

**PUBLIC HEALTH DEPRESSION  
INITIATIVE: A REVIEW OF  
DEPRESSION CAMPAIGNS -  
LESSONS FOR NEW ZEALAND**

RESEARCH REPORT FOR



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***Author***

Kathryn NemeC M.Soc.Sci. Dip.Psych (COMM)

**NOTE:**

At the time this report was prepared, this project was known as the "National Depression Initiative". By the time the final reports for this project had been prepared, we were recommending that the project be called the "Public Health Depression Initiative".

To avoid confusion between the four reports for this project, the title of this report has been changed to include the recommended new project name. However, the rest of the report has been left unaltered, and therefore refers to the "National Depression Initiative".

The other three Phoenix Research reports for this project are:

- Public Health Depression Initiative: Environmental Scan
- Public Health Depression Initiative: Benchmark Survey
- Public Health Depression Initiative: Feasibility Report

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# 1. CONTEXT

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The National Depression Initiative (NDI) is a national project to raise awareness of depression, to aid early recognition, appropriate treatment and recovery. It is part of the Government's commitment to addressing suicide prevention, as well as improving the mental health and wellbeing of all New Zealanders.

This review forms part of the planning work of the National Depression Initiative. The planning phase, to be completed in September 2005, involves two components:

- Designing and implementing a depression survey (future repeats will monitor changes in the public's knowledge, attitudes and behaviour around depression)
- A scoping project to look at what has worked overseas; best approaches; target audiences; costs; timing; and workforce issues. This includes a literature review, environmental scan/ stakeholder consultation, and costings for various modules or programmes to make up a multi-pronged NDI.

The purpose of the review is to inform the planning of a NDI for NZ by drawing on the learning from other depression campaigns and health promotion activities, both in NZ and overseas.

## 2. SUMMARY

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Lessons from evaluations of international depression initiatives can be used to inform the planning of a NDI for New Zealand. This review has identified the following key depression campaigns, which have been evaluated to varying degrees. These campaigns are summarised in tabular format on page 13. They are:

- *beyondblue* (Australia)
- Defeat Depression (UK)
- Changing Minds (UK)
- Depression Awareness Recognition and Treatment (DART; US)
- National Depression Screening Day (US)
- Nuremberg Alliance Against Depression (Germany)

The three campaigns that stand out in terms of their evaluation are Defeat Depression, the Nuremberg Alliance and *beyondblue*. These campaigns have been (or are being) evaluated to assess whether they are achieving programme objectives. However, evaluations of the US campaigns have been weak or nonexistent.

Results on attitude changes are available for both the Defeat Depression and *beyondblue* campaign and these show that the campaigns had achieved some desired changes in the community's understanding of depression, its causes and treatments.

Most of the campaigns have applied health promotion techniques to distribute educational information to the community through the written and electronic media including fact sheets, advertisements, press conferences and web sites. In addition, the campaigns appear to have utilised a range of interventions. This is consistent with other efforts to tackle complex public health issues where it is generally realised that multiple interventions are more effective than a single intervention.

Key points that emerge from the review of international depression initiatives include:

- Mass media can raise awareness and change attitudes towards depression. However, understanding the link between attitude change and behaviour change needs to be built into any evaluation. In addition, the sustainability of attitude changes following mass media campaigns is unclear.

- Some attitudes held by the public about depression and its treatment are not evidence based and may require a particular approach in a communications campaign.
- Improving recognition and treatment of depression cannot be tackled by GP education alone. The best way of targeting GPs is by using multiple channels. Interestingly, guidelines for recognition and management of depression had the most impact on GPs in the UK Defeat Depression campaign.
- Findings from the *beyondblue* evaluation suggest that that awareness campaigns do not necessarily lead to sudden, increased demand for GP services.
- Depression initiatives have included a range of strategies which include:
  - Mass media
  - GP Education
  - Community education initiatives
  - Web based interventions
  - People with experiences of depression and carers
  - Work place interventions
  - School based interventions
  - Fund and support research and evaluation

The above strategies are explored in more detail in the report. Key points that emerged, and can potentially be applied to a NDI within a New Zealand context are summarised below. In addition, lessons can also be learnt from the way in which interventions can be designed and implemented. Social marketing and community action incorporate strategic approaches that aim to maximise the effectiveness of campaigns. Relevant aspects of these approaches are also summarised below.

## **MASS MEDIA**

- The literature suggests that mass media campaigns may be effective in increasing awareness and changing attitudes towards depression.
- After depression awareness campaigns, higher levels of depression literacy are more apparent amongst some sectors of the population than others. These groups are more likely to recall recent media stories, spontaneously recall relevant depression organisations, to have had direct or family experiences of depression, to be younger and to have achieved higher levels of education.
- Mass media is unlikely to lead to recognising depression as a major general health problem.
- Educating media professionals may enhance the extent and accuracy of the media portrayal of depression, and could form an element of a mass media campaign.

- High profile people generate further interest and debate about depression.
- The Like Minds campaign can potentially provide a platform from which media activities can be launched.
- The impact of increased awareness on the use of primary care services is unclear. The *beyondblue* finding of no change in depression-related GP visits suggests that while awareness is increasing and attitudes are changing, people's help-seeking behaviour has not changed. However, in Finland during the 1990s, depression awareness policies resulted in increased use of depression services.

## **GP EDUCATION**

- Educational interventions that target GPs alone are insufficient to improve depression management in primary care.
- Integrated and complex approaches appear to be clinically effective in the management of depression in primary care. Research has identified that strategies effective in improving patient outcome are generally those with complex interventions that incorporated clinician education, an enhanced role of the nurse (nurse case management), and a greater degree of integration between primary and secondary care (consultation-liaison).
- In terms of screening tools to detect depression in primary care, the WHO-5 wellbeing questionnaire is the most sensitive and practicable.
- Evaluation of educational interventions need to identify the extent of behaviour change with regards to better recognition and treatment of depression in primary care settings.

## **COMMUNITY EDUCATION INITIATIVES**

- Community education can potentially form an important component of an overall initiative.
- Both Mental Health First Aid and the Depression Awareness Research Project (DARP) provide interesting and different examples of how depression literacy outcomes can be achieved. Their content and delivery mechanisms should be carefully reviewed to tailor community education initiatives for New Zealand's cultural context.
- The opportunity to deliver the initiative in partnership with local community agencies should be explored.

## **WEB BASED INTERVENTIONS**

- A range of benefits of web-based resources have been identified that enable communities, employers etc to promote awareness, early detection, and intervention about depression.
- Organisations can promote online screening in conjunction with other initiatives throughout the year
- While web-based on-line screening is becoming increasingly popular, their efficacy in terms of the uptake of services following screening, or the prevention of depression, is unknown.

## **PEOPLE WITH EXPERIENCE OF DEPRESSION AND CARERS**

- Other depression initiatives have initiated self help groups that have continued beyond the initiative, highlighting potential need and role of such groups.
- BlueVoices, the *beyondblue* initiative for people with experiences of depression, has improved networks, and undertaken advocacy, policy and promotion work.
- Networks can potentially provide a forum around which existing depression related NGOs and groups can mobilise.

## **WORKPLACE INTERVENTIONS**

- Workplaces can potentially provide a suitable environment for education about depression to a range of different audiences.
- Evaluations of both the *Beyondblue* Depression in the Workplace and the Mental Health First Aid indicate effectiveness in terms of improving mental health and depression literacy in the workplace.

## **SCHOOL BASED INTERVENTIONS**

- Findings indicate that there has been some positive results from the RAP programme, both in New Zealand and Australia. However, at this stage there is insufficient evidence to warrant wider roll out.
- Findings from resiliency building programmes appear contradictory; while the Travellers Programme enhanced protective factors, the Gatehouse Project showed no effect on reducing depressive symptoms.
- Further research on the efficacy of depression prevention programmes is warranted.

## **FUND AND SUPPORT RESEARCH AND EVALUATION**

- Research and evaluation has been a core strategy for other depression initiatives.
- The scope of research undertaken is potentially very wide – encompassing evaluation through to medical research, and incorporating both qualitative and quantitative methodologies.
- Research needs to be strategic (i.e. gaps in knowledge need to be identified and research to fill the gaps funded).
- Multiple stakeholders should be involved with setting a research agenda and strategy.
- The review highlights the importance of evaluating any depression initiative both in terms of attitudinal and behaviour change.

## **SOCIAL MARKETING**

- Social marketing (the process of using marketing concepts to change consumer behaviour for the social good) could provide an overall approach for the depression initiative, including mass media, along with other interventions.
- Social marketing incorporates a wider strategic approach (ie addresses organisational, structural and environmental issues) which could be incorporated into a NDI.
- Any social marketing campaign requires the inclusion of an appropriate and adequately resourced evaluation. (This applies to any health promotion or prevention initiative).
- Social marketing must be sustained over time to be effective.

## **COMMUNITY ACTION**

- It appears that elements of a community action based approach may be useful for inclusion in a national depression initiative.
- Lessons from the evaluation of community action projects which could potentially be relevant to a NDI include:
  - Community partnerships can be an effective mechanism to plan, develop and deliver activities.
  - Community strengths and assets should be developed to enable local communities to undertake local delivery.
  - Activities should be developed and delivered to and by appropriate ethnic groups.

### 3. INTRODUCTION

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Depression is a major public health issue and it imposes a considerable economic and emotional burden upon the community (Murray and Lopez, 1997). At any one time the prevalence of major depression is around 5% and at least another 5% of the population have other depressive conditions (cited in Goldney, 2001). Within New Zealand, and as a part of a community survey on psychiatric disorders in Christchurch in 1986 (Oakley-Browne, 1989; Wells, J, 1989), the prevalence of major depression was assessed. Lifetime prevalence rates were found to be 13%. The analysis also revealed that major depression was higher in females than males (16% cf 9%), In addition, a trend emerged for depression in both sexes to be increasing in prevalence, and for it to be occurring at an earlier age (Joyce, et al.,1990, pg 83). Indeed, up to 24% of young people will have suffered from at least one clinically significant depressive episode by the age 18 years (NHMRC, cited in Merry, 2004).

Although common, depression can be difficult to recognise, diagnose and treat. A range of factors identified in the international literature explain why this is:

- 'Mental health literacy' is low. Mental health literacy has been defined as

*“Knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help seeking”*

(Jorm et al, 1997i, pg 183)

A higher public level of depression literacy would make early recognition of depression and appropriate intervention more likely.

The literature suggests that GP recognition of depression is low. For patients attending GPs with symptoms of depression, only half were correctly diagnosed (Paykel et al, 1992; cited in Payket et al, 1997), and a number other studies have found shortcomings in its detection and management (cited in Goldney et al, 2001; Ohayon et al, 1999; The MaGPIe Research Group, 2003).

- People with depression can be reluctant to discuss emotional problems with their GP, tend to present with physical symptoms and face limited time for consultation (Baldwin et al, 1996).

## 4. INTERNATIONAL DEPRESSION INITIATIVES

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In order to address the problems identified in the previous section, some countries have developed national depression initiatives. This review has assessed these initiatives in order to identify the elements that have been effective, or not so effective. Such lessons can help to inform the planning for a New Zealand NDI and are highlighted in subsequent sections of this review.

Six international depression initiatives have been identified and reported in the peer-reviewed literature;

- The Defeat Depression Campaign was conducted across the UK from 1992 to 1996. It was run by the Royal College of Psychiatrists.
- The Changing Minds Campaign, a more general campaign to reduce stigma associated with mental health problems in the UK, which ran from 1998 to 2003. This was also run by the Royal College of Psychiatrists<sup>1</sup>.
- The US National Institute of Mental Health (NIMH) Depression Awareness, Recognition and Treatment Programme (DART) was established in 1998 and hosts a range of initiatives aiming to help educate different communities about depression.
- The US National Depression Screening Day (an off-shoot of DART) was initiated in 1990 and continues as an annual event supported by various screening sites.
- The Nuremberg Alliance Against Depression was conducted in Nuremberg, Germany between 2000 and 2001.
- *beyondblue* is Australia's national depression initiative which started in 2000 and runs until 2010.

This review Table 1 provides further information on each of these initiatives.

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<sup>1</sup> Their current campaign is aiming to raise awareness of depression amongst caregivers. See [www.partnersincare.co.uk](http://www.partnersincare.co.uk).

Name of campaign	Where	When	Overall aim	Main strategies for achieving change	Key evaluation findings
Defeat Depression	UK	1992-1996	Reduce stigma associated with depression, education of the public about the disorder and its treatment, and encouragement of earlier treatment seeking. (Paykel et al, 1998). In addition, it aimed to assist healthcare professionals in the recognition and treatment of depressive illness (Baldwin et al, 1996)	Information based media campaign directed toward the general public; GP education plus material; Defeat Depression Action Week; Scientific conferences	<p>Attitudes of the general public to depression and its treatment changed positively. Most of the changes involved shifts in view of between 5-10%. Attitudes to GPs as primary treaters of depression were mixed. Among treatments, the public regarded counselling very positively, but viewed antidepressants with some doubt (Paykel et al, 1998).</p> <p>Two thirds of GPs were aware of the campaign and 40% had definitely or possibly made changes in practice as a result of it. Impact of material was highest for a consensus statement on the recognition and management of depression in general practice and for guidelines derived from it. (Rix et al, 1999). Rix (1999) notes that other initiatives influencing GP attitudes and their practice were occurring at the same time.</p> <p>Regarding GPs, while a national campaign of this kind can have a useful impact, it needs to be supplemented by local and practice-based teaching activities. (Rix et al, 1999). Hart (personal communication) also notes the importance of primary care work on depression being owned at a local level with local commitment, for example via a network of family doctors. In addition, primary care nurses are an important audience. (Deborah Hart, personal communication).</p>
Changing Minds Campaign	UK	1998 – 2003	Reduce stigma and discrimination;	Development of tool kit of materials for different	A baseline survey showed that stigmatising opinions about people with psychiatric disorders

Name of campaign	Where	When	Overall aim	Main strategies for achieving change	Key evaluation findings
			Increase public and professional understanding of mental health problems (including depression) (Crisp et al, 2000)	audiences; Develop website; Public education through collaboration with key groups.	are widely held A follow up survey was conducted in 2003. It showed some positive changes since the 1998 survey, with small decreases in the percentages of respondents recording negative opinions about people with mental disorders. A direct causal link cannot be attributed to the campaign as other initiatives were underway. (press release, 2003)
Depression, Awareness, Recognition and Treatment Campaign (DART)	US	1988, ongoing	Increase acceptance and knowledge of depression symptoms and treatment	A public campaign (information and education) to educate both the public and professionals (primary care physicians and mental health specialists) that depressive disorders are common, serious and treatable.  Effort was put into profession education in anticipation of increased demand for services. (Regier et al, 1988).	No overall evaluation to date. An evaluation of one training programme targeting professionals who provide services to rural residents was conducted in 1996. Following the training programme, participants (physicians, psychologists, social workers and nurses) showed significant increases in level of knowledge of depression and a high degree of satisfaction with most elements of the programme. A six month follow up indicated a continued positive evaluation of the programme (O'Hara et al, 1996).
National Depression Screening Day	US	1991, ongoing	Raise profile of depression on a national level; Educate the public about its symptoms and effective treatments; Offer individuals the opportunity to be screened for depression; Connect	National Depression Screening Day is held each October during Mental Illness Awareness Week.  Public education through written and electronic media	Starting with only 90 sites in its first year, the Screening Day program has grown to reach more than 85,000 people at 3,000 sites nationwide. To respond to the year-round need, the program also maintains a toll-free, year-round phone line for free, anonymous screening locations in local areas. <a href="http://www.nmha.org/ccd/support/screening.cfm">http://www.nmha.org/ccd/support/screening.cfm</a>  Impact of the initiative on attitudes changes have not been evaluated.

Name of campaign	Where	When	Overall aim	Main strategies for achieving change	Key evaluation findings
			those in need of treatment to the mental health care system. <a href="http://www.nmha.org/ccd/support/screening.cfm">http://www.nmha.org/ccd/support/screening.cfm</a>		
Nuremberg Alliance Against Depression	Germany	2001-2002	Establish and assess the effectiveness of a 4-level intervention programme for improving the care of depressed patients; Reduce the number of suicides by improving awareness and treatment of depression; Implement a community based intervention program	Training of family doctors and support through different materials; Public relations campaign informing about depression; Co-operation with community facilitators (teachers, priests, local media, etc); Support for self-help activities as well as for high risk groups. (Althaus, 2005).	Reduction of approximately 20% of suicide acts (suicides + suicide attempts). This effect was confirmed statistically in comparison to the baseline and a control region (Wuerzburg popn. 270,000) for the total of suicide acts and for suicide attempts (Althaus, 2005).  On the basis of the results, the 4 level approach has been adapted to other regions in Germany and Europe, and the European Alliance Against Depression was created in 2004
European Alliance Against Depression	Europe	2004 -	Improve the care of depressed patients	The 4-level intervention programme developed in the Nuremberg Alliance (as above)	At this stage regional networks have been set up, common intervention and evaluation instruments have been agreed, some training has been conducted, and some partners have collected baseline data. (Tim Pfeiffer-Gerschel, personal communication).  <a href="http://www.eaad.net">www.eaad.net</a> .
<i>beyondblue</i>	Australia	2000-2010	To increase the capacity of the Australian community to prevent and	Increase community awareness of depression and reduce stigma via mass media initiatives,	In terms of increasing awareness and depression literacy, data from the depression monitor survey conducted by <i>beyondblue</i> , and the Australian National Mental Health Literacy

Name of campaign	Where	When	Overall aim	Main strategies for achieving change	Key evaluation findings
			<p>respond effectively to depression. (Cost of campaign: \$35 million - \$17.5 million from the Commonwealth Government and \$17.5 from the Victorian Government).</p>	<p>community activities and education campaigns; Provide people living with depression and their carers with information; Develop depression prevention and early intervention programs; Improve training and support for GPs and other healthcare professionals; Initiate and support depression-related research (Pirkis, 2004).</p>	<p>Surveys suggest that <i>beyondblue</i> has enhanced the mental health literacy of the Australian community. More specifically, there were increases in public awareness of prevalence of depression (54% to 61% between 2002 and 2004), and knowledge of its symptomatology (50% to 70% between 2001 and 2002), causes and treatment (Pirkis, 2004). Other evaluation findings suggest a range of programme initiatives (website, celebrity spokespeople, etc) have raised the level of depression literacy, and the profile of <i>beyondblue</i> and their work on depression.</p>

## 5. LESSONS FOR NEW ZEALAND FROM INTERNATIONAL DEPRESSION INITIATIVES

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Is there useful information to be drawn from the reports of these initiatives that could assist in the development of an effective NZ depression initiative?

- The three campaigns that stand out in terms of their evaluation are Defeat Depression, the Nuremberg Alliance and *beyondblue*. These campaigns have been (or are being) evaluated to assess whether they are achieving programme objectives. However, evaluations of the US campaigns have been weak or nonexistent.
- The Defeat Depression and *beyondblue* campaign have resulted in some desired changes in terms of the community's understanding of depression, its causes and treatments.
- The effectiveness of the DART and National Depression Screening Day remain unknown.
- Most of the campaigns have applied health promotion techniques to distribute educational information to the community through the written and electronic media including fact sheets, advertisements, press conferences and web sites. In addition, the campaigns appear to have utilised a range of interventions. This is consistent with other efforts to tackle complex public health issues where it is generally realised that multiple interventions are more effective than a single intervention.
- Key points that emerge from the review of international depression initiatives include:
  - Mass media can raise awareness and change attitudes towards depression. However, understanding the link between attitude change and behaviour change needs to be built into any evaluation. In addition, the sustainability of attitude changes following mass media is unclear from the literature on international depression initiatives.
  - Some attitudes held by the public about depression and its treatment are not evidence based and may require a particular approach in a communications campaign.
  - GP education alone is insufficient and the best way of targeting GPs is by using multiple channels. Interestingly, guidelines for recognition and management of depression had the most impact on GPs in the UK Defeat Depression campaign.
  - While DART considered the implications of increased awareness on demand for services, the actual impact on services was not presented.
  - Initiatives have included a range of strategies which include:
    - Mass media

- GP education
- Community education
- Web based interventions
- People with experience of depression and carers
- Work place interventions
- School based interventions
- Fund and support research and evaluation
- Social marketing
- Community action

The literature review will explore each of these strategies in more detail. However, before any initiative is implemented, baseline data on public and professional attitudes towards depression needs to be collected. This provides the basis from which changes can be monitored. This was conducted in both the UK Defeat Depression and *beyondblue* initiative and changes are summarised in the above table. The following section highlights the level of depression literacy amongst the public and health professional. Any initiative should aim to increase depression literacy and findings from other surveys highlight the type of information that needs to be communicated in awareness raising and education initiatives.

The following section provides insight into the type of knowledge and attitudes about depression that are likely to exist in New Zealand.

## 6. KNOWLEDGE AND ATTITUDES TOWARDS DEPRESSION – UNDERSTANDING THE BASELINE

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In 1995 a national household survey of the Australian public's knowledge and beliefs about mental disorders. Key findings were:

- Participants were presented with a vignette of a person with either major depression or schizophrenia. With the depression vignette, 72% of respondents recognised that there was some sort of mental health problem, but only 39% gave the conventional label of depression.
- When various professionals were rated as likely to be helpful or harmful, GPs, counsellors, close friends, family and telephone counselling were rated more highly than psychiatrists and psychologists. The literature reports an overall preference to consult family and friends, and other community based supports rather than general healthcare professionals or mental health experts.
- When various types of medication were rated as likely to be helpful or harmful, vitamins, minerals, tonics or herbal medications were most frequently rated as likely to be helpful, while antidepressants were more frequently rated as harmful rather than helpful.
- When a broad range of non pharmacological treatments were presented, the most frequently rated as likely to be helpful were getting out and about more, increased physical activity and doing a course on relaxation, stress management medication or yoga<sup>2</sup>.
- Various lifestyle interventions were rated as more helpful than psychotherapy.
- Being admitted to a psychiatric ward or having ECT were rated as harmful.

*(Jorm et al, 1997i)*

Similar results have emerged from public surveys in other countries (Reiger et al, 1988, McKeon et al, 1996; Priest 1996, Jorm 2000i, Golding et al, 2001; Hight, 2002; Hugo et al, 2003) Limited knowledge and inaccurate beliefs

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<sup>2</sup> Following on from this finding, Jorm et al (2002) reviewed the evidence for the effectiveness of complementary and self-help treatments for depression. The treatments with the best evidence of effectiveness are St John's wort, exercise, bibliotherapy (i.e. standardised treatment in book form which is worked through independently) involving cognitive behaviour therapy and light therapy (for winter depression). There is some limited evidence to support the effectiveness of acupuncture, light therapy (for non-seasonal depression), massage therapy, negative air ionisation (for winter depression), relaxation therapy, S-adenosylmethionine, folate and yoga breathing exercise. They conclude that although none of the treatments reviewed is as well supported by evidence as standard treatments such as antidepressants and cognitive behaviour therapy, many warrant further research. (pg S84)

about depression have important consequences for prevention, early intervention, and treatment of depression; they can lead to delays in help-seeking, hinder acceptance of evidence based mental healthcare, and mean that depressed people do not receive appropriate support from others in the community (Parslow et al, 2002). Therefore, if depression is to be recognised early in the community and appropriate intervention sought, the level of depression literacy needs to be raised.

The gap between public and professional beliefs about depression was confirmed in a survey of Australian GPs, psychiatrists and clinical psychologists (Jorm et al, 1997ii). For depression, the biggest discrepancies were in the higher ratings the professionals gave to antidepressants and conversely, the public tended to give much more favourable ratings to vitamins, minerals and special diets. These results could indicate a lack of willingness by the public to accept help from mental health professionals or poor adherence to advice given. In addition, they suggest that health education campaigns are needed to help close the gap between professional and public beliefs.

The experience of depression changes beliefs about the helpfulness of interventions for depression (Jorm et al, 2000). Those currently depressed or with a history of depression are less likely to regard family as helpful, possibly due to poorer social support. Generally speaking, having sought help is associated with beliefs closer to those of professionals.

Based on these findings, and a review of the evidence about how people change their health attitudes and behaviours, and which behaviours lead to better depression outcomes, Parslow et al (2002) identified the knowledge, beliefs and attitudes that relate to the motivation to act on depression. These are:

- Knowledge of depression symptoms
  - Knowledge of modifiable risk factors
  - Belief in help-seeking
  - Knowledge/attitudes to health professionals
  - Knowledge/attitudes to effective treatments and self-help
  - Society attitudes to depression; and
  - Family and friends' knowledge/attitudes to help-seeking, treatments and self help
- (Parslow et al, 2002)*

As people need to know what works, Jorm and colleagues attempted to provide this information in a 2001 publication "*Help for Depression: What works & what doesn't*". This is a small booklet which is promoted by *beyondblue* for use by the public.

The above points highlight the areas to target in an awareness raising campaign aiming to change behaviour.

## 7. STRATEGIES TO PROMOTE AWARENESS AND FOSTER ATTITUDE AND BEHAVIOUR CHANGE TOWARDS DEPRESSION: WHAT WORKS?

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Initially, an attempt was made to define whether potential strategies and interventions are mental health promotion or prevention interventions. However, the distinction between these two approaches is unclear. Indeed, WHO (2004) describe the interface between promotion and prevention, noting that:

*“Prevention and promotion elements are often present within the same programmes and strategies, involving similar activities and producing different but complementary outcomes. Since mental health promotion and mental disorder prevention both deal primarily with the enhancement of mental health and the influence of its antecedents, they should be understood as conceptually distinct but interrelated approaches.”*

(WHO, 2004, pg 19)

Within the literature on depression interventions and strategies, prevention is referred to more commonly than promotion. Helpfully, distinctions within prevention help to classify different types of depression interventions.

Mrazek and Haggerty's (1994) three typologies of prevention programmes were applied to depression prevention programmes by both Jane-Llopis (2003) and WHO (2004). The typologies are:

- **Universal prevention interventions:** These target a whole population group that has not been identified on the basis of increased risk. These programmes aim to strengthen protective factors among populations which have been found to reduce depressive symptomatology. Examples include school-based programmes targeting cognitive, problem-solving and social skills of children and adolescents.
- **Selective prevention interventions** which targets subgroups of population whose risk of developing a mental disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors.
- **Indicated prevention interventions** which targets high risk persons who are identified as having minimal symptoms foreshadowing mental disorder or biological markers indicating predisposition for mental disorder but do not meet diagnostic criteria for disorder at that time.

Do depression prevention programmes work? Jane-Llopis et al (2003) conducted a meta analysis of 69 depression prevention programmes that aimed to reduce depression or depressive symptoms. The analysis highlighted that an 11% (equivalent to a weighted mean effect size of 0.22) improvement in depressive symptoms can be achieved through prevention programmes. There was no significant difference between the type of preventive approach (ie. universal, selective or indicated) and changes in depressive symptoms or risk factors. The predictors of effectiveness of prevention programmes were having;

- Multiple components that included competence techniques,
- More than 8 sessions and each session running for 60-90 minutes
- High quality research design and delivered by a health care provider in targeted programmes

*(Jane-Llopis et al, 2003).*

Given the population based approach adopted for the NZ depression initiative, universal prevention strategies, such as the strategies utilised in other campaigns and initiatives, will be the focus of this literature review.

## 8. MASS MEDIA

Depression campaigns such as Defeat Depression, the Nuremberg Alliance and *Beyondblue* have all used mass media to raise awareness about depression as part of their overall campaign. Examples of media activities are described in the following table.

Campaign	Description of Mass Media Activities
Defeat Depression (UK)	<ul style="list-style-type: none"> <li>• Publication of leaflets for the general public on depression, depression for the elderly, depression in the workplace, postnatal depression and depression in men.</li> <li>• Fact-sheets on depression in minority languages include Hindi, Gujarati, Bengali, Punjabi, and Chinese</li> <li>• Publication of books for a general readership on depression and depression in children and adolescents</li> <li>• Publication of educational videos on self-help for patients with depression and manic-depression and their cares.</li> <li>• Production of audio cassettes on coping with depression and coping with stress at work</li> <li>• 'Defeat Depression' Action Week and Action Days. (Baldwin et al, 1996).</li> </ul>
Nuremberg Alliance Against Depression (Germany)	<ul style="list-style-type: none"> <li>• Publicly known people were patrons for the campaign and supported public relation activities.</li> <li>• Lectures and events for the general public.</li> <li>• Brochures and information leaflets were distributed.</li> <li>• Posters advertised the campaign's key messages ("depression can be treated", "depression has many faces", "depression can affect everybody").</li> <li>• A cinema advertisement was produced and has been running since the beginning of the intervention period.</li> <li>• A web site was established (<a href="http://www.buendnis-depression.de">www.buendnis-depression.de</a>), which offered information about depression, important mental health care institutions in Nuremberg and current events of the campaign. (Reference – personal communication)</li> <li>•</li> </ul>
<i>beyondblue</i> (Australia)	<ul style="list-style-type: none"> <li>• Workshop with media professional about positive, appropriate and responsible reporting of mental health issues.</li> <li>• Brochures, pamphlets, posters and other written material.</li> <li>• A website (<a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a>), which includes fact sheets, an online self assessment, and a media centre for journalists.</li> <li>• TV and radio community service announcements involving</li> </ul>

	<p>celebrities and family doctors, as well as announcements aimed at particular target groups.</p> <ul style="list-style-type: none"> <li>• A TV campaign to address gaps in community knowledge about depression.</li> <li>• Specialist media activities, such as special supplements on depression in the Medical Journal of Australia to reach mental health providers. (Pirkis, 2004)</li> </ul>
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The direct causal relationship between mass media activities and changing public attitudes is difficult to evaluate. Generally other interventions and activities are likely to be running, and control groups are generally not feasible. However, Jorm et al (2005) reported that in Australia, awareness of *beyondblue* in the states that provided funding was found to be around twice the level of those that did not. Using the low-exposure states as a control, the high-exposure states had greater change in beliefs about some treatments, particularly counselling and medication, and about the benefits of help-seeking in general.

Hight et al (2005) also reported on the relationship between public awareness activity, such as mass media, and community and education campaigns, and the recognition of the impacts of depression, as promoted by the *beyondblue* initiative. The results indicate that active promotion of depression-related material to the community appears to have contributed to recognition of the commonality and impacts of depression. Respondents with greater understanding that depression is common and debilitating were more likely to recall recent media stories, spontaneously recall relevant organisations such as *beyondblue*, to have had direct or family experiences of depression, to be younger and to have achieved higher levels of education. They conclude that while depression is commonly recognised as a mental health problem, it is not yet considered a major general health problem. Further, like many public health campaigns, those so far reached appear more likely to be female, younger, better educated and residing in metropolitan areas.

Other elements of the *beyondblue* media campaign that have been evaluated are the website and media reporting of depression during the 12 months after the launch of *beyondblue*. There has been an increase in website traffic (Pirkis, 2004), and Francis et al (2002) noted that the quantity of media reporting increased, for example, a large proportion of media reports focused on particular high profile individuals associated with *beyondblue* (i.e. Jeff Kennett, politician; Garry MacDonald, actor) among others), and this in turn generated further interest in and debate about issues relating to depression. However, the quality of reporting remains variable, with scope for increasing the level of accurate information provided about depression.

In addressing media portrayal of depression, future strategies should focus on improving the extent and accuracy of information available, in order to

promote mental health literacy and early help-seeking behaviour in the population. It is also important that further research be conducted to determine the impact of specific approaches designed to improve media coverage of depression, particularly with respect to providing appropriate information and encouraging help seeking behaviour. (Francis et al, 2002).

Within New Zealand, the Like Minds campaign has already provided a successful medium for raising awareness and changing some attitudes about mental illness (Ministry of Health, 2005).

One of the concerns about a mass media campaign on depression is the impact it would potentially have on demand for primary care services. However, the link between raising awareness and utilisation of GP services is unclear. On one hand, Kaltiala-Heino et al (2003) notes that depression awareness policies during the 1990s in Finland increased inpatient use of depression services. However, in Australia, the evaluation of *beyondblue* notes that the overall level of depression-related GP visits has remained essentially unchanged (Pirkis, 2004).

## **WHAT CAN WE LEARN?**

- The literature suggests that mass media campaigns may be effective in increasing awareness and changing attitudes towards depression.
- Some sectors of the population have greater understanding about depression than others. These groups are more likely to recall recent media stories, spontaneously recall relevant depression organisations, to have had direct or family experiences of depression, to be younger and to have achieved higher levels of education.
- Mass media is unlikely to lead to recognising depression as a major general health problem.
- Educating media professionals may enhance the extent and accuracy of the media portrayal of depression, and could form an element of a mass media campaign.
- High profile people generate further interest and debate about depression.
- The Like Minds campaign can potentially provide a platform from which media activities can be launched.
- The impact of increased awareness on the use of primary care services is unclear. The *beyondblue* finding of no change in depression-related GP visits suggests that while awareness is increasing and attitudes are changing, people's help-seeking behaviour has not changed. However, in Finland during the 1990s, depression awareness policies resulted in increased use of depression services.

## 9. GENERAL PRACTITIONERS (GP) EDUCATION

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Interventions aiming to educate GPs in primary care settings have played an important role in previous depression initiatives. Along with strengthening GP services, and targeting deficits in GP recognition of depression, such interventions ensure that services are available and responsive to the public after an awareness raising campaign. However, and as mentioned previously, the link between awareness raising and increasing presentation of depression to GPs is unclear.

There are some diagnostic and therapeutic deficits concerning depressive disorders in primary care settings. Most patients contact their GP initially, but not all affected patients are identified as suffering from depression in the primary care setting and of those only a small proportion are treated adequately. Additionally, compliance problems mean that the range of available and reliable therapeutic options is only received by a fraction of affected patients (Pfeiffer et al, 2005).

As previously mentioned, public attitudes to help seeking behaviour and treatment are additional barriers to utilisation of primary care services. *beyondblue* conducted a study of the Australian public which found that for the public, the first choice of treatment was self-help and non-pharmacological strategies and a heavy reliance on family, friends and non-professional therapies. Although GPs were identified as the preferred point of medical contact, most people (especially younger people) were highly reliant on family and friends (Highet et al, 2002).

Attempts to address such deficits have been implemented in the past. An educational campaign for GPs was run on Gotland Island, Sweden during 1983 and 1984. Referred to as the 'Gotland study', it influenced the GP education element of the Defeat Depression Campaign (Rix et al, 1999). While an evaluation of the Gotland campaign showed decreases in hospital admission and illness absence for depression, increased prescribing of antidepressants, and decreased prescribing of tranquillisers (Rutz et al, 1996), the results need to be treated with caution as the numbers were small.

As part of the UK Defeat Depression campaign, the following activities targeting GPs were undertaken:

- Publication of consensus statements on the recognition and treatment of depression in general practice, and recognition and management of late life depression in general practice.
- Distribution of guidelines derived from consensus statements to GPs and consultant psychiatrists.

- Aide-memoire card for recognition and treatment of depression and detection and management of suicide risk.
- Video training packages on recognition and treatment of depression and interviewing and counselling skills.
- Education package on depression in the workplace.

*(Baldwin et al, 1996)*

In an evaluation of these activities targeting GPs, Rix et al (1999) noted that two-thirds of GPs were aware of the campaign and 40% had definitely or possibly made changes in practice as a result of it. The consensus statement and the guidelines derived from it had had the highest impact in terms of depression recognition and management. The authors conclude that a national campaign can have a useful impact, but it needs to be supplemented by local and practice-based teaching activities.

However, the effectiveness of GP education programme in improving the recognition and outcomes of primary care depression was tested in a randomised control trial in England and concluded that although the 'in practice' programme was well received, it did not deliver improvements in GP recognition or recovery from depression (Thompson et al, 1996 & 2000). This finding is supported by a recent systematic review of studies on educational and organisational interventions to improve the management of depression in primary care. The review came to the conclusion that only integrated and complex approaches appear to be clinically effective. Strategies effective in improving patient outcome generally were those with complex interventions that incorporated clinician education, an enhanced role of the nurse (nurse case management), and a great degree of integration between primary and secondary care (consultation-liaison). Telephone medication counselling delivered by practice nurses or trained counsellors was also effective (Gilbody et al, 2003). Examples of complex interventions in primary care settings that have been effective were described by both Ludman et al (2000) and Asarnow et al (2005).

Interestingly, one of the lessons from the UK Defeat Depression campaign was primary care nurses are a very important audience. In order to reach this group, work was undertaken at a local level which involved influencing their curriculum, and establishing a network of primary care nurse educators. In addition, the primary care work needs to be owned at a local level and the initiatives/commitment needs to be at a local level, not from top down. A network of family doctors with a specific interest in mental health was established to work at a local level (personal communication, Deborah Hart).

In terms of screening tools to detect depression in primary care, a prospective cohort study compared different methods and concluded that the World Health Organisation (WHO)-5 wellbeing questionnaire was the most sensitive and practicable (Henkel et al, 2003).

*Beyondblue* has also paid considerable attention to the area of primary care, and has put in place a number of initiatives aimed at better equipping GPs (and, to a lesser extent non-medical primary care practitioners). The interventions have been designed to address 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).

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*. 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, which may lead to better recognitions and treatment in primary care. On the other hand, the overall level of depression-related GP encounters has remained essentially unchanged over time (Pirkis, 2004).

Within New Zealand, a further consideration is the need for services delivered at a primary care level to be culturally appropriate. Different cultural understandings of depression require GPs to appreciate these differences, and thus enhance the therapeutic relationship and improve treatment outcomes.

## **WHAT CAN WE LEARN?**

- Educational interventions that target GPs alone are insufficient to improve depression management in primary care.
- Integrated and complex approaches appear to be clinically effective in the management of depression in primary care. Research has identified that strategies effective in improving patient outcome are generally those with complex interventions that incorporated clinician education, an enhanced role of the nurse (nurse case management), and a greater degree of integration between primary and secondary care (consultation-liaison).
- In terms of screening tools to detect depression in primary care, the WHO-5 wellbeing questionnaire is the most sensitive and practicable.
- Evaluations of educational interventions need to identify the extent of behaviour change with regards to better recognition and treatment of depression in primary care settings.

## 10. COMMUNITY EDUCATION INITIATIVES

Community education initiatives have been implemented as part of depression campaigns, particularly in the Nuremberg Alliance Against Depression and *Beyondblue*. Community education aims to raise awareness and improve depression literacy.

Depression Campaign	Community Education Activity	Evaluation
Nuremberg Alliance Against Depression (Germany)	Training sessions for community facilitators, who included priests, teachers, help-line staff, geriatric care givers and counselling centres, were conducted.	While an evaluation of the overall activity has yet to be reported in the literature, the effectiveness of training geriatric care givers has been evaluated. They were trained in early diagnosis of depressive symptoms and suicidality in order to improve the care of depressive patients, and the training programme was found to be effective (Ziervogel et al, 2005).
<i>beyondblue</i> - Depression Awareness Research Project (DARP) (Australia)	Community volunteers were recruited and trained as educators to present information about major depression within their community. Information was tailored to suit their local community. A project co-ordinator was appointed in each region to recruit and support the educators.	Knowledge levels about major depression were measured immediately before the presentation, and again on average 17 weeks after they heard the presentation. The results showed that after hearing a presentation about major depression delivered by a local community member resulted, on average 4 months later, in a 59% higher score in knowledge, recognition and appropriate help seeking for major depression than the general community. Key elements were delivery by a community member, flexibility to respond to individual community needs, and presenting opportunities for delivery in partnership with local community organisations (Sundram, et al. 2004).

Another community education programme that has been developed in Australia is the Mental Health First Aid (MHFA) training course which aims to increase mental health literacy, but doesn't target depression specifically. Several evaluations of the MHFA training course have been conducted. One evaluation concluded that the MHFA training appears to be an effective method of improving mental health literacy which can be widely applied. (Kitchener et al, 2002). A further finding that emerged from a randomised controlled trial of the MHFA training in a work place setting was that it improved the mental health of the participants themselves (Kitchener, et al 2004).

A cluster randomised trial of the MHFA training was conducted in more typical conditions in a rural area where the course was delivered by staff of an area health service. Training was still found to produce improved mental health literacy. The first aid training produces positive changes in knowledge, attitudes and behaviour when the course is given to members of the public by instructors from the local health service (Jorm et al, 2004).

On the negative side, the results indicated that participants were less likely to advise seeking professional help when they provided first aid to someone (but were more likely to help themselves), and a slight increase in labelling of ordinary life problems as mental disorders.

Jorm et al (2004) identifies the advantages of the MHFA training as:

- Provides intensive education to a smaller number of interested people which can complement less intensive education of the whole community (such as via a mass media campaign)
- Is potentially sustainable in the long term. Like conventional first aid courses, it can be run on a fee-for-service basis and requires no long-term government commitment<sup>3</sup>

Over 100 mental health first aid instructors have now been trained and the course is available throughout much of Australia, and in Scotland, Hong Kong, and New York State, USA. The Scottish Government plans to have sent 6% of its population to this training by 2010. Dissemination to other localities (e.g. Finland) is planned in the near future (Kitchener, et al, 2004).

## **WHAT CAN WE LEARN?**

- Community education can potentially form an important component of an overall initiative.

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<sup>3</sup> MHFA was initially funded by a grant from the Australian Capital Territory government, but now that this has ended the course is being run as a fee-for-service programme and demand continues, particularly from workplaces.

- Both Mental Health First Aid and the Depression Awareness Research Project (DARP) provide interesting and different examples of how depression literacy outcomes can be achieved. Their content and delivery mechanisms should be carefully reviewed to tailor community education initiatives for New Zealand's cultural context.
- The opportunity to deliver the initiative in partnership with local community agencies should be explored.

## 11. WEB BASED INTERVENTIONS

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The introduction of the Internet into clinical practice as an information-sharing medium has brought about many opportunities for innovative interventions for individuals with illnesses and their care providers. These interventions are often designed to address deficiencies in patient knowledge and illness self-management skills. Such interventions have been shown to be more effective than non-web-based interventions in terms of improved health outcomes (Wantland et al, 2004).

### Web-Based Therapies

The internet provides a mechanism to deliver tailored depression prevention interventions to the community en masse. Christensen et al (2002) suggest that interventions, such as those based on cognitive behavioural therapy<sup>4</sup> (CBT), can be delivered to a large audience cost effectively and anonymously. In addition, the internet offers advantages of data collection which can be used to help refine intervention programmes.

However, possible limitations to such interventions included selective access to the internet, inability to promote the sites to potential users and the issue of uptake once users access the sites.

In 2004, Christensen et al, published the results from an randomised controlled trial in Australia on delivering interventions for depression by using the internet. They evaluated the efficacy of two interventions for individuals with symptoms of depression – a psychoeducational website offering information about depression (BluePages) and an interactive website offering CBT (MoodGYM<sup>5</sup>). They found that both sites were effective in reducing symptoms of depression.

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<sup>4</sup> There is now evidence that psychological interventions involving CBT may be effective in the prevention of depression. A recent review of 9 randomised controlled trials of prevention interventions in young people reported that CBT can reduce depressive symptoms and the incidence of depression (Andrews et al, 2002).

<sup>5</sup>MoodGYM offers CBT for the prevention of depression. It teaches the principles of cognitive behaviour therapy, which has been found to be helpful for people with depression. Using flashed diagrams and online exercises, [MoodGYM](http://www.anu.edu.au/cmhr/moodgym.php) demonstrates the relationship between thoughts and emotions - users are taught to come to grips with their own feelings and the 'warpy' thoughts that might accompany them. MoodGYM also works through dealing with stress, handling separation and relationship break-ups, as well as relaxation and meditation techniques. (<http://www.anu.edu.au/cmhr/moodgym.php>)

## **Web-Based Screening for Depression**

On-line screening has also become more popular and there is a range of depression on-line screening tests available on the internet. On-line screening forms the basis of the National Depression Screening Day, noted in Table 1 on depression initiatives. Ogles et al (1998) suggests that new technology promotes curiosity and interest and as a result, a computerised depression screening and awareness program was created to use at fairs and other local events. If individuals complete the on-line screening they receive a one page print out that describes the common symptoms of depression, a score indicative of their level of depressed mood, a brief explanation of the score and a telephone number where additional information could be obtained. The Centre for Epidemiological Studies Depressed Mood Scale (CES-D), which is used for the screening, has been validated (Ogles et al, 1998). An analysis of who uses the screening revealed that older adults and minorities may visit screening sites less frequently than other populations (Houston et al, 2001). However, they conclude that the internet provides a continuously available, inexpensive, easily maintained platform to anonymously screen a large number of individuals from a broad geographic area.

## **WHAT CAN WE LEARN?**

- A range of benefits of web-based resources have been identified that enable communities, employers etc to promote awareness, early detection, and interventions about depression.
- Organisations can promote online screening in conjunction with other initiatives throughout the year
- While web-based on-line screening is becoming increasingly popular, their efficacy in terms of the uptake of services following screening, or the prevention of depression, is unknown.

## 12. PEOPLE WITH EXPERIENCE OF DEPRESSION AND CARERS

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Consistent with the emphasis on improving service quality, consumer rights and consumer participation, consumer related initiatives have been set up as part of both the UK Defeat Depression Campaign, the Nuremberg Alliance against Depression and *beyondblue*.

Towards the end of the Defeat Depression Campaign, the Depression Alliance, a self-help organisation run by and for sufferers of depression and their carers, was launched in the UK in 1995. Still active today, and through local groups, and a central office, Depression Alliance provides support, information and understanding for depressed people, whilst also seeking to educate the public and encourage research. Baldwin et al (1996) argues that as public education campaigns should be broad based and involve patients and their carers as well as health professionals, it is essential that the Depression Alliance and other self-help organisations should adopt a major role in any future activities designed to defeat depression. Indeed, the Depression Alliance undertook a major role in the UK Changing Minds campaign, highlighting the sustainability of the initiative. The sustainability of consumer participation was emphasised by the Nuremberg Alliance against Depression. They initiated 8 self-help groups at the beginning of the initiative and five of them were still active after two years.

*beyondblue* has put in place a number of initiatives that are designed to promote and 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. At the forefront of these is the development of BlueVoices, a national network of consumers and carers. (Pirkis, 2004) *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 and support for consumer representation on other key bodies.

There is evidence that these initiatives – particularly Blue Voices – have led to improved consumer and carer networks. Blue Voices has a membership of 9,650 (as at 10 August 2004), and close links with other relevant organisations (Pirkis, 2004). BlueVoices has also publicised and advocated the needs and experiences of those living with depression. As a result, the community reports high levels of exposure to the personal experiences of others who live with depression. There is a strong correlation between such exposure and recognition of depression, supporting the key role for the active portrayal of the lived experience of persons with depression (Hight, 2005).

There is less evidence that the acknowledgement of many of the issues faced

by consumer and carers has extended into the broader community. Ongoing discrimination and deficiencies in the treatment system appear to remain major issues for consumers and carers (Pirkis, 2004).

Within New Zealand, there are a range of resources and activities which support people with experience of depression. These are described in the Environmental Scan, which is also informing the planning of the New Zealand NDI, and accompanies this review.

## **WHAT CAN WE LEARN?**

- Other depression initiatives have initiated self help groups that have continued beyond the initiative, highlighting potential need and role of such groups.
- BlueVoices, the *beyondblue* initiative for people with experiences of depression, has improved networks, and undertaken advocacy, policy and promotion work.
- Networks can potentially provide a forum around which existing depression related NGOs and groups can mobilise.

## 13. WORK BASED INTERVENTIONS

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Depression is costly. An Australian study last year estimated the excess costs associated with depression were AUD\$1921 million per annum. (This excluded non-health service and other social costs, e.g. family breakdown, legal costs) (Hawthorne et al, 2003). Part of these costs is due to lost productive time in the workplace. A study on the cost of lost productive time among US workers with depression concluded that the majority of lost productive time is invisible and results in reduced performance at work. In addition, use of treatments for depression appears to be relatively low. They suggest that the combined effect of lost productive time and low levels of treatment highlights to opportunity for cost-effective interventions for improving depression-related outcomes in the US workforce (Stewart et al, 2003).

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 (Pirkis, 2004).

Evaluation of work based depression interventions have been conducted as part of the *beyondblue* evaluation, and the mental health first aid kit evaluation. While the long term impact of depression initiatives on lost time and costs in the workplace have yet to be reported, short term results from the *beyondblue* Depression in the Workplace Programme show:

- Increased knowledge and understanding about depression, and how to recognize and manage depression in a workplace setting
- Increase willingness to engage with a person
- Improved attitudes toward depression (i.e. reduced stigma)
- Increased knowledge about helpful/unhelpful behaviours and management practices
- Increased confidence and likelihood of assisting people to access appropriate help for depression

([http://www.beyondblue.org.au/index.aspx?link\\_id=4.66](http://www.beyondblue.org.au/index.aspx?link_id=4.66))

## **WHAT CAN WE LEARN?**

- Workplaces can potentially provide a suitable environment for education about depression to a range of different audiences.
- Evaluations of both the *beyondblue* Depression in the Workplace and the Mental Health First Aid indicate effectiveness in terms of improving mental health and depression literacy in the workplace.

## 14. SCHOOL BASED PROGRAMMES

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As noted in the introduction, up to 24% of young people will have suffered from at least one clinically significant depressive episode by the age 18 years. Depression is associated with poor academic performance, social dysfunction, substance abuse, suicide attempts and completed suicide (NHMRC, cited in Merry, 2004).

As such, adolescents in schools form a particular population to target with a depression prevention programme. While they might have a cursory knowledge of depression facts, research indicates gaps in terms of their knowledge about treatment and symptom identification (Hess et al, 2004). They are far more likely than other groups to speak to family and friends, rather than GPs, and this highlights the impact that knowledge and attitudes of family and friends will have on the experiences of adolescents with depression.

School based programmes are universal prevention interventions as they target whole populations of adolescents within schools. Some school programmes (e.g. The Resourceful Adolescent Programme (RAP)) have been found to reduce depression and sense of hopelessness (Shocket et al, 2001). The authors evaluated whether a universal school-based programme, designed to prevent depression in adolescents, could be effectively implemented within the constraints of the school environment. Adolescents who took part in the RAP programme reported significantly lower levels of depressive symptoms and helplessness at post-intervention and 10 month follow-up, compared with those in the comparison group (Shocket, 2001, pg 303). Merry (2004i) explored the effectiveness of the RAP in more detail by conducting a randomised placebo-controlled trial in 2 New Zealand schools. Immediately after participation in RAP-Kiwi depression scores were reduced, and these results were sustained at 6 months and 18 months. It was concluded that the RAP-Kiwi programme is a potentially effective public health measure.

However, Merry (2004ii) also conducted a review evaluating the evidence for the effectiveness of psychological and/or educational interventions (both universal and targeted) for the prevention of depression in children and adolescents. She concludes that although there is insufficient evidence to warrant the introduction of depression prevention programme currently, results to date indicate that further study would be worthwhile. Recommendations for the type of study that should be conducted are made.

Resiliency development programmes that aim to build mental health protective factors and emotional wellbeing are another type of programme that have been implemented in schools. For example, the TRAVELLERS programme is an early intervention programme designed to enhance mental health protective factors for young people. A pilot study was recently

conducted which concluded that targeted interventions provided within a supportive school environment can contribute to enhancing protective factors such as personal and interpersonal coping strategies, increased help-seeking behaviour, and young people feeling more positive about themselves and their lives. The pilot programme has been amended and prepared for a two year trial phase in 10 secondary schools during 2002–2003 (Dickinson et al, 2003)

The Gatehouse Project incorporates a similar approach, aiming to increase levels of emotional wellbeing and reduce rates of substance use amongst young people in schools. It aimed to do this by building a sense of security and trust, increasing skills and opportunities for good communication, and building a sense of positive regard through valued participation in aspects of school life. However, while there was a reduction in smoking in the intervention group, there was no significant effect of the intervention on depressive symptoms, and social and school relationships (Bond et al, 2004).

The authors conclude that while further research to determine fully the processes of change, this study shows that a focus on general cognitive skills and positive changes to the social environment of the school can have a substantial impact on important health risk behaviours. (Bond et al, 2004).

The Injury Prevention Research Centre (IPRC) conducted an evaluation of the Mentally Healthy School Initiative (the first mental health promotion initiative in New Zealand) in 1999. The initiative involved implementation of the Mental Health Matters curriculum programme with year 9 and 10 students in 8 schools, staff training on mental health issues, and an overall health promotion approach targeting the development of a safe physical and emotional environments in schools. Overall findings from the Mentally Healthy Schools student survey indicated no change in student mental health status pre- and post-intervention. Findings did support a slight positive effect of the Mental Health Matters curriculum programme. For example, participation in the initiative had enabled a number of school to undertake changes to school policies and practices (i.e. violence and harassment policies), and recognise and acknowledge school activities that promote positive mental health.

## **WHAT CAN WE LEARN?**

- Findings indicate that there has been some positive results from the RAP programme, both in New Zealand and Australia. However, at this stage there is insufficient evidence to warrant wider roll out.
- Findings from resiliency building programmes appear contradictory; while the Travellers Programme enhanced protective factors, the Gatehouse Project showed no effect on reducing depressive symptoms.
- Further research on the efficacy of depression prevention programmes is warranted.

## 15. FUND AND SUPPORT RESEARCH AND EVALUATION

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Research and evaluation needs to be an integral component of any depression initiative in New Zealand. Other campaigns have included a research component within their overall strategy.

In Germany, the Nuremberg Alliance has developed into the 'German Research Network on Depression and Suicidality', providing a common roof for different professions and institutions working in the overlapping field of depression and suicidality. Professionals and scientists, as well as patients, their relatives and the general population are addressed by activities of the network. The activities are grouped within 6 key project areas:

- Prevention and neurobiology of suicidality
- Treatment of minor and sub-threshold depression
- Quality management of depression treatment
- Mechanisms of pharmacological anti-depressive therapies
- Molecular genetics/ pharmaco-genetics
- Therapy non-response, chronicity, and their prediction in major depressive disorders

Underpinning these projects is the overall aim to improve the overall awareness of the general population of depression, suicidality and related problems, the role of GPs, and development of effective treatment strategies (Pfeiffer et al, 2005).

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. For example:

- Establishment of the Victorian Centre of Excellence in Depression and Related Disorders, which is funded with approximately \$1.3 million per annum. The Centre supports innovative, high quality research across disciplines to improve prevention and treatment of depression and related disorders.
- Other strategic research initiatives include 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.
- *beyondblue* requires all of its funded programs and projects to devote a significant proportion of their budgets to detailed evaluations.

- *beyondblue* has 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. 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.

(Pirkis, 2004)

Pirkis notes that 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.

The UK Defeat Depression campaign also had an emphasis on research. The campaign hosted a number of scientific conferences, with the dual aim of gathering interested professionals together to discuss the findings for research into a particular aspect of depression, and to provide a forum for the launch of campaign materials. These meetings have focussed on areas such as postnatal depression, depression in the workplace, social aspects of depression, depression in a multi-ethnic society, etc (Baldwin et al, 1996).

While the examples identified above highlight a range of research initiatives, the evaluations do not identify:

- Systems that enhance utilisation of the research utilisation (for example, whether the research funded has led to development and implementation of evidence based interventions).
- Funding and infrastructure (except for *beyondblue*).
- Systems to manage and capture the range of interests and concerns of multiple stakeholders and reflect them in a research strategy.

These are important issues to consider in the development of a research strategy for a New Zealand depression initiative.

## **WHAT CAN WE LEARN?**

- Research and evaluation has been a core strategy for other depression initiatives.
- The scope of research undertaken is potentially very wide – encompassing evaluation through to medical research, and incorporating both qualitative and quantitative methodologies.
- Research needs to be strategic (i.e. gaps in knowledge need to be identified and research to fill the gaps funded).

- Multiple stakeholders should be involved with setting a research agenda and strategy.
- The review highlights the importance of evaluating any depression initiative both in terms of attitudinal and behaviour change.

## 16. SOCIAL MARKETING

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Social marketing is a tool commonly used to effect attitudinal and behavioural change on a population level in public health. There are a range of New Zealand examples which have incorporated social marketing such as smoke-free homes and healthy eating. Within the mental health area, the Like Minds campaign have used social marketing to address stigma and discrimination against people with experiences of mental illness (Phoenix Research, 2005).

Social marketing is an approach which uses marketing principles and techniques to improve the welfare of people and the physical, social and economic environment in which they live. It is a carefully planned, long-term approach to changing human behaviour. The behaviour change may involve doing something new (covering up in the sun), doing something differently (washing the car on the grass rather than the side of the road) or stopping doing something altogether (drink driving). Social marketing is also used to help create environments that support the desired behaviour. ([www.socialmarketing.co.nz](http://www.socialmarketing.co.nz)).

Mass media are frequently used as one of the major channels of communication in social marketing intervention strategies. While the literature on depression campaigns describes mass media campaigns that have been implemented as part of an overall strategy, these are not described in terms of social marketing. Do we have something to learn from a social marketing approach?

There are many definitions of social marketing, however one of the most widely accepted is by Andreasen (1995). It is defined as:

*“The application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society” (pg 5)*

While most social marketing campaigns tend to focus on individual behaviour change, reviews consistently recognise the need for a greater focus on organisational (standards and practices, and formal and informal structures within an organisation), structural (policy, rules, laws and regulations) and environmental changes (improving availability, access, pricing, and education, as well as family support, friends, peers, social networks and norms) (Health Sponsorship Council, 2004). Therefore, social marketing is unlikely to succeed in isolation from other interventions, and if applied to a depression campaign, suggests that a social marketing approach to increase depression literacy is best supported by a comprehensive and systematic

approach that involves as number of interventions that target attitudes and behaviours.

Social marketing efforts have proved efficient and effective in areas such as sexual and reproductive health, breast cancer, and other social areas. (Social Marketing and Public Health: Lessons from the Field, cited in Health Sponsorship Council, 2004). Within New Zealand, social marketing is a relatively new and growing concept, particularly amongst individuals, groups and organisations with a desire to address social issues. Some examples of how social marketing principles have been applied successfully in New Zealand are:

- **Breast Screening Campaign** (Hughes, 2004): Awareness of advertising has been tracked for the last 4 years. It shows that:
  - 94% of women are aware of the programme
  - Prompted recall of the advertising is 93%
  - 90% think it is important to have a regular mammogram – the attitude measure
  - 81% said they had or were likely to enrol – the intention measure
  - 62% of eligible women have been screened – the action measure.

Key learning from the breast screening campaign were:

- Social marketing must have the aim of changing behaviour
- Utilising good quality research particularly during the planning stages of the campaign makes positive results much more likely
- Different phases of a campaign require different approaches. This is particularly true if the goal is behaviour change. The early adopters only need to hear about the issue and as long as they are not put off in some way, they will go along with it. The next group will often need more convincing so they will need to be given more information. And to enrol the next group an appeal to something deeper is required.
- Funding for social marketing needs to be sustained over time. Monitoring a range of measures over 4 year indicates that they drop when the advertising is not running.
- **Sunsmart Campaign** (Health Sponsorship Council, described on [www.socialmarketing.co.nz](http://www.socialmarketing.co.nz)): This campaign aims to increase sun protective behaviors of children (under 12 years) and their caregivers. Sun protection population monitors undertaken in 2000 and 2003 suggest increased uptake of sun protection behaviours in this period, specifically;
  - An increase in the proportion of people who wore a hat in the weekend prior to being interviewed.

- An increase in the proportion of people who wore sunscreen in the weekend prior to being interviewed and this is especially evident among 12 to 14 year olds.
- An increase in the proportion of people who used SPF 30+ sunscreen in the weekend prior to being interviewed.
- An increase in the proportion of people who said they had never been sunburnt.

Key learnings from the sunsmart campaign were:

- When the budget is small and unable to sustain multiple target audiences, it is important to have a clear focus, with a clear direction for the future of the issue.
- As New Zealand is largely one communications environment there must be collaboration at the delivery end so that messages are consistent and not competing.
- It is important to engage organisations outside health that play a significant role in the issue of sun safety.

Any social marketing campaign conducted in New Zealand also needs to reach different ethnic and socio-demographic group. For example, the women the breast screening campaign was trying to reach was diverse. They varied considerably in their social and economic status and ethnicity and the task was to find some common ground. However, different messages were required to reach different audiences. For example, in response to the Maori focus group an additional advertisement was produced which focussed on the importance of women for the Whanau and being there for their mokopuna (Hughes, 2004).

New Zealand Quitline also sought to reach different ethnic groups through different television advertising campaigns. Wilson (2004) examined the effectiveness of different advertisements used in a TV campaign to motivate smokers of different ethnic groups to call the NZ Quitline. One of the advertisements in the campaign was entitled 'It's about Whanau', designed to cover a broader range of smoking and health issues, and have wider health benefits through strengthening whānau, whakapapa and other aspects of cultural identity.

The author identified a number of factors that appeared to be associated with increased effectiveness of call generation by different ethnic groups over a 2 year period:

- Use of the most effective TV commercials (TVC) (identified by number of calls generated one hour post screening to Quitline)
- Use of particular channels (e.g. TV1 and Prime)

- Placement of TVCs within particular types of programmes (e.g. those with a special interest for a Maori audience)
- TVC placement at the start of the week and on particular days
- TVC placement during the day time (particularly around late morning and lunch time).

In other areas of health, a multi-media campaign was found to have had a beneficial impact on reducing burn injuries among Maori children (Skinner et al, 2004, cited in Wilson, 2004). Some road safety mass media campaigns have clearly had Maori as a priority audience in select TVCs but there is no published data on the effectiveness of this campaign on Maori road crash mortality. Data from an experimental setting in New Zealand indicates that audio-visual material is perceived differently by different ethnic groups (Fleming et al 1995, cited in Wilson 2004).

## **WHAT CAN WE LEARN?**

- Social marketing (the process of using marketing concepts to change consumer behaviour for the social good) could provide an overall approach for the depression initiative, including mass media, along with other interventions.
- Social marketing incorporates a wider strategic approach (ie addresses organisational, structural and environmental issues) which could be incorporated into a NDI.
- Any social marketing campaign requires the inclusion of an appropriate and adequately resourced evaluation. (This applies to any health promotion or prevention initiative).
- Social marketing must be sustained over time to be effective.

## 17. COMMUNITY ACTION

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While community action has not been identified explicitly as a strategy within other international depression initiatives, it is an approach which may warrant further investigation. New Zealand has a strong history of community action projects, particularly in the alcohol area, and some lessons can be drawn from these projects.

Community organisation was undertaken as part of a community action project on alcohol in the late 80s in New Zealand (Casswell et al, 1989). The project was designed to address structural and policy issues in relation to alcohol problem prevention. Activities ran parallel and complementary to a mass media campaign and included:

- Attempt to stimulate discussion of alcohol policy issues in the local unpaid or editorial media (i.e. news and feature articles/commentaries in the local newspapers and on radio, letters to the editor and editorials in local newspapers, radio call-in shows) and, more generally in the community.
- Community organisers building links with local alcohol treatment personnel, but at the same time undertaking an educational role with a non-treatment focus.
- Community organisers working with existing local organisations and having input into ongoing local projects. For example, they either established or revived a local alcohol co-ordinating committee, made up of personnel from a number of social services and treatment facilities, with the aim of establishing task-oriented groups to work on a range of key issues.
- Bring to public attention the implications of increasing the availability of alcohol and alcohol advertising. For example, displays, meetings and the laying of complaints against perceived breaches of the voluntary code governing alcohol advertising.
- Promoting the availability of non alcoholic drinks
- Public speaking engagements.

The project was run in two cities (with four comparison cities) and the authors concluded that the project did indicate that an approach to alcohol problem prevention using both mass media and a community organisation approach is viable. The results suggest that during a time of increasing liberalisation, attitudes in the treatment areas held steady, while attitudes in the non-treatment areas shifted in favour of increasing liberalisation.

Hingson et al (1996, cited in WHO, 2004) also noted that community mobilisation has been effective in raising awareness of problems associated with on-premises drinking, to develop specific solutions to problems and pressure bar owners to recognise that they have a responsibility to the

community in terms of bar-related issues such as noise level and patron behaviour. Evaluation suggests that community mobilisation can be successful at reducing aggression and other problems related to drinking in licensed premises. For example, a comprehensive locally designed intervention under the Saving Lives Project, including media campaigns, business information programmes, speeding and drunk driving awareness days, speed watch telephone hotlines, police training, high school peer-led education, college prevention programmes and other activities, led to a 25% decline in fatal crashes, a 47% reduction in the number of fatally injured drivers who were positive for alcohol, a 5% decline in visible crash injuries and an 8% decline in crash injuries affecting those aged 16–25 years.

Based on several years of experience with implementing community action projects, the optimum elements were identified by Conway et al (2003). These included:

- Realistic objectives and timeframes negotiated and reviewed regularly with all stakeholders
- Community readiness to be engaged in community action or sufficient time, allowed for initial development work to build community capacity including infrastructure to support the project,
- Development of a partnership/relationship between community organisations and evaluators, building on the strengths of each partner
- Designated community organisers working from a supportive local community organisation base.
- Strategies developed and delivered by the most appropriate ethnic group to ensure cultural knowledge for better reach, engagement and uptake.
- Research data/evidence, critical feedback, local knowledge and experience brought together to develop project strategies and activities, responsive to the political, social and economic context.
- Focus on specific environmental strategies for structural change
- Intersectoral collaboration with key stakeholders
- Use of local media to raise community awareness and informed debate
- Supportive national level mass media debate, social marketing strategies and policy framework.

Similar factors for success were identified in a meta analysis of community action projects which provided evidence of the factors that enable or inhibit effective community action (Greenaway et al, 2004). An evaluation of community based injury prevention projects also identified some of the above as key success factors (Coggan et al, 1998).

Like Minds have used several such approaches in its work, such as strategies developed by Maori for Maori, and community partnerships to plan and deliver activities.

## **WHAT CAN WE LEARN?**

- It appears that elements of a community action based approach may be useful for inclusion in a national depression initiative.
- Lessons from the evaluation of community action projects which could potentially be relevant to a NDI include:
  - Community partnerships can be an effective mechanism to plan, develop and deliver activities.
  - Community strengths and assets should be developed to enable local communities to undertake local delivery.
  - Activities should be developed and delivered to and by appropriate ethnic groups.

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