An Extract from the Report on The Depression Awareness Research Project

Suresh Sundram
Neil Cole, Maggie McGuiness,
Anthea Rutter, Kylee Bellingham,
Catherine MacBean, Tom Trauer and
Wayne Chamley

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Executive Summary

Major depression was globally the fourth leading cause of disease burden in the world in 1990 and is projected to become the second leading cause by 2020. In Victoria it was the leading cause of non-fatal disability in 1996. This great burden is contributed to by a lack of recognition of the features of the disorder and a delayed or absent help seeking response. It is anticipated that improving this poor mental health literacy about major depression will increase early recognition and appropriate help seeking. This, in turn, will reduce the morbidity and mortality associated with this disorder and will result in improved health outcomes for individuals, their families and communities.

The Depression Awareness Research Project (DARP) was undertaken by the Mental Health Research Institute of Victoria (MHRI) and funded by *beyondblue* between 2001 and 2004 to develop, implement and evaluate a model to improve community literacy about major depression. Further, this model was envisaged to be effective, time and resource efficient, sustainable and adaptable to local and specific community needs. A community based approach was used and partnerships established with the following local community organisations in metropolitan, regional and rural Victoria:

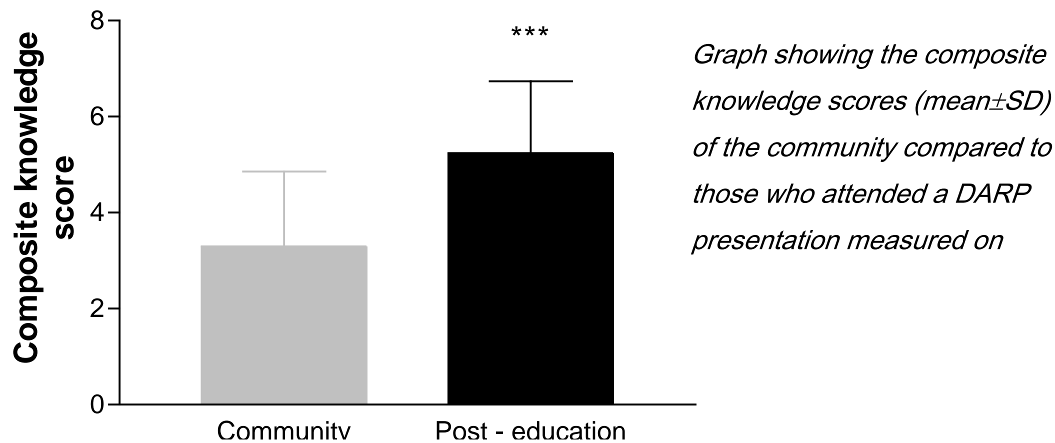
- Aspire – South-West Victoria
- City of Yarra Council – City of Yarra
- Pathways Rehabilitation and Support Services – Geelong
- Prahran Mission Uniting Care – Cities of Stonnington and Glen Eira
- Southern Mental Health Association – Cities of Kingston and Bayside

(NB. Southern Mental Health Association is now known as Reach Out Southern Mental Health.)

The model involved the recruitment and training of community volunteers as educators to present information about major depression. These educators would tailor the material in a manner suitable for their local community and present this information back to the community. A project coordinator was appointed in each region to recruit the educators and support them in their presentation activities. The project was evaluated for the effectiveness of the training program and the effectiveness of the model in improving mental health literacy within the community.

The project trained 218 volunteers to be educators in the five regions. These educators gave 449 presentations to an estimated audience of 7540 people within their communities. Of this estimated audience it was possible to measure knowledge levels about major depression from 5443 people immediately before the presentation and from 2413 people on average 17 weeks after they heard the presentation. To determine if the model was effective a composite score derived from the survey questions was developed to measure knowledge about major depression. The maximum score was 8 indicating a high knowledge about major depression. A general community telephone survey of knowledge about major depression in the selected regions prior to DARP revealed a knowledge score of 3.30 ± 1.56 (mean ± standard deviation). The audience who listened to the presentations had a knowledge score of 3.75 ± 1.91 immediately before hearing the presentations. However on average 17 weeks after hearing the presentation, audience

members scored 5.24 ± 1.50 on the composite knowledge score. Therefore, 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 about major depression than the general community (see figure). As a before and after (mean=17 weeks) comparison of this audience group this amounted to a 25% increase in knowledge. Interestingly and importantly, although not explicitly tested for, there was no apparent effect of length of follow up on knowledge levels suggesting that knowledge gained in this way was not quickly forgotten.



Graph showing the composite knowledge scores (mean±SD) of the community compared to those who attended a DARP presentation measured on

To our knowledge of the published literature these data represent the most effective campaign to improve literacy about major depression undertaken and evaluated. The DARP has created an effective and well-liked training program that is flexible to individual community needs and that forms the basis for a model that is easily implemented in metropolitan, regional and rural areas in partnership with local community organisations. Most significantly it increased knowledge about major depression for sustained periods of time that ultimately may lead to earlier recognition and appropriate help seeking behaviour for individuals and their families suffering from major depression resulting in better outcomes for those affected and their communities.

Key recommendations:

1. The DARP as tested in this report be implemented broadly as part of a state and national plan to increase mental health literacy about major depression.
2. The DARP be explicitly adapted and tested in target groups, for example, adolescents, men, the elderly, culturally and linguistically diverse communities and indigenous communities as a pilot prior to full implementation in these groups.
3. The DARP be adapted and piloted as an even simpler version potentially suitable for remote or developing communities.
4. Any further implementation of DARP be rigorously monitored and evaluated.

INTRODUCTION

Scope of Major Depression as a problem

It is not possible to find a true measure of the misery that major depression causes. This is because the suffering is personal, private and strikes at the core of what it is to be human. It is also, as the novelist William Styron describes, "…as to verge close to being beyond description"(1). It is in the very nature of this isolation and incomprehensibility that major depression reverberates through families, loved ones, friends, work, study – life in all its facets. Add to this the startling fact of its lifetime incidence of one in five individuals and the multiplication of its effects with the number of people afflicted we can begin to see the total burden of this illness upon Australia and the world.

Using economic based indicators, major depression is the fourth leading cause of disease burden in Australia at the present time, accounting for 3.7% of the total burden. If suicide is taken as an attributable burden and if self-inflicted injury is included, as the majority of these individuals experience major depression, then major depression rises to third place. This accounts for 5% of the total burden of disease and injury in Australia(2).

In one year about 6% of Australians experience ill health due to major depression. In women, major depression is the third most common cause of illness and in men it is the tenth most common cause. In calculating the average numbers of years that a person lives with a disability, mental illness accounts for over 27% of those years. The World Health Organisation (WHO) and the World Bank have indicated that major depression will be one of the greatest health problems in the world by 2020, as well as being the second largest cause of healthy years of life lost due to disability and mortality. This cost of major depression is attributable to affected individuals being unable to perform their usual tasks, even more so if associated with a physical illness and the low rate of help seeking behaviour (3). Only forty percent of affected people had consulted their general practitioner and it is unknown how many were accurately assessed and treated (3).

Tackling Major Depression – National Mental Health Strategy

The National Mental Health Strategy is an agreement between the Commonwealth and all State and Territory governments and its main aim is to improve the lives of people with a mental illness. Although it recognises that people with severe mental illness will require hospitalisation, the emphasis of the strategy is to treat and support people with a mental illness in their own communities.

The National Action Plan for Depression is a major initiative formulated under the second National Mental Health Strategy. The Action Plan aims to reduce both the prevalence and impact of major depression in Australia and sets out target areas where this can be achieved. It recognises that the problem of major depression is much larger than simply treating depressed people. It is important to take action before major depression occurs, to assist people to recognise major depression early when it does occur, to encourage appropriate help seeking, to reduce the stigma and discrimination that people experience and to ensure that the help they receive is effective and based on current research and understanding (3).

Preventative strategies for major depression

There are several ways in which depressive disorders and symptoms can be modulated depending upon severity. These are as follows:

- Modifying where possible the specific risk factors that influence the development of disorders.
- Enhancing specific protective factors that help people reduce their vulnerability to major depression.
- Developing awareness that the earlier people recognise symptoms and seek treatment, the more effective the outcome may be.
- Helping those individuals and specific groups who are at higher risk of developing depressive disorders to minimise risk factors and enhance protective factors.

This involves the implementation of interventions to increase protective factors and decrease risk factors for major depression across each stage of the lifespan and across a range of community settings, including education, employment, family, and health(4).

Aims of the Depression Awareness Research Project

Utilising some of the characteristics and avoiding some of the limitations in the projects above-mentioned, DARP aimed to develop, implement and evaluate a community model that had the potential to be economically viable, time efficient, sustainable, capable of responding to community needs as well as being able to engender a community sense of learning and support.

Therefore, the Depression Awareness Research Project aimed to:

- Develop a model incorporating local communities to improve literacy about major depression that was effective, time and resource efficient, sustainable and adaptable to local needs.
- Develop a feasible method of implementation adaptable to a variety of organisational structures
- Implement the model across relatively diverse regions and populations within the state of Victoria
- Evaluate the baseline levels of literacy about major depression within each community prior to implementation of the model (in conjunction with beyondblue).
- Evaluate the effectiveness of the model in improving literacy about major depression.

The Depression Awareness Research Project

Outline

The Depression Awareness Research Project (DARP) was conducted over three years between 2001 and 2004. The DARP aimed to develop, implement and evaluate a community focused model to increase awareness about major depression. This model endeavoured to be economically viable, time efficient, sustainable and capable of responding to community needs and of engendering a community sense of learning and support. The DARP model used local community members to develop their own community's awareness of major depression. In this approach voluntary participants (educators) were recruited from five diverse regions in Victoria, Australia and were trained to disseminate basic messages about major depression using their community networks. These messages were:

- Major depression is common
- Major depression is an illness not a character flaw
- Major depression is serious
- Major depression is treatable

The training was conducted over three rounds in each region (two rounds in Yarra) by mental health professionals (psychiatrist and psychologist); those with a personal or family experience of major depression and specialist trainers. Information was provided about these core messages and educators took part in training exercises and discussions about how these messages could best be taken to their local communities. They were then supported by a local project co-ordinator in disseminating this information within their established community networks.

The key tenets of this project were that it improve mental health literacy about major depression in the general community; that it be able to be undertaken by local community organisations with minimal specialist mental health input; and that whilst maintaining a core evidence-based format it be sufficiently flexible and sensitive to accommodate to local community resources, characteristics and base-line knowledge levels. These tenets allow local communities to be active participants in gaining and sharing health knowledge.

To strengthen this community focus, MHRI formed collaborative partnerships with five community organisations; a local municipal council, three non-government psychiatric disability and rehabilitation support services and a multi-sectored charitable organisation in the five target regions (two inner-urban, one suburban, one regional, one rural/regional). The organisations and their respective target regions for this project were:

- Aspire: South-West Victoria - rural/regional
- City of Yarra council: City of Yarra – inner-urban
- Pathways Rehabilitation and Support Services: City of Greater Geelong - regional
- Prahran Mission Uniting Care: Cities of Stonnington and Glen Eira – inner urban
- Southern Mental Health Association: Cities of Kingston and Bayside - suburban

A local project co-ordinator based with each partner organisation was responsible for the recruitment and support of participants in performing their presentations and implementing some evaluation processes in the target region.

The evaluation components of the project were both quantitative and qualitative in nature:

Quantitative assessment of knowledge about major depression:

- Baseline community survey conducted by *beyondblue.*
- Educators before, after and six months after training conducted by coordinators.
- Audience before and after (mean=17 weeks) receiving presentation by educator conducted by educator and MHRI.

Qualitative evaluation of DARP participants and stakeholders

- Effectiveness of training questionnaires
- Interviews with educators about their experience with DARP
- Interviews with coordinators regarding their role with DARP
- Interviews with partner organisations regarding their experience with DARP.

Development of package

Survey of pre-existing materials and development process of the package

During the development of the training package, the DARP sought to draw together and refer educators to pre-existing resources that would effectively communicate information about major depression. A wide range of mental health information, including books, information brochures, websites and resources from other awareness and training programs were reviewed to advise the content, format and resources used in the DARP.

Content
Four fundamental concepts concerning major depression were extracted following an extensive review of the literature and evidence-based treatments for the disorder. These four concepts were then distilled into easily comprehensible and straightforward messages:

- Major depression is common
- Major depression is an illness, not a flaw
- Major depression is serious
- Major depression is treatable.

Further, these four key messages were consistent with the philosophies of the partner organisations and concordant with the funding body *beyondblue's* other promotions and projects.

Given the difficulties in presenting potentially complex information about a psychiatric disorder to widely heterogeneous audiences, focusing on four simple messages served to establish a 'common denominator' between all educators and regions and ensure some consistency in the information being disseminated. Furthermore, the simplicity of these messages helped lessen educators' expectations and anxieties that they be experts on major depression. While the information presented at the training covered some of the complex issues related to major depression in order to cater for various knowledge and skill levels within each training group, all information presented was centred on these key messages.

Skills training
Once educators had the requisite information about major depression they needed training to develop the skills to impart this information to other members of their communities. The skills training component of the package, the communication module, was developed by VICSERV, the peak body for psychiatric disability rehabilitation and support services which has a well-regarded training and professional development unit.

Adult learning principles guided the development of the communication module, recognising that individuals bring their own experiences, needs, meaning systems and expectations to any learning situation. The module worked to strengthen the interpersonal skills of the educators and help them to identify and address local factors which would impact on their capacity to make presentations. The trainers used group exercises, role-play and group discussions throughout the training days to enhance the learning of the potential educators. A sense of belonging and camaraderie was fostered between the educators so that they could offer support to one another when they were delivering their presentations. The module included information on adult learning and community development principles, reflection on participants' experience of good and bad learning situations, information on differing learning styles, a role play of a presentation and some role plays of how to deal with people who interrupt. Participants were also taught how to prepare for their talks, how to present and how to deal with the unexpected. The coordinators were available to be contacted after the presentations to offer support and debriefing where necessary.

Format
Given the diverse nature of the DARP target audiences, the training program employed a variety of formats to effectively communicate the DARP aims and messages. The use of oral, visual and experiential formats each had their own benefits and, collectively, provided a thorough but flexible training program.
- Oral presentations reached those who could not or preferred not to read, while allowing opportunities for questions, clarification and building rapport.
- Visual materials, including the use of PowerPoint screens, artwork, cartoons and diagrams during oral presentations reinforced the information. Handouts of written materials allowed participants to review and refer to information after the training and utilize resources in developing their community presentations.
- Role-plays, group discussions and ‘buddy’ systems (working with a partner educator) provided a safe environment for educators to ‘practice’ and enhance their dissemination activities and presentations.

Resources
The review of pre-existing materials also revealed the diversity of resources for mental health awareness already available. DARP was able to incorporate and promote some of the excellent resources delivered by Australian National University, Sane Australia, DARP partner organisations and *beyondblue*. However, it became apparent that many educators, even with direct or indirect knowledge and experience of major depression, were not aware of many resources readily available to them. Therefore, the DARP was in a position to not only promote key awareness messages about major depression, but also attune educators to the existing resources available to them in their local community.

Nevertheless, there remained the need to weave the breadth of information and resources together into a clear, well-defined training package. Where there were gaps in bringing the key information to a communicable level, DARP created tailor made resources. These included presentation resources and a user-friendly summary of key information. An example was the fact card DARP developed in consultation with *beyondblue* about core information that could possibly be used beyond the DARP.

The development of these aspects of the package was responsive to educator feedback. Evaluation measures and feedback from project coordinators during the time of the project allowed DARP to assess the effectiveness of the training program and package. For example, the initial guidelines for dissemination were relatively broad to allow individual educators to impart their own style and tailor their presentations according to individual and community needs/preferences. However, project coordinators’ feedback from working with educators indicated that some educators would benefit from more defined support. Therefore, more structured resources were proffered and were well received by educators. The structure provided a base for educators to work from and another source of consistency when communicating the DARP messages.

Components of the package

To achieve the aims of the DARP, a unique training program was developed conjointly by mental health professionals, professional trainers and individuals who have personally experienced the impact of major depression. The training package was specifically tailored to DARP aims to accommodate different learning styles and allow flexibility in the way information about major depression can be delivered. As such, the DARP training was presented as a two-day group program with information and skill training sessions (Refer to Appendix 1 for program agenda).

The separate 'Information' and 'Communication' modules were developed to equip educators with basic knowledge and skills to assist them in disseminating information about major depression within their local communities. The emphasis in both modules remained on publicising the four fundamental messages about major depression.

Information module

The information module developed and presented by mental health professionals, consumers and carers, incorporated background information to the four key messages. This information included:

- Prevalence and impact of major depression
- Signs and symptoms of major depression
- Outcomes and complications of major depression
- Potential predisposing, precipitating and associated factors
- Treatments shown to be effective
- Outcomes and complications of treatment
- Resources and practical advice for those in contact with or suffering from major depression
- The personal impact and experience of major depression for individuals and families

(Refer to Appendix 2 for an outline of the aims, learning goals and content of the information module).

Two mental health professionals (a psychiatrist and psychologist) presented four information sessions under the four key messages on the first day of training. The use of two people with complementary expertise provided balance and interest by offering different clinical approaches. Each information session concluded with an exercise from the Communication module in which the participants were taken through the relevant information session with a matrix that asked, "What do I say; How do I say it; To whom do I say it; and When will I say it". This formed the basis of their presentations.

The DARP was informed both in its development and implementation by discussions with and information from consumers and carers. At each training weekend one or two people gave their personal accounts of major depression. This helped the educators witness the human effects of major depression in conjunction with the knowledge provided by the mental health professionals.

Communication module

As mentioned above, the Communication module was developed to strengthen the communication and interpersonal skills of the educators and included information on adult learning and community development principles and differing learning styles. Group exercises, role-play and small and large group discussions helped participants to:

- Reflect on their own experience of positive and negative learning situations and also on community attitudes about mental illness, particularly major depression
- Identify local factors (for example cultural, geographical) that might influence their capacity to disseminate the key messages
- Consider methods of delivering information that were most appropriate for their style and the intended audience
- Learn strategies for preparation of talks and making presentations and for dealing with interruptions and unexpected situations
- Begin developing the framework for their community presentation
- Begin to develop the skills to feel comfortable in giving public presentations.

(Refer to Appendix 3 for an outline of the aims, learning goals and content of the Communication module)

An important element of the training weekends that was cultivated was a sense of belonging and camaraderie between educators so they could support one another when they were delivering their presentations. The educators were encouraged to discuss any fears of talking in public, of being part of a research project and of being able to cope with questions and stories from their community audiences. These issues were dealt with at length and this section of the communication module was tailored to meet the local needs.

A professional trainer with a background in mental health conducted these sessions, in conjunction with the local project coordinator. The presence and participation of the local project coordinator provided consistency for the educators throughout the project and in supporting the dissemination process. Project coordinators had the opportunity to build rapport during the two training days and many ideas and issues that arose could be followed through post-training.

Written materials and 'accessory' components

All topics presented during the training program were reinforced with written materials. Each participant attending the DARP training received the DARP package of written materials containing:

- A spiral bound, indexed handbook containing all the information presented at the DARP training
- Supplementary information, including booklets on the treatments and family impact of major depression, and resource lists relevant to local areas
- Presentation materials, including specifically designed fact cards for distribution at community sessions, overhead transparencies or

PowerPoint slides, checklists and suggestions for community presentations
- Evaluation materials

These materials were particularly relevant post-training to reinforce information and assist dissemination. They were especially well received when participants required more structure as a base to developing their own style of presentation.

Partnerships

Selection of regions
To evaluate if the DARP model was widely applicable, it was conducted in five metropolitan, regional and rural areas within Victoria encompassing diverse cultural, socio-economic and indigenous communities. It was recognised as important to engage with community organisations that were able to provide local knowledge of health resources and community networks and basic infrastructure support (such as office space, telephone, photocopying, computer and internet access). The DARP was conducted through a partnership arrangement with four non-government service providers in the mental health field and a local government council. Each partner organisation had a full time project co-ordinator based in their geographic area.

Partner organisations in urban areas
City of Yarra: City of Yarra Council
The City of Yarra is an inner urban municipality of Melbourne created in 1994 from a merger of four former municipalities (population 70,000). It is densely populated with a high proportion of residents in public housing estates, a median gross weekly household income of $970 and has 8000 registered businesses. Yarra is also culturally diverse with a large population of Vietnamese and Indo-Chinese origin and approximately 30% of residents born outside Australia and 50% with at least one parent born outside Australia.

Local government was identified as potentially a key player for health promotion because of their extensive local knowledge, pre-existing health networks and infrastructure. The DARP team was eager to explore whether their apparent status of not being aligned to a mental health service could potentially reduce the stigma that could attach to such aligned organisations. Therefore, successful implementation could provide a model for subsequent involvement of other local councils. The City of Yarra was deemed as having these characteristics within an inner city municipality of great diversity within metropolitan Melbourne and agreed to be involved with DARP.

Cities of Stonnington, Glen Eira and Port Phillip: Prahran Mission Uniting Care
A second urban target region of Melbourne encompassed inner eastern municipalities (population 296,000) with a predominantly English speaking population and median gross weekly household income between $1000 and $1499.

Prahran Mission Uniting Care (Prahran Mission) is a not-for-profit service provider for these local government areas. Prahran Mission runs a large range of services in the area of community psychiatric disability support including drop in centres, support groups, rehabilitation programs, prevocational training and employment access. Such an organisation had an established culture of providing health related services, local knowledge of communities and was able to provide infrastructure support.

Cities of Kingston and Bayside: Southern Mental Health Association
The local government areas of Kingston and Bayside comprised the third Melbourne urban target region for DARP, more specifically suburban (population 220,000). A large majority of the population were born in Australia and only speak English and an excess proportion of those are aged over 60 years. Median weekly household incomes vary widely between $700 and $1499.

The Southern Mental Health Association (SMHA) was the partner organisation for DARP in this region. SMHA provides programs and services to people with psychiatric disability and to their carers. It has the ability to provide a broad range of supports and interventions to people with a psychiatric disability, especially in collaboration with other organisations.

Partner organisations in regional and rural areas
City of Greater Geelong: Pathways Rehabilitation and Support Services
The City of Greater Geelong is located 85km south-west of Melbourne, incorporates Victoria's largest regional city and covers an area of 1247 square kilometres. With a population of over 200,000 residents, approximately 30,000 residents (15%) were born outside Australia. Median gross weekly household income for the area is between $700-$999. Local industries include motor vehicle manufacturing, petrol refining and metal manufacturing.

The DARP partner organisation for this region was Pathways Rehabilitation and Support Services. Pathways is a community-managed agency offering a wide range of community based rehabilitation, social, vocational and recreational support programs for people aged 16-65 who are experiencing problems as a result of mental illness.

South West Victoria: Aspire
The DARP targeted a rural region of south-west Victoria incorporating five shires of an area of 23,200sq kilometres and a population of approximately 100,000 people. Although the training was located in the main regional centres of Portland, Warrnambool and Hamilton, the emphasis was to attempt to recruit educators from the rural centres. The median weekly household income ranged from $500-$999. The main industries are agriculture (mostly dairy) and some manufacturing and marine fishing.

The DARP partner organisation for this region was 'Aspire. Aspire is a non-profit, non-government community organisation formed in 1989 to provide community based support and rehabilitation services for those affected by mental illness. The comprehensive services provided by Aspire in south west

Victoria include support and rehabilitation, supported housing, respite, drop in and day programs, home based outreach, planned respite, a carers service, Koori (indigenous population) support program, health promotion and education. The DARP operated out of the Warrnambool and Portland offices.

Structure of relationships

Steering Committee

To oversee the implementation of DARP a steering committee was formed consisting of the senior DARP investigators from MHRI, senior representatives from the funding organisation *beyondblue* and each of the partner organisations. This committee met quarterly throughout the length of the project to ensure the project achieved its targets and timelines. The committee was particularly valuable in fostering a sense of collective responsibility for the success of the project. The committee was governed by Memoranda of Understanding between MHRI and *beyondblue* and MHRI and the partner organisations.

IMPLEMENTATION OF DARP

Ethical Considerations

Ethical permission to conduct the project was obtained from the relevant body, the NorthWestern Behavioural and Psychiatric Research and Ethics Committee auspiced by the Research Directorate of Melbourne Health. This was to recruit participants to be trained as educators, their quantitative and qualitative evaluations and the quantitative evaluation of audiences.

Selection of Co-ordinators

A local project coordinator was appointed to each region. These coordinators were either seconded from the partner organisation or employed directly by MHRI and all were based locally with the partner organisation. It was believed important for the success of the DARP that the coordinator was a local person, based in a community organisation and connected to local networks to promote a sense of community ownership of the project.

Project coordinators had the tasks of working with community networks to promote the DARP and link educators with potential audiences, recruit educators and organise training facilities. The coordinators also supported educators as they developed and initiated community dissemination activities, and coordinated the collection of data from these activities to the central research office at MHRI (An overview of tasks for project co-ordinators is listed in Appendix 4). The vital role of project coordinator required communication, organisational and marketing skills, balanced by sensitivity to individual educator and community idiosyncrasies. However, the largest challenge confronting DARP was the dual roles that project coordinators undertook balancing the need to gather consistent and reliable data versus

the implementation of the community development model. To facilitate this dual role it was deemed important to instigate a reporting and supervisory structure back to the coordinating centre to ensure a consistent implementation and evaluation across all regions. This supervisory structure was put in place to ensure coordinators felt supported and worked with a set of goals and processes which were common to each area.

Selection of Educators

Recruitment selection criteria and methods of determining suitability
An important determinant for the success of DARP was the recruitment of adequate numbers of participants to be trained as educators. A variety of recruitment strategies were used across the regions, such as local media coverage (newspaper and radio), approaches to organisations for interested people and word of mouth. An information kit was sent to individuals and agencies expressing interest in the DARP.

With these strategies there was minimal difficulty in recruiting the requisite number of participants and most had a personal or close-hand experience of depression. However, the coordinators reported a number of shortcomings with this relatively non-selective process in round one. These included participants unwilling to initiate dissemination activities for the following reasons; feeling overwhelmed by the task; struggling with depression personally and thereby finding the task confronting; or having overly high expectations regarding the expertise with which they were to deliver information, hence avoiding presentations. The most common hindrance to dissemination was a lack of established community networks.

In response to these issues, the recruitment and selection of participants for rounds two and three training were more rigorous and expectations were clarified from the outset. Selection criteria were tightened to include only those who were linked to established community networks, were willing and had time to share the DARP information within these networks.

Essential criteria for DARP participants in rounds two and three included:
- Living, working or studying in DARP target areas
- Willing and able to access existing community networks within the local target areas
- Willing and able to attend a two-day training program and participate in DARP activities for six months after training (for up to 20 hours per month)
- Willing and able to initiate presentations to individuals/groups and share key awareness messages about major depression
- Understanding of evaluation procedures to be followed

Desirable criteria included experience of public speaking.

All potential participants were required to meet with the local project coordinator for a selection interview to ensure they had an accurate understanding of the project requirements and criteria. Occasionally, in the rural region, a phone interview was conducted where geographical distances

made it difficult to meet personally. A standard interview question sheet (see appendix 5) was developed with coordinators for the selection interview process in all regions. Questions were based on selection criteria and asked in the same way for each person while secondary questions arising from their answers gave further indications of the person's ability to participate. The DARP plain language statement and consent forms were discussed, emphasising the need for MHRI to obtain informed consent and carry out evaluation procedures. Project coordinators discussed with participants concrete strategies and timeframes for accessing networks at the selection interview.

Project co-ordinators also discussed the selection of potential participants with the training and operations manager to make a consensus decision about selection. All interviewees were notified of the outcome of their interview. Selected participants received a letter of invitation to attend designated training days and a plain language and consent form to be returned in the enclosed reply paid envelope. Only subjects who met all these criteria and were able to provide written informed consent were eligible to be involved and trained as educators.

Ongoing participation in the DARP required attendance at the entire DARP training program, willingness to engage with other participants during the training program, individual presentations to reflect, and be consistent with, the four key DARP messages and attendance at post-training meetings.

Training Days

Preparation of Educators

Prior to training, project coordinators completed a 'Depression Literacy Survey' (DLS) with potential educators by telephone. The first of three DLS completed by each educator, this survey was designed to provide some baseline data on the educator's level of knowledge of major depression. This contact was also used as an opportunity to motivate and ensure the educator's commitment to the DARP.

Venue and format

Training venues were hired at private conference or community centres, or generously donated by local governments and partner organisations. The suitability of venues varied in different regions and different rounds with regard to space, seating, catering and logistical support. The venue was required to provide a comfortable space for up to 30 people, audio-visual facilities, breakout rooms, appropriate food for lunches and breaks and parking facilities for participants. It was considered important to convey to the participants that their voluntary donation of time and effort was valued by the project and amenities, where possible, were chosen to reflect this

Structure of the training days

On the first morning of the training weekend the participants were formally introduced to the DARP and then were taken through team building exercises from the communication module. It was recognised that developing a sense of camaraderie in the educators would encourage them to support one another both in writing their talks and in presenting to their communities. It was also essential to develop a bond between the coordinator and the community educators. There were also exercises in Adult Learning Principles, Community Development, Learning Models and Training methods.

The four information sessions on major depression followed interspersed with small group work to consider and process the information in a way suitable for each educator's presentations. The first day concluded with a role play of a presentation.

At the first session on the second day the participants were given time to discuss how they felt following the intensive information sessions on the first day. This was followed by presentations from consumers and/or carers which always elicited questions and discussion and, often, life stories from the educators. Time was allowed for people to consider this very emotional section of the training. The remainder of the second day was taken up with further outlining of the community presentations, workshops on public speaking, presentations and group work. The second day concluded shortly after lunch with completion of the DLS and training evaluation forms.

Presentations

Following the training weekend educators returned to their communities and with the support of their coordinators were expected to present the information learnt about major depression to their target groups. The support provided by coordinators was not proscribed by the project, as it needed to account for local factors such as geography, community networks and infrastructure and the individual capacities and requirements of the educators. A brief outline of some of these implementation issues are presented below.

Approaches to potential audiences

In identifying potential audiences some educators had very clear targets whereas others needed suggestions and some strategies to approach and book presentations. This second group was assisted by the coordinators who were able to facilitate this to some extent by providing lists of potential groups who would welcome presentations. This was controlled through the coordinator to prevent organisations being inundated with requests from educators to do presentations. Coordinators, in some regions, also rang groups in their communities requesting a time to do a presentation and then recruiting a suitable educator. In this regard, some coordinators believed it was important to get educators presenting as soon as possible after training to maintain their enthusiasm for the task.

Role of Co-ordinators

Generally the role of the coordinator was to recruit, support and encourage the educators in fulfilling their task of presenting. For some educators, the presentation was easy, for others extremely daunting. Most coordinators attended at least the first presentation by an educator and some coordinators attended most of their educators' presentations. There were two reasons for this. Firstly to show encouragement and interest and secondly to suggest, if necessary, tips on how they could improve, or better engage the audience. Coordinators also provided practical support, additional information and materials to educators to use in their presentation as requested by the educators.

Post-presentation support

A calendar was kept of all the educators' presentation dates so that the coordinator could contact the educator (if they were not at the presentation) after the event to see how s/he went. A check was also made that they had enough information fact cards and other materials for the next presentation. Each educator was encouraged to contact the coordinator as often as they wanted. This was also important for potential debriefing or requests for health information where audience members may have requested such information. Any requests for information that coordinators were unable to address were referred to the DARP team at MHRI.

Educators were strongly encouraged by the coordinators to participate in some follow-up activities to gauge and foster the level of implementation of DARP within the communities These activities were:

- A group meeting with fellow educators 4-6 weeks after training arranged by project coordinator. These meetings became essential in maintaining enthusiasm and a corps d'esprit and some coordinators held them bi-monthly for each round of training (6 months).
- Respond to communication with the local project coordinators at least once a month by phone or face-to-face. This was increased in some regions to weekly and became an important gauge as to the likelihood of an educator being a successful presenter.
- Complete and forward log sheets of community presentations and respective audience survey forms to the local project coordinator in a timely manner
- Attend a final face-to-face interview with project coordinator approximately six months post training and participate in the designated evaluation activities.

Discussion

The Depression Awareness Research Project was undertaken by the Mental Health Research Institute of Victoria through funding from *beyondblue* to develop, implement and evaluate a community based model to improve literacy about major depression. This model aimed to be effective in its primary aim of increasing knowledge about major depression but had secondary aims of being time and resource efficient, sustainable and adaptable to local and specific community needs. To underpin its effectiveness and efficiency aims it clearly needed to be uncomplicated, well liked and acceptable to broad sections of the community. The outcomes of these aims will be discussed below.

Community

The community DLS was performed so as to determine what the knowledge levels about major depression were in the DARP regions prior to implementation. This also provided a helpful comparator for evaluating the characteristics of educators and to determine the effectiveness of the DARP in increasing knowledge levels in the audience sample. It must be remembered, however, that due to the small scale implementation of the DARP, the community DLS, if repeated, cannot be used in isolation to evaluate the effectiveness of the DARP due to its sampling size.

All DLS were based, in part, on an initial national survey conducted by beyondblue (Highet et al. 2002) to which the community DLS may be compared. The composite knowledge score was constructed by the DARP and was not recorded in the survey conducted by Highet et al. (2002) precluding a simple comparison between the DARP regions in Victoria and the national study. On individual question comparisons, the national survey recorded mental health as an identified major health problem by 3% of the sample but by 7.4% of the DARP community sample. 39% of the national sample identified depression as the major mental health problem compared to 44% of the DARP sample. No data was presented from the national study on symptoms and the DARP community sample could only list 1.33 core symptoms and 0.19 associated symptoms. Of note, is the 15.7% response rate listing low mood as a symptom. This may indicate that people assume this is inherent within the name and do not differentiate it from the clinical disorder. If this is the case then it could usefully provide a target for public health campaigns. Identical percentages in both surveys, 36%, listed the correct prevalence for the disorder as 1 in 5. More in the community survey, 56%, suggested professional help than in the national survey (28%), however, the questions were worded slightly differently. Interestingly, attitudes towards treatment were roughly similar and overall it would seem the community survey broadly reflected the national findings without it being possible to statistically test this.

Educators

As stated above the recruitment of educators was relatively straightforward indicating a ready pool of interested volunteers. When stricter selection criteria were applied this marginally decreased the number of volunteers. There was, however, also an exhaustion effect with decreasing numbers expressing interest in each successive round. Hence it may be necessary in any subsequent implementation of the DARP to appropriately space training rounds within any circumscribed region. This spacing could sensibly be a minimum of 12 months but may need to be longer depending upon the size of the target community.

The volunteers who were willing to be trained as educators, not surprisingly, knew 33% more than the community about major depression and rated both mental health and major depression as key health issues. This may have been due to their much higher level of personal experience of the disorder and their wish to learn about it and this, in turn, may explain the preponderance of females. Mean age comparisons were not possible but the increased proportion of educators within the middle age spectrum parallels the increased working proportion compared to the community sample and may reflect community trends in volunteering. The lack of retired educators was somewhat surprising but could possibly signal the perceived lack of relevance of mental disorders to older Australians (Highet et al. 2002), a decreased recognition of major depression (Fisher and Goldney 2003), or the stigma of mental illness in this age group.

When examining individual questions, the educators knew more than twice as many symptoms as the community and more correctly identified the prevalence rate, expected findings given the interest to participate and the high level of personal experience. They were, however, much less likely to suggest a family member seek professional help or to provide a helpful action. This is a baffling finding that is not easily explicable given the very high rate of personal experience of major depression and may suggest some hopelessness or futility concerning help from a personal perspective. This explanation does not, however, easily accord with the approximately 90% who identified antidepressants, psychological therapies and counselling as effective treatments. These responses, especially for antidepressants, are far in excess of other published studies (Paykel et al. 1998) and may well be due to personal experience as might their greater knowledge of resources for major depression.

Conducting the DLSe immediately after the training program was simply to determine if the program was effective in teaching the educators about major depression. This was the critical and fundamental basis for the DARP for if the educators did not obtain sufficient knowledge about major depression then it would not be possible for them to effectively educate their communities. The increase in the composite knowledge score of 40% is a good indicator that the training program achieved this goal especially around the 4 key messages about major depression. Of note, were the large increases in the number of symptoms identified, the correct prevalence, the likelihood of

recovery and number of identified resources. However, the most dramatic increase was in the number who now would recommend that a family member seek professional help (31.9% to 88.1%) and may underscore the importance of having mental health professionals educate on and demystify the process of diagnosis and treatment.

The training program was universally well received with most educators finding it informative and interesting. Both professional and personal accounts of major depression were highly rated by the educators and perceived by them as of greatest relevance to their task. It would seem these elements need to be reproduced in any subsequent program. The training package was also considered by educators to be useful and provided them with the requisite resources for their own presentations. The program devoted some time to explanations around the process for evaluation of the audience, which may not be necessary for the subsequent implementation of the DARP. This will result in considerable time savings, however, it is imperative to remember that this does not mean any change in the content or duration of the training program.

The final quantitative evaluation of the educators was performed approximately 6 months after the training program to measure the retention of knowledge in the educators. Using the composite knowledge score there was no deterioration of knowledge concerning major depression (6.18 to 6.14 ns) although there was variation around individual questions. This is a remarkable retention of information. Given the drop out of educators from the post training to the follow up (24% were not followed up) and that the majority of those who presented were followed up (88%), then this retention of knowledge may reflect a practice effect associated with educators rehearsing information for their presentations. In contrast, the majority (69%) that were not followed up also did not do presentations and if followed up may have shown a much greater degree of knowledge decay even though their pre and post training composite scores were not different from the followed up group.

This is supported by the observation that the group of educators who did not present and were followed up scored a significantly lower mean composite knowledge score compared to those who did present. The most critical factor regarding educators was that their composite score before training strongly predicted their overall impact. It is not possible from the collected data to determine conclusively the factors responsible for this important finding. However, it may suggest that those who know most about the disorder are those who are also most motivated to increase awareness. This indicates that it may be possible to screen volunteers, if so desired, to select and train those with the highest knowledge scores in an attempt to improve the efficiency and success of the program. Although, this may be feasible for large scale implementation programs it needs to be considered against the potential disenfranchising of rejecting some volunteers.

The interaction of the partner organisation, the educator and the particular geographical region in which the DARP was located all had an effect on how the project was implemented. It was clear in local government that the intent

of the DARP had not been communicated by management throughout the organisation, so that the very stigma of depression that the project was set up to ameliorate was perpetuated as some staff felt they would be targeted as a sufferer of depression if they attended the talks. For the country regions, the community development approach was of paramount concern to the partner organisations and the main object of the DARP to concentrate on numbers of presentations and questionnaire completions became secondary. However, for those agencies concerned, the project was seen as successful as it has provided some networks and community resources. The project which displayed the most elements of success in terms of the DARP requirements was the Kingston-Bayside site where the goals of DARP, the local coordinator and the partner organisation were in harmony.

The tight timelines for the project rounds, the late start of round one and the inability of the project to give talks in government schools were a source of frustration for coordinators and community educators alike. Possibly more ground-work could have been put in prior to DARP's commencement in this regard.

A positive side of the project was the frequent meetings of the educators when these were organised by the coordinators. (This was difficult in the South West owing to the geographical distances). The get-togethers were beneficial as they made the educators feel valued and part of a team, as well as giving them a forum to air concerns or share ideas with others.

Overall, it could be concluded from the qualitative and quantitative data presented that the DARP training program was effective, efficient, well liked and suitable to the vast majority of attendees. Furthermore, it was equally well received and effective in metropolitan, regional and rural areas of Victoria. Therefore, based on these findings it may be concluded that the DARP training program (in the described format) is valid to implement as the basis for a literacy program for major depression.

Audience

The audience that attended presentations by educators was different from the community sample. Similar to the educators, the audience tended to be female, in the middle age cohorts and working, although there was little difference in the retired group. They were less likely to be young and studying. This may be explained, in part, by the ethical exclusion of all those under the age of 18 years and all school children. It may also, however, reflect a bias in the model. Although the DARP was implemented in a variety of socio-demographic regions, there was no provision to develop anything except a single model and this was necessarily based upon accessibility to the mainstream. Therefore, the recruitment process for educators may have been biased in attracting particular groups of individuals who, in turn, would present to their peers. The DARP team always considered such a bias and the training program was devised so as to try and permit flexibility and adaptability to other groups. This flexibility and adaptability was not, however, systematically tested within the current project due to the constraints of the

project size. Any adaptation to particular groups would require alterations to the training program, package and implementation tailored for the relevant groups, for example young people, men and culturally and linguistically diverse groups. It is critical to stress two points; firstly, that any such modifications have not been evaluated; and secondly, that audiences did incorporate many of these groups indicating a relative rather than absolute bias.

The project audience prior to hearing the presentation scored higher on the composite knowledge score than the community sample (3.75 to 3.30). This was across a variety of the questions including symptoms, prevalence rate and resources. They were less informed about psychological therapies and counselling and were more cynical about alternative and self help treatments. The difference in knowledge scores may have been attributable to the demographic differences described above or, possibly, that the audience that attends a presentation on major depression may already possess more interest and knowledge or that there was a priming effect. It was not easily possible to distinguish between these options.

There were major differences between those in the audience who consented to be followed up after hearing the presentation and those that did not. The consenters were more likely female and less likely to work full time but the groups did not differ on age. The consenters were, however, much better informed about major depression than either the non-consenters or the community sample based on mean composite knowledge scores (4.14, 3.23, 3.30) even before receiving the presentation. This may well indicate that the consenters were interested and primed about major depression. This in turn raises the possibility that they may have paid more attention and thereby acquired more information than those who did not consent to be followed up. Of course, this hypothesis cannot be tested and based on the available data it is not possible to explain the difference between these two groups nor whether this difference influenced the final outcomes. Again, the consenters who could actually be followed up scored slightly but significantly higher than those who were not followed up on the composite knowledge score. The non-completion rate of 22% was not excessively high for studies of this kind and it would seem unlikely that this difference would markedly alter the final outcomes.

The ultimate measure of the DARP model was whether those who attended a presentation given by an educator acquired and retained information about major depression. Using this most rigorous measure (paired pre/post comparison) the DARP model led to a 25% increase in knowledge about major depression that was highly significant ($p<0.001$). Furthermore examining the effect of length of follow up on retention of knowledge using two methods showed no appreciable decay of knowledge with time with a mean follow up of 17.5 weeks. This increase in knowledge was not in symptom recognition but in knowing more about available resources, appropriate treatments and services and identifying the correct prevalence rate.

When compared to the community sample, this group scored 59% higher in their composite knowledge score reflecting increased knowledge in symptoms, prevalence, resources, appropriate treatments and services. To our knowledge, there are no other similar projects that have been evaluated with the only published pre/post-education design being the Defeat Depression campaign in the UK (see introduction), although this was a media based approach to the whole community (Paykel et al. 1998). This study reported maximal changes in the order of 5-10% for the variables examined, considerably less than the effects we have documented with the DARP. One comparison that highlights the success of DARP is that in the Defeat Depression campaign 60% of people rated antidepressants as helpful after the campaign compared to 86.9% of our audience completers. Although this needs to be viewed in the light of the different approaches mentioned above it is a telling indicator of the effectiveness of the DARP model at a community level.

Ultimately, the success of public literacy campaigns such as DARP is whether they influence earlier recognition and appropriate help seeking behaviour at an individual and family level and decrease stigma at a community level. To evaluate these outcomes require a much greater scope and were beyond the means and mandate of the DARP. The success of DARP, however, now provides a vehicle through which such a public health initiative in major depression could be implemented. This should be conceived of in the same context as drink driving and anti smoking campaigns, however, requiring a conceptually different approach. We believe we have developed such an initiative and look forward to developing its implementation.

Based on our findings we believe that the following four key recommendations can be justifiably drawn from this report based upon the research conducted:

1. The DARP as tested in this report be implemented broadly as part of a state and national plan to increase mental health literacy about major depression.
2. The DARP be explicitly adapted and tested in target groups, for example, adolescents, men, the elderly, culturally and linguistically diverse communities and indigenous communities as a pilot prior to full implementation in these groups.
3. The DARP be adapted and piloted as an even simpler version potentially suitable for remote or developing communities.
4. Any further implementation of DARP be rigorously monitored and evaluated.