

I completed my PhD at Victoria University in 2018, focussing on the self-management of depression in older adults. For this work, I was awarded the Victoria University Medal for Academic Excellence. I'd like to outline some facts before listing several findings and implications from my study.

#### **Facts:**

- Depression is the most common mental disorder in older adults (World Health Organization, 2015).
- In developed countries, it is experienced by between 10 and 40% of community dwelling older adults (Blackburn, Wilkins-Ho, & Wiese, 2017).
- Establishing the incidence of depression in older Australians living in the community is challenging, with variability in estimates attributed to researchers' use of different instruments, sample sizes, age parameters and age-related screening bias. Hence, the estimate of up to 15% continues to be cited widely (Pirkis et al., 2009). However, it is highly likely that depression in older adults is under-estimated and under-treated.
- This is significant, because depression in older adults follows a more chronic course and higher relapse rates than depression earlier in life. Left undiagnosed and untreated, it also often produces adverse effects such as physical illness, a decline in functioning and loss of independence. There are reciprocal associations between depression in older adults and increased falls, overall frailty and greater self-neglect, and death by suicide. There are also indications of a link between long-term depression and cognitive impairment, including dementia (Do Couto et al., 2016; Soysal et al., 2017).
- Individuals and health professionals are still influenced by the erroneous belief that depression is a normal part of ageing.
- It is difficult for older adults to obtain a diagnosis and appropriate treatment for depression (Xiang, Danilovich, Tomasino, & Jordan, 2018).

#### **Findings from my Australian study:**

- Participants' symptoms were frequently attributed to age or remained undistinguished from normal ageing (Polacsek, Boardman, & McCann, 2018).
- Numerous examples were given of health professionals, especially GPs and psychiatrists, patronising participants, listening less to their views and cutting short the clinical consultation time spent with them (Polacsek, Boardman, & McCann, 2019).
- Health professionals, including GPs, frequently lacked the skills to diagnose depression in older adults, and/or confused participants' symptoms with those of physical illness.
- All had initially been prescribed antidepressants, but very few had been referred for psychotherapy. The relatively low referral for psychotherapy may reflect the erroneous belief that older adults are less likely than younger adults to benefit from this therapy.

#### **Implications:**

- Population ageing will require that healthcare systems meet the needs of a growing number of older adults with depression.
- Older adults, GPs and other mental health/aged care clinicians need to improve their understanding of the experience of depression in older age.
- Practical strategies are needed to reduce stigma and address the deleterious effects of ageism.

- Individuals and their significant others should be informed and empowered to recognise symptoms, seek a diagnosis and engage in treatment.
- At all levels of health care, the erroneous view that older adults are less functional or capable of actively participating in their treatment should be addressed.
- Despite their critical role, GPs need more education on diagnosing and treating depression in older adults in their standard practice.
- Consideration should be given to promoting the availability and increasing the accessibility of mental health nurses to provide education and support.
- We must ensure that older adults who should be receiving appropriate diagnosis, treatment and support do not remain marginalised.

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