

CADS: Carer and Depression Support Group

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This article is about a small community group of consumers and professionals working together to provide support for people with depression and their carers. The group runs regular support groups, and recently held a community forum on depression. The group is a good example of partnerships and consumer-driven services.

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There aren't many services available in rural Australia for people suffering from depression, but, when people get together and talk, more things become possible. The Carer and Depression Support Group (CADS) is an example of this. The World Health Organization Charter for Health (1978) states that "people have the right and duty to participate individually and collectively in planning and implementing their healthcare". This is also supported by the National Mental Health Strategy (Department of Health and Ageing, 2003). Many times, particularly with mental health, people do not have the opportunity to participate. A group of people had a dream in the country town where I practice and they have been able to do this.

A woman who had cared for her husband throughout his depression and suicide, and whose daughter had experienced depression, wanted to do something that was not driven by the "professionals" but was developed and run by consumers of mental health services. She gathered a small group of people, asked for some guidance from a community agency that had well-developed consumer advocacy policies and practices, and CADS was started.

An advertisement in the local paper inviting people to attend a meeting about setting up a support group for people and carers associated with depression had an overwhelming response. Over forty people attended, and they seemed starved for information. There were many stories of not being able to get help and several parents desperate to understand how they could help their depressed young adult children. Suicide rates in rural areas are high and depression a growing issue. Those of us involved in setting up CADS were excited that so many people were willing to talk about depression and mental health issues, although we found the demonstration of such

obvious needs—needs which too often seemed unmet—of some concern. My role in CADS was to "provide a little assistance to get them started", and this included facilitating that first public meeting.

The group decided that support meetings twice a month would be held, and they were supported by the community agency with a venue and advertising for the meetings until the end of the year (about six months). The agency also provided a telephone contact point, photocopying, and space in a community office with a filing cabinet.

The support group meetings were held mornings and evenings, alternating to allow maximum accessibility. They were attended by 10-16 people—not always the same people. A small group of constant people organised tea and coffee, gold coin donation, and opening and closing the rooms.

It became clear quite early that any group has to make decisions, but if there is no structure who makes the decisions? To protect the consumers a steering committee was established. Professionals were invited but there were always more consumers involved. The CADS group still operates with this steering committee under the auspice of the community agency. A manager from the agency is a member of this committee, as are three other professionals (TAFE counsellor, and two private practice counsellors), three consumers and an interested community member with expertise in printing, computers advertising, leaflet production etc. The committee meets monthly and generally operates well.

Another issue that arose was the actual running of the support groups. At certain meetings some people would not stop talking; at other meetings people attended looking for converts to religious and other causes. The consumers running the groups did not feel equipped to deal with these issues. To

overcome this problem initially we wrote to all the local counsellors and psychologists and asked them to volunteer their time to facilitate a support group. The response was, and continues to be, positive, and we are never without a volunteer facilitator. Few people have not responded to the request. This has ensured that the support groups run well, and if any people are at risk they can be assessed and supported at the time. An unintentional benefit has been that many members of the support group have enjoyed meeting professionals and getting to know them. As many of these people also work for agencies or services they have been able to provide information as well.

Our local general practitioners have also been supportive and at times attend the support group meetings to talk about a topic (decided by the group); these meetings are always well attended.

Shortly after starting the group applied for funds in the local government community grants scheme. We received \$3,500 for advertising, pamphlets, and guest speakers. As our local guest speakers all contribute voluntarily we decided to run a community forum on depression. Beyondblue had offered to contribute also, as one of the founding consumers was a consumer advocate on Beyondblue committees.

A committee of local agencies was formed, including the Division of General Practice, SNAP (support program for people with mental illness), Kilmany Uniting Care, East Gippsland Shire, Lifeline, and BOIMH (Better Outcomes in Mental Health Program). CADS consumers were also on the committee. Jeff Kennett agreed to be the guest speaker. Other speakers were a local GP, a local professor of psychiatry, and a consumer. Over 300 people attended the forum, which, in addition to the speakers, included an expo of local agencies that provided information about their services. Evaluations collected on the night indicated that, apart from the venue being too small, people were very positive.

CADS has just received some funding from the local Catholic Bishop's Trust—enough money to cover another year of advertising for the support meetings and money to pay the consumers who co-ordinate each meeting and the consumer who takes responsibility for organising the facilitators. It is a small amount of money, but it is recognition of the work that is done.

CADS is a very good example of a group of

consumers developing a service, however small, which obviously meets a need. The Ottawa Charter (WHO, 1986) has as one of its five strategies the strengthening of community action. CADS has achieved this. The outcomes of the support groups include support for people with depression and their carers, awareness of services, demystifying local professions, showing people they can do something themselves, and demonstrating this to local services. While it is not possible to measure, I believe the increased sense of empowerment, especially for the consumers involved in running CADS, has been an important aspect in their own recoveries.

There has been no systematic collection of data or evaluation about the support groups, but, anecdotally, the group has received a lot of positive comments. The people attending tend to fall into three "types": those who attend regularly, those who attend between two and four sessions, and those who come infrequently, but more than once. They also tend to be older, and predominantly female.

The group process is jointly managed by the participants and the facilitator. Typically, the facilitator welcomes everyone and asks for any news or information of interest. This may trigger a discussion. If not, the facilitator will present briefly on a topic of interest (e.g., self-esteem, anxiety management, strategies for coping) or about the agency they are from, if that is appropriate. Essentially the group process is interactive and shares information.

Group members say they find the group very supportive, and wish it had been in existence earlier. They like the sharing and getting together with others to talk about experiences and possible solutions. This is similar to the sharing of stories in narrative therapy, which many different groups have found very useful (Carey, 1998; Couzens, 1998; Wingard & Lester, 2000; Towney, 2005). For mild depression problem solving has been found to be an effective treatment (Ellis & Smith, 2002). The support groups provide this when participants talk about strategies. They also report that they like the opportunity to meet counsellors, general practitioners and others who attend as facilitators. Rowe (1983) provides information about the usefulness of support groups such as CADS, and encourages people to join and/or develop their own groups. I believe one of the best outcomes of CADS has been the reminder to the professional network of the importance of consumers' views.

Increased knowledge about depression has been found to be helpful (Bird & Parslow, 2002) and CADS, has provided this, through the support groups and the community forum. One of the offshoots of CADS has been the establishment of a similar support group in a nearby town, and this is also well supported and attended. Another offshoot for one of the CADS members has been that she now has paid part-time employment in the field.

A consumer survey held in 2001 by The Victorian Mental Illness Advisory Council (VMIAC) found that

consumers wanted more social development, drop-in support, information on services, and consumer input (VMIAC, 2001). CADS is a small attempt to do some of this. The consumers involved in CADS have often said that CADS wouldn't exist without the help of the professionals. They are wrong because the professionals would not be doing the work if the consumers hadn't asked them to. CADS is an example of a consumer-driven service that operates due to a partnership between consumers and services.

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