PROGRAM EVALUATION UNIT

beyondblue: the national depression initiative 2000-2004

An independent evaluation report

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October 2004

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Foreword

In July 2000, I readily took on the role as Chair of *beyondblue: the national depression initiative*, because I held the belief that it could really make a difference to the lives of people living with depression in Australia. Like others in the community, I had developed a growing awareness of the significant emotional and economic burden of depression – and its insidious contribution to the growing numbers of suicides each year – and I believed that the bi-partisan and population health approach of *beyondblue* had the potential to provide some much-needed solutions.

Since then, I and others who have been closely involved with *beyondblue* have felt confident that it has developed into a major force to combat depression, but it's fair to say that we are not disinterested parties. I welcome this report because it represents an independent, objective, scientific evaluation of *beyondblue.* It systematically brings together evidence from a range of sources and assesses the extent to which *beyondblue* has achieved its objectives to date.

I am extremely pleased, but not in the least bit surprised, to find that the evaluation confirms my belief that *beyondblue* is having a substantial impact. The evaluation shows that *beyondblue* has put a plethora of initiatives in place under each of its priority areas. These initiatives have contributed to improving the community's awareness and understanding of depression and through partnerships with the media, are making a dent in the stigma associated with the illness. They have raised the profile of consumers and carers and the lived experience of depression and have created networking opportunities within and across sectors that did not previously exist. They have increased the number and range of effective prevention and early intervention initiatives that are available, involving both the health sector and sectors outside health, such as education and employment. They have strengthened the capacity and confidence of primary care providers to respond to depression. And importantly, they have added to the body of knowledge about depression and how to prevent it, via targeted research activities.

In addition to the main evaluation report, which is organised around *beyondblue's* five priority areas, a supplementary report is included as an appendix. The latter report describes a survey of *beyondblue's* program partners – organisations and individuals from within and outside the health sector who share *beyondblue's* vision and have worked with *beyondblue* to achieve common objectives. According to the survey results, the partners were, in the main, extremely positive about how well *beyondblue* has addressed its mandates. The main evaluation and the survey of program partners are complementary, in that the former examines in detail the extent to which each of *beyondblue's* objectives has been met, whereas the latter constructively informs the broader picture.

Overall, the evaluation suggests that the landscape has changed for the better with regard to depression in Australia and that *beyondblue* can claim a good portion of the credit for this. Of course there is still much to be done, but *beyondblue* has made an impressive start. *beyondblue's* record to date suggests that it is well placed to continue its endeavours, and I firmly hope that it will be given the opportunity to do so. I congratulate the stakeholder governments for their vision and confidence in 2000, particularly the Victorian and Federal Governments, and I offer this evaluation to them and others who might join us as a sound example of our capacity to deliver with a further term.

The Honourable Jeff Kennett
Chair, *beyondblue: the national depression initiative*

Executive summary

A description of *beyondblue*

beyondblue: the national depression initiative is an independent national initiative designed to raise awareness, build networks and motivate action in the area of depression prevention. Its 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 by it.' 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 to it.'[1] Underpinning its mission is a series of five priority areas for action: (1) Community awareness and destigmatisation; (2) Consumer and carer participation; (3) Prevention and early intervention; (4) Primary care; and (5) Targeted research.[2-4]

beyondblue was originally funded for five years from July 2000 to July 2005. The initial funding totalled approximately $35 million, $17.5 million from the Commonwealth Government and $17.5 million from the Victorian Government.[2-5] It was initially anticipated that this funding would grow to $50 million over the five year period, through additional support from other state/territory governments and corporate sources, but to date it has reached approximately $39 million. Additional in-kind support equivalent to a further $3-5 million has been provided by corporate sponsors.[5]

Evaluation design and method

In its Strategic Plan,[1] *beyondblue* calls for its own evaluation towards the end of its first five year period. It notes that the evaluation should consider the extent to which it has achieved its goals of bringing about the structural change and community motivation necessary to prevent depression and minimise its effects. If it has fully achieved its goals, it should hand back its activities to the community. If it has made no inroads into achieving its goals, it should not continue to be funded. If it has partially achieved its goals, particularly with regard to changes in professional and community attitudes, careful consideration should be given to what action is necessary to foster positive change that is sustainable to the point that *beyondblue* no longer needs to exist.

The Program Evaluation Unit of The University of Melbourne's School of Population Health was commissioned to develop an evaluation framework to inform these issues,[6] and then to conduct an evaluation of the achievements of *beyondblue* to date.

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 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 in general, and *beyondblue* in particular
e. Data on the use of *beyondblue's* website

f. Independent assessments of the quality of the *beyondblue* website
g. Data from the Australian National Mental Health Literacy Survey
h. *beyondblue's* Depression Monitor data
i. *beyondblue's* consultative processes with consumers and carers
j. Other consultative processes with consumers and carers
k. blueVoices membership data
l. A review of *beyondblue's* project funding
m. Data from evaluation activities associated with the Better Outcomes in Mental Health Care Initiative
n. Data from the BEACH (Bettering the Evaluation and Care of Health) Project
o. An audit of research activities in the area of depression.

Key evaluation findings

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

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

Objective 1.1: Key initiatives in place

The key initiatives associated with Priority Area 1 are in place, taking the form of a broad range of mass media initiatives (e.g., a seminar for media professionals; media commentary; promotional materials; a website; community service announcements, including a major national public awareness campaign, known as Blue Skies; and special supplements on depression in the *Medical Journal of Australia*) and community activities (e.g., Ybblue; Rotary community forums; the Depression Awareness Research Project; and special events).

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

The above key initiatives have led to an increase in the quantity of information available about depression through media and educational sources. 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 heavily used, the Blue Skies campaign has been widely aired, 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 being ranked highly by independent assessors, the specialist publications being peer-reviewed, and the *beyondblue* website, the Blue Skies campaign and many of the community activities being positively evaluated. 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.

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

The above increase in the quantity and quality of information about depression appears to have translated into gains in the community's 'depression literacy', although there is still room for improvement. Repeated cross-sectional population surveys suggest 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.* However, there was little shift in the population's recognition of the magnitude of the

problem, with a high proportion of the population continuing to underestimate both the prevalence and the burden of depression.

Objective 1.4: Increased understanding of the experiences of people whose lives have been affected by 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 indirect evidence, however, that suggests that there is movement in the right direction. According to survey data, an increasingly high proportion of the population report experiencing depression themselves, or are close to someone who has. This augurs well for the community empathising with those affected by the condition.

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

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. Again, there is some indirect evidence that bodes well. Results from repeated administrations of surveys suggest that there is an increased acknowledgement of the stigma and discrimination experienced by people with depression. In addition, there is some evidence that some of the systems that foster discrimination (e.g., the insurance industry) are changing. However, consultations with consumers and carers indicate that discrimination remains a problem.

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

Objective 2.1: Key initiatives in place

beyondblue has put in place an impressive range of initiatives under Priority Area 2. At the forefront of these is the development of blueVoices, a national network of consumers and carers. *beyondblue* also has several research projects underway, each of which explores the experiences of consumers with particular disorders, and their carers. In addition, *beyondblue* has acted as a catalyst in bringing consumers and carers to the policy and planning table – e.g., through membership, funding and/or support for existing consumer and carer organisations (e.g., the National Network of Private Psychiatric Sector Consumers and Carers, the National Consumer and Carer Forum, the Mental Health Council of Australia) and support for consumer representation on other key bodies (e.g., the Strategic Planning Group for Private Psychiatric Services).

Objective 2.2: Improved consumer and carer networks

There is evidence that these initiatives – particularly blueVoices – have led to improved consumer and carer networks. blueVoices has a membership of 9,650 (as at 10 August 2004).

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

beyondblue has fostered genuine participation by consumers and carers in its own depression-related initiatives. Over and above its own activities and programs, *beyondblue* has successfully ensured participation by consumers and carers in external initiatives, particularly through the advocacy role of blueVoices.

Objective 2.4: Genuine acknowledgement of issues faced by consumers and carers

While it is true to say that *beyondblue* itself has genuinely acknowledged, and tried to address, many of the issues faced by consumers and carers, there is less evidence that such an acknowledgement has extended into the broader community. Ongoing discrimination and deficiencies in the treatment system appear to remain major issues for consumers and carers.

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

Objective 3.1: Key initiatives in place

beyondblue has put in place a broad range of prevention and early intervention activities associated with Priority Area 3. These have occurred within a population health framework, and are aimed at changing knowledge, attitudes and behaviour across the whole population and targeted sub-populations (particularly young people, women, Indigenous communities, people in workplace settings and people with physical conditions).

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

There is evidence that the efforts of *beyondblue* have led to a net gain in terms of the current number and range of effective prevention and early intervention initiatives for depression, although there are questions about their sustainability. Because the projects are targeted and use appropriate models, they provide lessons for the future suite of effective projects and programs on which others could draw.

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

There is also some evidence that the initiatives of *beyondblue* are beginning to lead to systemic changes in the health sector and beyond (e.g., in families, schools, workplaces and communities). Examples include the VicChamps project, which is increasing the involvement of adult mental health and community services in addressing the needs of children of parents with a mental illness, and the *beyondblue* National Depression in the Workplace Program, which is improving the capacity of workers to respond effectively to colleagues, subordinates and managers with depression and has been implemented nationally in government and non-government sectors.

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

Many of the prevention and early intervention activities have aimed to improve the community's 'depression literacy', including influencing those who are experiencing depression to seek help early. According to their evaluation reports, participants in many of these projects report an improved understanding of depression and an increased awareness of appropriate sources of referral and assistance. This augurs well for improving the likelihood that people with depression will seek professional help in a timely fashion, but it must be regarded as evidence of intentions, rather than of actual help-seeking behaviour.

Objective 3.5: Reduction in risk factors and promotion of protective factors

Much of the work of *beyondblue* seeks to reduce modifiable risk factors and promote protective factors, at a range of levels. As yet, there is a dearth of evaluative evidence that examines whether *beyondblue* is successfully achieving this end. In part, this is because it is too difficult or too early to measure the outcomes that would indicate success. The sound evidence base upon which these initiatives are drawing augur well for their success, but there is a need to ensure that formal, ongoing evaluation efforts are in train.

Objectives achieved under Priority Area 4 (Primary care)

Objective 4.1: Key initiatives in place

beyondblue has focused considerable attention on the area of primary care (Priority Area 4), and has put in place a number of initiatives aimed at better equipping GPs (and, to a lesser extent non-medical primary care practitioners) to provide mental health care for people with depression and related disorders. It has also supported parallel primary care initiatives.

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

The initiatives of *beyondblue* are making inroads in terms of addressing systemic and service-related barriers to primary care professionals providing mental health care (e.g., lack of training, financial rewards, personal incentives and support from the specialist mental health sector). *beyondblue* has acted as a catalyst for some of the most significant systemic changes in primary care in the last five years, including the Better Outcomes in Mental Health Care Initiative. It should be noted, however, that some systemic changes were beginning to occur prior to the advent of *beyondblue.*

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

There is evidence that the absolute number of primary care practitioners who feel equipped to take on treatment roles (and potentially community education roles) in the area of depression has increased during the life of *beyondblue.* Some of these increases can be directly attributed to *beyondblue*; others are not solely due to *beyondblue*, although the organisation can take some credit. The evidence regarding whether these primary care practitioners are actually fulfilling their potential in terms of these roles is more equivocal. On the one hand, there has been a large amount of activity associated with the Better Outcomes in Mental Health Care Initiative. On the other hand, the overall level of depression-related GP encounters has remained essentially unchanged over time.

Objectives achieved under Priority Area 5 (Targeted research)

Objective 5.1: Key initiatives in place

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 initiative. In addition, *beyondblue* encourages rigorous evaluations of all its funded programs and projects. *beyondblue* has also linked with other key research initiatives, such as the establishment of the Depression and Anxiety Consumer Research Unit.

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

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 and *beyondblue's* strategic research initiative alone have supported around 50 studies. The evidence suggests that this is redressing the imbalance identified by Jorm et al's audit of depression-related research activities, conducted prior to the launch of *beyondblue.* Not only has the number of projects increased, but the research is now better aligned with priorities identified by stakeholders. There are some questions, however, about whether the body of research has sufficient strategic direction and emphasis on capacity building.

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

Some of these projects are beginning to yield results that are addressing gaps in knowledge about depression (particularly regarding the evidence base for community education, prevention and treatment), of relevance in Australia and overseas. Some of these findings have helped shape specific initiatives of *beyondblue.* Other research efforts supported by *beyondblue* have not yet led to increases in knowledge, but, perhaps equally as importantly, have increased research capacity.

Achievement of high level objectives

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

Indirect evidence suggests that *beyondblue* may partially have achieved its mission (i.e., increased the capacity of the broader Australian community to prevent and respond effectively to depression).

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 by it

beyondblue's vision (i.e., 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 by it) is more ambitious than its mission, and involves substantial cultural change that has not yet been realised.

Conclusions

The achievements of *beyondblue* should be considered in the light of its own Strategic Plan, which, as noted above, outlines three possible scenarios.[1] To reiterate, the Strategic Plan states that if *beyondblue* has fully achieved its goals, it should hand back its activities to the community; if it has made no inroads into achieving its goals, it should not continue to be funded; and if it has partially achieved its goals, careful consideration should be given to what action is necessary to foster positive change that is sustainable to the point that *beyondblue* no longer needs to exist. It is possible to state with confidence that the third scenario most accurately describes the current situation. *beyondblue* has achieved a significant amount in a relatively short space of time, but there is still some way to go and *beyondblue* continues to have an important contribution to make, working in concert with Federal, state/territory and local initiatives. *beyondblue* has recognised this in its recent 'Ways Forward' document, which outlines a plan for building on its achievements over the next five years.[7] 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.

Chapter 1: Background

An overview of *beyondblue*

beyondblue: the national depression initiative 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).[1]

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 by it.' 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 to it.'[1]

Underpinning *beyondblue's* mission is a series of five priority areas for action. These were outlined originally in *beyondblue*'s Strategic Plan,[1] and have been reiterated in a slightly modified form in the organisation's three Annual Reports.[2-4] They are as follows:

Priority Area 1. Community awareness and destigmatisation: *beyondblue* will reduce stigma by increasing awareness of the symptoms, causes and treatments of depression, and by promoting the experiences of people whose lives have been affected.

Priority Area 2. Consumer and carer participation: *beyondblue,* in partnership with consumers and carers, will promote community-wide response to and advocacy for the issues raised by people with depressive illness and their carers.

Priority Area 3. Prevention and early intervention: *beyondblue* will support programs that provide opportunities to prevent depression or promote early intervention, rigorously evaluating their impact.

Priority Area 4. Primary care: *beyondblue* will assist primary care practitioners to increase their community education and treatment roles.

Priority Area 5. Targeted research: *beyondblue* will promote depression-related research, particularly where it offers new knowledge about community education, prevention and treatment.

beyondblue was originally funded for five years from July 2000 to July 2005. The initial funding totalled approximately $35 million, $17.5 million from the Commonwealth Government and $17.5 million from the Victorian Government.[2-5] It was initially anticipated that this funding would grow to $50 million over the five year period, through additional support from other state/territory governments and corporate sources, but to date it has reached approximately $39 million. Additional in-kind support equivalent to a further $3-5 million has been provided by such sources as Network Ten and other commercial television stations, jeans west, Mission Australia, Virgin Blue, Diana Ferrari, Medical Benefits Fund and Athlete Development Australia.[5] Detail of the nature of this in-kind support is provided in subsequent chapters, as relevant.

Specific initiatives of *beyondblue*

A series of national, state/territory-based and local initiatives have been funded within each of the priority areas of *beyondblue.* These are described in more detail in Chapters 4-8.

Developing an evaluation framework for *beyondblue*

In its Strategic Plan,[1] *beyondblue* calls for its own evaluation towards the end of its first five year period. It notes that the evaluation should consider the extent to which it has achieved its goals of bringing about the structural change and community motivation necessary to prevent depression and minimise its effects. If it has fully achieved its goals, it should hand back its activities to the community. If it has made no inroads into achieving its goals, it should not continue to be funded. If it has partially achieved its goals, particularly with regard to changes in professional and community attitudes, careful consideration should be given to what action is necessary to foster positive change that is sustainable to the point that *beyondblue* no longer needs to exist.

The Program Evaluation Unit[a] of The University of Melbourne's School of Population Health was commissioned to develop an evaluation framework to inform these issues. 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 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 these questions. The design is multifaceted, incorporating a range of different data sources and approaches to analysis. It can be viewed as a series of optional components. The full evaluation framework is described elsewhere,[6] but much of it is reiterated in the current report.

Content and structure of the current report

Drawing directly on the original evaluation framework document,[6] 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 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.

[a] The Program Evaluation Unit was previously part of the Centre for Health Program Evaluation, a joint initiative of The University of Melbourne and Monash University.

Chapter 2: The program logic of *beyondblue*

beyondblue is a major undertaking, which involves a sophisticated set of activities occurring in an already 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 the evaluation framework for *beyondblue*.

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, a 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?).

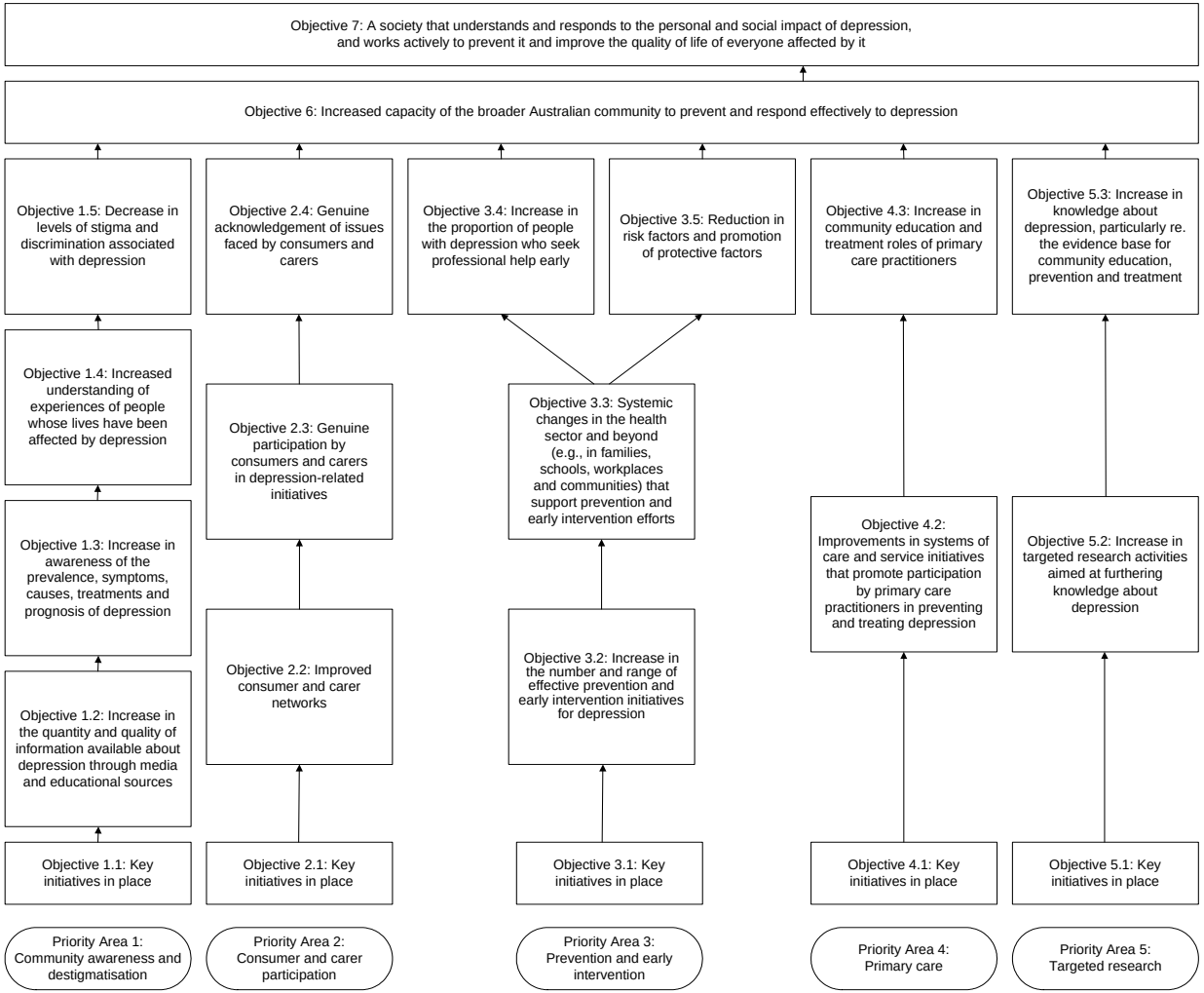
A hierarchy of objectives for *beyondblue*

A hierarchy of objectives for *beyondblue* is shown in Figure 1. In 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 is related 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.

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 priority areas for action are described in *beyondblue's* Strategic Plan[1] and Annual Reports,[2-4] and is more appropriate for in 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'.[3] 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.

Figure 1: A hierarchy of objectives for *beyondblue*



Chapter 3: Evaluation design

The current evaluation also differs from the original evaluation framework in that its evaluation components rely more on secondary analysis of existing data, and less on purpose-designed, primary data collection and analysis.[6]

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?

It should be noted that the original evaluation framework also considered a second question, namely 'What structures and processes led to this success or lack of success?'. Answering this additional question was beyond the resources of the current evaluation, but it is recommended that this be considered in future evaluation efforts.

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. Having said this, one component of the overall evaluation did include an examination of local evaluations of selected projects. The projects (and their evaluations) were selected on the basis that they were of particular note, either because of their magnitude or because of their novel approach.

- *Triangulation:* A range of evaluation components was 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 there 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, 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.

Evaluation components

(a) Review of *beyondblue* program and project documentation

Relevant *beyondblue* program and project documentation (e.g., *beyondblue's* Strategic Plan,[1] Annual Reports,[2-4] project implementation reports and updates[8]) were retrieved and reviewed. 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'.[1] 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.[9] Supplementary data have been provided by Rehame.[10] *beyondblue* also monitors the number of media releases it issues.[9] In addition, Neilsen Media Research have 'tracked' *beyondblue's* community service announcements.[11] Data from all of these sources informed the current evaluation.

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

Quantitative and qualitative data on how Australian newspapers (n=184), radio stations (n=225) and television stations (n=106) report and portray depression were collected and analysed in 2000 by Blood et al[12] and Francis et al[13 14]. Additional data were collected on newspaper items from a restricted range of newspapers (n=11) by Blood in 2001 and 2002. *beyondblue* itself continued this data collection during the whole of 2003 and up till and including April 2004,[15] and supplementary data were available from Rehame and *beyondblue*.[10 16] Together, these data provide a picture of the coverage of depression in general, and *beyondblue* specifically, over time, thereby informing the current evaluation.

(e) Data on the use of *beyondblue's* website

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 hosts the website server has monitored the number of 'hits' on the site, on a monthly basis.[9] These data were tabulated for the current evaluation. Visitors to the site were offered the opportunity to provide feedback, and selected responses were included in the current evaluation.

(f) Independent assessments of the quality of *beyondblue's* website

A study of Australian Internet depression websites was conducted in 2001 by Griffiths and Christensen. These authors identified 15 sites in total, including the site of *beyondblue.* They systematically rated the sites for quality and accessibility, thereby providing information on the relative (and absolute) quality of the *beyondblue* site.[17 18]

In addition, an assessment of *beyondblue's* website was available from HealthInsite.[19] HealthInsite is an Australian Government initiative, funded by the Department of Health and Ageing. It aims to improve the health of Australians, acting as a single entry point to quality information to facilitate access to approved sites. Sites are approved on the basis of their satisfying various content and process criteria.[20]

In the current evaluation, data from these sources complemented the above quantitative data on 'hits' on the *beyondblue* website.

(g) Data from the Australian National Mental Health Literacy Survey

Jorm and his colleagues introduced the term 'mental health literacy', defining it as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention'.[21] They developed a survey instrument to measure various aspects of the concept, and provided baseline information collected via face-to-face interviews with a community sample of over 2,000 in 1995.[21] Since then, they have given particular consideration to 'depression literacy'.[22] In 2004, they conducted a repeat survey with over 4,000 respondents.[23] The surveys include questions concerned with depression, most of which relate to vignettes about depression or schizophrenia. Data from these surveys were used in the current evaluation to explore changes in 'depression literacy' over time.

(h) *beyondblue's* Depression Monitor data

beyondblue has conducted two cross-sectional telephone surveys examining the community's awareness and understanding of depression and its treatments and detailing factors that contribute to attitudes towards depression. The first was conducted in 2001 (with 900 respondents) and the second in 2002 (with 2,000 respondents). A third administration of the survey is planned for October 2004.[24-27] Several of the questions in the Depression Monitor surveys are identical to those used in the mental health literacy surveys of Jorm and colleagues,[21 22] enabling some comparisons over time that were of value in the current evaluation.

(i) *beyondblue's* consultative processes with consumers and carers

beyondblue has been responsible for a variety of consultative processes with consumers and carers, including 21 public meetings with 1,529 participants, 41 focus groups with 177 attendees, written feedback and website-based interactions, and consultations with consumer and carer organisations. These processes have been designed to elicit information from consumers and carers about their experiences with depression, anxiety and bipolar disorder.[28] They therefore provided useful background information for the current evaluation.

(j) Other consultative processes with consumers and carers

More recently, other key mental health advocacy organisations have conducted consultations with consumers and carers. In 2002, the Mental Health Council of Australia consulted with over 400 organisations and individuals nationally.[29] In the same year, SANE Australia conducted around 200 interviews and analysed data from approximately 6,000 calls to their helpline.[30] Data from these consultative processes were used in the

current evaluation to provide some insight into whether the experiences of consumers and carers are changing over time.

(k) blueVoices membership data

beyondblue's virtual consumer and carer network, blueVoices, collects membership data. These data were used in the current evaluation as a simple measure of the 'reach' of the network.[31]

(l) A review of *beyondblue's* project funding

In 2003, the Population Health Committee of the Victorian Public Health Research and Education Council (VPHREC) was commissioned to conduct a review of *beyondblue's* project funding. Specifically, it considered '… whether the engagement of priority areas, program principles and a population framework would, through effective early intervention and prevention strategies, enable *beyondblue* to reduce the incidence and/or prevalence and/or harmful impact of depression and related mental disorders'.[32] The current evaluation incorporates key findings from this review, as relevant.

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

Evaluation activities associated with the Better Outcomes in Mental Health Care Initiative yielded data that proved valuable for the current evaluation, permitting a description of the extent to which GPs (and allied health professionals) are providing mental health care for people with depression and related disorders.[33-35]

(n) 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 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.[36] BEACH data were used in the current evaluation to explore changes in the level of depression-related GP encounters over time.

(o) An audit of research activities in the area of depression

Jorm et al[37] collected some useful baseline information on research activities in the area of depression. These authors reviewed research activities in the area of mental health in the period prior to the establishment of *beyondblue.* Specifically, they examined academic journal articles published in 1998 and academic grants awarded or renewed in 2000, and considered the related research projects in terms of the type of mental disorder being investigated, the goals of the research, the participant type and setting where the research was carried out, and the inclusion of special interest groups in the research. They then assessed the extent to which the profile of existing research matched the identified need, in terms of the relative prevalence, burden and cost of particular disorders and the stated priorities of stakeholders. The current evaluation drew on this work in its examination of the research initiatives put in place by *beyondblue.*

Relationship of evaluation components to the hierarchy of objectives

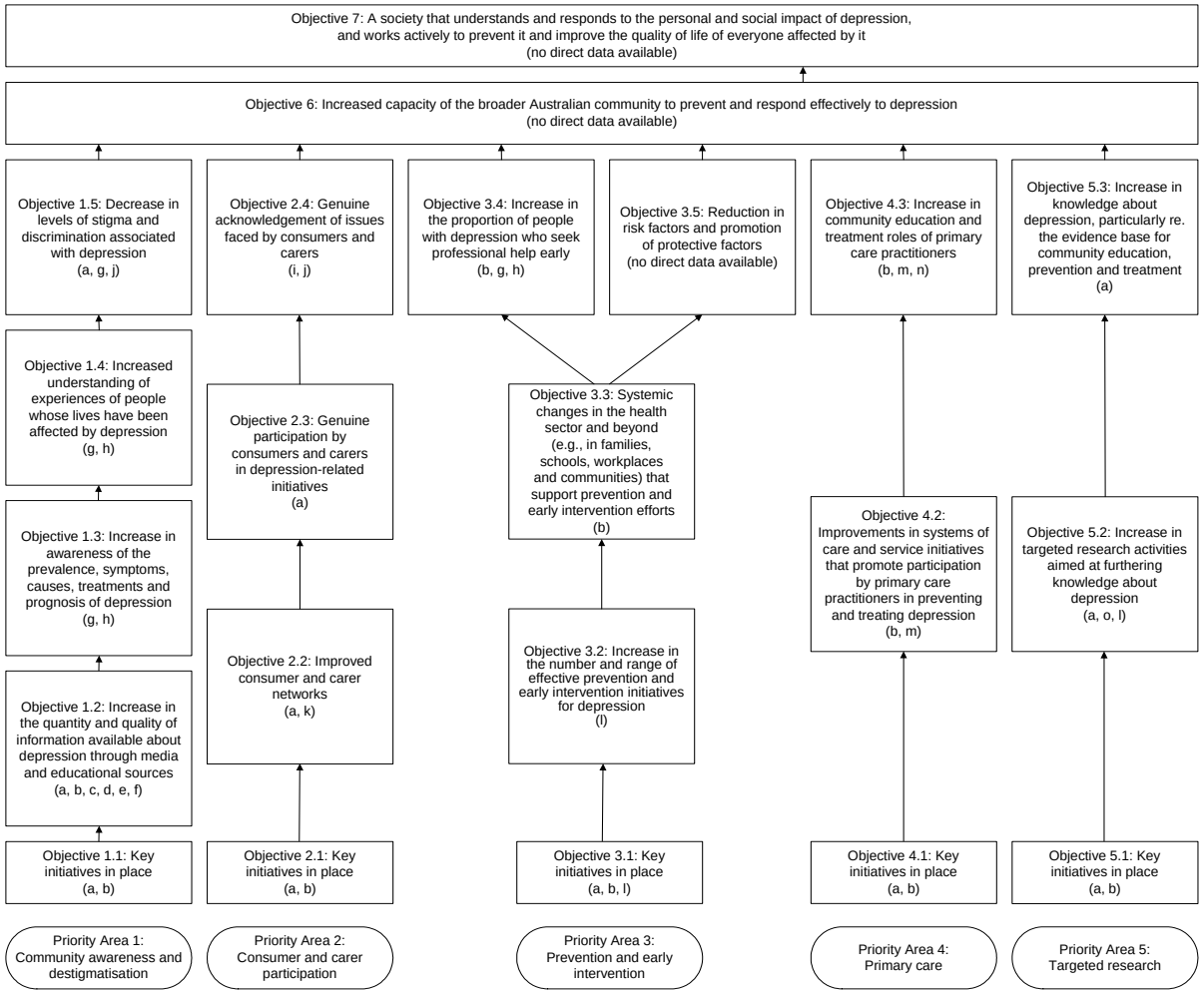
Each of the above evaluation components was used to assess the extent to which one or more of the objectives in the previously-described hierarchy of objectives had been achieved. Sometimes several evaluation components were used to evaluate the achievement of a single objective.

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 1.3 (Increase in awareness of the prevalence, symptoms, causes, treatments and prognosis of depression). The achievement of this objective was examined using evaluation components (h) and (i), data from the Australian National Mental Health Literacy Survey and Depression Monitor data, respectively. It should be noted that no data were available to assess the extent to which the highest level objectives (Objectives 6 and 7) had been achieved.

A note on additional evaluation evidence from *beyondblue's* program partners

It should be noted that some additional data were being collected as the current report was being finalised, but the timing of their collection precluded their being considered among the above evaluation components. Specifically, a survey was administered to *beyondblue's* program partners, in order to assess the impact of the overall initiative. The findings from the survey complement those of the current evaluation, and the final report of the partners' survey is included at Appendix 1.

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



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 announcements

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

(e) Data on the use of *beyondblue's* website

(f) Independent assessments of the quality of the *beyondblue* website

(g) Data from the Australian National Mental Health Literacy Survey

(h) *beyondblue's* Depression Monitor data

(i) *beyondblue's* consultative processes with consumers and carers

(j) Other consultative processes with consumers and carers

(k) blueVoices membership data

(l) A review of *beyondblue's* project funding

(m) Data from evaluation activities associated with the Better Outcomes in Mental Health Care initiative

(n) Data from the BEACH (Bettering the Evaluation and Care of Health) Project

(o) An audit of research activities in the area of depression

Chapter 4: Objectives achieved under Priority Area 1 (Community awareness and destigmatisation)

Objective 1.1: Key initiatives in place

beyondblue's community awareness and destigmatisation strategy has involved a variety of mass media initiatives (utilising most forms of media and including a broad range of stories), as well as community activities.[9]

Mass media initiatives

Soon after it was established, *beyondblue* held a two-day media seminar called Blueprint (28 February to 1 March 2001). Blueprint was designed to engage media professionals in positive, appropriate and responsible reporting of mental health issues. Seventy one international and national 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 nurture relationships with key media representatives.[38]

beyondblue has also been an active commentator about depression in print, radio and television media. *beyondblue's* Chairman, the Honourable Jeffrey Kennett, and Chief Executive Officer (now Clinical Advisor), Professor Ian Hickie, have been particularly prominent in raising community awareness and educating the public about depression.[9]

As part of its mass media strategy, *beyondblue* has also disseminated information about depression 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* website (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-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 Ybblue (see below), 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).[39]

beyondblue has broadcast a range of general television and radio 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).[9] It has also aired some more specific community service announcements aimed at particular target groups (e.g., community service announcements aimed at children and adolescents have been broadcast under the auspices of Ybblue, described in more detail below).

Recently, *beyondblue* has devoted funds to a national, time-limited public awareness campaign, Blue Skies, transmitted on all major television networks (which have provided airtime free of charge) from 4 July 2004.[38 40] Blue Skies addresses gaps in the community's knowledge about depression, identified in research conducted by *beyondblue.*[25 28 41] Specifically, it highlights the fact that depression is a common health problem, affecting one in five Australians at some point in their lives. It aims to educate the community about the signs and symptoms of depression, encourage people to reach

out and help others with depression, and direct people to the *beyondblue* website for more information about depression and how to help someone with depression. There are plans to follow the television broadcasts with cinema, print and radio advertising throughout August 2004 and beyond.[38 40 42] It should be noted that some criticism has been levelled at *beyondblue* for not conducting a national campaign earlier.[32]

beyondblue has also made use of the entertainment media to get its message across. A key example is its support for the Melbourne and Sydney seasons of *Dr Cade*, Neil Cole's play which tells the true story of the Melbourne psychiatrist who discovered Lithium as a treatment for bipolar disorder. He tested the treatment on himself, and then administered it to his patients, some of whom had been institutionalised for years and all of whom fully recovered. Lithium remains the most successful treatment for bipolar disorder today. The play addressed Dr Cade's relationship with a manic-depressive patient at the hospital where he worked. The play received excellent reviews and achieved a high level of ticket sales, thereby helping to raise awareness about bipolar disorder, and decrease the stigma associated with it.

beyondblue has engaged in some specialist media activities, which have complemented those aimed at the general community. For example, 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 July 2001, the second in May 2002, and the third in October 2002. A fourth supplement is currently in production, and will be published in October 2004. The articles included in these supplements have covered a broad range of topics within the general area of depression.[9]

Community activities

Numerous community activities and education campaigns have occurred through *beyondblue*. Key among these is Ybblue, *beyondblue's* youth program which involves a campaign designed to increase awareness about the warning signs for youth suicide, and provide avenues of assistance for those at risk. It uses a multifaceted approach that involves a website, community service announcements, merchandise, ambassadors and other initiatives. Corporate sponsors have provided in-kind support for many of these activities (e.g., Network Ten has provided free airtime for community service announcements, jeans west has sponsored marketing materials and provided ongoing fundraising support, Mission Australia has provided financial support, and Virgin Blue has offered free flights for ambassadors and supporters).[38]

beyondblue has conducted a number of community forums aimed at increasing awareness and decreasing stigma associated with depression and anxiety. During its early stages, *beyondblue* ran 35 metropolitan and rural forums across the country, which were generally well-attended.[31] Later, Garry McDonald AO (Australian Actor and *beyondblue* Board Member) and Professor Ian Hickie conducted five community forums in regional Queensland, New South Wales and Victoria to raise awareness about depression and anxiety. Over 1,900 people attended these forums, at which Garry McDonald shared his experiences, Ian Hickie provided information, and a local GP spoke about depression and anxiety from a primary care perspective.[4 38]

In addition, *beyondblue* has conducted a number of community forums with 1,200 Rotary clubs across Australia, through its partnership with the Australian Rotary Health Research Fund. Again, these forums are designed to increase awareness, and reduce stigma associated with mental illness in the Australian community. To date 314 public community forums have been held, and these have been attended by almost 38,000 individuals. 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.[38]

The Lifeline Depression Awareness Program is a partnership between *beyondblue* and Lifeline aimed at improving the level of understanding, support and practical help offered by Lifeline staff to people with depression, their families and friends. The Lifeline Depression Awareness Project is a train-the-trainer program, developed by *beyondblue* and implemented with Lifeline staff in each state and territory throughout Australia. The program involved *beyondblue* training 110 trainers, who in turn delivered the program to over 700 Lifeline employees across Australia. Training evaluation revealed the program to be successful in increasing knowledge awareness of depression and increasing likelihood of staff engaging in appropriate helpful behaviours to assist people to care.

Another example is the Depression Awareness Research Project, which was conducted by the Mental Health Research Institute, and involved 260 trained community educators delivering four key messages (i.e., major depression is: (a) common; (b) an illness; (c) serious; and (d) treatable) to approximately 8,000 people in their local communities.[38]

The Volunteer Program of the Melbourne Fringe Festival, which *beyondblue* sponsored in 2003, provides a further example. *beyondblue* staff briefed over 300 volunteers about the organisation's activities, and educated them about depression. These volunteers, in turn, passed on information about *beyondblue* and communicated relevant messages about depression to Fringe artists and the wider Fringe audience.[38]

A further example is the annual World Mental Health Day. Since its establishment, *beyondblue* has been an active player in each World Mental Health Day. At the most recent event (10 October 2003), *beyondblue* partnered with the Mental Health Council of Australia to pursue the national campaign theme, 'Protecting and Promoting the Health of All Children'. The campaign involved a number of strategies that included a national Ministerial launch in Melbourne, 14 local community forums across the country, the production and distribution of promotional materials, a media campaign, Internet promotion, and ongoing promotion of the national symbol for mental health (the Flannel Flower).[38]

Objective 1.2: Increase in the quantity and quality of information available about depression 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. Figure 3 shows that between 1 January 2001 and 30 September 2004, 2,267 media stories were recorded – 970 (43%) in newspapers, 1,063 (47%) on radio, and 234 (10%) on television. The trendline indicates that there was an overall increase in the number of items over time, but that there was variability on a month-by-month basis. The highest rating month was July 2004, in which a total of 217 media items were recorded.[9 10 16]

In some instances, the pattern of media reporting can be attributed to specific activities of *beyondblue*, many of which were promoted by media releases (133 of which were issued during the period under study).[9 10 16] For example, several reports occurred as a direct consequence of the Blueprint seminar, including 13 print articles, five radio interviews and two television stories in March 2001. Similarly, periods of significant reporting followed World Mental Health Day in October 2002 and October 2003, and the regional tours by Garry McDonald in May 2003. Likewise, many of the stories in July 2004 were a direct consequence of the Blue Skies campaign.

Blood et al reiterated the finding that news and feature items were relatively prominent in newspapers during their own study period, which covered the calendar years 2000-2002, inclusive.[12] *beyondblue* confirmed this finding for 2003 and the first half of 2004.[15] Blood et al concluded that 'the establishment of *beyondblue* increased coverage of issues surrounding depression', although they noted that this increase was more noticeable in Victoria than in other states/territories. They also observed that the nature of this coverage changed over time, with early reports of *beyondblue* focusing on Jeffrey Kennett and later reports placing more emphasis on depression as a major public health issue. They were unable to ascertain whether the quality of reporting improved over time, but noted that it was variable, commenting on news stories that linked depression and violence, exploitative coverage of celebrity depression/suicide, stories that framed depression as 'odd' or 'bizarre', and stories that presented a confusing or inaccurate picture of the causes, treatment, prognosis and/or epidemiology of depression.[12]

Promotional materials

There are no systematically-collected data 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:

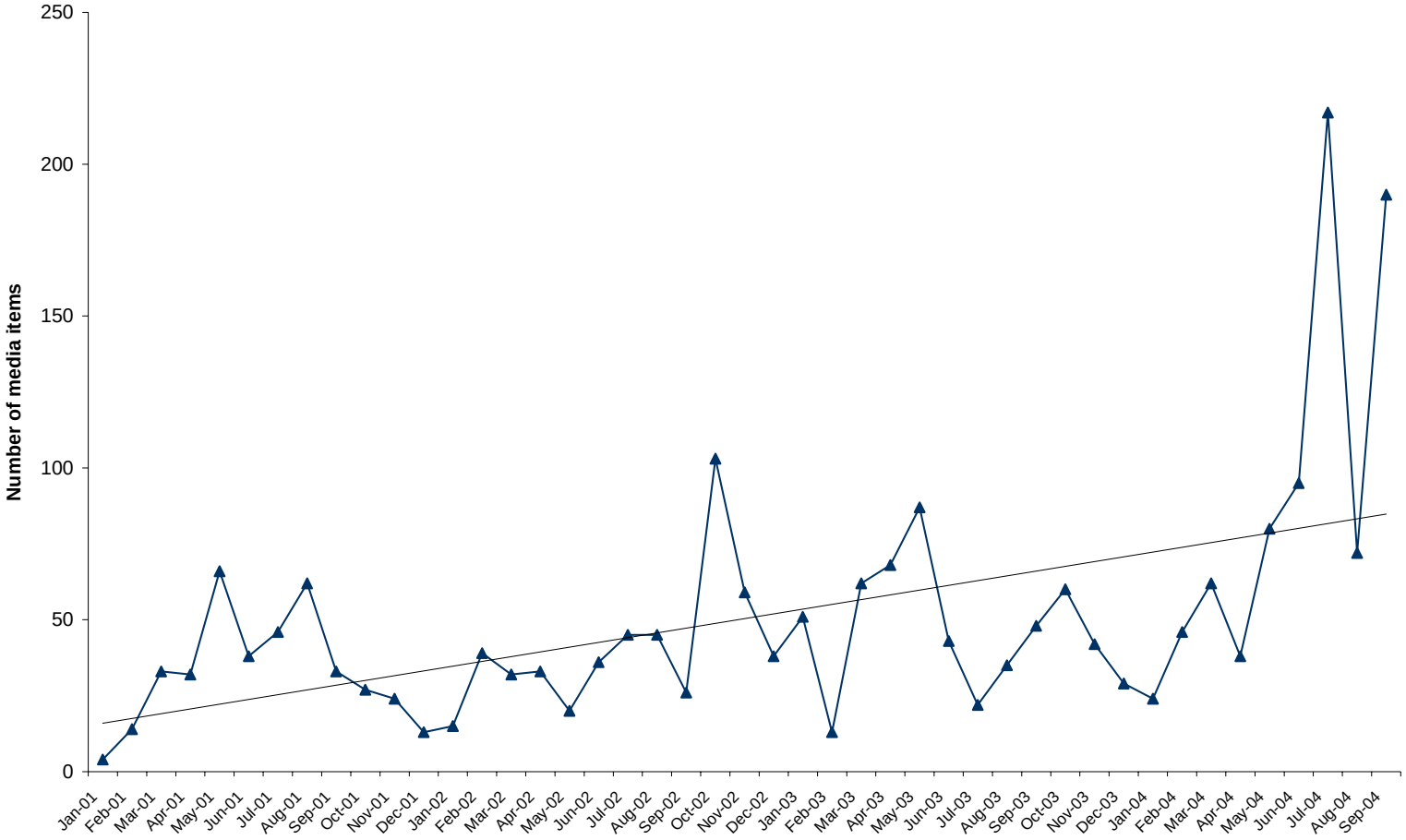
- *beyondblue* program launches;
- schools (via the *beyondblue* Schools Program), including all Melbourne secondary schools;
- universities;
- community events (e.g., World Mental Health Days, the Melbourne Fringe Festival, the Melbourne Comedy Festival, the Queenscliff Music Festival, the Sunny Sedgewick Music Festival, the Melbourne Youth Mental Health Forum);
- Rotary community forums (see above);
- community groups;
- corporate organisations (through the *beyondblue* National Depression in the Workplace Program described in Chapter 6); and
- General practice clinics, community health centres and other primary care agencies.[31]

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.[31]

No data are available on the absolute number of promotional materials disseminated by *beyondblue*, but as an indication, over 80,000 items were distributed on World Mental Health Day 2003.[43]

In terms of quality, the content of all of *beyondblue's* 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.[44]

Figure 3: *beyondblue* media stories (featuring in newspapers and on radio and television) by month, January 2001 to September 2004



Source: Adapted from Hickie et al[9], Rehame[10] and *beyondblue*[16]

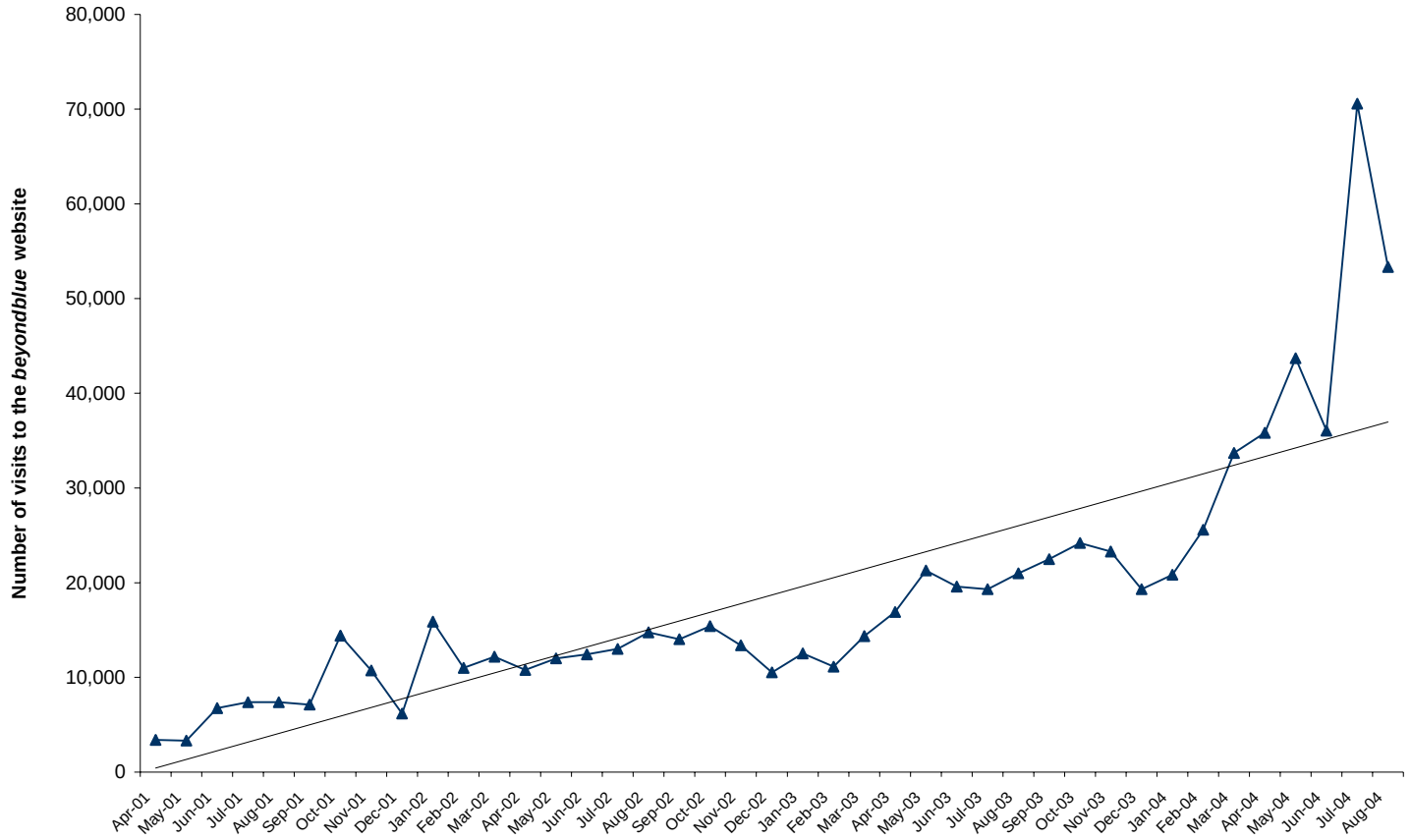
The Internet

In total, 767,059 individuals[b] visited the *beyondblue* website during the period between 1 April 2001 and 31 August 2004. Figure 4 provides a breakdown of their visits by month, and shows that there has been a significant increase in website traffic over time, as indicated by the trendline. In May 2001 there were only 3,335 visits, but by July 2004 the number of visits risen to 70,561. [9 45] In general, the increase over time has been attributed to increased promotion of the website address through all *beyondblue's* communication channels, including presentations, publications, media exposure and community campaigns.[39]

Despite this overall increase, there have been peaks and troughs. The peaks may be explained by surrounding events. So, for example, when Professor Ian Hickie was interviewed on Channel Nine's *60 Minutes* program on 29 February 2004, the number of daily visitors to the website increased from an average of 882 to 1,489 on the day of the broadcast.[46] The most notable peak, in July 2004, may be explained by the Blue Skies campaign. There were 13,349 visits to the website in the week beginning 4 July, when the campaign was launched, compared with 5,624 visits in the previous week.[42 47 48] By August 2004, the number of hits was decreasing, but had not yet returned to its original level.

[b] 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.

Figure 4: Visits to *beyondblue's* website by month, April 2001 to August 2004



Source: Adapted from Hickie et al[9]; additional unpublished data from Web Development Group[45]

By itself, this impressive increase in 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.[49]

Revisions to the website go through extensive user-testing processes, and there are ongoing opportunities for user feedback.[46] Qualitative information from visitors to the website suggests that they find the information accessible, helpful and relevant (see Table 1).

Table 1: Feedback from visitors to the *beyondblue* website

'Thank you for such a well-planned and professional site! I found the information presented very useful. I have suffered from depression since years ago, and I wish I had had access to this site then!'[39]

'I found the fact sheets extremely helpful. Having information and tools to work with gives hope and a sense of having some control'.[39]

'As someone who has been in and out of darkness, I was amazed how much information and help there was on one website. It's like the bible to all sufferers. Just reading and searching the site lifted my mood.'[39]

'An excellent website! My best friend has depression, and I have been finding it hard to deal with because I feel so helpless. This gave me heaps of great information and helped me realise that I'm not the only one who feels like that in this situation.'[47]

'As a sufferer of anxiety and depression for the last 10 months (since diagnosed) I found the site quite informative and helpful. The site has increased my motivation to keep plugging away with the program I already had from my psychologist in place to beat my demons and return to the happy times I still remember. I've had several minor setbacks and relapses, but simply knowing that the site is here for me to visit anytime is reassuring as just reading about things can be motivational. Keep up the good work! AND THANK YOU!!'[47]

'Very helpful and informative. I will continue to use this site to gather further information, to assist with my treatment. I have found this so helpful, and I will download information to help my parents understand my condition.'[47]

Additional evidence regarding the quality of the *beyondblue* website comes from the work of Griffiths and Christensen. 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.[17 18]

Likewise, the recent approval of the *beyondblue* website as a HealthInsite partner is testament to its standard. As noted earlier, 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.[20] The *beyondblue* website was approved by HealthInsite in July 2004, and met all of the above criteria.[19]

The Blue Skies community awareness campaign

Between its launch on 4 July 2004 and the last day of that month, the Blue Skies community service announcement was aired a total of 1,209 times on commercial television stations across Australia, typically in prime time slots.[11] The launch also generated considerable additional media activity in that month (see above).

The campaign is, in part, a call to action to encourage people to access the *beyondblue* website. As noted above, it has clearly been successful in doing this, as there was a near-tripling of the number of individuals visiting the website between the week prior to the campaign and the week it was launched.[42 47 48] The number of visitors to the website who have consequently joined the consumer and carer advocacy network, blueVoices, increased by 400% in July 2004.[44]

Feedback on the campaign via the website, email and letter has generally been excellent, with viewers stating that they have gained useful information and that they believe awareness-raising in this area is beneficial. These positive comments have been counter-balanced by some negative remarks about the depiction of people with depression, the use of music, or the style of the advertisement. All have agreed that the content is appropriate, however.[42]

Specialist media

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.[50] 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 no reliable data exist to quantify them exactly. Some indication of their reach can be gleaned from specific examples, however. A case in point is *beyondblue's* Rotary community forums; to date, 314 forums have been held nationally across Australia attracting over 38,000 people.[38 51 52] Another example is the Depression Awareness Research Project, which has trained 260 community educators who have given over 400 presentations to 7,540 community members.[52 53] In a similar vein, over 300 volunteers were briefed by *beyondblue* staff via Volunteer Program of the Melbourne Fringe Festival in 2003 and 2004, who then disseminated information to Fringe artists and audience members.

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, Ybblue has been evaluated as highly successful, in terms of 'hits' on the Ybblue website, an increase in calls to other services (e.g., Kids Help Line and Reach Out!), and feedback from young people involved in the Ybblue steering committee.[54] Similarly, the Volunteer Program of the Melbourne Fringe Festival was also evaluated positively, with the partnership between the Fringe and *beyondblue* being regarded as a 'strong fit', the volunteers responded 'extremely positively' to *beyondblue*, and the festival being seen as a 'perfect way of communicating to a wide range of people'.[55]

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

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. Next, it is important to consider whether this increase has translated into an increase in the Australian community's awareness of the prevalence, symptoms, causes, treatments and prognosis of depression. In other words, has the 'depression literacy'[21 22] of the Australian community improved as a result of *beyondblue's* awareness-raising and educational efforts?

Data from the Depression Monitor surveys conducted by *beyondblue* in 2001 and 2002[24 25] shed some light on this question. Additional evidence comes from the 1995 and 2004 Australian National Mental Health Literacy Surveys of Jorm et al.[21 23] Further evidence can be gleaned from the evaluations of specific projects. Together, these sources of evidence suggest that the efforts of *beyondblue* (e.g., media work, Rotary forums, workplace education) have enhanced the mental health literacy of the Australian community.

Prevalence

In 2002, 54% of Depression Monitor survey respondents had seen, read or heard something about depression in the media in the previous 12 months.[9] By 2004, this figure had risen to 61% in the Australian National Mental Health Literacy Survey.[23]

Evaluation of the Depression Awareness Research Project found that when community recipients of presentations delivered as part of the project were followed up three months after presentations delivered as part of the project, their ability to estimate the prevalence of depression had improved compared with the general population.[52]

In both 2001 and 2002, 39% of Depression Monitor respondents cited depression as the major mental health problem in Australia. However, only 2% of respondents ranked it as the major (general) health problem and about two thirds underestimated its prevalence in both years.[9 25]

Symptoms

In 2001, 50% of the Depression Monitor survey sample could distinguish between normal sadness and depression, based on severity and duration. By 2002, this figure had increased to 70%.[9 25]

Evaluation of the Depression Awareness Research Project found that three months after the program, recipients could recognise a mean number of 2.43 symptoms of major depression, compared with 1.52 in the general community.[52]

Causes

There appears to have been a shift in the community's knowledge of causes of depression, as evidenced by responses to the 1995 and 2004 Australian National Mental Health Literacy Surveys. In 2004, a greater proportion of respondents endorsed each of the correct underlying causes (e.g., problems from childhood) and immediate triggers (e.g., death of someone close) offered in a list than had done so in 1995. Notably, fewer of the later respondents endorsed incorrect responses, such as 'weakness of character'.[21 23]

Treatment

Between 1995 and 2004, there was a significant shift in Australian National Mental Health Literacy Survey respondents' perceptions of where to turn for treatment. Specifically, there was a decrease in the proportion of respondents in respondents who felt that dealing with depression alone was likely to be helpful (29% in 1995; 13% in 2004), and an increase in the proportion of respondents who felt that each type of mental health professional (GPs, pharmacists, counsellors, social workers, psychiatrists and psychologists) could be helpful.[21 23]

In 2001, the most frequently endorsed choice of treatment in the Depression Monitor survey was counselling, nominated by 21% of respondents in the Depression Monitor survey. By 2002, this figure had increased to 29%.[9 25] The response most akin to counselling in the Australian National Mental Health Literacy Survey, namely psychotherapy, was also endorsed by an increasing proportion of respondents over time (34% in 1995; 43% in 2004).[21 23]

Antidepressant medication was recognised as being helpful by about two thirds of those questioned in each year of the Depression Monitor survey (65% in 2001 and 68% in 2002).[9 25] Antidepressants were rated as helpful by a smaller proportion of respondents in the 1995 Australian National Mental Health Literacy Survey (29%), although this proportion increased in the 2004 repeat survey (46%).[21 23] Eighty eight per cent of recipients of the Depression Awareness Research Project presentations recognised antidepressants as being helpful three months after the project had been completed.

Prognosis

The 1995 and 2004 Australian National Mental Health Literacy Surveys asked respondents to consider the likely prognosis for a person with depression, in the presence and absence of professional help. Compared with their 1995 counterparts, fewer 2004 respondents anticipated that a person who received professional help would experience a full recovery (43% in 1995; 38% in 2004), and more predicted a full recovery with relapse (37% in 1995; 43% in 2004). The later respondents were also more likely to suggest that, without professional help, a person with depression would get worse (56% in 1995; 64% in 2004).[21 23]

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

Evidence from the Depression Monitor surveys and the Australian National Mental Health Literacy Surveys also informs the question of whether, during the early years of *beyondblue*, the Australian community has developed an increased understanding of the experiences of people whose lives have been affected by depression. Collectively, these sources of evidence suggest that *beyondblue* has achieved success in increasing understanding, by shining the spotlight on the experiences of those living with depression (e.g., through the work of blueVoices).

In 2001, 56% of Depression Monitor survey respondents indicated that they or someone very close to them had experienced an episode of depression. In 2002, this figure had increased slightly to 61%, and 37% of respondents reported that there was a 75% chance that family member or close friend would experience depression at some point in their lives.[9 25] Similarly, a greater proportion of Australian National Mental Health Literacy Survey respondents indicated that they had experienced depression than had done so in

1995 (33% versus 24%). The same pattern held true for respondents' acknowledgement of having a family member or friend who had experienced depression (63% versus 45%).[21 23]

While this does not necessarily translate to 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. 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.[21 23]

In addition, there is some evidence that some of the systems that foster discrimination are changing. One such system is the insurance industry; people with depression frequently experience difficulties in accessing insurance products. *beyondblue*, in association with the Mental Health Council of Australia, has co-ordinated negotiations with the insurance industry representative body, the Investment and Financial Services Association Limited. As a direct result, detailed guidelines now govern risk assessment and claims disputation with respect to life insurance and income protection products. The goal of achieving equity for people with depression has now been accepted as a basic principle for practice.[9]

However, there is a paucity 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.[28-30]

Summary of findings

The key initiatives associated with Priority Area 1 are in place, taking the form of a broad range of mass media initiatives (e.g., a seminar for media professionals; media commentary; promotional materials; a website; community service announcements, including a major national public awareness campaign, known as Blue Skies; and special supplements on depression in the *Medical Journal of Australia*) and community activities (e.g., Ybblue; Rotary community forums; the Depression Awareness Research Project; and special events).

These key initiatives have led to an increase in the quantity of information available about depression through media and educational sources. 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 heavily used, the Blue Skies campaign has been widely aired, 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 being ranked highly by independent assessors, the specialist publications being peer-reviewed, and the *beyondblue* website, the Blue Skies campaign and many of the community activities being positively evaluated. 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', although there is still room for improvement. Repeated cross-sectional population surveys suggest 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.* However, there was little shift in the population's recognition of the magnitude of the problem, with a high proportion of the population continuing to underestimate both the prevalence and the burden of 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 indirect evidence, however, that suggests that there is movement in the right direction. According to survey data, an increasingly high proportion of the population report experiencing depression themselves, or are close to someone who has. This augurs well for the community empathising with those affected by the condition.

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. Again, there is some indirect evidence that bodes well. Results from repeated administrations of surveys suggest that there is an increased acknowledgement of the stigma and discrimination experienced by people with depression. In addition, there is some evidence that some of the systems that foster discrimination (e.g., the insurance industry) are changing. However, consultations with consumers and carers indicate that discrimination remains a problem.

Chapter 5: Objectives achieved under Priority Area 2 (Consumer and carer participation)

Objective 2.1: Key initiatives in place

beyondblue has put in place a number of initiatives that are designed to promote extend 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 is the development of blueVoices, a national organisation with consumer and carer membership in each state/territory. The goal of blueVoices is to raise awareness of depression and its impact by encouraging consumers and carers to 'give voice' to the lived experience of depression and related disorders. In recognition of the fact that the 'wrong' messages can be counter-productive, key individuals are chosen to promote understanding and acceptance of depression. blueVoices also aims to contribute to an improved health service environment through information provision, informing policy and program debates, partnering with other groups (such as the Mental Health Council of Australia) 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 postnatal depression, depression in the elderly, bipolar disorder, consumer-based research into depression, and depression in rural areas.[38 44] blueVoices is well-represented on major committees, providing a consumer and carer perspective that did not previously exist.[56]

beyondblue has also supported the participation of consumers and carers in research. Aside from supporting the Depression and Anxiety Consumer Research Unit at the Australian National University's Centre for Mental Health Research (described in more detail in Chapter 8), *beyondblue* has funded a range of qualitative research projects that explore the lived experiences of consumers with particular disorders, and their carers (typically using a focus group methodology). The key consumer project concerns consumers' experiences of bipolar disorder.[38 57 58] Separate carer projects focus on carers' experiences of living with a family member with depressive disorders,[38 41 59-61] eating disorders[38 62 63] and anxiety disorders.[38 64-66]

beyondblue has acted as a catalyst in bringing consumers and carers to the policy and planning table – e.g., through membership and support for existing consumer and carer organisations and funding for consumer positions on other key bodies. For example, it contributes to the funding of and is a member of the National Network of Private Psychiatric Sector Consumers and Carers, which is dedicated to effective consumer and carer participation as the driving force in all elements of change in private sector mental health services. *beyondblue* provides support for the National Consumer and Carer Forum, auspiced by the Mental Health Council of Australia, which enables consumers and carers to meet on a regular basis. *beyondblue* also supported the community forums conducted by the Mental Health Council of Australia which underpinned a nationwide review of the experiences of those who use and provide mental health services, and which led to the publication of *Out of Hospital, Out of Mind*.[67] *beyondblue* has also provided limited funding to the Australian Mental Health Consumer Network, to support participation in the annual The Mental Health Services (THEMHS) conference. In addition, *beyondblue* funds a consumer representative on the Strategic Planning Group for Private Psychiatric Services. These partnerships, and others described elsewhere (e.g., with Rotary and Lifeline), have strengthened the mental health sector and contributed to *beyondblue's* achievements.

Objective 2.2: Improved consumer and carer networks

beyondblue's website states that 'The establishment of this national network [i.e., blueVoices] may well prove to be the most enduring and influential aspect of the whole *beyondblue* initiative.'

There is evidence that the establishment of blueVoices has led to improved consumer and carer networks. blueVoices has a membership of 9,650 (as at 10 August 2004), creating opportunities for information- and experience-sharing that did not previously exist. It should be noted that 1,125 of these expressed interest after exposure to the Blue Skies campaign. Importantly, around 65 individuals have posted their personal experiences on the blueVoices website, validating them in a way that was not previously available.[38] In addition, blueVoices had developed close links with other organisations, such as the Mental Health Council of Australia. This has served to broaden and strengthen the networks available to any individual consumer or carer.

Having said this, there may be additional ways of improving consumer and carer networks, over and above the activities of blueVoices. For example, assisting consumers and carers to develop and consolidate networks in existing services and programs may be more sustainable in the long term.

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

According to *beyondblue's* own website, 'Genuine participation in all *beyondblue* programs by people whose lives have been affected by depression is a key aspect of *beyondblue*'. 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.*

Beyond its own activities and programs, *beyondblue* has strived to ensure genuine participation by consumers and carers in external depression-related initiatives. For instance, blueVoices has risen to the challenge of its advocacy role, working in collaboration with organisations such as the Mental Health Council of Australia to lobby for policy and practice change to achieve positive outcomes for consumers and carers.

Objective 2.4: Genuine acknowledgement of issues faced by consumers and carers

While it is true to say that *beyondblue* itself has genuinely acknowledged, and tried to address, many of the issues faced by consumers and carers, there is less evidence that such acknowledgement has extended into the broader community.

In 2001, the first full year of *beyondblue's* existence, the organisation conducted a series of consultations to gauge the major concerns of people with depression and their families and carers. Information was collected nationally via community meetings, focus groups, written feedback and website-based forums. These consultations identified stigma (from health care providers and the general community) as the main issue experienced by consumers and carers, followed by inadequacies in primary care and specialist treatment systems (e.g., lack of access to high quality primary care and non-pharmacological treatments). Poor availability of information and support was identified as problematic for both consumers and carers.[28]

Although no formal follow-up consultations have been conducted as yet by *beyondblue*, there is some evidence from other sources that permits an examination of whether any changes have occurred over time. Reports by the Mental Health Council of Australia and SANE, both released in 2003, shed some light on the issue. Like the work by *beyondblue*, these reports were based on consultations with individuals (and organisations), although their scope included people with the full range of mental health problems rather than just depression, and their focus was more specifically on the mental health care system. Despite these differences, these reports suggest that the picture has not changed greatly over time. In both reports, ongoing discrimination and deficiencies in the treatment system were identified as major issues for consumers and carers.[29] [30]

Summary of findings

beyondblue has put in place an impressive range of initiatives under Priority Area 2. At the forefront of these is the development of blueVoices, a national network of consumers and carers. *beyondblue* also has several research projects underway, each of which explores the experiences of consumers with particular disorders, and their carers. In addition, *beyondblue* has acted as a catalyst in bringing consumers and carers to the policy and planning table – e.g., through membership, funding and/or support for existing consumer and carer organisations (e.g., the National Network of Private Psychiatric Sector Consumers and Carers, the National Consumer and Carer Forum, the Mental Health Council of Australia) and support for consumer representation on other key bodies (e.g., the Strategic Planning Group for Private Psychiatric Services).

There is evidence that these initiatives – particularly blueVoices – have led to improved consumer and carer networks. blueVoices has a membership of 9,650 (as at 10 August 2004), and close links with other relevant organisations.

beyondblue has fostered genuine participation by consumers and carers in its own depression-related initiatives. Over and above its own activities and programs, *beyondblue* has successfully ensured participation by consumers and carers in external initiatives, particularly through the advocacy role of blueVoices.

While it is true to say that *beyondblue* itself has genuinely acknowledged, and tried to address, many of the issues faced by consumers and carers, there is less evidence that such an acknowledgement has extended into the broader community. Ongoing discrimination and deficiencies in the treatment system appear to remain major issues for consumers and carers.

Chapter 6: Objectives achieved under Priority Area 3 (Prevention and early intervention)

Objective 3.1: Key initiatives in place

beyondblue has taken a population health approach to addressing depression, and was commended for doing so by the VPHREC Population Health Committee in its review of *beyondblue's* project funding. Such an approach recognises that depression and related disorders result from a complex interplay of biological, psychological, social, environmental and economic factors, at individual, family and community levels. It also recognises the importance of addressing depression across the lifespan, across diverse groups within the population, and within particular settings. It also encompasses the spectrum of interventions, from prevention to continuing care. The VPHREC Population Health Committee noted that, within this population health framework, *beyondblue* had given particular emphasis to prevention and early intervention, changing community knowledge, attitudes and behaviour across the whole population and in targeted sub-populations.[32]

beyondblue is a major sponsor of a number of initiatives aimed at promoting mental health and preventing depression and related disorders in children and adolescents. Key among these is the *beyondblue* Schools Research Initiative, which is a research partnership between school systems, local communities, the health sector and academics. The partnership will work with schools during 2002-2005 to find out more about how school communities help prevent depression in young people. The initiative draws on the groundbreaking work conducted with Australian schools in the past decade, as well as international research. It is designed to increase individual and social environmental protective factors within the school community in an attempt to reduce the development of adolescent depression and health-compromising behaviours such as drug and alcohol use. By targeting school environments and teaching young people life skills through the curriculum, this program aims to intervene at the individual, school, and community levels. It seeks to buffer the effects of adverse life events by building protective factors in the individual, harnessing the capacity of schools to provide supportive environments through strengthening participation and relationships, and engaging the wider community in assisting young people with mental health problems. This comprehensive approach aims to increase resilience in young people leading to more positive mental health, social health, and school health outcomes.[38]

beyondblue also supports a number of community- and family-based initiatives aimed at promoting mental health among young people. The Compass Strategy,[38 68] for instance, aims to increase rates of help-seeking and reduce treatment delays in young people using a range of media. Likewise, the 'Aspire, Achieve, Affect' (A3) Program,[38 69] the Role Models for the Future Project,[38] the Affirming Diversity project,[38 70] and Positive Choices[38] all increase young people's life skills and connectedness, using AFL footballers and other elite athletes as community role models. Another example is Reach Out!,[38 71] whose website provides a viable alternative for help-seeking behaviour in young people, and whose rural and regional tours of Victoria have promoted positive mental health outcomes for young people in rural and regional areas. Two further examples, aimed at children and younger adolescents, are the Every Family Initiative[38] (which involves health, education and media professionals in the delivery of the internationally recognised Triple P 'Positive Parenting Program'[72] to parents) and the Children of Parents with a Mental Illness initiative[38] (which increases resilience and coping among this group via strategies such as peer support). In-kind support has been provided by corporate sponsors for some of these initiatives (e.g., Athlete Development Australia

provided financial support to fund a research and evaluation cell for the Role Models for the Future Project; and Medical Benefits Fund and the Bounce Back Foundation provided support for Positive Choices).[31 38]

beyondblue has a particular focus on women with postnatal depression, providing funding for the four-year *beyondblue* National Postnatal Depression Prevention Program. This program combines service delivery and research, evaluating the use of the Edinburgh Postnatal Depression Scale in an Australian population to identify women who may be at risk of antenatal and postnatal depression and the provision of information, resources and referral options for 100,000 women. Each participating state/territory will develop its own treatment program, considering current resources and practicality of implementation. These different approaches will be directly compared.[38 73-75]

beyondblue has also supported projects that target Indigenous communities. For example, Ngaripirliga'ajirri, or 'helping each other clear a path for the future', is a Tiwi Islands early intervention program that developed out of concern surrounding the rates of suicide and self-harm among young people. Young people are referred to the program from their school, and attend the program over nine weeks with one parent or caregiver. The process for the program is to work with the children and parents initially in separate groups; and, then together in a combined group.[38] The Aboriginal Mental Health Program, also being conducted in the Northern Territory and described in more detail in Chapter 7, provides another example. This project involves supporting community-based Aboriginal mental health workers in the early detection of depressive and other symptoms.[38 76 77]

In recognition of the high degree of lost productivity associated with depression, *beyondblue* has supported two major initiatives set in the workplace. The first is the *beyondblue* National Depression in the Workplace Program, which aims to increase awareness and understanding about depression and its appropriate management in a workplace setting, highlighting common signs and symptoms of depression, challenging preconceptions and prejudices, demonstrating appropriate responses, and allowing meaningful evaluation.[38] The second is the Work Outcomes Research and Cost-benefit (WORC) Project, which will assess the cost-benefit of proactively screening for and treating depression in the workplace.[38]

beyondblue has also offered direct support to health professionals who may be well-placed to recognise early warning signs of depression. For example, in 2002, the organisation supported the National Heart Foundation to run a pilot series of depression workshops with cardiac rehabilitation professionals (comprising nurses, social workers, physiotherapists, occupational therapists, dieticians, psychologists and other allied health professionals), with the aim of improving their skills in identifying and managing depression in consumers with cardiac disease. The rationale here was that many physical conditions, including cardiac disease, increase the risk of depression.[38 78]

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

Although the VPHREC Population Health Committee's review did not explicitly state that the projects of *beyondblue* had led to an increase in the number and range of effective prevention and early intervention initiatives for depression, it alluded to this. It suggested that these projects complemented those funded by state-based agencies (thereby implying a net increase), although it warned about their viability and ongoing sustainability in times of uncertain funding.[32]

The VPHREC Population Health Committee also praised *beyondblue* for piloting new interventions and contributing to improved evidence. Specifically, it ranked *beyondblue's* major prevention and early intervention projects as being targeted at the appropriate population, taking a population health approach, using appropriate models (e.g., evidence-based, theory-driven and culturally appropriate), and value for money. A reasonable corollary of this is the interpretation that the efforts of *beyondblue* would have impacts on the future suite of effective projects and programs on which others could draw.[32]

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

Consistent with a population health approach, the prevention and early intervention initiatives of *beyondblue* specifically aim to change systems in a way that increases the capacity of health services, families, schools, workplaces and communities to combat depression. Realistically, systems change typically occurs gradually and incrementally, but there is some evidence that the initiatives of *beyondblue* are beginning to have an impact in this regard.

For example, the VicChamps project (one of two projects funded to achieve the goals of the Children of Parents with a Mental Illness initiative) has implemented a range of strategies designed to achieve systemic changes in adult mental health and community services, some of which are now coming to fruition. Specifically, the strategies are increasing the involvement of these agencies in addressing the needs of children of parents with a mental illness, so that this becomes a shared responsibility and not just the province of VicChamps. The penultimate evaluation report concludes that 'while it is early days, it appears that the service system is responding to this approach'.[79]

A second example is provided by the *beyondblue* National Depression in the Workplace Program. As noted earlier, this program aims to increase awareness, knowledge and understanding about depression and the experience of it, using a train-the-trainer approach. In doing so, it seeks to achieve systemic changes at an organisational level, which would improve the response of workers to colleagues, subordinates or managers who might be living with depression. The training provided through the Depression in the Workplace Program has been shown to lead to increases in participants' knowledge of helpful and unhelpful responses for a person with depression, in their willingness to engage with a person with depression, and in their confidence and likelihood of assisting a person with depression to access appropriate help. It has been implemented nationally in government and non-government sectors.[38 80 81]

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

The evaluation reports from many of the above prevention and early intervention projects provide indirect evidence that those who have participated in the projects are likely to seek professional help early if they experienced depression.

For example, the evaluation of the Compass Strategy indicated that it was associated with an increase in the level of recognition of depression from 48% to 59% in its target regions, and a strengthening of the view that family/friends and counsellors/psychologists are important sources of help.[38 68] Having said this, it should be noted that an independent review of the Compass Strategy evaluation noted that there were also

increases in the level of recognition of depression in 'control' regions, and that an original component of the evaluation that would have directly assessed whether young people presented earlier to GPs as a result of the Compass Strategy had to be abandoned because of difficulties in recruiting GPs.[82]

The evaluation of the Reach Out! rural and regional tours of Victoria was encouraging. It showed that after participating in a Reach Out! presentation, 69% of young people learned where to go for help if they or a friend were going through a tough time, 59% of young people knew who to speak with if they were going through a tough time, and 77% of young people would recommend Reach Out! to a friend going through a tough time. The evaluation found that the involvement of local agencies in the Reach Out! presentation was crucial in promoting help-seeking behaviour among young people.[38 71]

Similarly, the evaluation of the *beyondblue* National Depression in the Workplace Program found that it was highly effective in achieving increased understanding about depression, and increased confidence in assisting people to access appropriate help for depression. Specifically, participants gained more knowledge about the condition, as well as greater awareness about appropriate sources of referral and assistance.[38 80 81]

Likewise, when participants in the Depression Awareness Research Project were followed up three months after the presentations, 73% said they would seek professional help if they or a family member experienced depression.[52]

These evaluation reports are generally positive, and augur well for improving the likelihood that people with depression will seek professional help early. They are consistent with the findings of the community-based surveys described in Chapter 4, which showed that the general population is becoming increasingly aware of where to turn for treatment for depression.[9 21 23 25] However, it must be acknowledged that, at best, these results can be regarded as evidence of intentions to seek help, rather than evidence of actual help-seeking behaviour.

Objective 3.5: Reduction in risk factors and promotion of protective factors

Much of the work of *beyondblue* seeks to reduce modifiable risk factors and promote protective factors, at a variety of levels that range from the individual to the community. The *beyondblue* Schools Research Initiative is a case in point. As described earlier, this initiative is concerned with building resilience in young people, with a view to laying the foundations for positive outcomes in later life. As yet, there is a dearth of evaluative evidence that examines whether *beyondblue* is successfully reducing modifiable risk factors and promoting protective factors. In part this is because the short-term outcomes like resilience are difficult to measure, and it is premature to be evaluating longer term outcomes, particularly ones that relate to the amelioration of distal risk factors. The sound evidence base upon which the *beyondblue* Schools Research Initiative is drawing augurs well for its success, but there is a need to ensure that formal, ongoing evaluation processes are in train.

Summary of findings

beyondblue has put in place a broad range of prevention and early intervention activities associated with Priority Area 3. These have occurred within a population health framework, and are aimed at changing knowledge, attitudes and behaviour across the whole population and targeted sub-populations (particularly young people, women, Indigenous communities, people in workplace settings and people with physical conditions).

There is evidence that the efforts of *beyondblue* have led to a net gain in terms of the current number and range of effective prevention and early intervention initiatives for depression, although there are questions about their sustainability. Because the projects are targeted and use appropriate models, they provide lessons for the future suite of effective projects and programs on which others could draw.

There is also some evidence that the initiatives of *beyondblue* are beginning to lead to systemic changes in the health sector and beyond (e.g., in families, schools, workplaces and communities). Examples include the VicChamps project, which is increasing the involvement of adult mental health and community services in addressing the needs of children of parents with a mental illness, and the *beyondblue* National Depression in the Workplace Program, which is improving the capacity of workers to respond effectively to colleagues, subordinates and managers with depression and has been implemented nationally in government and non-government sectors.

Many of the prevention and early intervention activities have aimed to improve the community's 'depression literacy', including influencing those who are experiencing depression to seek help early. According to their evaluation reports, participants in many of these projects report an improved understanding of depression and an increased awareness of appropriate sources of referral and assistance. This augurs well for improving the likelihood that people with depression will seek professional help in a timely fashion, but it must be regarded as evidence of intentions, rather than of actual help-seeking behaviour.

Much of the work of *beyondblue* seeks to reduce modifiable risk factors and promote protective factors, at a range of levels. As yet, there is a dearth of evaluative evidence that examines whether *beyondblue* is successfully achieving this end. In part, this is because it is too difficult or too early to measure the outcomes that would indicate success. The sound evidence base upon which these initiatives are drawing augur well for their success, but there is a need to ensure that formal, ongoing evaluation efforts are in train.

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

Objective 4.1: Key initiatives in place

From the outset, *beyondblue* has focused considerable attention on the area of primary care. The main thrust of this work has been on better equipping GPs to provide mental health care for people with depression and related disorders. *beyondblue* has commissioned and published a set of evidence-based guidelines which recommend first-line and subsequent treatment choices for consumers presenting to primary care settings with the full spectrum of depressive disorders.[38 83] *beyondblue* has also funded the trial of MoodGYM, an Internet-based cognitive behaviour therapy (CBT) intervention designed to treat and prevent depression and/or anxiety. The trial is establishing whether MoodGYM leads to improvements in depression and/or anxiety outcomes over and above those that would be expected by 'essential GP care' alone.[38] *beyondblue* has also installed information boards ('informboards') in over 300 general practices across Australia. The informboards are designed to educate consumers about depression, and, in the event that they identified any signs of depression in themselves or someone close to them, to prompt them to discuss concerns with their GP and seek appropriate advice.[38]

Importantly, *beyondblue* has also supported parallel primary care initiatives. Most prominent among these is the Better Outcomes in Mental Health Care Initiative, which is seeking to improve the mental health care available to Australians through primary care.[84] The initiative has several inter-related components, which together provide training and education for GPs, remove systemic barriers to their providing mental health care, and provide access to specialised psychological treatments for consumers. So, for example, it enables GPs to be reimbursed for providing a structured three-step mental health process (involving assessment, management and review) and evidence-based mental health care (termed focused psychological strategies). *beyondblue* acted as a catalyst for the Better Outcomes in Mental Health Care Initiative in four ways. Firstly, it had sensitised the community to the significance of depression and anxiety as public health problems, and therefore eased the lobbying path by strengthening the argument that something needed to be done.[85] Secondly, and as a part of this process, *beyondblue* had drawn together the evidence in a coherent manner, citing local and international research that supported the planned future directions.[85] Thirdly, *beyondblue* had developed a high profile, and had engendered the support of policy-makers and politicians, which meant that it could help its key community and professional partners (such as the Australian Divisions of General Practice and the Mental Health Council of Australia) lobby effectively.[85] In association with these parties, *beyondblue* was a vocal advocate for these changes, having a lead role in meetings at Parliament House in Canberra, and putting pressure on governments and relevant agencies.[5 86] Finally, and on a related note, one of the reasons that the proposal for the Better Outcomes in Mental Health Care Initiative had ministerial and bureaucratic support was that its advocates were multidisciplinary in their composition. They brought different perspectives to the policy-making table, but argued for an agreed end-point. *beyondblue* played a key role in this multidisiplinary process.[85] *beyondblue* has continued to support the initiative, through, for example, its involvement in relevant committees.[5]

Although the majority of *beyondblue's* primary care efforts have been concerned with general practice, it has also focused some attention on non-medical primary care. The Mental Health Aptitudes into Practice (MAP) Training Program, for instance, is a training and capacity-building project targeting the community-based primary care workforce in Victoria.[38 87 88] The Aboriginal Mental Health Program in the Northern Territory provides another example. It is funded to support the employment of community-based Aboriginal

mental health workers to work in health clinics in partnership with other health professionals.[76 77]

In addition to furthering the capacity of primary care providers to deal with depression, *beyondblue* has tried to address the paucity of relevant data available in primary care. For example, it has funded the development of a novel classification and a nationwide system for longitudinal data collection in primary care.[38]

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

During the 1990s, a considerable amount of work was conducted that identified systemic and service-related barriers to primary care professionals providing mental health care. These included a lack of training and education, insufficient financial rewards, few professional incentives, and limited support from the specialist mental health sector.[89 90]

Some of the above-mentioned initiatives of *beyondblue* are making inroads in terms of addressing these barriers, creating improvements in systems of care and service initiatives that promote participation by primary care practitioners in preventing and treating depression. So, for example, the identified lack of training and education is being addressed in several ways. *beyondblue's* evidence-based guidelines can be considered an educational tool, and have the potential to improve GPs' ability to provide optimal care for people with depression.[38] Likewise, the MAP project is filling a gap in education and training that is likely to have flow-on effects in terms of the capacity of non-medical primary care providers to deliver services.[38]

It is probably fair to say that bigger systemic changes have been achieved by initiatives that *beyondblue* is aligned with, but is not directly responsible for. The Better Outcomes in Mental Health Care Initiative has substantially changed the primary care landscape, in terms of mental health care delivery.[84] Through this initiative, GPs are: (a) more encouraged to participate in accredited education and training activities; (b) better recompensed for the time they spend with consumers with mental health problems; and (c) given greater opportunities to form partnerships with and draw on the expertise of specialists, including allied health professionals and psychiatrists. Although *beyondblue* can claim a considerable amount of credit for these changes, in that it has worked tirelessly to advocate for and promote the Better Outcomes in Mental Health Care Initiative, it cannot claim sole responsibility.

It is also true to say that changes were happening before the establishment of *beyondblue*, although some of these have since been widely promoted by the organisation. An example is SPHERE: A National Mental Health Project.[91] This began in the late 1990s, and is an educational project aimed at increasing GP's rate of identification, effective treatment and management of common psychological disorders (eg. depression, anxiety and somatic distress). It has four components: (a) a case identification system that screens all practice attendees for psychological and somatic distress; (b) ongoing and diversified continuing professional development (CPD) programs; (c) a 12-month disease management program for consumers with common mental health problems; and (d) ongoing support for GPs (in the form of training materials, consumer information and Internet-based support systems). *beyondblue* has drawn on SPHERE in some of its own programs and projects (e.g., 'essential GP care' in the *beyondblue*-funded trial of MoodGYM comprises care provided by GPs who have undergone SPHERE training).[38]

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

Various data sources inform the question of whether there has been an increase in the role of primary care practitioners in depression during the life of *beyondblue.* It should be noted that most of these data sources relate to these providers' treatment roles, rather than their community education roles.

There is some evidence to suggest that the absolute numbers of primary care practitioners who feel equipped to take on treatment roles (and potentially community education roles) is increasing. Some of these increases can be directly attributed to *beyondblue*, such as the doubling of Aboriginal mental health workers in the Northern Territory's Top End.[77]

Other increases, while impressive, are not solely due to *beyondblue*, although the organisation can claim considerable credit. For example, an interim evaluation of the Better Outcomes in Mental Health Care Initiative showed that in the first 15 months of the initiative (1 July 2002 to 30 September 2003), 3,046 GPs (or 15% of all GPs in Australia) had received the required training to make them eligible to participate in the initiative, including 387 who were registered to be reimbursed for providing focused psychological strategies. GPs had completed 11,377 three-step mental health processes and 6,472 sessions of focused psychological strategies. In addition, 346 GPs had referred consumers to allied health professionals through the initiative (134 individuals and 10 agencies).[33] These figures have continued to increase. For example, more recent data suggest that by the end of June 2004, 20,890 three-step mental health processes had been delivered,[35] and there were up to 926 were referring consumers to 229 allied health professionals.[34]

The evidence regarding whether these primary care practitioners are actually fulfilling their potential in terms of these roles is more equivocal. There has certainly been considerable activity through the Better Outcomes in Mental Health Care Initiative. By 30 September 2003, participating GPs had completed 11,377 three-step mental health processes and 6,472 sessions of focused psychological strategies.[33] By June 2004, the allied health professionals associated with the initiative had delivered 8,678 sessions of care.[34]

However, these figures must be balanced against the latest data from the Bettering the Evaluation and Care of Health (BEACH) Project, which collects annual data on general practice encounters. According to the BEACH data, depression 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. During the same period, depression has also consistently accounted for approximately 2.4% of all problems managed by GPs.[36] It is possible that these proportions will increase as the BEACH data 'catch up' to the Better Outcomes in Mental Health Care data.

Summary of findings

beyondblue has focused considerable attention on the area of primary care (Priority Area 4), and has put in place a number of initiatives aimed at better equipping GPs (and, to a lesser extent non-medical primary care practitioners) to provide mental health care for people with depression and related disorders. It has also supported parallel primary care initiatives.

The initiatives of *beyondblue* are making inroads in terms of addressing systemic and service-related barriers to primary care professionals providing mental health care (e.g., lack of training, financial rewards, personal incentives and support from the specialist

mental health sector). *beyondblue* has acted as a catalyst for some of the most significant systemic changes in primary care in the last five years, including the Better Outcomes in Mental Health Care Initiative. It should be noted, however, that some systemic changes were beginning to occur prior to the advent of *beyondblue.*

There is evidence that the absolute number of primary care practitioners who feel equipped to take on treatment roles (and potentially community education roles) in the area of depression has increased during the life of *beyondblue.* Some of these increases can be directly attributed to *beyondblue*; others are not solely due to *beyondblue*, although the organisation can take some credit. The evidence regarding whether these primary care practitioners are actually fulfilling their potential in terms of these roles is more equivocal. On the one hand, there has been a large amount of activity associated with the Better Outcomes in Mental Health Care Initiative. On the other hand, the overall level of depression-related GP encounters has remained essentially unchanged over time.

Chapter 8: Objectives achieved under Priority Area 5 (Targeted research)

Objective 5.1: Key initiatives in place

Included in the remit of *beyondblue* is a commitment to supporting the development of evidence-based practice in Australia. As a consequence, *beyondblue* has supported a range of research initiatives and research partnerships. Several warrant particular mention here.

beyondblue auspices the Victorian Centre of Excellence in Depression and Related Disorders, which is funded with approximately $1.3 million per annum 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 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 $50,000, awarded for an initial 12-month period, which may be renewable.[38]

In addition, *beyondblue* supports a variety of other strategic research initiatives. In particular, it supports research efforts investigating how to better deliver services, how to improve measurement of key outcomes, how to include consumer and carer perspectives, and whether the efforts deliver genuine population health outcomes.[38]

beyondblue also 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.[38]

beyondblue has also linked with other key research initiatives, such as the establishment of the Depression and Anxiety Consumer Research Unit at the Australian National University's Centre for Mental Health Research.[38] This unit is staffed by academics who also have personal experience of depression and/or anxiety, and is undertaking research that specifically focuses on the priorities and needs of consumers.[92 93]

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

Jorm et al[37] provide some 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*, using explicit criteria. They found that depression was under-researched, accounting for only 15% of journal publications and 13% of academic grant funding, but contributing the highest disease burden and being 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 the exercise undertaken by Jorm et al, in order to ascertain whether there has been an increase in targeted research activities aimed at increasing knowledge about depression. 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 2 and Table 3 show the research funded by *beyondblue* through the *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders and the *beyondblue* Strategic Research initiative, respectively. Together, these tables indicate that *beyondblue* has funded around 50 research studies in the area of depression and related disorders. This figure underestimates the research support of *beyondblue* as it does not include the evaluations of funded projects; nor does it include projects conducted by the Depression and Anxiety Consumer Research Unit. 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 input 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 had been a commensurate 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 would have been a net gain. It is worth noting that, in its review of *beyondblue's* project funding, the VPHREC Population Health Committee commented that '*beyondblue* has funded research projects that may not have been funded through the National Health and Medical Research Council or other possible sources because of their size, riskiness or applied nature.'[32]

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 identified by Jorm et al.[37] Together, Table 2 and Table 3 show that a high proportion of these projects are being carried out in a primary care setting or in specific communities. Many have a focus on prevention and promotion and/or on evaluations of mental health services, and a number involve investigations of training and education of mental health professionals. Having said this, it should be noted that the VPHREC Population Health Committee's review was critical of *beyondblue's* program of research, describing it as lacking strategic direction. 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 …'[32]

Table 2: Research funding through the *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders (2002-03 and 2003-04 funding rounds)

Consortium grants

- The Primary Care Evidence-Based Psychological Interventions (PEP) Collaboration (03-04)
- Diagnosis, Management and Outcomes of Depression in Primary Care (DIAMOND) (03-04)

Funded projects

- A collaborative therapy treatment package for people with bipolar affective disorder (03-04)
- Depression and heart disease collaboration (03-04)
- Health problems among patients with a dual diagnosis: To what extent to these patients slip through the net? (03-04)
- The prevention of depressive relapse in young people using mindfulness based cognitive therapy (03-04)
- Screening for co-morbid affective disorder and substance abuse by general practitioners (03-04)
- Depression and musculoskeletal pain in primary care: An examination of practitioner, patient and socio-economic influences on detection and management (03-04)
- The integration of CBT for obsessive compulsive disorder into the primary care context: An evaluation of three models (03-04)
- Pathways of care for socially marginalised people with depression and related disorders (03-04)
- Caring for the depressed elderly in the emergency department: Establishing linkages between sub-acute, primary and community care (03-04)
- The emotional and lifestyle impact of type 2 diabetes: Exploring the association between diabetes and depression (03-04)
- A training program for professional carers in recognising late-life depression: Impact on the delivery of health care services for depression among older people (03-04)
- Models of care: Evaluating a best practice model for treating postnatal depression (03-04)
- Depression in people living with HIV/AIDS: Outcomes, risks, and opportunities for intervention(03-04)
- The development and evaluation of an intervention aimed at improving the mental health of a group of refugee women presenting to the Royal Women's Hospital for obstetric care (03-04)
- Overcoming barriers to care: Toward optimal practices for paramedics treating people with depression and related non-psychotic disorders (02-03)
- An integrated approach to young people presenting with depression and substance use (02-03)
- A self-management package for people with bipolar affective disorder (02-03)
- Finding out what experienced general practitioners mean by 'depression': A step towards developing a meaningful taxonomy of depression in primary care (02-03)
- Exploring Melbourne's hidden epidemic: Medication overdose, depression and their management by paramedics (02-03)
- A randomised controlled trial of a brief psycho-educational intervention to prevent the development of depression in anxious first-time mothers of newborns (02-03)
- Diagnosis, management and outcomes of depression in primary care (DIAMOND): A longitudinal study (02-03)
- Attitudes towards and pathways to and from a young people's mental health service (02-03)
- Comprehensive GP shared care following stroke: Selective secondary intervention for depression and other morbidities in a high risk group (02-03)
- Depression in farmers and farming families (02-03)
- Shared care pathways for depression and related disorders (02-03)
- Models of collaboration between general medical practitioners and psychologists in the delivery of cognitive behavioural treatment for obsessive compulsive disorder (02-03)
- An interdisciplinary approach to recognising and treating depression among older Australians living in residential care (02-03)
- Recognising and screening for depression among older people living in residential care (02-03)
- Early detection and treatment of depression in mildly intellectually disabled adults (02-03)
- A randomised controlled trial of mindfulness-based cognitive therapy and adherence therapy for the prevention of relapse and recurrence of depression in primary care (02-03)
- Models of care: Evaluating a best practice model for treating postnatal depression (02-03)
- Supporting mental health care in general practice in relation to Australian ethnic minority communities (02-03)
- Therapeutic Family Involvement (TFI) in the management of persistent clinical depression: Psycho-education, family support and multi-family group intervention (02-03)
- Evaluation of the efficacy of an Internet-based treatment for panic disorder in general medical practice (02-03)
- National study into the management of depression in general practice: Extension and follow-up (02-03)
- Staying well with a 'Stay Well Plan' (02-03)
- Young people's responses to emotional distress: A descriptive study (02-03)
- Linking the health and leisure sectors: Using physical activity in the management of depressed older people (02-03)
- Time for a future: Effective treatment of depressed youth in urban and rural primary care settings (02-03)
- Diagnosis and treatment of depression in adults with intellectual disability through general practitioner and psychiatric collaboration (02-03)

Source: *beyondblue* website[38]

Table 3: Research funding through Strategic Research

- *beyondblue* Depression Monitor
- Depression as a risk factor to heart disease
- Depression and child sexual abuse
- Depression and changing families
- Preventing depression in young people
- Depression and heroin use
- A brief perceived need screening and assessment instrument
- Attachment of unit costs to the National Survey of Mental Health and Wellbeing

Source: *beyondblue* website[38]

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

Some of the above-mentioned research activities are beginning to bear fruit in terms of addressing gaps in knowledge about depression, particularly regarding the evidence base for community education, prevention and treatment (although there are still many unknowns). These findings are of significance in the Australian context, and also have relevance for an international audience. Preliminary results are emerging from the *beyondblue* Victorian Centre of Excellence-funded study examining Therapeutic Family Involvement (TFI) in the management of persistent clinical depression, for example. This study involves a randomised controlled trial of multi-family group treatment, involving sixty families with a family member in the 40-60 year age group with persistent depression. Although the study is still in the recruitment and assessment phase, certain characteristics are becoming apparent among this group. Their depression is typically complex and multi-faceted, they have often experienced trauma (illness events, past abuse, socio-economic decline), and they often have high levels of relational/social dislocation. The treatment available to them is generally individually-focused, creating opportunities for the study to make a valuable contribution to knowledge in the area of multi-family interventions.[94 95]

beyondblue has drawn on new knowledge from research that it has funded or conducted, in order to inform its own programs. For example, the work that it has undertaken that examines the experiences of consumers and carers has informed its work with these groups. Specifically, the findings from the research projects described in Chapter 5 that explore the experiences of consumers and carers affected by particular disorders,[38 41 57-66] has shaped a variety of initiatives. The research has highlighted the need to increase awareness of mental health problems, both within the general community and among mental health professionals. As a consequence, *beyondblue* has emphasised the 'lived experience' of mental health problems, developing training tools and encouraging the sharing of information through such forums as blueVoices.

Likewise, the project entitled 'Preventing depression in young people',[96 97] (funded through *beyondblue's* Strategic Research program) has informed the activities of *beyondblue*. This involved a systematic review of the literature examining risk and protective factors associated with depression. The investigators were able to fill a significant knowledge gap, when they drew the following conclusions: (a) negative life events, early adversity and parental depression can lead to depression in children; (b) negative cognitive schemata, pessimistic attributional style and ruminative response style (in combination with negative life events) can lead to depression in teenagers; (c) school and family environment can mediate the effect of negative life events and early adversity; (d) prevention programs targeting cognitive restructuring and problem solving may be of benefit in the prevention of depression; and (d) prevention programs targeting the

promotion of positive school and family environments may be of benefit in the prevention of depression. These findings were subsequently used by *beyondblue* to inform its Schools Research Initiative.

Other research efforts supported by *beyondblue* have not yet led to increases in knowledge, but, perhaps equally as importantly, have increased research capacity. This is significant, as it lays the foundation for future discoveries that can help reduce the impact of depression and related disorders. The DIAMOND and PEP collaborations provide examples of this. Both began as *beyondblue* Victorian Centre of Excellence project grants, involving specific studies (a longitudinal study examining the diagnosis, management and outcomes of depression in primary care, and 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, respectively). Both were subsequently provided with further funding, through *beyondblue* Victorian Centre of Excellence consortium grants, and have joined forces to strengthen primary mental health care research. The projects are still in their early stages, but much has been done in terms of increasing capacity through activities such as developing websites, supporting higher degree students, obtaining collaborative grant funding, hosting academic visitors, establishing national and international networks of researchers, and contributing to policy at state and national levels.[98-100]

Summary of findings

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 initiative. In addition, *beyondblue* encourages rigorous evaluations of all its funded programs and projects. *beyondblue* has also 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. The *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders and *beyondblue's* strategic research initiative alone have supported around 50 studies. The evidence suggests that this is redressing the imbalance identified by Jorm et al's audit of depression-related research activities, conducted prior to the launch of *beyondblue.* Not only has the number of projects increased, but the research is now better aligned with priorities identified by stakeholders. There are some questions, however, about whether the body of research has sufficient strategic direction and emphasis on capacity building.

Some of these projects are beginning to yield results that are addressing gaps in knowledge about depression (particularly regarding the evidence base for community education, prevention and treatment), of relevance in Australia and overseas. Some of these findings have helped shape specific initiatives of *beyondblue.* Other research efforts supported by *beyondblue* have not yet led to increases in knowledge, but, perhaps equally as importantly, have increased research capacity.

Chapter 9: Achievement of high level objectives

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

Given the achievements of *beyondblue* in relation to many of the objectives lower down the hierarchy of objectives (see Chapters 4-8), it is likely that the organisation has, at least partially, achieved its mission (i.e., increased the capacity of the broader Australian community to prevent and respond effectively to depression). Having said this, no data sources were available to the current evaluation to allow any quantification of the extent of this increase.

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 by it

The vision of *beyondblue* is more ambitious than its mission, as reflected by its higher position in the hierarchy of objectives. As with the mission, no data were directly available that could inform the question of the extent to which *beyondblue's* vision has been achieved to date. However, taken together, the evidence presented in Chapters 4-8 suggests that it is doubtful that society 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 everyone affected by it. *beyondblue* has made good inroads, but the cultural change required for an overall societal response of this nature is substantial, and would be unlikely to be achieved within a time-frame as short as four years.

Summary of findings

No data were available to directly evaluate whether *beyondblue* has achieved its mission or its vision. However, evidence used to assess the achievement of objectives lower in the hierarchy of objectives is informative in this regard. The evidence suggests that the organisation may partially have achieved its mission (i.e., increased the capacity of the broader Australian community to prevent and respond effectively to depression). *beyondblue's* vision (i.e., 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 by it) is more ambitious than its mission, and involves substantial cultural change that has not yet been realised.

Chapter 10: Discussion and conclusions

Overview of findings

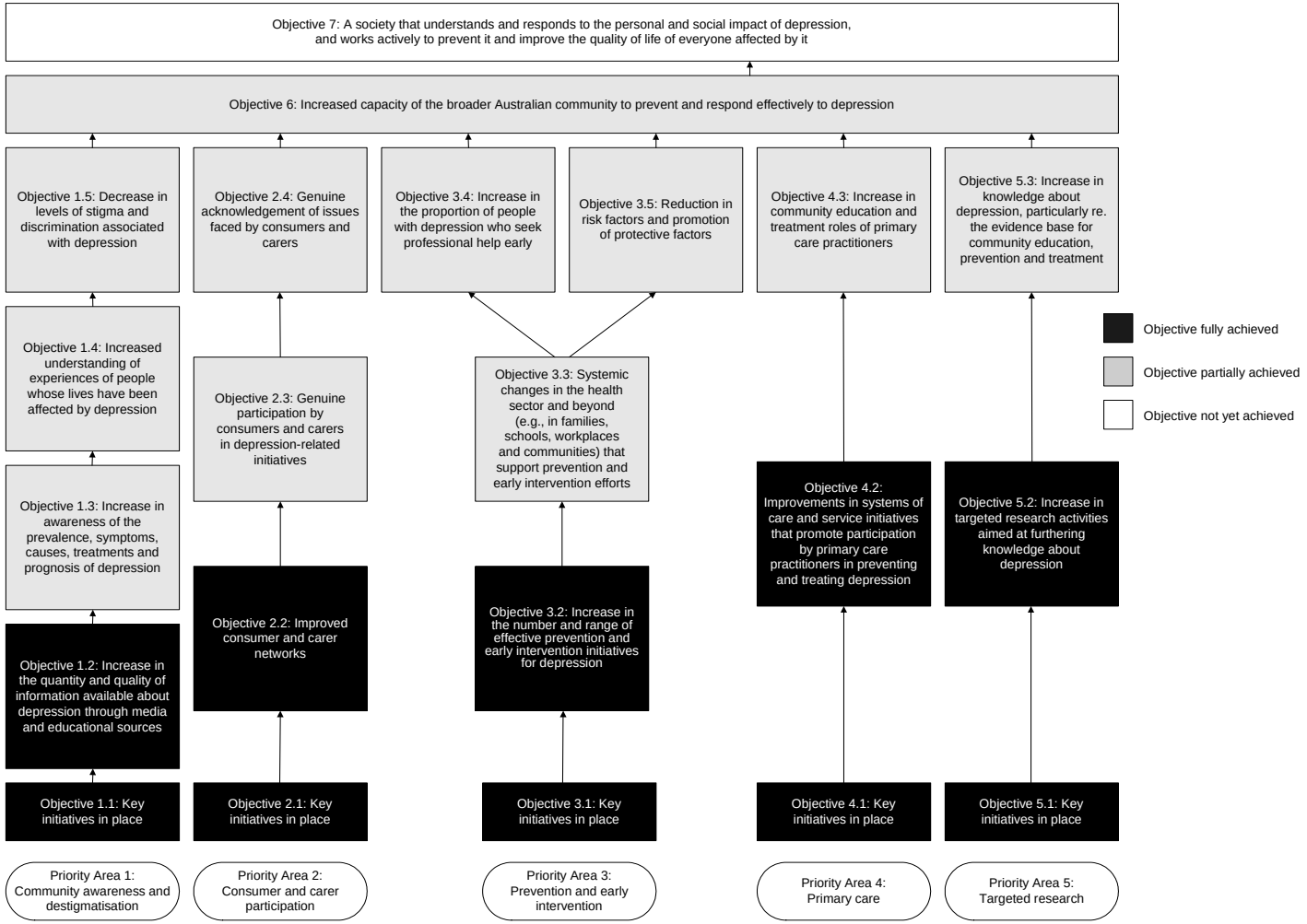
Figure 5 provides an overview of the findings of the current evaluation. Specifically, it describes, in broad terms, whether the individual objectives in *beyondblue's* hierarchy of objectives have been fully achieved, have been partially achieved or have not yet been achieved.

A number of the lower-level objectives 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 majority of *beyondblue's* intermediate-level and high-level objectives have been partially achieved. Some headway has been made in terms of increasing the community's 'depression literacy' and understanding of the experiences of people with depression, and there is some evidence to suggest that this may be impacting on stigma and discrimination, but the situation is still far from perfect. *beyondblue* has worked hard to include consumers and carers in all of its activities, and has genuinely acknowledged issues experienced by them; there is some evidence that the incorporation of a consumer/carer perspective is beginning to spill over into external arenas as well. There are indications that the health workforce is becoming better equipped to recognise and deal with depression, that people with depression are beginning to seek help earlier, and that the range of prevention and early intervention options is increasing, but there is still some way to go. The role of primary care practitioners in community and education roles is increasing, although it is not yet optimal. New knowledge is emerging about depression, but there remains much to learn. Together, these achievements are gradually increasing the capacity of the broader Australian community to prevent and respond effectively to depression. Ongoing efforts are still required, however.

Despite these major successes, it is fair to say that *beyondblue's* vision, or highest-level objective, has not yet been realised. Society does not yet understand and respond to the personal and social impact of depression, nor does it work actively to prevent it and improve the quality of life of everyone affected by it. *beyondblue* has begun to make an impression, but it would be unrealistic to expect a cultural change of this magnitude to be achieved within a time-frame as short as four years.

Figure 5: Achievement of individual objectives within *beyondblue's* hierarchy of objectives



Some caveats

Some caution must be exercised in interpreting the above findings, as the current evaluation design had two limitations.

Reliance on secondary analysis of existing data

For reasons of expediency and resource constraints, the current evaluation relied almost exclusively on secondary analysis of existing data and information, rather than on primary data collection and analysis. This is defensible, particularly as a broad range of data sources were used to examine the achievement of *beyondblue's* objectives. However, it must be acknowledged, that purpose-designed data collection instruments and methods would have had the potential to inform the evaluation exercise in additional ways, particularly if they include direct consumer/carer input. It should be noted that the original evaluation framework promoted a greater balance between primary and secondary analysis.[6]

Difficulties establishing causality

The current evaluation was not always able to examine cause and effect. Whenever they were available, data sources were used that provided a picture of change over time, permitting an examination of the extent to which a given dimension (e.g., the level of the community's 'depression literacy') had improved during the life of *beyondblue.* However, even when it was possible to demonstrate a positive change over time, it was not always possible to attribute this change to *beyondblue.* Many other positive initiatives have occurred during the same time period, which might also be expected to have an impact on depression-related indicators. For example, the Second National Mental Health Plan[101] re-focused the attention of the National Mental Health Strategy on to high prevalence disorders such as depression, and there have been various state/territory and regional efforts in the area (e.g., the Black Dog Institute was established in New South Wales as an educational, research and clinical facility offering specialist expertise in mood disorders[102]). The overall thrust of *beyondblue* aligns closely with many of these initiatives, and indeed *beyondblue* has worked closely with several of them. The fact that these initiatives have coincided with *beyondblue*, combined with their complexity, makes it difficult to disentangle their direct effects.

Limitations of an objectives-based approach to evaluation

The evaluation identified a hierarchy of objectives, and examined the extent to which each objective was achieved. In doing so, it can be regarded as taking an objectives-based approach.[103] This had advantages, in that it allowed statements to be made about the effectiveness of the initiative.

However, it also had some disadvantages. Firstly, it concentrated on the achievements of the initiative as a whole, and its constituent priority areas, rather than the achievements of individual projects or components within these priority areas. The successes of individual projects and components were provided as examples where relevant, but were not systematically examined. This whole-initiative approach was considered appropriate under the circumstances, but it is acknowledged that it does not allow individual projects to be showcased.

Secondly, to the extent that an objectives-based approach revolves around a series of defined objectives, it can be regarded as hypothesis-driven. This was seen as desirable in the current evaluation, since it added a level of scientific rigour and guided the lines of inquiry. However, it is fair to say that this approach did not lend itself to exploring any unintended consequences (positive or negative) of *beyondblue.*[103]

Finally, the objectives-based approach permitted an examination of the extent to which particular objectives had been achieved, but did not allow comment to be made on their likely sustainability. Having said this, the fact that much of *beyondblue's* work is based on fostering partnerships within the mental health sector and beyond, it is likely that many of the observed achievements would have some longevity.

Implications for future evaluation efforts

The above caveats have several direct implications for future evaluation efforts. Firstly, there is a clear need for some additional, purpose-designed data collection that directly informs the extent to which *beyondblue* is meeting its objectives. For example, additional qualitative work that systematically examines consumers' and carers' experiences with various *beyondblue* initiatives (e.g., blueVoices) would be desirable, as would surveys of GPs, psychiatrists, psychologists and other mental health care providers (perhaps conducted through their relevant professional organisations). Such evaluation efforts should aim to tease out the extent to which any changes in knowledge, attitudes, behaviour or experiences can be attributed directly to *beyondblue.* As noted earlier, some additional data were being collected at the time the current report was prepared, but were not available for inclusion in the evaluation. A key example is the survey of *beyondblue's* program partners aimed at assessing the impact of the overall initiative, included at Appendix 1.

Secondly, it would be beneficial to maximise the use of pre- and post- data, in order to examine the extent to which positive (or negative) changes of different kinds have occurred during the life of *beyondblue.* There are several untapped opportunities where excellent baseline data have been collected (some internally by *beyondblue* and some externally), and follow-up data collection exercises could be extremely informative. For example, data on media professionals' attitudes and reporting practices in relation to depression were assessed at the Blueprint seminar, creating the potential for follow-up. Likewise, further administrations of *beyondblue's* Depression Monitor[24-27] and Jorm et al's Australian Mental Health Literacy Survey[22 23] (ideally with a child and adolescent component to complement the adult component), would provide additional data on changes in the community's 'depression literacy' over time. Similarly, there is scope for a repeat of the quantitative and qualitative media monitoring exercises conducted by Blood et al.[12-14]

In addition to repeated cross-sectional data collection exercises of the type described above, there is value in longitudinal studies that assess changes within specific cohorts of individuals over time. Some of these longitudinal studies might be quite short term, such as studies examining pre- and post- training scores on various dimensions, with post- surveys conducted immediately after training and possibly re-administered three or six months later (e.g., pre- and post-training surveys examining the effectiveness of the Lifeline Depression Awareness Program, which have been conducted but not yet reported upon). Others might be longer term, and would involve following groups of individuals exposed to particular *beyondblue* initiatives for extended periods. The latter approach might be particularly useful to assess some of the objectives which would not be expected to occur quickly (e.g., children and adolescents involved in activities through the *beyondblue* Schools Research Initiative might be followed over time to determine whether such exposure is related to a reduction in risk factors and promotion of protective factors). Whether the longitudinal studies are short- or long-term, they will be strengthened by the inclusion of control groups who are not exposed to the initiative under study, in that this will increase the potential for making causal inferences.

Particular attention needs to be paid to the extent to which some of the higher level objectives in the hierarchy can best be assessed. In the current evaluation, assessment of these objectives was difficult because no relevant data were available. To some

extent, this is permissible because the program logic of *beyondblue* was sufficiently well explicated that it would be anticipated that the achievement of lower level objectives would ultimately lead to the achievement of higher level ones. However, concrete evidence regarding the achievement of these objectives would be desirable. Consideration should be given to identifying and selecting indicators of community/societal change, and/or consequences of depression (e.g., suicide, unemployment and substance use rates).

Comparison with similar international initiatives

Despite the above caveats and data limitations, the available evidence suggests that *beyondblue* has achieved a lot in a relatively short space of time. To put its achievements in context, it is worth considering the impacts of similar initiatives overseas. Parslow and Jorm identified four international campaigns that had been reported in the peer-reviewed literature, had similar goals to *beyondblue*, and shared at least some of the same approaches. 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).[22]

Parslow and Jorm systematically reviewed these campaigns, focusing specifically on the extent to which these campaigns had improved mental health literacy. 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.[22]

beyondblue fares well in comparison with these other initiatives. Not only does it appear to have made a significant impression on the Australian community's mental health literacy as it relates to community awareness and destigmatisation, but it has seemingly begun to have an impact on consumer and carer participation, prevention and early intervention, primary care and targeted research.

Conclusions

The achievements of *beyondblue* should be considered in the light of its own Strategic Plan, which, as noted in Chapter 1, outlines three possible scenarios.[1] To reiterate, the Strategic Plan states that if *beyondblue* has fully achieved its goals, it should hand back its activities to the community; if it has made no inroads into achieving its goals, it should not continue to be funded; and if it has partially achieved its goals, careful consideration should be given to what action is necessary to foster positive change that is sustainable to the point that *beyondblue* no longer needs to exist. Even bearing in mind the caveats outlined above, it is possible to state with confidence that the third scenario most accurately describes the current situation. *beyondblue* has achieved a significant amount in a relatively short space of time, but there is still some way to go and *beyondblue* continues to have an important contribution to make, working in concert with Federal, state/territory and local initiatives. *beyondblue* has recognised this in its recent 'Ways Forward' document, which outlines a plan for building on its achievements over the next five years.[7] 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.

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Appendix 1: *beyondblue's* partners' survey (July-September 2004)

Initially, *beyondblue* was established to provide a national focal point on depression over a five-year term. As the fourth year draws to a close, it is timely to review *beyondblue's* achievements as well as the areas requiring improvement and priority action. Evaluations of *beyondblue's* activities have now been completed.

Partnerships have been formed with organisations and individuals from the mental health, schools and primary care sectors as well as the media, who have the capacity to work with *beyondblue* to achieve common goals and objectives. They share a vision around mental health reform, prevention and promotion. It is these partnerships that have helped *beyondblue* reach more of the population and expand the range of projects undertaken. In July 2004, questionnaires were sent to *beyondblue* partners, seeking assessment of how well *beyondblue's* mandates had been addressed through activities, programs and community awareness campaigns. Partners were also asked for input regarding where future efforts would be best directed.

Method

One hundred and three questionnaires were sent to *beyondblue* partners including corporate organisations, consumers, government departments, community organisations and universities across Australia. A partner is considered to be an organisation or individual with the capacity to work with *beyondblue* to achieve common goals and objectives. They share a vision around mental health reform, prevention and promotion.

Results

As of September 7 2004, 53 questionnaires (51%) had been completed and returned. The majority of questionnaires (34/52, 65%) were completed on behalf of an organisation. Almost half the sample was from Victoria (25/51, 49%), followed by New South Wales (8, 16%), the ACT (7, 14%), Queensland (5, 10%), South Australia (4, 8%) and one response each from Tasmania and the Northern Territory (n=2 state unknown).

Approximately one third (16/53) of responses were from mental health research or evaluation organisations or employees. Survey participants also identified themselves as: public providers of specialist treatment (n=6), health policy makers or advisors (n=5), persons from the education sector (n=4), and from non-government community service organisations (n=4).

The majority (58%, 30/52) of respondents identified themselves as program partners (of whom two were also research partners, one a funder/stakeholder and one a member of the board), 15% (n=8) as general partners, and 8% (n=4) as *beyondblue* board members. Two participants were from a Government run integrated mental health service, one described themselves as a 'potential partner/ joint finder of prospects', one as a carer, one as a consumer and carer, one as a stakeholder, one as a past grant holder, one as a publisher and two others did not specify their relationship to *beyondblue*.

Participants were asked to rate some responses using a five-point likert scale that ranged from strongly agree to strongly disagree.

Question 6a: When asked about the extent to which they believed that *beyondblue* had increased awareness of depression in Australia, 72% (34/47) strongly agreed, 26% agreed and 2% of respondents were unsure.

Question 8a: When asked the extent to which they believed *beyondblue* had reduced stigma experienced by people with depression in the Australian community during its first phase, 20% (10/51) strongly agreed, 49% agreed, 27% were unsure and 4% disagreed.

Respondents were asked to **rank in order of importance the possible reasons why *beyondblue* has made a contribution to depression awareness in the Australian community (Question 7):**

1. Increased media on depression (ranked most important)
2. Use of high profile consumers and advocates
3. Effective community education via advertising campaign
4. Increased community education of depression
5. Widespread program activity by *beyondblue* in mental health
6. Development and promotion of the *beyondblue* website
7. National community events (ranked least important)

Respondents were asked to **rank in order of importance the possible reasons why stigma remains prevalent in the Australian community (Question 9):**

1. Ignorance (most important)
2. Misunderstanding
3. Fear
4. Lack of education
5. Poor attitudes
6. Misinformation
7. Confusing messages in the media
8. Negative personal experiences (least important)

The majority of respondents (81%, 43/53) thought that **the work of *beyondblue* would be of enduring or long-term value to the Australian community (Question 11)**, 2% disagreed, and 17% were unsure. Twenty-four participants provided further detail (n=16/43 who agreed, and 8/9 who were unsure). Two main themes emerged: firstly that the work of *beyondblue* would only endure if the organisation continued (n=13/29 comments, 45%), and secondly that the work regarding increased community awareness would be long-lasting (n=5).

Other comments included:

- *will endure providing mental health issues remain on the national agenda*
- *cross sector consortia/coalitions are needed*
- *I'd like to think so, but I've seen a few such organisations over time - it's hard to maintain*
- *all education is worthwhile, but we do not yet know if what is being done is sustainable*
- *beyondblue has provided a conduit or lightening rod for powerful social sentiments*
- *beyondblue and prevention of depression are now synonymous*
- *advocacy and 'marketing' are the main contributions, it needs to be continued and expanded*
- *will endure due to stimulating consumer activity*
- *unsure in regard to promotion, increased awareness does not necessarily lead to better attitudes*
- *'beyondblue' is bright and catchy*

Eighty-five percent (45/53) believed **that *beyondblue's* programs would inform future policy (Question 12)**, 11% were unsure and 4% did not believe the programs would contribute to policy. Twenty-one participants provided further detail (17 who agreed, three unsure, one who disagreed). The most common comment was that research results

would provide the evidence base required to drive policy change (n=9/23 comments, 39%).

Other comments included:

- *there needs to be strong emphasis on the overlapping social factors and programs*
- *such benefits are hard to demonstrate - rarely achieved*
- *can never be sure what governments will do*
- *the stakeholders will want their policies to be informed by beyondblue's work, therefore in participating states, there should be effects on policy development*
- *it is likely beyondblue's programs will inform future policy, but there is still much to be done in allocating resources to these programs*
- *beyondblue's programs should inform future policy, but will still need to be considered in light of a range of competing issues, priorities and pressures*
- *beyondblue phase 2 will be important regarding policy contribution from learning of phase 1*
- *not sure what policies will be informed, more the attitudes of the Australian community to seeking help and reduction in stigma*
- *work in pregnancy (postnatal depression) and schools will emphasise ways forward, as well as the practical difficulties involved*
- *the beyondblue board needs new blood*
- *bureaucracy and politicians must be encouraged to respond*
- *results have already influenced policy*
- *the Triple P work and Schools Research Initiative are positive examples, but I see little else that could be put under the label of prevention and early intervention*
- *hopefully the funds will provide evidence and advocacy*

With regard to **the academic contribution of the *beyondblue* research programs (Question 13)**, 87% (46/53) felt that the programs were of national significance (13% unsure), and 64% felt the programs were internationally significant (36% unsure). Fourteen participants provided further comments.

Positive:

- *research into some areas of depression by beyondblue is unique*
- *regardless of outcome, well planned and carefully evaluated research programs will contribute meaningfully to our body of knowledge*
- *the research program has been sufficiently diverse and so well partnered that the work should be presented and noted internationally*
- *brought together experts in the field for projects that will fill substantial gaps in knowledge - nationally and internationally*
- *targeted large-scale interventions very important for public health approaches worldwide*
- *Schools Research Initiative is timely*
- *beyondblue is absolutely at the international cutting edge of depression awareness work (there is nothing equivalent internationally thought there have been attempts)*
- *clear evidence of this in publications and presentations*
- *activities have been cohesive, strategic and sustained for a significant time (which is unusual)*

Neutral:

- *it depends on the results of the research projects - as yet there is no clear indication*
- *I'm aware of very few research programs*
- *dissemination of research findings will be international*

- *I think there should be less emphasis on research and more on advocacy and publicity*

Negative:

- *It's mixed. The work in the Medical Journal of Australia Supplements has not been of high international standard and some is not of high national standard.*

Question 6b: In your opinion, has *beyondblue* been effective at …

Question	N	Strongly Agree	Agree	Neutral	Disagree
increasing community education	53	36%	58%	6%	-
increasing media on depression	53	70%	28%	2%	-
promoting/running community events/forums	50	32%	46%	20%	2%
using the website as a communication tool	51	28%	47%	23%	2%
promoting high profile consumers	53	49%	43%	8%	-
promoting high profile advocates	53	66%	30%	2%	2%

Question 8b: Rate the extent to which you believe *beyondblue* has been effective in countering …

Question	N	Strongly Agree	Agree	Neutral	Disagree
misunderstanding	53	11%	55%	34%	-
poor attitudes	53	11%	55%	30%	4%
lack of education	53	11%	68%	19%	2%
consumers negative experiences*	53	6%	30%	56%	4%
fear	52	8%	38%	44%	10%
misinformation**	53	13%	57%	26%	2%
confusing messages in the media	53	21%	41%	36%	2%

* n = 2, strongly disagree = 4%, so line total in table is only 96%
** n = 1, strongly disagree = 2%, so line total in table is only 98%

Question 10: Rate the extent to which you believe *beyondblue* has …

Question	N	Strongly Agree	Agree	Neutral	Disagree
increased knowledge of depression in Australia	53	55%	39%	6%	-
increased likelihood of seeking help or treatment*	53	21%	51%	22%	4%
implemented successful community education of the preventative factors of depression	53	11%	51%	27%	11%
promoted personal experiences	52	35%	50%	15%	-
positively influenced changes in mental health policy	53	11%	41%	40%	8%
increased access to primary care services	53	17%	38%	26%	19%
contributed to important and valuable research*	53	51%	34%	6%	7%
influenced sectors outside of mental health, creating a broader community response*	53	30%	51%	15%	2%

* n = 1, strongly disagree = 2%, so line total in table is only 98%

Respondents were asked to **rank in order of importance the priority areas *beyondblue* should focus on over the next five years (Question 14):**

1. Prevention and early intervention (most important)
2. Community awareness and destigmatisation
3. Primary care
4. Targeted research
5. Consumer and carer participation (least important)

Question 15: In your opinion, are there any other activities that *beyondblue* should focus on over the next five years?

Forty-three participants responded to this question, of whom 51% (n=22) believed that there were other activities deserving attention, 28% disagreed, and 21% were unsure.

1. Community awareness and destigmatisation
    - *involve consumers/carers to educate the community and professionals*
    - *more aggressive approach needed, even changes to legislation, required to combat stigma*
    - *target specific groups*
    - *increase community awareness of available treatments*
    - *encourage governments to give mental health a higher priority in policy*
    - *hold a major annual national summit, telethon, walk against depression events etc*
    - *lots more work needs to be done to change community and professional attitudes*

2. Consumer and carer participation
    - *linking with organisations in other health and/or disability sectors*
    - *target specific groups*
    - *ensure more services are available, especially in rural areas*
    - *provide resources so consumers/carers can track course of illness*
    - *develop a focussed plan of action for participation*
    - *expand existing programs*

3. Prevention and early intervention
    - *target specific groups (eg. youth, postnatal depression, parenting with depression)*
    - *expand existing programs (eg. workplace)*
    - *extend research on prevention/early intervention*
    - *education regarding treatment options for mild depression other than medical referral*
    - *should link with other health organisations*
    - *National Action Plan 2000 is a good blueprint*
    - *increase awareness of factors contributing to depression*

4. Primary care
    - *target specific groups (eg. youth)*
    - *new treatment approaches*
    - *broaden primary care beyond health care (not all persons with mental health issues go to health professionals)*
    - *capacity building, partnerships (eg. working with RACGP, Divisions and GPs)*
    - *access to psychologists and GP training*

5. Targeted research
    - *specific areas of research mentioned include:*
        - *safety/efficacy of antidepressants in children/adolescents*
        - *parenting with depression*
        - *association between social changes and depression*
        - *treatment options for mild depression*
        - *association between suicide and depression*
        - *co-morbid depression and medical/chronic diseases*
        - *focus on prevention/early intervention*
        - *consumers/carers should be in partnership with academics*
        - *facilitate alliances between new and different groups in the Centre of Excellence work*
        - *support dissemination of research findings, especially to policy makers*
        - *do not support research which could be funded through NHMRC or other funding body*

6. Other activities
    - *increase access for people from non-English speaking backgrounds (eg. website in different languages)*
    - *increase focus on gender and cultural issues*
    - *focus on training mental health professionals in evidence-based, effective treatments*
    - *broaden to include all mental health issues (not just depression)*
    - *bring together all medical groups to work on priority areas*
    - *investigate role of other non-psychiatric medical practitioners*
    - *fund successful research projects to be rolled out in to the community*

Question 16: In your opinion, are there any other priorities that *beyondblue* should focus on over the next five years?

Forty participants responded to this question, of whom 53% (n=21) said yes, 37% disagreed, and 10% were unsure. All 21 participants who believed there should be other priorities provided at least one suggestion, 13 provided two suggested priorities, six provided three suggestions, two gave four suggestions and one participant provided five suggested priorities.

The suggested priorities included:

- *service development (especially allied health), and increased access to help (especially in rural areas) (n=7)*
- *targeting specific groups (eg. drug and alcohol, prisoners, homeless, Indigenous persons; parents with depression; elderly; refugees and others disconnected from their communities and culture; family support programs; n=7)*
- *training or education of service providers (n=6)*
- *prevention (n=5)*
- *research programs which systematically fill the knowledge gap (eg. social changes which contribute to depression)*
- *increased focus on gender and cultural issues*
- *legislation or more aggressive measures to counter stigma*
- *assessing methods to evaluate existing depression programs*
- *amalgamate depression programs into a unified approach*
- *make resources and activities more relevant to a multicultural and multilingual society*
- *implement successful research projects*
- *only study new interventions with strong likelihood of success because of effort involved for consumers*

- *work with stakeholders so that research is understood*
- *feed important research findings into the policy process*
- *convince governments that mental health issues should have higher priority in government policy*
- *target the policy domain, but not via health departments or ministers*
- *establish care and support standards and protocols*
- *include all states*
- *branch out diagnostically (eg. national program for mental health advocacy and awareness)*
- *explore the role of other (non-psychiatric) medical providers*

Question 17: Finally, participants were asked to provide any other comments about the performance of *beyondblue*.
Twenty-nine or 55% of the sample provided at least one comment. There were only a few negative comments, more specifically regarding poor communication, poor organisational aspects and needing to review the leadership structure: 'too many chiefs'. Fifty percent (26/52) of the comments were general positive feedback about the organisation; 13% (7/52) of comments were about successes in priority areas (eg. community awareness, primary care and research work), four comments were in support of continued financial and community support and the remainder pertained to specific comments about working together in the future, about the questionnaire, the application of research findings and being more focussed so as not to 'spread too thin'.

Summary of findings

Almost three-quarters of the sample agreed that *beyondblue* had increased awareness of depression and reduced the stigma experienced by people with depression in Australia. The three most successful strategies identified were: increased media on depression; the use of high profile consumers and advocates; and, effective community education via advertising campaigns. The majority of respondents thought that the work of *beyondblue* would be of enduring or long-term value to the Australian community and that *beyondblue's* programs would inform future policy. Almost all respondents agreed that *beyondblue* had increased knowledge about depression in Australia, and 85% agreed that the organisation had contributed to important and valuable research.

When asked about priority areas on which *beyondblue* should focus over the next five years, prevention and early intervention were identified as the most important, followed by community awareness and destigmatisation, primary care, targeted research and consumer and carer participation.