



**Learning Guide:  
Another Shade of Blue –  
Depression in Older Australians**

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produced in association with  
*beyondblue: the national depression initiative*

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## Additional resource

***A Guide to Facilitating Adult Learning*** is a booklet developed by the Rural Health Education Foundation to support the facilitation of discussions with small groups. It covers the basic aspects of how people think and learn, how to conduct groups and facilitate learning in face-to-face settings. It is designed to provide some basic instructional information to assist people facilitating face-to-face learning.

We encourage you to read this booklet before you work with groups as a guide to facilitate the learning guide discussion. Extra copies are available from the Rural Health Education Foundation at [www.rhef.com.au/programs/learning-guides/](http://www.rhef.com.au/programs/learning-guides/) or *beyondblue* at [www.beyondblue.org.au](http://www.beyondblue.org.au)

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# DEPRESSION

## NOTES

Depression is more than just a low mood – it's a serious illness. People with depression find it hard to function every day. Depression can have serious effects on physical and mental health.

Depression in older people is common and can have different causes. The onset of a physical illness or personal loss and sadness may contribute to depression, but depression is not a normal or inevitable part of ageing.

Older people may be depressed, if **for more than two weeks** they have:

1. Felt sad, down or miserable most of the time OR
2. Lost interest or pleasure in most of their usual activities AND
3. Experienced symptoms in **at least three of the following four categories:**

### **1. Behaviour**

- Stopped going out
- Not getting things done at work
- Withdrawing from close family and friends
- Relying on alcohol and sedatives
- No longer doing things they enjoyed
- Unable to concentrate

### **2. Thoughts**

- "I'm a failure."
- "It's my fault."
- "Nothing good ever happens to me."
- "I'm worthless."
- "Life is not worth living."

### **3. Feelings**

- Overwhelmed
- Guilty
- Irritable
- Frustrated
- No confidence
- Unhappy
- Indecisive
- Disappointed
- Miserable
- Sad

#### 4. Physical symptoms

- Feeling tired all the time
- Sick and run down
- Unexplained headaches, backache or similar complaints
- Churning gut
- Sleep problems
- Loss or change of appetite
- Significant weight loss or gain

Everyone experiences some or all of these symptoms from time to time, but when symptoms are severe and lasting, it's time to seek professional help.

Dementia can also co-exist and mask depression, so a thorough assessment is recommended.

Early detection and treatment may help to keep depression from becoming severe. It is important to be aware that depression is treatable and effective treatments are available.

#### What makes an older person more at risk of depression?

- An increase in physical health problems/conditions, e.g. heart disease, stroke, Alzheimer's disease
- Chronic pain
- Side-effects from medications
- Losses: relationships, independence, work and income, self-worth, mobility and flexibility
- Social isolation
- Significant change in living arrangements e.g. moving from living independently to a care setting
- Admission to hospital
- Particular anniversaries and the memories they evoke

#### How common is depression?

Depression is very common. Over one million Australian adults live with depression each year. On average, one in eight men and one in five women will experience depression in their adult lifetime.<sup>1</sup>

For more information about depression, anxiety and related disorders – including *beyondblue's Help for depression: What works for older people* handbook and Fact sheet 17 Depression in older people – visit [www.beyondblue.org.au](http://www.beyondblue.org.au) or call the *beyondblue* info line **1300 22 4636** (local call cost from a landline).

<sup>1</sup> Australian Bureau of Statistics, 2008. 2007 National Survey of Mental Health and Wellbeing; summary of results. ABS Cat. No. 4326.0. Canberra: ABS.



NOTES

# HOW TO USE THIS LEARNING GUIDE

## NOTES

This **Learning Guide** has been designed with a framework and activities that can be used to facilitate a group discussion on the key issues raised in the program.

### Session planning

When planning a session, allow time for:

- viewing the particular DVD chapter as the prompt to the activity
- delivering the background material provided in each section.

As a guide, each session could be delivered in a two-to-four hour workshop.

The activities in the Learning Guide are short and not intended to present a full story. Rather, they provide a stimulus for participants to think about the information and the issues that arise.

The case studies and activities provide an opportunity to relate information to real-life situations and to use the content to build skills in reflective practice.

The following table presents an overview of the activities in this Learning Guide. Activity time is based on having five to six members in the group. Activities with larger groups are likely to take up to twice as long.

### Activity schedule

Activity Time	Activity	Page
20 minutes	<b>1. Case study: Sally Garrett</b>	<b>11</b>
10 minutes	<b>2. Risk factors</b>	<b>12</b>
10 minutes	<b>3. Telling my story</b>	<b>16</b>
30 minutes	<b>4. Recognition and assessment of depression in older people</b>	<b>19</b>
20 minutes	<b>5. Determining the depressed person's degree of morbid preoccupation with death</b>	<b>20</b>
30 minutes	<b>6. Differential diagnosis, best practice and treatment</b>	<b>23</b>
10 minutes	<b>7. Role of carers</b>	<b>24</b>
20 minutes	<b>8. Peer education – <i>beyond maturityblues</i></b>	<b>25</b>

## NOTES

<sup>1</sup> Australian Bureau of Statistics, 2008. 2007 National Survey of Mental Health and Wellbeing; summary of results. ABS Cat. No. 4326.0. Canberra: ABS.

<sup>2</sup> Challenge Depression Project, Australian Government Department of Health and Ageing, 2001  
<http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Mental%20health-3>

<sup>3</sup> Australian Institute of Health and Welfare. 2008. Australia's health 2008. Cat. No. AUS 99. Canberra: AIHW

<sup>4</sup> Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V. & Ustun, B. 2007. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet*, 370, 85 – 858.

## PROGRAM SUMMARY

### NOTES

One in five Australians is reported to be affected by a mental health condition.<sup>1</sup> Depression in older people is common and may occur for a range of reasons.

Depression rates are higher in residents in aged-care facilities than in community populations, with as many as 51 per cent of high-care and 30 per cent of low-care residents reported as being depressed.<sup>2</sup>

These figures highlight the significance of mental health issues for older people and the health care professionals who care for them. Access to appropriate services and a team-based approach to care is paramount to achieve the best outcomes for individuals affected.

According to recent research, depression is a leading cause of disease burden<sup>3</sup> and it is now regarded as being more damaging to health than some major chronic diseases.<sup>4</sup> Depression is a common condition that affects all age groups in the Australian community, but is often unrecognised, misdiagnosed or untreated in older Australians. The signs and symptoms are often accepted by health professionals and older people themselves as a normal part of the ageing process.

#### **Depression is not a normal part of ageing.**

Depression is an illness that can have serious consequences if not treated.

The common symptoms of depression include:

- loss of interest in life
- poor sleep
- poor concentration and memory
- apprehension
- chronic unexplained pain.

These symptoms can be incorrectly attributed by health professionals to old age, dementia or just poor health. Generally, older people are less likely than other age groups to report or even acknowledge being sad, down or depressed.

*Another Shade of Blue* aims to provide information to rural health professionals on best practice, multi-disciplinary interventions for depression in older Australians, including older Aboriginal and Torres Strait Islander People and older people from culturally and linguistically diverse (CALD) backgrounds.

This program aims to challenge misconceptions about ageing and depression and to help promote a better understanding of depression to older people in practice settings. It encourages health professionals to promote a healthy and active lifestyle and a positive approach to ageing.

## NOTES

### Learning outcomes

After watching the program, you will be able to:

- discuss the stigma associated with older people and depression
- undertake informed prevention and early intervention strategies with older people
- recognise more effectively, assess, treat and manage depression in older people
- evaluate issues relating to older Aboriginal and Torres Strait Islander People and culturally and linguistically diverse Australians who are at risk of or who are experiencing depression.

#### Key messages from the program

- *Depression is not a normal part of ageing.*
- *Depression is an illness and should not be seen as a weakness.*
- *Treatment and support are available for people with depression.*

DVD Program Duration: 68 minutes

## The Panel

### Dr Norman Swan (Chair)

Presenter of the *Health Report* on ABC Radio National

### Professor David Clarke

Professor in the School of Psychology, Psychiatry and Psychological Medicine at Monash University, and Research Adviser to *beyondblue: the national depression initiative*

### Associate Professor Gerard Byrne

Psychiatrist, Head of Psychiatry, The University of Queensland

### Dr Jane Sims

Psychologist, Senior Research Fellow, Healthy Ageing Research Unit, Monash University

### Ms Trudi Sebasio

Social Worker, Principal Adviser Indigenous Mental Health, Northern Area Health Service, Queensland

### Dr Jill Benson

Director, Health in Human Diversity Unit, The University of Adelaide

## SECTION 1: INTRODUCTION, CLASSIC PRESENTATION AND RISK FACTORS

### NOTES

#### **Activity 1: Case study: Sally Garrett**

Sally lives in Tasmania and was a professor of nursing at La Trobe University. She has a history of depression related to chronic illness and as a side-effect of the medication used to treat her illness. Sally is currently a member of *beyondblue's* older person's reference group and has been an advocate for older people in Tasmania.

In small groups, discuss the major issues raised in Sally Garrett's interview and the implications for your practice.

#### **Key issues to discuss**

- Chronic illness
- Drug therapy and side-effects
- Unsuccessful procedures
- Ageing – slow to mend physically and mentally
- Treatment for depression
- Fragmented care – need for holistic care
- Feeling powerless
- Stigma of obesity
- Need for empathy and compassion

#### **Panel discussion**

How does depression fit the spectrum of mental health disorders and is it different for older people?

Sally provides a classic presentation of depression in an older person:

- depression that arises in the context of a series of serious physical problems and treatment, in this case with steroids, which can commonly precipitate mood disorder
- the psychological impact of the treatment that she has received by various doctors, specialists and GPs
- several co-morbid conditions that are chronic and progressive.

#### **Difficulty in diagnosis**

It is often difficult to diagnose depression in older people and it can be missed easily. Often when a person has an overwhelming number of conditions, it is very hard to work out if the person has depression or if the low mood is part of the stress, difficulty and the grief associated with other ailments that are part of the illnesses. Also, Sally would have been in pain. Medications have side-effects that may make her tired, but in this case, tiredness is not necessarily a symptom of depression. There are a lot of different things that could have been happening.

## **Risk factors**

Older people may be at risk of depression due to:

- an increase in physical health problems such as heart disease, stroke and dementia
- chronic pain
- side-effects from medications
- losses/adjustment issues – relationships, independence, work and income, mobility
- death of a spouse or family members
- social isolation
- injury through falls
- significant changes in living arrangements, such as moving from independent living to a care setting
- admission to hospital
- loss of independence and control (particularly within the medical system)
- particular anniversaries and the memories they evoke.

However, none of these alone causes depression. For example, it's normal to grieve for a loved one, but if the grieving persists and becomes a risk factor for depression, it must be recognised and treated.

## **Activity 2: Risk factors**

In small groups, discuss:

- the risk factors
- how you have identified these risk factors in the past
- what you might do in the future to look out for these risk factors in your daily practice.

## **Depression in older Aboriginal and Torres Strait Islander People**

In general, Aboriginal and Torres Strait Islander People experience chronic illness around 20 years earlier than other Australians. 'Older', among Aboriginal and Torres Strait Islander People, means 55 years and over.

Due to the range of chronic illnesses that Aboriginal and Torres Strait Islander People usually experience, depression is often the last thing to be diagnosed.

In diagnosing depression, it's important to create an opportunity for the person to tell his/her story: let the person talk about what's going on in his/her life, rather than asking direct questions.

## **Prevalence**

There is currently no specific data available on the prevalence of depression in older Aboriginal and Torres Strait Islander People. The 12 month prevalence in the general population is about 6 per cent i.e. 6 per cent of the population will have depression in a year. The prevalence in older people (55 years - 85 years) is slightly less than the general population.

Dementia-related conditions such as Parkinson's disease, cerebrovascular disease, stroke and Alzheimer's disease are all associated with an increased risk of depression. Depression may be accounted for by the reaction to the development of a very serious neurological disorder or it may be partly a direct effect of damage to the brain caused by the illness.



NOTES

## SECTION 2: IDENTIFYING UNDERLYING PROBLEMS AND TREATMENT OPTIONS

### NOTES

#### **Diagnosis**

Diagnosing depression is not enough. It's like seeing a rash on the arm. You need to diagnose the underlying cause and establish the nature of the depression.

Diagnosing or recognising distress and depression is the first step. The next step is to understand why the person is depressed. A person could become depressed and feel a sense of losing control of his/her life through becoming:

- ill
- physically disabled
- financially insecure (e.g. "The farm is going badly.")
- isolated, alone or estranged (e.g. The person's family has left home or become estranged.)
- unable to manage his/her illness.

#### **Adjustment disorder and demoralisation**

People can feel helpless. If there isn't a cure for their illness, they can feel hopeless and despairing and lose self-esteem. They may become demoralised which is an important form of depression. It's commonly called *adjustment disorder*, but often adjustment disorder, the label, is trivialised as not being important. People with demoralisation can be severely depressed and not want to live. Hopelessness leads to despair and to not wanting to live.

#### **Endogenous depression or clinical depression**

There is another form of depression called *endogenous depression or clinical depression*. This is characterised by specific biological markers and particularly anhedonia i.e. the inability to experience pleasure in activities that would normally be pleasurable.

A different sort of treatment to adjustment disorder is needed here, probably a biological treatment, whereas with demoralisation there's lots of help that can be given. If a demoralised person were removed from his/her situation, morale would lift. But when a person loses the ability to experience pleasure, even if something good happens, he/she won't feel pleasure. That's a sign that something biological has happened.

#### **Grief or sorrow**

The third important category is *grief or sorrow*. This is important to recognise, because it's natural to want to do something when someone is depressed, but a loss cannot be replaced and a grief has to be felt. To assist with loss or grief, it's important to provide comfort. It's important to remember not to over-medicalise grief, especially with the use of antidepressants.

## NOTES

The picture can become very complex because in some situations a person will have elements of all three types of depression:

- grief (after an irreplaceable loss)
- helplessness and hopelessness (in a difficult situation)
- anhedonia (an internal loss of ability to experience pleasure).

Each of these requires its own treatment.

### **Activity 3: Telling my story – working with Aboriginal or Torres Strait Islander people**

#### **Role-playing in pairs**

You are a GP. An older Aboriginal or Torres Strait Islander Person has come to see you for a rare check up. Invite the person to tell his/her story.

The person has multiple chronic illnesses and is 59 years old.

Be ready for the person to tell you what is going on in his/her life rather than actively questioning and looking for symptoms. Asking direct questions may not give you the right information for an appropriate diagnosis and treatment plan.

#### **Treatment**

As the GP, you are in a good position to look at the situation and to see the whole context of the person. You will know if there's grief by the sense of hopelessness and you will be able to see the more evident forms of depression and can treat them accordingly.

For endogenous or clinical depression, medication would be suitable. For depression resulting from demoralisation, practical help is important and psychotherapies including Cognitive Behaviour Therapy (CBT) can work well. GPs can refer people to psychologists and other health professionals.

If grief is a factor in the situation, getting the family and the community to help, supporting the person in his/her grief and building up his/her social networks is important.

Both CBT and Interpersonal Psychotherapy (ITP) work with older people. If the person has a degree of cognitive impairment, CBT may be less effective. There is still more to learn about CBT and ITP in older people with cognitive impairment. Older people also tend to be less ready to engage with psychological or 'talking' therapies.

## NOTES

Older people could be made more aware of the effectiveness of IPT and CBT and understand how they could be helped by this treatment.

Much of the trial evidence relating to treatment of depression suggests that the combination of an antidepressant, such as an SSRI and one of the psychotherapies is better than either of these strategies alone. If people are demoralised and getting anxious because they feel they can't control the situation, providing information, reassurance, practical help and good pain relief treatment will contribute to relieving symptoms of depression.

When looking at ways of managing people, it's not a question of choosing one particular type of management – you may consider a range of options. If a person has a number of physical health conditions, it may be appropriate to add a physical activity program. GPs have that opportunity with the *Life Scripts* program which helps in managing the depression and the physical health of the person. Physical symptoms may be improved by a physical activity program which can also improve symptoms of depression. Further information about *Life Scripts* can be found at [www.health.gov.au/lifescrpts](http://www.health.gov.au/lifescrpts)

Often, health professionals are cautious about prescribing physical activity to older people, particularly when they have a range of co-morbidities. It's a matter of tailoring an appropriate program. Similarly, if you are considering using CBT or IPT as the main treatment, you will need to tailor these therapies to the older person and take into account their receptiveness to these methods. It's often easier, particularly in very old people or people with some mild cognitive impairment, to apply the behavioural components rather than the cognitive components.

Behavioural components would include things like scheduling pleasurable activities.

### **Drug therapy**

SSRIs are often the first line of choice in antidepressant medication as they are tolerated better than tricyclics by older people. Mirtazapine, which isn't an SSRI, is another option.



NOTES

## SECTION 3: HISTORY TAKING, ASSESSMENT AND MANAGEMENT APPROACH

### NOTES

#### **Activity 4: Recognition and assessment of depression in older people**

##### **Case study**

Spiro is a 70 year old man who was born in Greece. He migrated to Australia in the 1960's and now lives alone in a rural town. His wife died five years ago and he gave up his business shortly after. His three children live in the city and have professional careers.

He presents to his GP asking for something to help him sleep and complaining that he has no appetite. He says he feels lethargic and aches all the time. He has a history of high blood pressure and arthritis. He's on an ACE (angiotensin converting enzyme) inhibitor and a non-steroidal, anti-inflammatory medication.

In groups of three to four, discuss the management and approach you will take with Spiro. Report back to the larger group and consolidate the key points for management.

##### **Panel discussion – key considerations**

###### **Step 1 – Take a good history**

- Rule out some chronic diseases.
- Rule out some acute diseases.
- Make sure that because he is not eating properly, he has not become deficient in iron and vitamins or he has not developed thyroid disease.
- Ensure there is no malignancy.
- Determine the cause of his lethargy and his symptoms.
- Determine the cause of the insomnia.
- Consider whether he may be depressed and if so, how severely. Is he feeling hopeless? Does he have thoughts of suicide?

###### **Step 2 – Make a diagnosis or deal with the symptoms**

If possible, we make a diagnosis. Otherwise, we try to help at the 'symptom level'.

Interventions may include:

- information about the problem
- 'sleep hygiene'
- social activation, including exercise
- reassurance and support
- medication if indicated.

### Step 3 – Subsequent consultation

It is important to help Spiro find some further meaning in his life. At a subsequent consultation, you may ask questions about things such as:

- his spirituality
- what it means for him being old and by himself.

### Risk Assessment

Older males are at high risk of suicide if they are depressed, demoralised or lonely. They are the highest risk age of all populations and five times the risk of older females. So it's important to take the possibility seriously.

### Activity 5: Determining the depressed person's degree of morbid preoccupation with death

After watching the DVD and listening to the dialogue between Gerard Byrne and Norman Swan, role play, in pairs, initiating a discussion with Spiro to determine his degree of pre-occupation with death.

Take it in turns to role play:

- a) the GP  
and
- b) Spiro as the person seeking help.

### Key points to consider in role play

You need to establish what's going through Spiro's mind.

- Are there thoughts of death?
- Are there thoughts of worthlessness?
- How is he currently feeling about his wife's death and not wanting to go on living?
- Does he think about whether he would be better off dead?
- Has he thought of killing himself?
- Has made any plans to kill himself?
- Does he have any sub-intentional suicidal thoughts? This is where people don't actually want to confront the issue of deliberately killing themselves, but might leave themselves open to the possibility of dying e.g. hitting a tree while driving on the freeway.
- What is his social support like?

Also, observe how depressed he looks and how hopeless he seems.

### **Suicide risk**

If you have someone whom you believe is at reasonable risk of attempting suicide, you need to assess that risk. If you believe the person is feeling hopeless and has a moderate intent, then he's very vulnerable, especially if he has no social support. Explore his level of intent, level of hopelessness and level of support and see whether certain supports can be put in place.

If he has no social support, you need to get external help through the Mental Health Service.

### **Guidelines for an Aboriginal or Torres Strait Islander Person**

- Allocate time to see what is going on in his/her life.
- Determine any recent losses.
- Determine what's happening with family connections.
- Be sensitive – if there's an Aboriginal Medical Service (AMS) in that town, but he/she has come to you, there could be shame and family connections in the AMS as well.
- Any visit by an Aboriginal or Torres Strait Islander Person is a good opportunity for you to do a full assessment physically, emotionally and socially and get a really good picture about what's going on in the person's life – because he/she may not come back again.
- Give the person space to tell his/her story, to talk about what's going on in his/her life. If the person walks out feeling that he/she hasn't been heard or listened to, then you have missed the mark. Similarly, don't place too much emphasis on looking for physical illness, when the person has come to you feeling depressed and/or suicidal.
- Aboriginal or Torres Strait Islander People define health and well-being holistically, therefore try to respond holistically as well, looking at a complete picture of the person's life.
- Make sure that the person is connected with someone – a support person – either with an Aboriginal Health Worker or some other support person in the family or the community.
- Ensure there is support from the extended social network if commencing medication.
- Identify and employ the resilience measures they have engaged to date e.g. their relationships with community, with other people and preferred (supportive) activities.

An important approach in the primary health care setting for depression is watchful waiting. That is, keeping an eye on a person and going on the journey with them. But the imperative for treating depression increases, the more severe it becomes and the longer it goes on.



NOTES

## SECTION 4: DIFFERENTIAL DIAGNOSIS, MEDICATIONS, PAYING ATTENTION TO CARERS AND FAMILY

### NOTES

#### **Activity 6: Differential diagnosis, best practice and treatment**

##### **Case study**

June is an 84 year old woman whose husband of 60 years died 18 months ago. June has always cared for herself and her husband and now lives alone. In the last six months, June has become more and more dishevelled, doesn't do housework, has lost weight and has forgotten her grandchildren's birthdays. The garden is dying, she doesn't have any interests any more and there is mouldy food in the fridge. She isn't sleeping for which blames her noisy neighbours and says that her garbage bin has been stolen. June says that no one cares about her and that nobody visits her, but her daughter says that someone visits twice a day.

In groups of three, discuss how you would manage June.

##### **Key management points**

- This is a short deterioration time.
- It could be pseudo-dementia.
- Use a mini mental scale to determine dementia.
- Maybe use an assessment tool to look at depression.
- Probably initially, treat as depression... watch and wait to see what happens.
- Ensure she is eating properly.
- If people are anxious but miserable, SSRIs could be used as they are good anti-anxiety drugs.
- Err on the side of caution, therefore treat the depression fairly assertively.
- Treatments for depression are better than the treatments available for dementia.
- Determine if any physical illnesses, such as Urinary Tract Infection, malignancy, vascular problem or any other pathology (acute or chronic) exists.

##### **With Aboriginal or Torres Strait Islander People:**

- Get more information from other members of the family to see what's going on. Who is the direct carer and who provides indirect care?
- Ensure that you remain sensitive to the cultural context of the person.

## Activity 7: Role of carers

In small groups, discuss the issues that the carer may have. Identify strategies to support the carer in the new role.

### Key points to consider

- The health and well-being of the other family members, their support etc.
- Social isolation of carers
- Role identity shift
- Prevalence of depression in carers is high.

### With Aboriginal or Torres Strait Islander People:

- The carer may feel or be held responsible for person's health or illness.

### Rural carers on-line

Rural carers on-line: a feasibility study was a research project funded by *beyondblue* and conducted through the National Ageing Research Institute in Melbourne with partners in rural western Victoria. This program looked at the feasibility of using an online resource to introduce the use of the internet to enhance social connectivity.

For the full report go to [www.beyondblue.org.au/index.aspx?link\\_id=6.777](http://www.beyondblue.org.au/index.aspx?link_id=6.777)

To reduce their isolation, 14 rural carers were provided with computers in their homes and six months internet access. Each carer attended a four-week training program on basic computer skills and how to use email and the internet.

It meant that carers could spend time accessing useful health information online, learning more about health conditions and activities/support they could access in their area.

It also helped carers socially because they reported being able to communicate by email with friends and family members when they weren't able to visit them. It was seen as a preventive health measure and helped reduce symptoms of depression with some trend towards improvements in social isolation.

## SECTION 5: INVOLVING THE FAMILY, COMMUNITY AWARENESS AND PREVENTION

### NOTES

#### **Activity 8: Peer education – *beyond maturityblues***

##### **Case study** (Video clip – 4 minutes)

Colin is a Peer Educator with the *beyond maturityblues* program which *beyondblue* funds through COTA (Council on the Ageing). Colin lives in Canberra and has a generational perspective of depression and mood disorder in his family. His personal experience includes growing up with a parent who had depression at a time when stigma was very common. Colin outlines his reasons for being involved in peer education and the difference he thinks it makes to older Australians.

After viewing the video clip in small groups, discuss the key issues raised and the implications of these issues for the management of the depressed older person in general practice.

##### **Key issues**

- Depression is a treatable illness
- Stigma of depression
- Early intervention
- Positive ageing
- Awareness and education
- Treating other diseases to reduce associated depression
- Diet
- Physical activity
- Connectedness
- Carers/family issues
- Carers' internet linking/resources
- Aboriginal or Torres Strait Islander-specific and culturally and linguistically diverse factors in preventing depression
- Use of health workers in Aboriginal or Torres Strait Islander communities
- Building resilience

## TAKE AWAY MESSAGES

### NOTES

#### **Professor David Clarke**

Professor in the School of Psychology, Psychiatry and Psychological Medicine at Monash University, and Research Adviser to *beyondblue: the national depression initiative*

- We need to think of depression as having different types, or at least different components, and that will guide our interventions.
- Treatments can include psychotherapies and drug treatments, but also good information and mobilisation of social resources.
- The role of the doctors and health professionals can help, but can sometimes hinder or make things worse. If we're not thoughtful, we can make a depressed person draw into themselves and feel worse.

#### **Dr Jill Benson**

Director, Health in Human Diversity Unit, The University of Adelaide

- We need to be thoughtful. We need to be aware of what we're doing ourselves especially in relation to people across cultures and in relation to people who are older.
- We also need to be listening and we need to listen well to what the issues are for the person and make our treatment person-centred.
- We need to have our bio-psycho-socio-spiritual hat on and be taking all of those things into consideration. That hat will help us diagnose and treat that patient in all of those different areas.

#### **Ms Trudi Sebasio**

Social Worker, Princial Adviser Indigenous Mental Health, Northern Area Health Service, Queensland

- GPs, if they are working with an Aboriginal or Torres Strait Islander person, need to be prepared to spend more time with them.
- We need to recognise that if we are seeing an older person, they may be 65, but they've probably had the life experiences of a person 165.
- The person needs to feel that they are valued and recognise that they are a dignified elder in their community.
- Recognise that for the older Aboriginal or Torres Strait Islander person to even come to a GP wouldn't have been an easy pathway for them.

## NOTES

### **Dr Jane Sims**

Psychologist, Senior Research Fellow, Healthy Ageing Research Unit,  
Monash University

- Older people tend to have a great deal of trust in their GP and there are great opportunities for the GP to assist, not only in providing the treatment, but also in empowering the older person.
- We live in a world where there are still very negative stereotypes about older people and those tend to compound the feelings that a person has when they are depressed.
- We need to work with the older person to bring them into the management of their condition. They are not going to cure any of their long-term physical health problems, but they're going to optimise their physical and mental health and then be able to have a better quality of life.

### **Assoc. Professor Gerard Bryne**

Psychiatrist, Head of Psychiatry, The University of Queensland

- The evidence shows that for both treatment and prevention of relapse for depression, the combination of a psychological intervention and a biological one, medication, is far more affective than either alone.
- GPs and other health professionals need to form strong therapeutic relationships with co-workers, nurses, clinical psychologists in order to be able to deliver these packages of treatment.

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