programs, plus 2-month follow up using: Kessler Psychological Distress Scale (K10), Alcohol Use Disorders Identification Test (AUDIT), Coping Strategy Indicator-Short Form (CSI-SF), Resilience Scale-Short Form (RS-SF), Satisfaction with Life Scale (SWLS)
- participants also completed items regarding mental health stigma, help-seeking, program satisfaction and applicability; program usage was also collected
Findings

– for females: all outcome variables significantly changed in positive direction for life satisfaction, psychological distress, resilience, problem solving and seeking support

– for males: life satisfaction decreased at follow up, resilience slightly decreased post-program, avoidance behaviour increased at post-program and follow up

– willingness to seek help from mental health professional improved for both males and females at post-program and follow up

– ROC, on average, accessed only 1-2 times by males/females during intervention phase

Conclusions – ROC has the potential to enhance protective factors that decrease the likelihood of developing clinical psychological problems. It could be incorporated into mental health literacy programs at schools and for use with mental health professionals. Although, ROC was predominantly designed to appeal to male participants, their numbers were low. Females tended to show more positive changes. Overall, ROC has the capacity to be a useful primary and early intervention tool.

Recommendations – studies examining the impact and perception of ROC on males compared to females, a comparison of ROC against maturation effects and the impact of the addition of some form of communication forum for ROC users would help further understanding of how best to design and deliver internet-based mental health programs to young people.

INDIGENOUS YOUTH

6.14 Save A Mate Our Way – SAM Our Way (pilot study)

Aims

– to increase rural and remote Indigenous community capacity to respond to youth social and emotional wellbeing

Objectives

– to increase the awareness of holistic health issues among young people, as well as SAM, peer education, peer leadership and community development skills

– to enhance processes that encourage and support young people to develop and use their skills and abilities to improve their own lives and the lives of their community

– to increase the awareness among Aboriginal communities of Australian Red Cross (ARC), the pilot program, mental health, substance misuse strategies, peer development and first aid

Activities

– recruitment of experienced support staff and establishment of Advisory Group

– SAM Alcohol and Other Drugs Emergencies course (power point presentations)

– accredited CPR and mental health training provided to all young people

– training in SAM Program principles to all selected communities

– information and skill development in social and emotional wellbeing component

– purposeful activities: dilly bag making, artwork, traditional games, jewellery making, etc

Outcomes

– four sites involving six communities

– 31 young people completed the full SAM Our Way program and also obtained CPR accreditation

– 74 completed elements of the program

– 2 youth-led activities

– 243 young people were involved in activities and in turn exposed to the program and ARC
38 Government Departments, stakeholders and service providers were engaged in the consultation and negotiation phases.

Development of a Framework for Best Practice for future ARC projects of this nature.

Evaluation – YES

Evaluation design – formal and informal, qualitative analysis (young people and community)

Methods
- giving young people video cameras to ‘interview’ each other on the program
- creating tick and flick survey forms
- oral reporting and written communication
- artwork and quizzes
- community: meeting with stakeholders and project team regarding feedback; formal feedback session with ARC managers external to process; questionnaires
- young people: pre (face-to-face yarns) and post testing (email and phone conversions); informal data and outcome collection throughout process; external evaluation with young people represented/selected by their peers

Findings
- formal evaluation: all young people reported that SAM Our Way program was good and suitable for Aboriginal youth; all reported confidence in recognising and responding to a drug emergency; 50% reported confidence in talking to a counsellor or support person; all thought that SAM program should return to their community
- informal evaluation: most participants retained key messages several months after the program; majority felt the learning style was appropriate and fun

Conclusions – SAM Our Way was ‘tailored’ from the standard SAM program to meet the diverse needs of rural and remote Aboriginal communities. It is embedded in the framework of Indigenous paradigms of holistic health care and has aspired to establishing culturally appropriate wellbeing partnerships within Indigenous communities.

Recommendations – SAM Our Way should undergo further program development and piloting before being scaled up. Further development of approaches to working alongside Indigenous communities is required. As the program develops further, a performance monitoring and evaluation system should be established.

6.15 Indigenous Hip Hop Projects – IHHP

Aims
- to facilitate interactive workshops in hip hop dance and music targeting Indigenous youth by engaging participants in positive exercises whilst actively raising awareness and promoting the key messages of Youthbeyondblue – Look, Listen, Talk and Seek Help

Objectives
- to address mental wellbeing of the indigenous population
- to provide awareness of depression and anxiety in both a preventative and active manner
- to involve elders and the whole community in workshops and events that develop community spirit and morale
- to focus on capacity building on an individual and community platform
- to provide skills, information, messages and a safe environment for engagement in the important areas of community and personal development
**Activities**
- promoting education, encouragement and exposure to messages of Look, Listen, Talk and Seek Help to youth from capital cities, urban areas, isolated and remote communities
- IHHP workshops covering 53 communities totalling 58 projects
- collaboration with several different partners forming IHHP partnerships, in 2008
- distribution and usage of beyondblue materials at all IHHP performances
- IHHP performances (18) and special workshops at events, conferences and concerts

**Outcomes**
- IHHP undertook projects in 56 communities in VIC, NSW, Queensland, NT, SA and WA
- Worked with 53 schools in VIC, NSW, NT and WA
- excluding schools, IHHP worked in collaboration with 53 partners forming 97 partnerships throughout 2008
- engaged with 22,970 young people through direct workshops within 5 states and 1 Territory
- worked with, performed to, and promoted the key messages of Youthbeyondblue to 701,220 youth in VIC, NSW, Queensland, NT, SA and WA through all workshops, festivals, performances and conferences
- distributed approximately 10,000 Indigenous Information cards; 7,300 Sweat bands; 8,800 Youthbeyondblue wrist bands; 1,000 beyondblue wrist bands; 5,000 wallet cards; 5,000 fact sheets; 2,000 Rural flipper cards; 10,300 Youthbeyondblue flipper cards; 1,500 magnets; 1,300 DL cards

**Evaluation** – YES, currently pending as at date of report

**Conclusions** – organisations and bodies that partnered with IHHP highlighted the desire for involvement with this interactive health promotion project. IHHP provides unparalleled mental health promotion aimed and delivered to Indigenous youth. IHHP’s innovative means of engaging young people include social inclusion, engagement, motivation and the positive messages of beyondblue are transformed into an attractive language for young people in Indigenous community to understand. IHHP has been received well, recommended and sought after, being effective in the prevention, early intervention and awareness raising surrounding depression, anxiety and social and emotional wellbeing. An evaluation is currently being undertaken by the Edith Cowan University for release by the end of 2009.

**Recommendations** – include targeting smaller communities which are not actively serviced by Youth Services and AMS Services, to reinforce and sustain IHHP. Targeting the 18 – 25 age group (i.e. those no longer in the school system) due to lack of structures to support them. Although, IHHP have been effective in engaging females, without the support of other female-specific or encompassing programs, this remains a more difficult task for IHHP to achieve.
**YOUNG CHILDREN**

**6.16 Every Family**

**Aims**
- to prevent/reduce severe behavioural, emotional and developmental problems in children making transition to school by enhancing the knowledge, skills and confidence in parents (based on Triple P – Positive Parenting Program)

**Objectives**
- to reduce the prevalence of common emotional and behavioural problems in children, including conduct problems and anxiety as precursors to later depression
- to increase parents’ confidence and competence in their parenting role
- to decrease the prevalence of parental distress (depression, anxiety, stress) associated with parenting
- to refine pathways to different levels of mental health promotion, prevention and early intervention that could be adapted for implementation in other parts of Australia and overseas

**Activities**
- intensive parenting support services based on Triple P through the media, community child health services, general practices, schools and preschools
- *Parentline* telephone counselling (through Triple P trained counsellors)
- *Every Family* website
- a Computer Assisted Telephone Interview (CATI) conducted with parents of 4-7 year olds in socio-demographically matched comparison suburbs in Brisbane, Sydney and Melbourne receiving usual services
- five levels of intervention on a tiered continuum of increasing strength

**Outcomes**
- coordinated media strategy about Triple P, including print, radio and TV media
- series of 90-minute parenting seminars through schools, community centres and Child Health Centres
- Positive parenting newsletters through schools
- 8-hour parenting groups through schools and Child Health Centres
- tip sheets on parenting through schools, libraries, GPs, Child Health Centres
- GPs trained in Primary Care Triple P and Workplace Triple P for teachers
- specialist interventions through Community Child Health Centres

**Evaluation** – YES

**Evaluation design** – randomised, cluster experimental design using qualitative and quantitative methods

**Methods**
- 30 socio-demographically matched school catchment areas: 10 exposed to full intervention (high intensity), 10 to partial (medium intensity), and 10 to usual care (low intensity)
- evaluated against following criteria: knowledge of the prevalence of child problems being targeted; knowledge of prevalence of parent risk and protective factors; knowledge that changing risk and protective factors improves child outcomes; having effective interventions available; making interventions widely available; having an effective training and dissemination system available; and tracking outcomes at a population level

**Findings** – all of the aforementioned criteria were met satisfactorily
Conclusions – there is a clear need for a population level parenting intervention; large-scale parenting interventions are feasible and accepted by the community; the capacity of the workforce to deliver evidence-based parenting programs was strengthened; Every Family helped create a shared vision across sectors about the value of parenthood preparation; Triple P is effective as a multilevel public health approach to strengthening parenting in the community.

Recommendations – the Commonwealth Government in partnership with other relevant stakeholders could fund a staged national roll out of Every Family throughout Australian States and Territories; develop an appropriate governance structure to manage the implementation process; implement Every Family so as to optimise population level benefits; fund specific research examining the engagement of indigenous and CALD populations; further develop the media and communication strategy used in Every Family; develop a national TV series on parenting; seek the support of the private sector; establish an appropriate evaluation framework for a national roll out of Every Family.

6.17 KidsMatter Primary Schools
Aims
- to improve the mental health and wellbeing of primary school students
- to reduce mental health problems amongst students
- to achieve greater support for students experiencing mental health problems

Objectives
- to promote collaboration between health and education sectors
- to provide a framework (which comprises of four components) for mental health promotion, prevention and early intervention (PPEI) in primary schools
- to utilise KidsMatter tools and resources to develop capacity of schools to promote mental health and wellbeing, and to effectively respond to mental health concerns of their students
- to strengthen protective factors and minimise risk factors for students’ mental health by encouraging a positive school community, social and emotional learning for students, parenting support and education, and early intervention for students experiencing mental health difficulties

Activities
- KidsMatter framework encourages creating a sense of belonging and inclusion within the school community, providing a welcoming and friendly school environment, and collaborative involvement of students, staff, families and the community in the school (component 1)
- to include the Social and Emotional Learning (SEL) competencies into the school curriculum that is taught to all students, and opportunities provided for students to practice and generalise SEL skills in the classroom, school and wider community (component 2)
- KidsMatter has comprehensively reviewed both Australian and international programs for teaching SEL competencies and compiled a resource guide, KidsMatter Programs Guide, for schools to select the program that best suits their needs for coordinated implementation across the curriculum
- providing effective parenting support and education through effective parent-teacher relationships, provision of parenting information and education to parents on parenting practices, child development and children’s mental health, and opportunities for parents/families to develop support networks/environments with school, community services and agencies that specialise in parenting education (component 3)
- early intervention for students experiencing mental health difficulties by promoting early intervention for mental health difficulties, improving attitudes towards mental health difficulties, and implementing processes to address the needs of students experiencing mental health difficulties (component 4)
- KidsMatter professional development by project officers assists teachers to achieve component 4.
Outcomes

- establishment of an Action Team to coordinate and run the program; consisting of school principal, classroom teacher, parent representative, and a representative from welfare/wellbeing team (i.e. school counsellor/psychiatrist or student welfare coordinator) if the school has one
- 2-day briefing session for Action Teams by State and Territory based KidsMatter Project Officers prior to commencing the program in schools
- KidsMatter Staff Survey developed by Action Teams to conduct an audit in schools to identify what they are already doing to address mental health and wellbeing
- information from survey then collated into a School Mental Health Map (MHM) in order to identify which KidsMatter component needs to be prioritised
- following the MHM, the Action Teams work with State-based Project Officer to develop and apply a tailored action plan for each KidsMatter component in each participating school
- supporting resources include KidsMatter implementation manual, program guide, State and Territory-based project officers
- KidsMatter program posters, parent/carer information sheets, and mental health resource packs on relevant topics related to children
- E-newsletter produced four times per year and a KidsMatter website

Evaluation – YES

Evaluation design – qualitative, cross-sectional analysis

Methods

- information for evaluation collected at specific time intervals (Feb 2007, Nov 2007, March 2008 and Nov 2008)
- Questionnaires for parents and teachers of a randomly selected sample of 75 students in each school; measures implementation/outcomes of KidsMatter initiative for staff, students and parents
- focus group discussions/interviews for a small number of teachers and students from some schools

Findings

- statistical and practically significant improvement across all four components of the KidsMatter framework.
- practically significant improvement in students’ measured mental health, in terms of both reduced mental health difficulties and increased mental health strengths.
- the impact more apparent for students who were rated as having higher levels of mental health difficulties at the start of the trial.
- substantial similarity in the findings for schools formally involved in KidsMatter for one year and for schools formally involved over two years. However, there were some measures that showed stronger effects in the schools involved for two years.

Conclusions – KM appeared to have had an impact on and changed schools in multiple ways. These included holistic changes associated with school culture and approaches to mental health difficulties, as well as serving to strengthen protective factors within the school, family and child. Importantly, KM was associated with improvements in students measured mental health, especially for students with higher existing levels of mental health difficulties. The evaluation findings showed that the KM trial was associated with a systematic pattern of changes to schools, teachers, parents and students. The outcomes of the KM trial are consistent with an emerging body of national and international literature that a ‘whole school’ approach can be protective for students, promoting mental health and helping to enhance academic and social competencies.
Recommendations – the broad framework, processes and resources of KidsMatter be maintained as the basis for a national roll-out; additional support be provided for school communities to consolidate and develop the four components, with a particular emphasis on Components 3 and 4: Parent support and education and Early intervention for students who are experiencing mental health difficulties;

– guidelines be provided regarding strategies to enhance the quality of the KidsMatter implementation, and attention be given to the role of leadership in developing and sustaining KidsMatter, because effective leadership provides the foundation for the school and its staff to fulfill the potential of KidsMatter.

6.18 Children of a Parent with Mental Illness (COPMI) – Paying Attention to Self (PATS)

Aims

– to provide young people (12 – 18 years) who have parents with mental issues the opportunity to share their experiences, be supported, and reduce their risk of developing mental health difficulties

Objectives

– to increase young people’s knowledge of mental health and illness
– to improve their help-seeking behaviour and coping strategies
– to focus on mental health promotion and illness prevention

Activities

– peer support groups
– co-leadership
– leadership training and advocacy
– PATS socials

Outcomes

– peer support groups comprise of 6 – 8 young people, weekly meetings x 8
– Groups facilitated by a peer leader (a young person whose parent has a mental illness) and health professional
– PATS leadership training to develop skills of young people in peer support, mental health and illness, communication skills, group dynamics, leadership skills, public speaking and activity planning
– Social and recreational activities (e.g. PATS surfing camp) held for PATS participants each school term (usually after the 8-week group has been completed)

Evaluation – YES

Evaluation design

– to measure impact and outcome of participating – pre (wave 1) and post test (wave 2), with 6 (wave and 12 month (wave 4) follow up after participation in the PATS program
– to measure PATS program implementation, capacity building, and sustainability – qualitative

Methods

1. Pencil and paper questionnaires; pre-PATS administered on first night of group session, post-PATS on last night, by site coordinators/facilitators
   – On completion of waves 2, 3 and 4, feedback from participants on the program using a Likert-scale format and open-ended questions
   – Assessed on mental health literacy, stigma, burden of caring for a parent with mental illness, social support, social problem solving skills, depressive symptoms, positive emotional wellbeing, risk of homelessness, substance use, socio-demographic questions, work and study
2. Semi-structured interviews with program coordinators, at beginning and end of project
   - Journal writing (program coordinators) and reflective writing (workers)
   - Reflective writing, where deemed appropriate – PATS participant and/or parent (case studies)
   - Telephone interviews with key agencies (partners)

Findings
- only 25% of PATS participants' parents live together compared to 70% from a state-wide school based survey
- significant reductions in depressive symptoms (60% pre to 38% 12 months later); risk of homelessness (44% pre to 17% 12 months later); stigma (30% pre to 15% 12 months later)
- over the 12 months, no differences found for reported substance use, or measures of social support and social problem solving skills
- reduced feelings of isolation and self-blame, increased confidence and development of coping strategies were also reported by participants

Conclusions – PATS program provides a form of early intervention in a model that engages COPMI, provides emotional and practical support, and equips participants with help-seeking knowledge and skills that build on their strengths.

Recommendations – peer support programs such as PATS are recommended as an effective intervention (community based setting) in improving the health and wellbeing of COPMI. Capacity building is recommended to raise awareness and develop the skills and knowledge of workers, organisations and communities in relation to COPMI. Strong link need to be formed across community and mental health sectors to ensure the success and sustainability of peer support programs for COPMI. Ongoing funding is necessary to ensure the needs of COPMI are addressed.

6.19 Children of a Parent with Mental Illness (COPMI) – VicChamps

Aims
- to provide children (5 – 12 years) who have parents with mental issues the opportunity to share their experiences, be supported, and reduce their risk of developing mental health difficulties

Objectives
- to reduce isolation and improve social connectedness through the development of recreational, social and creative skills
- to provide opportunities to engage with parents and carers and provide respite
- to educate children about mental illness and wellbeing, and to build children’s strengths and promote resilience
- to enhance community capacity to assist these families through inter-sectoral peer support program provision, work force development and whole of community education

Activities
- programs for children 8 – 12 years old
- programs for children 5 – 7 years old
- workforce development (e.g. Getting There Together (GTT) program)
- program facilitator networks and network development
- family care plans
- community education: Supporting Kids in Primary Schools (SKIPS), pamphlets and website
Outcomes
- implementation of the Parents in Partnerships Project at Eastern Health Mental Health Program (Eastern Metropolitan Region) and the Supporting Kids Project at Eastern Hume Region (North East) – peer support school holiday and peer support after school programs
- website available at www.champsworldwide.net or www.easternhealth.org.au/mental/champs

Evaluation – YES

Evaluation design – mixed, based on type of activity (aforementioned), predominantly qualitative

Methods
- collecting Intervention (VicChamps) and Normative (community) data, and pre to post intervention comparisons
- facilitator interviews with children (at end of program) and parent support group evaluation questionnaire (pre and post test)
- pre and post data collection, employing a survey format that examined knowledge, skills and general activities in relation to COPMI
- facilitator interviews, network maps, secondary consultation numbers, and key stakeholders interviews
- single page (anonymous) questionnaire for 15 participants in a SKIPS train the trainer presentation

Findings
- the greatest percentage of problems was found in the emotional symptoms (45%) and peer problems (41%) categories, within the VicChamps intervention sample
- the three children who attended the YoungChamps program report having fun and making new friends, and parents reported increased ability to discuss their parenting concerns with others, and to access further parenting support and information after the program
- identified barriers to working with COPMI families which included the functioning of the ill parent, workers’ level of access to children, inadequate resources for the worker, including time, and workers’ perception that there would be a disruption to the worker-client/parent relationship
- support from all levels (upper, middle and key workers on the ground) is essential to facilitate organisational change and networking in mental health/welfare organisations
- all family members, including children, should take an active role in the development and implementation of family care plans which should include both crisis and care components
- SKIPS Train the Trainer program improved participants’ understanding of problems for COPMI and enhanced their enthusiasm to get started

Conclusions – VicChamps is a program of activities, which have been developed over the last decade, aimed at addressing the needs of families with a parent with a mental illness. Interagency partnerships have been central to the development and running of these activities. Including younger children with their older siblings in 8-12 year old program has been one successful strategy in attracting children to VicChamps programs. Further, achievements of this program have contributed to the development of the Victorian DHS 2006 state-wide strategy to support families where a parent has a mental illness.

Recommendations – Programs should have clear behaviour management guidelines (included in program manuals) for group facilitators to adhere to. It is recommended that programs be developed, trialled and evaluated with children aged 5-7 to provide evidence for program effectiveness. The GTT program is recommended as a vehicle to develop knowledge and introduce practice changes in mental health, general health and welfare workforces. It is recommended that some of the networking activities for workers of future programs include attendance and establishment of network forums, providing secondary consultation, joint program facilitation, and implementing ‘train the trainer’ programs. Further development and evaluation should be undertaken before substantive claims are made regarding the efficacy of family care plans.
PERINATAL


Aims
– to bring about change in healthcare for women with perinatal depression, to improve outcomes for them and their families, in order to reduce the potentially devastating consequences on current and future generations

Objectives
– to introduce routine screening for perinatal depression
– to facilitate provision of information to women and their families
– to educate and support primary healthcare professionals
– to focus on detection/intervention in each State across Australia
– to raise awareness of the importance of emotional health in the perinatal period, both within the general community and in health settings

Activities
– establishment and evaluation of the feasibility of routine screening for antenatal and postnatal depression at major maternity hospitals/health services in Australia
– development of materials to address community and health professional awareness of antenatal and postnatal depression and its treatment
– evaluation of change in health professionals and postnatal women’s knowledge and awareness of perinatal mood disorders
– provision of a national database of young families in Australia
– evidence of efficacy of early intervention initiatives

Outcomes
– the introduction of antenatal and postnatal depression screening and protocols for the sharing of patient information, in 43 antenatal hospitals/area health services across Australia, implemented since 2002
– health professionals from 160 different organisations received training in the detection and management of perinatal depression; 33,500 depression management guides and 25,000 guides to the use of the Edinburgh Postnatal Depression Scale (EPDS) have been distributed
– 205,000 women received an information booklet about emotional health during pregnancy and early parenthood (in 19 languages on website, www.beyondblue.org.au/postnataldepression) with the Chinese, Mandarin, Indonesian and Italian versions updated in March 2009
– provision of information postnatally in all child health centres in Australia (600,000 pamphlets); promotional posters in antenatal clinics, GP clinics and Maternal-Child Health centres; 244 newspaper/magazine articles; 215 TV, radio and promotional activities; 71,500 web-site visits; 73 scientific conferences
– State-based antenatal intervention initiatives implemented in VIC, SA, WA, QLD (2), NSW

Evaluation – YES (on feasibility and acceptability of perinatal depression screening)

Evaluation design – qualitative methods, random sample

Methods
– a baseline evaluation of women and health professionals (GPs, Maternal-Child Health Nurses and Midwives) assessing knowledge, level of depression and services accessed, prior to the PND Program commencing
– at the end evaluation, a random sample of postnatal women who had participated in screening and of health professionals were sent questionnaires evaluating the project, one to three years after introduction, by the PND Program, of routine screening
Findings

- postnatal women were better able to recognise and assess their own symptoms and coping; showed marked improvement in the ability to recognise depression in a hypothetical situation (though still significantly less than health professionals); were more accepting of the use of antidepressant medication postnatally; reluctance remained to consider medication antenatally; decreased their help seeking behaviour in the non-depressed group and had increased satisfaction with the help they did receive and; a significant number of women with high EPD scores did not seek treatment, even if they agreed with the “diagnosis” of depression

- significant increase in perinatal depression knowledge in MCHN and GPs (the latter showing the greatest improvement) but with a decrease in that of midwives, highlighting the importance of more intensive training and support for this group

- GP’s relied less on mental health professionals, with no increase in barriers or a negative impact of the PND Program’s implementation

- GPs had a significant propensity to recommend antidepressants, and midwives to select non-specific medications

Conclusions

- a majority of women found screening acceptable when delivered as part of routine care with her health provider, that the standard screening tool used (the EPDS) was appropriate and superior to alternatives, and when screening was combined with information, it significantly increased awareness of depression. Moreover, linking women to their GP, who had been trained to routinely ask about depression, appears a critical step in increasing early identification and intervention. The PND Program has become an identified source locally, nationally and internationally for cutting edge information resources and provision of education.

Recommendations

- specific resources to address the needs particular groups, such as Indigenous, culturally and linguistically diverse, multiple birth mothers and male partners, be supported. Screening programs need to be accompanied by ongoing training and support of all relevant health professionals involved in perinatal care. Each obstetric/area-health service needs to develop a local care-pathway including appropriate referral and allied-health service links. Put into practice antenatal screening in the third trimester and postnatal screening 6 – 8 weeks after childbirth. A “one-size-fits-all” approach is not appropriate, although, a blue-print for all services is required to ensure best minimal practice.


Aims

- to improve the prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing perinatal depression

Objectives

- training and workforce development: to identify and develop a quality framework for workforce training and development to address perinatal mental health care

- universal routine psychosocial assessment: to develop a quality framework for universal implementation of routine psychosocial assessment

- pathways to care: to identify and develop a framework for and recommend activities that supports the establishment or enhancement of quality pathways to care

Activities

- National Guidelines for policy and management, quality workforce training activities, and identified key components for accredited curricula

- National Guidelines for routine psychosocial assessment, detailed implementation planning at a local and regional level, and identification and development of workforce, referral and information system infrastructure to support sustainable implementation

- National Guidelines for clinical practice and service delivery, identification and development of infrastructure and resources required to establish sustainable quality pathways, and identification of consumer and carer preferences for care and recovery to inform quality pathways
Outcomes
- National Stock-take report based on surveys, key informant interviews, literature review
- the Plan provides data on modelling the direct cost of establishing routine assessment for perinatal mental health and wellbeing and delivering a training program to support the delivery of assessment
- the Plan provides data on the feasibility of doing a cost-benefit analysis of universal and routine psychosocial assessment and subsequent treatment and missed cases in the perinatal period

Evaluation – projected (refer to item 6.20)
NB: evaluation across all sectors will involve gathering baseline data from a sample of implementation sites at the Plan’s outset, followed by the collection of both quantitative and qualitative data across the course of the Plan’s implementation

Conclusions – the implementation of this Plan, in keeping with the current Council of Australian Governments National Action Plan on Mental Health (2006-2011), requires a whole of government and whole of community approach. While the Plan has arisen from within the health sector, it interfaces with the consumer, carer and non-government sectors (particularly early childhood). The Plan is embedded within the need for broad community awareness, health promotion and education about perinatal mental health (PMH) and wellbeing, its effect on the infant, father/partner and family, warranting a whole of family approach to care.

Recommendations – communication and consultation strategies targeting key stakeholders and the community; detailed mapping of existing services at jurisdictional level; development and endorsement of national PMH Guidelines; establishment of a national PMH database for evaluation and benchmarking; development and endorsement of an Aboriginal and Torres Strait Islander PMH Plan; development of training and clinician packages; commencement of Plan implementation aiming at long-term sustainability across Australia.

6.22 National Perinatal Depression Initiative (NPDI) 2008 – 2013
Aims
- to improve the early detection and prevention of perinatal depression (PD) and to provide better care, support and treatment for expectant and new mothers experiencing depression

Objectives
- to undertake community awareness activities and promotion of help-seeking behaviour in relation to perinatal depression
- to provide routine and universal screening for PD in antenatal and postnatal pregnancy
- to provide advice and inform all governments on best practice activities in PD, including advice in relation to particular population groups such as CALD communities and Aboriginal and Torres Strait Islander communities
- workforce training and development for health professionals
- provision of information on pathways to care for women at risk of or experiencing PD
- to develop materials that support professional practice such as national PD screening guidelines and training materials
- to provide a Centre of Excellence and best practice evidence on PD through research activities to enhance knowledge of PD
- best practice evidence on PD through research activities to enhance knowledge of PD
Activities
- Market Research: Focus groups to be conducted with consumers, carers and community by market research analysts to scope the target groups knowledge, attitude and understanding PD
- web pages to be updated to reflect PD terminology; scoping and pre-evaluation, revision and redevelopment of website, development of Medical and Allied Health Practitioners (MAHP) pathways to care, strategic partnerships for health promotion and dissemination
- development and revision of fact sheets and brochures to reflect NPD including perinatal terminology, and promote service availability, resources and beyondblue Infoline
- monitor quantity and quality of resource utilisation and develop new resource materials as appropriate
- scoping training needs through initial qualitative research and existing training materials and resources in consultation with target groups and key partners as required
- collate in consultation with key partners, consumers and carers information on help seeking, treatment options, pathways to care and support services

Outcomes
- establish a State and Territory Reference Group to provide an opportunity for beyondblue to collaborate with States and Territories and share information on the implementation of the NPD (June 2009)
- beyondblue to coordinate and assist the development of beyondblue Clinical Practice Guidelines for Perinatal Depression and Related Disorders of Anxiety, Bipolar Disorder, and Puerperal Psychosis in the perinatal period (for approval by the NHMRC)
- Draft Guidelines disseminated through public consultation using a series of national workshops and invitations for written submissions, then revised accordingly
- Final Guidelines to be submitted to NHMRC

Evaluation (projected) – YES
Evaluation design – beyondblue will conduct initial qualitative research in each state and territory to identify key themes, issues and needs of women, partners and health professionals in relation to PD, followed up by a quantitative study to assess the extent of these issues across each of the target groups nationally (baseline and final measurements)

Methods
- measurement of current knowledge of PD using beyondblue Depression Monitor Survey Instrument, development of additional PD items for the next beyondblue Depression Monitor Survey and conduct survey using beyondblue Depression Monitor during 2010
- collect data on the number and types of fact sheets and brochures available and developed, including dates last revised
- number and types of fact sheets and guideline resources available and developed including dates last revised, list of training programs to be collated and distributed nationally following consultation with key partner groups, and information on pathways to care, treatment and support options compiled in consultation with key partners for national distribution

Findings – currently pending
Conclusions – N/A
Recommendations – N/A
6.23 Perinatal Research

Aims & Objectives – refer to items 6.19 and 6.20

Activities

– the beyondblue National Depression Program, Prevention and Early Intervention, State-based Antenatal Intervention Initiatives


– beyondblue Sherryl Pope Memorial Scholarship

Outcomes – beyondblue funded several perinatal research projects in 2001 – 2009 including

1 beyondblue National Depression Program, Prevention and Early Intervention, Australia-wide

– antenatal support following depression – enhancing the parent-infant relationship, Vic

– helping him to help her, SA

– postnatal depression project for families with multiple birth children, WA

– education and training for rural, regional and remote health professionals, QLD

– indigenous women’s project: report of process and preliminary results, QLD

– clinical interventions for, and preference of, women from Vietnamese and Arabic speaking backgrounds, NSW

2 Optimising emotional health during pregnancy and early parenthood: Improving access to help women with perinatal depression, VIC

– models of care: Evaluating a best practice model for treating postnatal depression – Year 1 and Year 2, VIC

– a brief psycho education intervention to prevent the development of depression in anxious first-time mothers of newborn, VIC

– towards Parenthood: An antenatal self-help intervention for depression, anxiety and parenting difficulties, VIC

3 A comparison of anxiety, stress and depression across the perinatal period in women pregnant with twins and singletons

Evaluation – N/A

Conclusions – N/A

Recommendations – N/A

6.24 beyondblue Clinical Practice Guidelines for Perinatal Depression and Related Disorders of Anxiety, Bipolar Disorder, and Puerperal Psychosis in the perinatal period (for approval by the NHMRC)

Aims

– to assist in improving prevention and early detection of antenatal and postnatal depression (perinatal depression) and related disorders and improve the support treatment for expectant and new mothers experiencing depression, anxiety, puerperal psychosis and bipolar disorder

Objectives

– to provide advice to the Australian Government and State and Territory Governments on evidence-based best practice activities in perinatal depression

– to include aspects of perinatal depression screening, workforce training and development, care, support and treatment
– to advice in relation to particular population groups, such as CALD communities and Aboriginal and Torres Strait Islander Communities
– to address indigenous Australian perinatal mental health issues, as well as rural and remote issues

Activities
– follows the NHMRC requirements set out in its publication: A guide to the development, implementation and evaluation of clinical practice guidelines (1999) and companion documents
– approval by the CEO of NHMRC under section 14A of the NHMRC Act 1992 (as amended)
– Guideline Expert Advisory Group agreed to include mental health disorders related to the perinatal period of the mother
– Guideline Assessment Register consultant to support and guide the development of the CPGs from its inception, provided and funded by NHMRC

Outcomes
– projected publication of evidence-based NHMRC approved beyondblue guidelines
– guidelines will be of significance for pregnant women, the developing foetus and mothers, and infants up to one year
– development of guidelines indicate significant achievement in the mental health field
– draft guideline anticipated for release for a 60 day public consultation by mid 2010
– final guidelines with incorporated feedback from public consultation to be completed by late 2010

Evaluation – projected
Evaluation design – cross-sectional qualitative analysis

Methods
– baseline survey prior to release of guidelines
– a six-month post dissemination evaluation

Findings (projected)
– on usefulness and uptake of the guidelines
– on changes in clinical practice since the publication of the guidelines
– on changes in practice by target groups after the release of the guidelines

Conclusions – The development of the CPGs is one component of the National Perinatal Depression Initiative (NPDI) which was supported by the Australian Health Ministers’ Advisory Council and introduced by the Australian Government in the 2008-2009 Budget. beyondblue has received financial support for the development of these CPGs from the Commonwealth DoHA under the NPDI.

Recommendations (projected) – it is anticipated that the evaluation will provide useful feedback to assist in improving the dissemination, awareness-raising and perhaps the need for providing training in the implementation of the guidelines with key stakeholders.
Appendix 4

*beyondblue*-funded Primary care programs and associated research

7.1 NHMRC Depression in Adolescents and Young Adults Clinical Practice Guidelines

**Aims**
- to develop current clinical practice guidelines for depression in adolescents and young adults based on new data, burgeoning research in the area and changes in community awareness, policy and services over the last decade

**Objectives**
- to improve health outcomes and prevent the incidence of further depressive episodes and ongoing depression for adolescents and young adults
- to promote effective treatment, limit illness duration, advise on strategies if treatment is resistant and help prevent relapse

**Activities**
- project commenced as an update of existing NHMRC guidelines, however Working Committee decided that entirely new guidelines were required
- follows the NHMRC requirements set out in its publication: *A guide to the development, implementation and evaluation of clinical practice guidelines (1999)* and companion documents
- approval by the CEO of NHMRC under section 14A of the NHMRC Act 1992 (as amended)

**Outcomes**
- projected publication of evidence-based NHMRC approved *beyondblue* guidelines
- guidelines will be applicable to the entire Australian community
- development of guidelines indicate significant achievement in the mental health field
- draft guideline anticipated for release for a 60 day public consultation by mid 2010
- final guidelines with incorporated feedback from public consultation to be completed by late 2010

**Evaluation** – projected

**Evaluation design** – cross-sectional qualitative analysis

**Methods**
- baseline survey prior to release of guidelines
- 6-month post dissemination evaluation

**Findings** (projected)
- on usefulness and uptake of the guidelines
- on changes in clinical practice since the publication of the guidelines
- on changes in practice of all target groups after the release of the guidelines
Conclusions – the scope of the guidelines is for adolescents aged 13 – 18 years and young adults aged 19 – 24 years who are at risk of depression, have symptoms of depression or have been diagnosed with depression. While the focus is on depression, related disorders such as substance use disorders and self-harm are being considered as co-morbidities. The target audience are health and other service providers (GPs, psychiatrists, occupational therapists, primary health care workers, school counsellors), family, friends and the individuals themselves.

Recommendations (projected) – it is anticipated that the evaluation will provide useful feedback to assist in improving the dissemination, awareness-raising and perhaps the need for providing training in the implementation of the guidelines with key stakeholders.

7.2 beyondblue Clinical Practice Guidelines for Perinatal Depression and Related Disorders of Anxiety, Bipolar Disorder, and Puerperal Psychosis in the perinatal period (for approval by the NHMRC)

Aims
- to assist in improving prevention and early detection of antenatal and postnatal depression (perinatal depression) and related disorders and improve the support treatment for expectant and new mothers experiencing depression, anxiety, puerperal psychosis and bipolar disorder

Objectives
- to provide advice to the Australian Government and State and Territory Governments on evidence-based best practice activities in perinatal depression
- to include aspects of perinatal depression screening, care, support and treatment
- to advise in relation to particular population groups, such as CALD communities and Aboriginal and Torres Strait Islander communities
- to address Indigenous Australian perinatal mental health issues, as well as rural and remote issues

Activities
- follows the NHMRC requirements set out in its publication: A guide to the development, implementation and evaluation of clinical practice guidelines (1999) and companion documents
- approval by the CEO of NHMRC under section 14A of the NHMRC Act 1992 (as amended)
- Guideline Expert Advisory Group agreed to include mental health disorders related to the perinatal period of the mother
- Guideline Assessment Register consultant to support and guide the development of the CPGs from its inception, provided and funded by NHMRC

Outcomes
- projected publication of evidence-based NHMRC approved beyondblue guidelines
- guidelines will be of significance for pregnant women, the foetus and mothers, and infants up to one year
- development of guidelines indicate significant achievement in the mental health field
- draft guideline anticipated for release for a 60 day public consultation by mid 2010
- final guidelines with incorporated feedback from public consultation to be completed by late 2010

Evaluation – projected

Evaluation design – cross-sectional qualitative analysis
Methods
– baseline survey prior to release of guidelines
– 6-month post dissemination evaluation

Findings (projected)
– on usefulness and uptake of the guidelines
– on changes in clinical practice since the publication of the guidelines
– on changes in practice by target groups after the release of the guidelines

Conclusions – The development of the CPGs is one component of the National Perinatal Depression Initiative (NPDI) which was supported by the Australian Health Ministers’ Advisory Council and introduced by the Australian Government in the 2008-2009 Budget. beyondblue has received financial support for the development of these CPGs from the Commonwealth DoHA under the NPDI.

Recommendations (projected) – it is anticipated that the evaluation will provide useful feedback to assist in improving the dissemination, awareness-raising and perhaps the need for providing training in the implementation of the guidelines with key stakeholders.

7.3 RANZCP beyondblue Australian Indigenous Mental Health Website
Aims
– to achieve better health outcomes for the Aboriginal and Torres Strait Islander community through supporting health professionals in improving knowledge and understanding of Aboriginal and Torres Strait Islander mental health issues

Objectives
– to improve the training of mental health practitioners in Aboriginal and Torres Strait Islander mental health
– to assist health professionals to develop a strong understanding of the core values and culturally appropriate practices in Indigenous mental health assessment and treatment
– to provide culturally appropriate assessment and management for Aboriginal and Torres Strait Islander families and seek further assistance as required
– to formulate psychiatric problems within a broader holistic framework
– to work in a style of negotiation and collaboration with Aboriginal and Torres Strait Islander families, communities, organisations and mental health professionals
– to recognise and reduce barriers to effective service provision for Aboriginal and Torres Strait Islander families
– to begin to develop skills for critical analysis where outcomes for Aboriginal and Torres Strait Islander families are reduced or inadequate

Activities
– first face-to-face meeting of steering group held at Social and Cultural Psychiatry Conference, September 2006
– discussions and consultations by project officer with stakeholders to discuss gaps, approval of website content themes, formulate training and learning exercises/modules
– second face-to-face meeting of steering group, February 2007
– consultation with representatives of the relevant professions and the general public to ensure needs of target audience
– initial website content uploaded in February 2007
– feedback sought from beyondblue’s clinical and program advisors
– following feedback, website has been reviewed over the last six months
Outcomes
- the engagement of an expert steering group and content writers
- the engagement of an Indigenous graphic designer and extensive consultation on the appropriateness of the design features of the website
- an interactive and flexible learning platform that can easily adapt to the changing needs of website users and allow for the uploading of additional content and features at any time
- a high-quality website containing comprehensive pre-reading materials, ethical practice guidelines, and seven training modules, with three audio and visual resources
- telephone or email support provided by RANZCP staff member for website users
- testing phase engaging a range of professional groups conducted in all states and territories of Australia including input from urban, rural and remote communities
- promotion of project at a number of events: 2006 Social and Cultural Psychiatry Conference (Cairns), 2007 RANZCP Annual Congress (Melbourne), 2008 Creating Futures Conference (Cairns), and 2009 RANZCP Official Launch of the Website at Annual Congress (Adelaide)
- website usage: 5th May to 5th June 2009 317 visits; people from the United Kingdom and New Zealand accessed but (98%) were from Australia. There were 1,372 pages viewed in total. The vast majority of traffic (84%) entered the website via the direct website portal

Evaluation – NO

Conclusions – The website provides users with significant amounts of quality background reading material which covers important topics. Several key issues are highlighted to assist practitioners in understanding some of the broader issues impacting Aboriginal and Torres Strait Islander people’s mental health. The RANZCP has a variety of statements and guidelines pertaining to the practice of psychiatry, which are also featured on the website. The website is an informative resource for psychiatry trainees, consultant psychiatrists and all other mental health professionals wanting to improve their knowledge and understanding of Aboriginal and Torres Strait Islander mental health issues.

Recommendations – It is intended that the Aboriginal and Torres Strait Islander Mental Health Committee will continue to oversee the development of the website by regularly revising the content on the site and adding new materials as appropriate.

7.4 Aboriginal Mental Health Worker Program

Aims
- to empower Aboriginal Mental Health Workers (AMHWs) in order to improve the quality of mental health care services in remote indigenous communities

Objectives
- to train, mentor and provide ongoing support to AMHWs
- to develop a role for AMHWs and integrate them into clinical practice as members of a community-based mental health team
- to provide effective health care practices through application of local cultural knowledge and expertise of AMHWs
- to improve the level and quality of mental health care services assessed by participating community members
Activities
- unclear, no set activities/strategies (varies from site to site); program has no set protocol for clinical intervention against which outcomes can be measured
- a series of ‘Learning Both Ways’ workshops for AMHWs, GPs and mental health staff at BlITE held in Batchelor, in April and December 2000
- 15/68 applications from community councils expressed interest in employing AMHWs in response to TEDGP’s advertisement

Outcomes
- six participating communities – established AMHW program
- three AMHWs have graduated with Certificate III in Community Health (Non-Clinical) and enrolled in Certificate IV
- the program funded employment of 12 AMHWs; however, this fell to seven in six communities
- renewed MAHS funding for two years commenced in some participating communities, at the end of AMHW Program’s major funding period (June 2004)

Evaluation – YES, based on baseline evaluation conducted in 2002/03 and 2004 mid-term report

Evaluation design – both qualitative (predominantly) and quantitative research components present

Methods
- interviews with stakeholders
- site visits to communities to identify community and health centre processes; to audit patients’ files; to interview health care staff, including AMHWs; and to interview clients with mental health issues
- extraction of health service data from hospital and other databases
- brief semi-structured interviews with a limited number of clients (non-random sample) supplemented by participants observation of mental health work in the company of AMHWs

Findings
- inadequate support provided by GPs and other health care staff to develop clinical-based role for AMHWs
- no single model for the community roles of AMHWs
- development of role for community-based AMHWs not sustained due to lack of funding and infrastructure
- inconsistent terms of employment of AMHWs across sites
- no health care centre uses a standard mental health care plan in either paper or electronic form

Conclusions – Program lacks firm benchmarks for development of AMHW role across participating communities due to significantly diverse health service environments. Although AMHWs have significantly contributed to other practitioners’ understanding of cultural issues and backgrounds relating to clients’ problems, the AMHW-GP partnership model anticipated has not been sustained due to lack of support by other health professionals for AMHWs. Further, lack of shared understanding on the role of AMHWs between health centre and community organisations has diminished the clarity of direction provided to AMHWs. The sustainability of the program depends on secure recurrent funding as well as ongoing commitment of partners to provide support in the form of training, clinical and other services, administrative support, and strengthening relationship between DHCS and AHW Program, and with larger government programs.
Recommendations – to develop clearer objectives and strategies for the development of both clinical and non-clinical roles of the AMHWs; to implement systemised and consistent care planning protocols, and record keeping methods; to encourage AMHWs to include their consultations in clients records albeit records entered by GPs and RNs; to provide formal training to all mental health practitioners in the program (i.e. AMHWs, GPs and RNs); to allocate dedicated resources to provide community-based support to meet specific developmental objectives adopted by the program; local providers and councils to specify clearly on their ability/capacity to provide administrative and professional support to the AMHWs; a revised Partnership Agreement which sets out objectives for the program in the context of developing mental health care in the NT.

7.5 AGPN beyondblue Primary Care Youth Mental Health Initiative: Young Minds

Aims
- to develop a training program for GPs, practice staff and allied health professionals focusing on skills development in the diagnosis, management and treatment of high prevalence mental health disorders commonly occurring in young people

Objectives
- to form and convene a project advisory group to oversee and advise on the development of a youth mental health training package
- to undertake an audit and review of current youth mental health training resources for GPs and practice staff
- to undertake a needs analysis survey of GPs and practice staff
- to develop a training package and facilitators manual
- to apply for accreditation with the appropriate standards bodies
- to produce participants and facilitators manuals to a camera ready stage
- to host the training package on the ADGP website

Activities
- collection of information about three groups of primary care staff (GPs, practice nurses and administrative staff/practice managers)
- audit of existing training materials for primary care professionals in the area of youth mental health
- gathering of training resources
- development of training package based on literature review, audit of existing training materials and training needs survey results
- discussions with headspace Service Provider Education and Training team to include the training resource as part of their Clinical Service Provider Specialist Training Packages
- preliminary discussions with NSW Institute of Psychiatry to include training resource as part of its Graduate Diploma Program (CBT) for GPs and Allied Health Professionals

Outcomes
- project advisory group formed with teleconference meeting held August 2006 and face-to-face meeting held October 2006
- drafts of initial literature review on effective delivery methods of mental health skills training to health professionals presented and included in audit tool developed to evaluate existing training packages
- brief needs analysis survey developed and completed by either Division CEO or mental health project officer
- obtained six existing training packages from Divisions (with advise that 12 not available), seven from private providers, and relevant components of three courses from universities
- training materials developed by Flinders University and Monash University; two delivery formats – core resources for Face-to-Face training (train-the-trainer) and an Online Skills Program
face-to-face training format designed and revised to a camera ready stage; provided as four hard-copy bound manuals and a CD-Rom

online skills format developed by ORYGEN Research Centre incorporates interactive components, video vignettes, a reworking of all textual content and the interactive ‘training’ General Practice mental Health Care Plan (GPMHCP) forms

online program is ‘live’ and hosted by AGPN at www.ebmcbt.com

Accreditation of the face-to-face and Online Program has been granted by the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, the General Practice Mental Health Standards Collaboration, Australian Association of Social Workers and the Royal College of Nursing, Australia. Each training session run by a Division of General Practice or online is evaluated to meet the requirements of these Colleges. As part of its agreement with beyondblue, AGPN has undertaken to provide an interim report in February 2010 and submit an overall evaluation report summarising the training activities and feedback in July 2010.

Evaluation – YES

Conclusions – This training program focuses on the identification, diagnosis and treatment of high prevalence mental health disorders occurring in young people between the ages of 12 and 24. This training package is aimed at GPs, allied health professionals and other primary care workers who have an interest in youth mental health – prevention and early intervention. Further consideration as to implementation of the Face-to-Face training component and potential avenues for dissemination will require further investigation by beyondblue as to the packages’ applicability for other organisations, AGPN delivered the ‘Young Minds’ training package in ‘Evidence-based medical approaches of the treatment of anxiety and depression in adolescents’ as per contract deliverables.

Recommendations – AGPN will be recommending to DoHA that an underspend of funds in the Better Access orientation and information sessions project be allocated to supporting the dissemination and implementation of mental health skills training courses such as the Primary Care Youth Mental Health Initiative. AGPN suggested several avenues for dissemination of the training package, namely for review as a headspace Clinical Training Package for delivery by headspace Specialist Trainers; adaption of the package by the NSW Institute of Psychiatry for use in their graduate training programs; and to be made available for GPs and Practice Nurses seeking clinical mental health skills training. As the training program is applicable to practitioners other than GPs, AGPN recommends that beyondblue consider pursuing accreditation across a variety of primary health care disciplines which will contribute greatly to its value when seeking avenues for dissemination.

7.6 National Heart Foundation Strategic Research Partnership

Aims
- to build research capacity and to contribute to better understanding of the links between depression and cardiovascular disease

Objectives
- to fund strategic research of up to $5 million in the area of depression and cardiovascular disease
- to improve health outcomes for people with depression and cardiovascular disease or risk through the developing and testing of effective treatments and/or health practices

Activities
- identifying the real and significant risk to coronary heart disease (CHD) associated with depression, social isolation and lack of social support
- supporting quality research that is practical, with specific endpoints and clearly defined pathways to care

Outcomes
- collaboration of the Heart Foundation and beyondblue
- two grant rounds have been conducted with the following projects funded:
A Randomised Controlled Trial (ARCT) of a web-based intervention to improve depression, cognitive function and adherence in people with CVD;

does regular Tai Chi practice improve depression and metabolic syndrome for depressed adults at risk of developing CVD?

a longitudinal study of dietary risk factors for CVD (metabolic syndrome) and depression in adolescence;

the acceptability and effectiveness of a system based approach to reducing CV risk, including depression and lifestyle risk factors in rural and remote general practices – A Randomised Controlled Trial;

depression and CVD in a cohort of middle aged Australian women;

the Melbourne Depression in Heart Failure Collaborative – Medication Trial; and

omega 3 fatty acids for symptoms of depression and CVD.

Evaluation – N/A

Conclusions – N/A

Recommendations – N/A


Aims
– to summarise all of the completed beyondblue-funded research projects for period 2001-2007

Objectives
– to address gaps in depression-related research and critically evaluate the outcomes
– to support and encourage innovative, high-quality research to improve understanding of depression and related disorders

Activities
– full reports are available at www.beyondblue.org.au
– research projects range from small studies to large initiatives on issues of national significance

Outcomes – summaries of research projects presented in this report are:
– depression in primary care settings x 11
– depression in young people x 8
– depression in older people x 8
– depression and chronic illness x 6
– depression in ‘at risk’ communities x 5
– bipolar disorder x 5
– consumer and carer experiences of depression and anxiety x 4
– depression and substance-use disorders x 4
– postnatal depression x 4
– depression and people with an intellectual disability x 3
– depression in rural and remote communities x 2
– depression in the Workplace x 1
– depression and Indigenous Communities x 1

Evaluation – N/A
**Conclusions** – since its inception, beyondblue has supported a range of research initiatives and research partnerships with health services, schools, workplaces, universities, media and community organisations, as well as with people living with depression and anxiety, to bring together their expertise.

**Recommendations** – current research priorities include effective treatments and preventive interventions in areas of depression, anxiety and chronic illness (including heart disease and cancers); depression, anxiety, alcohol and related drug use; Indigenous mental health; and depression associated with cultural diversity. In all these areas, quality research and strong evidence base is needed to assist and improve primary mental health and specialist care.

**7.8 diamond Project**

**Aims**
- to raise the profile of primary care depression research and draw together researchers, practitioners, consumer groups and Division of General Practice who shared this research interest

**Objectives**
- to coordinate and communicate research activities across disciplines, organisations and geographical boundaries
- to facilitate the open exchange of information and sharing of resources
- to develop and implement a coherent and integrated research plan building upon the diamond pilot
- to nurture the careers of young researchers and research students
- to promote a ‘community of researchers’ with a strong element of mentorship
- to map pathways to and from mental health care for people experiencing depression
- to identify barriers and facilitators to effective models of primary care mental health
- to develop and test models of care based on a systems approach
- to build research capacity in primary care mental health

**Activities**
- 18 Steering Committee members met quarterly
- diamond Consortium activities focused on four key areas: communication strategy, research program, seed funding and capacity building
- two key events held in 2004 ‘Linking Research & Policy in Primary Care Mental Health’ (seminar and panel discussion) and in 2005 ‘Resource Allocation for Primary Care Mental Health’ (round table discussion)
- presentations to the Mental Health Network of General Practice Divisions of Victoria – 2004, 2007
- representing the general practice and primary care setting in the development of the 2007 National Survey of Mental Health and Wellbeing – ongoing since 2005
- Contributions to policy at State and National levels by diamond Consortium members

**Outcomes**
- communication strategy: development of Consortium website. www.diamond.unimelb.edu.au; circulation of newsletters (12) Australia-wide and internationally; dissemination of information via radio interviews, articles published in primary care and local newspapers (over 10), presentations at forums, conferences and meetings nationally and internationally (over 30); and policy input
- Research program: diamond longitudinal prospective observational study – since 2004; related research resulting from diamond study methodology – PEP project, re-order project, the party project, P.E.A.C.H. study, weave project, dialog study, SIM study, COMPASS project
- Seed funding awarded to seven projects
Evaluation – NO

Conclusions – the diamond Consortium developed and implemented a research program which resulted from the 2003 diamond pilot study. This study acted as a catalyst for the development of further research projects and research capacity building in mental health and depression research in primary care. Success of pilot enabled successful NHMRC grant and beyondblue VCoE applications. diamond study findings are being used to inform the development of general practice based models for depression care that suit the Australian health care setting through the re-order study. The diamond Consortium has built research capacity in primary care mental health by supporting the careers of early career researchers, young researchers and research students. On the whole, the diamond Consortium has enabled the development of a comprehensive program of primary care mental health research and has increased the research capacity for this work in Victoria.

Recommendations – N/A

7.9 Primary Care Evidence-based Psychological Interventions – PEP study

Aims
- to evaluate the impact of general practitioner (GP) training in Cognitive Behavioural Therapy (CBT) skills using randomised controlled design

Objectives
- to examine whether GPs who completed training in CBT strategies demonstrated:
  - an increased knowledge of CBT;
  - an increase in confidence in delivering CBT in general practice;
  - an improvement in the quality of CBT they deliver in simulated role plays;
  - improved clinical outcomes for patients (recovery rate from depressive disorder);
  - improvements in consumer satisfaction with GP psychological care

Activities
- CBT training for GPs
- recruitment of patients by intervention GPs (n=47) and control GPs (n=42)
- baseline surveys of recruited patients
- pilot studies on patient recruitment by GPs
- patient interviews post intervention
- simulated patient consultations that were rated by two experts blinded to GPs in intervention/control groups

Outcomes
- slight improvements in GP knowledge
- marked shifts in GP's confidence in CBT and specific CBT skills such as psycho-education
- activity planning, sleep wake cycle management and structured problem solving by GPs
- Improved CBT skills of trained GPs

Evaluation – YES
Evaluation design – randomised controlled trial

Methods – pre and post training surveys and interviews with GPs and patients (in intervention and control groups)

Findings
- GP confidence increased from 17.4% (pre) to 85.1% post training
- increased activity planning (from 50% to 100%), sleep wake cycle management (from 52% to 100%) and structured problem solving (from 41.7% to 100%)
- CBT skills increased from 16.7% (pre) to 89.6% post training
- both intervention and control group patients showed clinical improvements at three months compared to baseline on the Centre for Epidemiologic Studies Depression Scale (CESD)
- similar pattern with the Patient Health Questionnaire (PHQ-9) scores
- both groups reported reductions in disability (SF-12 scale) and improvements in quality of life on WHO Quality of Life (WHOQoL) instrument at three months

Conclusions – despite recruitment difficulties, patient groups recruited by both intervention and control GPs were highly similar in their demographic characteristics, clinical and service use pattern. Both groups improved in all four survey measures, indicating a reduction in depression symptoms and disability, and improvements in quality of life. However, patients of intervention GPs improved no more than those of control GPs, and both groups still had significant depressive symptoms at three months. Patient interviews suggest that though they were satisfied with their experiences of care, they support the idea that GPs work collaboratively with specialist mental health providers.

The PEP study has provided a platform for successful funding applications to the Australian Primary Health Care Research Institute and beyondblue’s VCoE in Depression and Related Disorders.

Recommendations
- GP recruitment requires active personal engagement with GPs; where possible, avoid asking GPs to recruit patients; using videotaped simulated consultations as a powerful methodology to assess GP skill acquisition; further training, peer support/supervision for GPs providing specific psychological treatments.
- policy implication – emphasise collaboration between GPs and mental health specialists; GP training in psychological treatments should include skills in assessing patient suitability for GP-provided care versus specialist psychological care.
Appendix 5

beyondblue-funded Targeted research and associated research

OLDER PERSONS

8.1 45 and Up Study – The Sax Institute, University of NSW

Aims
– to follow, in the long term, the health of men and women aged 45 and over from the general population of New South Wales, the most populous state in Australia

Objectives
– to strengthen knowledge and contribute to better information and targeted decision-making in terms of health needs and services in the future (i.e. a resource base for use by researchers and policy makers)
– to allow the integrated monitoring of risk factors, disease, treatment and outcomes in over 10% of the population aged 45 and over; provide an integrated picture of health in mid to later life
– to provide a framework for research into mental health

Activities
– raising funds from 2005 – 2009 to establish the cohort and for research using data
– establishing governance and management structures
– establishing mechanisms for ongoing linkage of 45 and Up Study baseline data with routinely collected databases providing information on mental health, treatments and outcomes
– a Policy in Action Roundtable to encourage early use of Study data for policy-relevant research
– annual meeting of 45 and Up Study Collaborators

Outcomes
– study website, www.45andUp.org.au, revised and updated
– distributed five issues of 45 and Up Study e-News
– 260,000 people recruited as full NSW cohort population by end of 2008
– 40 approved applications and 17 projects underway using the 45 and Up Study data
– three papers already published with further papers currently under review/preparation
– considerable publicity via participant newsletter, government interest and media coverage
– study has been included in the Centre for Health Record linkage Master Linkage Key
– early outcomes for beyondblue: study cohort includes people reporting on prior diagnosis of depression/anxiety and their current treatment; strategic partnerships (NHF/beyondblue); ongoing funding (NHMRC grant); substantial publicity via Study newsletter to 250,000 people
– beyondblue funded a one-year program to investigate relationship between mental health measures on the 45 and Up Study baseline questionnaire and socio-demographic factors, chronic health conditions and risk factors for chronic disease, and uptake of MBS mental health items

Evaluation – NO (five-yearly assessments of cohort population proposed – ongoing for ~ 20 years)
**Conclusions** – the 45 and Up Study established in 2005 is the largest population-based cohort study in the Southern hemisphere with around 260,000 participants. Participants provide detailed self-report data via questionnaires, and consent to link to major population health databases and to be re-contacted for substudies. The 45 and Up Study is fully established as an 'open resource' for internationally leading research to help understand how people can remain healthy and independent as they age.

**Recommendations** – maintain the existing cohort; encourage use of the data; maintain robust data and provide high quality data management; develop the biospecimens; expand the cohort; resurvey participants five years after initial enrolment; publicise the 45 and Up Study, its partners and outcomes; raise sufficient funds for the current five years and ensure financial sustainability of the cohort in the longer-term; maintain appropriate management and research governance of the cohort.

### 8.2 Beyond Ageing Research Project – Centre for Mental Health Research, The Australian National University

**Aims**
- to investigate the effectiveness of promoting physical activity, mental health literacy and combined folic acid and vitamin B12 as preventive interventions for depression in an older at-risk population

**Objectives**
- to test whether folic acid + vitamin B12 can prevent depression in older people
- to test whether promoting physical activity can prevent depression in older people
- to test whether improving mental health literacy can prevent depression in older people
- to test whether folic acid + vitamin B12 can prevent cognitive impairment in older people
- to test whether physical activity promotion can prevent cognitive impairment in older people

**Activities**
- all telephone interviewers underwent a two-day training program before the intervention commenced, and additional training every six months until the completion of the study
- half-day training sessions at six-month intervals, as well as regular contact with a senior telephone interviewer, the survey administrator, and trial manager – for telephone interviewers

**Outcomes**
- journal articles x 3; invited conference papers x 5; invited articles (non-refereed) x 2; manuals/handbooks x 6

**Evaluation** – **YES**

**Evaluation design** – factorial 2 x 2 x 2 design, community-based, double blind, placebo-controlled randomized trial, 909 participants aged 60 – 75 years from Canberra, Sydney or Wagga Wagga

**Methods**
- three interventions and their matched control interventions: first factor comprised folic acid (400 mcg) + vitamin B12 (100 mcg) and placebo tablets; second factor involved materials that promoted physical activity and match-controlled nutrition promotion materials; and third factor was a mental health literacy intervention (MHL) with pain and arthritis information as the control
- eligible participants were enrolled into three interventions for depression and three matched control interventions which were delivered in 10 modules over the 24-month intervention program at 1-5 weeks, and 4-, 8-, 13-, 18-, and 22-months
- depression and physical activity were assessed at baseline, 6 weeks, 6, 12, and 24 months using the Patient Health Questionnaire – 9 (PHQ-9)
- physical activity measured at baseline, 6-week, and 6- and 12-month assessments using the International Physical Activity Questionnaire – Short Form (IPAQ – SF)
Findings

- all trial and control interventions reduced depressive symptoms over 12 months
- only those who received MHL materials experienced a significant decrease in depressive symptoms at six weeks relative to the control condition
- importantly, however, the study found no specific additional effect of folic acid and B12 supplementation on reduction of depressive symptoms
- intervention to promote physical activity did not increase physical activity to a greater extent than the comparator invention; therefore, the hypothesis that physical activity would improve depression could not be tested

Conclusions – the study was well executed and participants were engaged. The interventions chosen were acceptable, safe, low cost and accessible. The dropout rate at 12 months of 8.6% (completion rate of 88.6%) was remarkably low relative to other psychosocial and lifestyle based intervention trials for depression. However, there may have been selection bias that threaten the generalisability of the findings due to the large number of people who did not want to continue their participation and, for ethical and risk management reasons, the comprehensive exclusion criteria. beyondblue is funding further research to allow 24 – 36 month follow-up data to determine whether benefits gained for folate and vitamin B12 levels contribute to improved depression levels or prevention of depression over time.

Recommendations – Again, investigations are needed to determine the appropriate dose-response levels of folate and vitamin B12, if there are indeed any, for treating depression in older adults. Further trials are required to determine whether mediated delivery (i.e., non-face-to-face) of physical activity interventions can be effective for promoting physical activity to the recommended levels needed for managing depressive symptoms.

GRANTS

8.3 beyondblue Victorian Centre of Excellence – bbVCoE

Aims

- to bring together capacity, expertise and skill to enable the development and delivery of high quality, best practice responses to depression and related disorders to the Victorian community

Objectives

- to bring together researchers and other health professionals with expertise and capacity to enable the development and delivery of innovative, high quality responses to depression, anxiety and related disorders to the Victorian community
- to focus on research and evaluation at the interface between the primary care, general medical, and specialist mental health systems
- to facilitate pathways to care for people with depression and related disorders

Activities

- 2005 round of grants: research related to marginalised populations and communities, including the elderly, young people (particularly within the juvenile justice system), people in regional and rural areas, and also co-morbid drug and alcohol use; depression linkages with suicide prevention; recognition of social factors, social support and involvement of families in depression management
- 2006 round of grants: research into early intervention and pathways to care, with a particular focus on populations at risk including men, Indigenous, rural and youth and included issues of gender and drug and alcohol use
- 2007 and 2008 grant rounds: research to address gaps in knowledge in relation to the co-morbidity of depression/anxiety and chronic illness, and the co-morbidity of depression/anxiety and substance use (focus included prevention, early intervention and treatment approaches)
Outcomes

bbVCoE Depression and Related Disorders Research Projects 2005 – 2009:
- Comorbidity with Chronic Illness x 24
- Primary Care x 3
- Youth x 16
- Substance Use and Addictions x 13
- Older People x 3
- Disability x 6
- Bipolar Disease x 3
- CALD x 3
- Perinatal Health x 3
- Rural x 5
- E-health x 1
- Indigenous x 5
- Men x 1

Evaluation – YES – Review of the beyondblue Victorian Centre of Excellence in Depression and Related Disorders Plexus Consulting 2005

Conclusions – bbVCoE places value on prevention, early intervention and treatment, a multi-disciplinary team approach, consideration of pathways to care, and consumer and carer involvement. Populations identified as being at particular risk, including children, young people, older people, men, women, Indigenous, and people with disabilities; and at risk circumstances including being of CALD background, living in regional, rural or remote areas or difficult social situations are of high importance.

Recommendations

Proactive, systematic capacity building [that is, to expand the range of participating researchers, their ability to conduct quality research, and their connections with other researchers, and to increase the ability of organisations to develop integrated and developing research programs

Management of a research agenda including integration of knowledge and support for utilisation [that is, actively developing programs of research based on a clear identification of knowledge gaps and policy needs, and supporting the systematic integration of research findings to meet policy needs and to guide the future development of the research program.
PARTNERSHIPS

8.4 Cancer Australia Partnership

Aims
– to fund strategic research into Cancer and Depression through the Priority-driven Collaborative Cancer Research Scheme (PdCCRS)

Objectives
– to provide a coordinated approach among funding organisations to fund cancer research in priority areas
– to foster collaboration between research groups and individuals on a single research project
– to lessen duplication and fragmentation of research effort at the national level

Activities
– priority-driven (relate specifically to the research priority area specified by beyondblue)
– outcome/impact focused (projects will improve outcomes in cancer control and/or impact on populations with poorer outcomes within the community)
– collaborative (projects are cross-disciplinary, national or multi-state and/or key researchers are part of the grant application)
– engage consumers (involved in the design and ongoing conduct of the research project)
– incorporate record of impact (Applications should describe how in the past, key researchers on the application had research findings translated into clinical practice, policy or further research)

Outcomes
– two grant rounds have been conducted; the 2009 round of the PdCCRS is currently underway with applications undergoing assessment

The following projects were successful in the 2008 round and all projects are co-funded by beyondblue and Cancer Australia:
– Improving the Psychosocial Health of People with Cancer and their Carers: A Community-Based Approach
– Understanding the psychosocial consequences of surviving testicular cancer
– Psychological morbidity, unmet needs, quality of life and patterns of care in migrant cancer patients: The first year
– A web-based intervention to reduce distress and improve quality of life among younger women with breast cancer: A RCT
– Blood cancer survivors and support persons: A national survey of rural/urban unmet needs and psychological disturbance
– A nurse led psychosocial intervention with peer support to reduce psychosocial needs in women with gynaecological cancer

Evaluation – N/A

Conclusions – beyondblue’s research priorities are collaborative research to achieve increased recognition of the co-morbidities of cancer and depression leading to an improvement in psychosocial care for people affected by cancer.

Recommendations – N/A
8.5 National Heart Foundation Strategic Research Partnership

Aims
– to build research capacity and to contribute to better understanding of the links between depression and cardiovascular disease

Objectives
– to fund strategic research of up to $5 million in the area of depression and cardiovascular disease
– to improve health outcomes for people with depression and cardiovascular disease or risk through the developing and testing of effective treatments and/or health practices

Activities
– identifying the real and significant risk to coronary heart disease (CHD) associated with depression, social isolation and lack of social support
– supporting quality research that is practical, with specific endpoints and clearly defined pathways to care

Outcomes
– collaboration of the Heart Foundation and beyondblue

Two grant rounds have been conducted with the following projects funded:
– A RCT of a web-based intervention to improve depression, cognitive function and adherence in people with CVD
– Does regular Tai Chi practice improve depression and metabolic syndrome for depressed adults at risk of developing CVD?
– A longitudinal study of dietary risk factors for CVD (metabolic syndrome) and depression in adolescence
– The acceptability and effectiveness of a system based approach to reducing CV risk, including depression and lifestyle risk factors in rural and remote general practices – A Randomised Controlled Trial
– Depression and CVD in a cohort of middle aged Australian women
– The Melbourne Depression in Hearty Failure Collaborative – Medication Trial
– Omega 3 fatty acids for symptoms of depression and CVD

Evaluation – N/A

Conclusions – N/A

Recommendations – N/A
RESEARCH PROJECTS

8.6 Greater Green Triangle: Chronic Disease Management of Co-morbid Depression, Heart Disease and Diabetes Project: The TrueBlue Study

Aims
- to determine whether practice nurse-led collaborative care is better than the usual method of GP-led episodic care for the management of co-morbid depression in patients with heart disease or diabetes by testing whether there is an improvement in the depression score at the end of the study

Objectives
- to achieve a 50% reduction in depression score
- to test whether it is a practical way to manage this complex and increasing chronic-disease burden
- to demonstrate that the model of care can use existing clinical staff and be funded within current Medicare arrangements
- to demonstrate that it can be used in large and small practices across rural and urban settings

Activities
- selecting practices from three regions (Adelaide, inner Melbourne and the NSW Northern Rivers area)
- practice recruitment, until 50 patients have been recruited
- practice nurse (PN) training workshop – two-day training workshop to prepare them for enhanced roles in nurse-led collaborative care
- intervention program – each patient/PN session scheduled to take approximately one hour
- practice facilitator in each region to offer support to PNs and to monitor progress of the research program

Outcomes – N/A

Evaluation – YES

Evaluation design – cluster-randomised intervention trial, nine intervention and nine control practices, each with 50 patients

Methods
- general practices were allocated either to an intervention group in which nurse-led collaborative care is to be undertaken or to the control group in which usual GP-led care is to be continued for six months and then implement the nurse-led care model
- Patient Health Questionnaire (PHQ-9) used to measure and monitor depression over time
- health and lifestyle measured using version 2 of the SF-36 questionnaire
- the GP Management Plan (GPMP) – data from PN assessment will form the basis for this plan
- in the second (6-month) and fourth (12-month) consultations, the patient will complete a new SF36v2 form to assess changes in quality of life
- during each review, patients complete a new PHQ-9 questionnaire so that any changes to their mental health can be monitored
- structured interviews with PNs and GPs, and telephone interviews with a randomly selected list of patients, at completion of program

Findings – currently pending (program still ongoing)
Conclusions – an important aspect is that patients, in collaboration with the practice nurse, will develop up to three goals that they feel will be able to help reduce their risk factors, thus making patients active participants in their own health care. Further, patients are recalled systematically to monitor the progress of their care. The collaborative care process is audited using patient feedback. Another important aspect is that the nurse-led care can be completely self-funded using the normal Medicare item numbers. Medicare funding will mean practices are remunerated for the more intense patient intervention. The strength of this program is that it provides a sustainable model of chronic disease management with monitoring and self-management assistance for physiological, lifestyle and psychological risk factors for high-risk patients with co-morbid depression, diabetes or heart disease.

Recommendations – the program uses the existing workforce but involves an enhanced role for practice nurses and so is applicable for wider roll out in using this potentially under-utilised resource. Practice nurses gain enhanced skills in the chronic disease management (CDM) set up and management that will be a useful model for patients with other chronic diseases.

8.7 Medical Journal of Australia Supplements
Aims & Objectives
– to showcase quality Australian research in depression and anxiety
Activities
– funding MJA supplements in the period from 2001 – 2004
– funding MJA supplements in the period from 2005 – 2010
Outcomes
– Depression and Anxiety with Physical Illness – April 2009
– Depression and Primary Care – June 2008
– Depression: Reducing the Burden – October 2004
– Depression and the Community – May 2002
– Preventing Depression – October 2002
Evaluation – N/A
Conclusions – the latest Supplement “Depression and anxiety with physical illness” features research highlighting the complex and compounding effects depression has on health outcomes for people with physical illness. beyondblue continues to support depression and anxiety specific research nationally and through the beyondblue Victorian Centre of Excellence, the National Heart Foundation Strategic Research Partnership, and with the Cancer Australia’s priority-driven Collaborative Cancer Research Scheme.
Recommendations – N/A

Aims
– to summarise all of the completed beyondblue-funded research projects for period 2001-2007
Objectives
– to address gaps in depression-related research and critically evaluate the outcomes
– to support and encourage innovative, high-quality research to improve understanding of depression and related disorders
Activities
– full reports are available at www.beyondblue.org.au
– research projects range from small studies to large initiatives on issues of national significance

Outcomes
Summaries of research projects presented in this report are:
– Depression in Primary Care Settings x 11
– Depression in Young People x 8
– Depression in Older People x 8
– Depression and Chronic Illness x 6
– Depression in ‘At Risk’ Communities x 5
– Bipolar Disorder x 5
– Consumer and Carer Experiences of Depression and Anxiety x 4
– Depression and Substance-use Disorders x 4
– Postnatal Depression x 4
– Depression and People with an Intellectual Disability x 3
– Depression in Rural and Remote Communities x 2
– Depression in the Workplace x 1
– Depression and Indigenous Communities x 1

Evaluation – N/A

Conclusions – since its inception, beyondblue has supported a range of research initiatives and research partnerships with health services, schools, workplaces, universities, media and community organisations, as well as with people living with depression and anxiety, to bring together their expertise.

Recommendations – current research priorities include effective treatments and preventive interventions in areas of depression, anxiety and chronic illness (including heart disease and cancers); depression, anxiety, alcohol and related drug use; Indigenous mental health; and depression associated with cultural diversity. In all these areas, quality research and strong evidence base is needed to assist and improve primary mental health and specialist care.

8.9 Monitoring Media Reporting of Depression – Dare A, Pirkis J, Blood R W & Burgess P

Aims
– to contribute to the international literature by systematically investigating how the Australian media report depression

Objectives
– to investigate media reporting prior to the Australian Government and beyondblue beginning their efforts to encourage responsible reporting (01/03/2000-28/02/2001)
– to investigate media reporting after their efforts were well established (01/09/2006-31/08/2007)
Activities
- extracting identifying and descriptive information for each media item related to mental illness, and rating each for quality, using criteria from *Reporting Suicide and Mental Illness*
- special attention to the items in which depression was the main focus, assessing them in terms of the accuracy of representation of symptoms (based on DSM-IV-TR criteria), and the accuracy of representation of causes, treatment and prognosis (based on *A Depression Management Program*, guidelines developed with support from beyondblue)

Evaluation – YES

Evaluation design – predominantly quantitative, but is complemented by a qualitative study

Methods
- current study was part of a larger project known as the Media Monitoring Project
- media items related to mental illness were collected from 632 print and broadcast sources, over two 12-month periods – one prior to the introduction of the initiatives of the Australian government and beyondblue, and one subsequent to their roll-out
- the 632 media sources included all metropolitan newspapers and a sizeable sample of suburban and regional newspapers, as well as all national radio and television networks

Findings
- in both study years, media items in which the main focus was depression accounted for around 20% of all items on mental illness; they were more common than items about any other specific mental illness, including schizophrenia, eating disorders, dementia, stress and substance abuse disorders; only items which were more general and not related to a specific mental illness consistently outnumbered them
- in terms of item content, depression-related items showed an increase in focus on individuals’ experiences (24.2% in 2000/01 versus 45.3% in 2006/07) and a decrease in references to policy/program initiatives (35.6% in 2000/01 versus 23.0% in 2006/07); items which focused on other categories of mental illness also showed an increased emphasis on individuals’ experiences, but displayed considerable variability in their profiles with respect to other forms of item content over time
- depression-related items showed an improvement in quality over the study period, as assessed against nine dimensions based on criteria in *Reporting Suicide and Mental Illness*; the mean total quality score for depression-related items showed a statistically significant increase from 76.0 (95%CI=74.4-77.6) to 80.0 (95%CI=78.2-81.8); items in all other mental illness category groupings also showed increases, although only those for dementia-related items and items not related to a specific mental illness were significant
- there was a greater tendency for depression-related items to include detail about the symptoms, causes and treatment of depression in 2006/07 than in 2000/01; by contrast, these items were less likely to discuss the prognosis of depression in the latter period; the accuracy of these descriptions was quite high in the earlier period and remained at the same level or improved still further, although causes of depression proved the exception to the rule; there was greater variability in over time in terms of whether symptoms, causes, treatment and prognosis were portrayed in a positive, negative or neutral fashion
- reference was made to beyondblue in 19.2% of all depression-related items in 2006/07; although comparative data from 2000/01 were not available

Conclusions – between 2000/01 and 2006/07, reporting of depression largely changed for the better. This finding is extremely positive, although there are still clearly some opportunities for improving reporting of depression.

Recommendations – in order to maintain/improve the current standard continued support should be provided for the media efforts of beyondblue and the Australian Government.
8.10 Perinatal Research

Aims & Objectives
- to improve the prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing perinatal depression

Activities
- the beyondblue National Depression Program, Prevention and Early Intervention, State-based Antenatal Intervention Initiatives
- beyondblue Sherryl Pope Memorial Scholarship

Outcomes
1. beyondblue funded several perinatal researches in 2001 – 2009 beyondblue National Depression Program, Prevention and Early Intervention, Australia-wide
   - Antenatal Support Following Depression – Enhancing the Parent-Infant Relationship, VIC
   - Helping Him to Help Her, SA
   - The beyondblue Postnatal Depression Project for families with multiple birth children, WA
   - Education and Training for Rural, Regional and Remote Health Professionals, QLD
   - Indigenous women’s project: Report of Process and Preliminary results, QLD
   - Clinical Interventions for, and Preference of, women from Vietnamese and Arabic Speaking Backgrounds, NSW
2. Optimising emotional health during pregnancy and early parenthood: Improving access to help women with perinatal depression, VIC
   - Models of care: Evaluating a best practice model for treating postnatal depression – Year 1 and Year 2, VIC
   - A brief psycho education intervention to prevent the development of depression in anxious first-time mothers of newborn, VIC
   - Towards Parenthood: An antenatal self-help intervention for depression, anxiety and parenting difficulties, VIC
3. A comparison of anxiety, stress and depression across the perinatal period in women pregnant with twins and singletons

Evaluation – N/A

Conclusions – N/A

Recommendations – N/A
Appendix 6
Data from the BEACH (Bettering the Evaluation And Care of Health)

The DoHA funded, BEACH Project continuously collects information about general practice encounters in Australia, using a design whereby 20 general practitioners collect data on 100 consecutive encounters each week. In total, 1,000 general practitioners are involved. Relevant data from the BEACH Project are reported annually by the Australian Institute of Health and Welfare. BEACH data was used in the current evaluation to explore changes in the level of depression-related GP encounters over time.

Aims
- to look at changes in the clinical activities of general practice in Australia over the decade 1998 to 2008, in the context of numerous government initiatives and national health priorities, changes in the general practitioner (GP) workforce/workload and changes in the population

Objectives
- to provide a unique insight into the clinical encounters between general practitioners and their patients
- to provide a reliable, independent and continuous measure of changes in general practice
- to utilise general practice as a platform for preventive care and encourage the development of chronic care plans and the better coordination of the range of services that these patients need

Activities
- BEACH began in April 1998, and presents data collected between then and March 2008, by 9,874 GP participants for 987,400 GP–patient encounters
- BEACH is conducted by the Australian General Practice Statistics and Classification Centre
- Focuses on general practice activities for eight health conditions (National Health Priority Areas), sexual health and gastro-oesophageal reflux disease, and Aboriginal and Torres Strait Islander

Outcomes/Findings
- BEACH program has generated many papers on a wide range of topics in journals and professional magazines; a complete list of publications is available from the Family Medicine Research Centre’s website, www.fmrc.org.au/publications/
- significant increase in the management of all psychological problems between 2002–03 and 2007–08, after the introduction of the 2002 BOIMHC initiative and the subsequent 2006 Better Access initiative
- significant increase in the management rate of depression from 1998–99 to 2007–08
- significant decrease in the use of clinical treatments (apart from psychological counselling) after 2004–05
- significant increase in the rate at which patients with depression and anxiety problems were referred, with a significant shift in referral patterns for patients with depression from psychiatrists to psychologists associated with the introduction of the MBS items for psychologist services
- encounters involving the management of depression, anxiety and drug and alcohol problems are, on average, longer than those where they are not managed
– no difference was found between patients from major cities and those from outside major cities in the proportion of psychological encounters covered by either the BOIMHC or Better Access item numbers, nor was there a difference between them in the proportion referred to a psychologist before or after the Better Access initiative was introduced.

– no difference was found between patients from disadvantaged areas and advantaged areas in the proportion of psychological encounters that were covered by BOIMHC or Better Access initiative item numbers.

**Evaluation** – NO

**Conclusions** – there have been substantial changes in the activities of general practice over time, both in numbers of services delivered and the focus of these services. These changes have occurred in parallel with the progressive ageing of our population, a consequent rise in demand by patients for treatment and management of chronic illnesses, changes in the provision of bulk billing, practice and service incentive payments through Medicare, a rising awareness of the need for accountable and evidence-based practice, and a push for greater patient involvement and responsibility in their own health care. This report has shown that whilst governments have acknowledged the importance of mental health in Australia, GP's central role and increased clinical activity correlates strongly with health policy initiatives.

**Recommendations** – many of the changes identified can be readily linked to policy changes that have occurred over the time of the study. However, some policies appear to have had little or no impact on general practice patterns of care, and this should raise questions in the minds of policy makers as to their value. A method for linking the measured changes in the process of care to improved health outcomes is needed to be developed and applied in Australia.
Appendix 7
Sample Journal articles

Journal articles authored or supported by beyondblue in 2007/08 include:


40. Priest, SR, Austin MP, Barnett B, & Buist A. A Psychosocial Risk Assessment Model (PRAM) for use with pregnant and postpartum women in primary care settings. Archives of Women’s Mental Health, accepted 8/08.


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