

Preventing depression: a challenge for the Australian community

Prevention is feasible by providing quality interventions at key moments

EACH YEAR, MORE THAN 800 000 adults¹ and 95 000 children and adolescents² are affected by depression. Depression is already a leading cause of both disability and premature mortality,³ and is likely to be second only to cardiovascular disease within 20 years.⁴ Even if effective treatments were provided to all those affected, the overall burden of depression may still only be reduced by 50%.⁵ By international standards, Australia spends a small proportion of its healthcare budget on mental health services (less than 7%), compared with more than 10%–12% in the United Kingdom, Canada and New Zealand.⁶ Before we spend more, however, we need to determine what priority should be given to the search for preventive strategies, new treatments, or new ways of delivering existing treatments.⁷ There is a clear need to move from simple advocacy for more services to a wider population health-based research and evaluation agenda. Australian research in psychiatry has previously neglected these key aspects, particularly for depression.⁷ This population-based need has been defined by the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health,⁸ and the National Action Plan for Depression.⁹

This Supplement brings together Australian experiences with specific depression prevention programs, and focuses on their strengths and their limitations. Although the move to depression prevention is very attractive in theory, currently we have a patchy evidence base and a lack of professional, clinical and government commitment to the implementation of population-based interventions.¹⁰ There is an urgent need to identify not only what interventions work, but also who is required to deliver them, at what cost, and if there are any unforeseen consequences such as increased stigma or discrimination.

The range of genetic, developmental, family, social and current environmental factors implicated in the genesis and recurrence of depression is large. However, this situation is not different from other common medical disorders, such as type 2 diabetes.¹¹ Our challenge is to identify the risk-reduction (such as teaching cognitive-behavioural or parenting skills) and protective (such as increasing social connection or increasing exercise) strategies that can be implemented broadly to achieve the greatest benefit.¹²

In this Supplement, some of the relevant settings for intervention are highlighted, including medical settings such as presentations to primary care¹³ and antenatal care.¹⁴ The personal aspects of postnatal depression are poignantly described.¹⁵ Additionally, the effects of interventions in key non-medical settings, such as primary and secondary schools, are discussed,¹⁶ and the limitations of such approaches in “real-life” settings articulated. Contentious issues, such as the introduction of screening and the relative priority to be given to identifying and treating people who

are already symptomatic,^{10,13,14} are presented. The combination of the population burden due to depression and the evidence for effects in people with existing symptoms argues strongly for a need to promote screening in combination with skilled interventions in both medical and non-medical settings. The introduction of such procedures, however, poses important ethical and service-access questions. This debate is no longer focused on whether we can screen or provide effective interventions, but rather whether sufficient education, information, treatment and social systems are in place to provide a sustained benefit. Prevention of depression requires an educated community,¹⁷ as well as serious government and professional commitment to improved access to effective social and non-pharmacological strategies.

It is salient to note that over the past 50 years there has been a probable shift in the demographic profile of those at greatest risk for depression.¹⁸ Older people who

are in good physical health now appear to be at lower risk than in the past. However, there are still further clear opportunities for prevention in later life, based largely on reducing vascular and other neurological risks.¹⁹ Unfortunately, younger people now appear to be at increased risk of a range of adverse mental health outcomes, including depression and anxiety, alcohol and other substance misuse, and suicide.^{1,2,20} Opportunities for prevention clearly exist in early life and through the primary²¹ and secondary school years.^{10,16} The challenge here is to identify the relevant societal sectors to deliver such interventions, and to ensure that people who may benefit are not stigmatised by such strategies. There are now clear and exciting opportunities for prevention based on electronic communication technologies such as the Internet.²² Australian innovations in this field offer particular opportunities for quality interventions to broad population groups, including people who are disadvantaged by distance or other economic or social barriers.

The systematic evaluation of both broad community strategies and more targeted interventions should remain a priority.¹⁰ Depression prevention is feasible if we focus on providing quality interventions to targeted populations at key moments along the known paths to illness onset or recurrence. The strategies described in this Supplement should be at the forefront of national planning, professional education and community engagement. What has often not been present is the combination of professional willingness, community leadership and national focus to achieve these goals. *beyondblue: the national depression initiative* (www.beyondblue.org.au) supports such national efforts for both the immediate and longer-term benefits to the Australian community.

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