Comparative Health Care Analysis of Depression in the Elderly

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According to the World Health Organization (2016), “Depression is the leading cause worldwide, and is a major contributor to the overall global burden of disease”. “Cultural differences and different risk factors affect the expression of the disorder.”

**Barriers:**

- **Lack of resources** (WHO, 2016): <25% of people across the world have access to treatments for depression. Lack of psychiatrist globally. Lack of trained health care providers (WHO, 2016).

- **Lack of patients seeking treatment.** Either social stigmas or lack of knowledge (WHO, 2016).

- **Screening tools (inaccurate assessments):** WHO (2016) study found “treatment gaps” worldwide to be a medium rate of approximately 50% untreated depression.
Global Outlook

- 350 Million people suffer from depression.
- Over 800,000 deaths are reported annually due to suicide.
- Less than ½ of people suffering from depression receive treatments.
- Life span is increasing – between 2015 and 2050, the proportion of the world’s population over 60 years will nearly double from 12% to 22%.
Health Concern Comparative

Globally, depression is a general concern as lifespan increases. Depressive symptoms are an important indicator of general well-being and mental health among the elderly. *(Federal Interagency Forum on Aging-Related Statistics, 2012).*

**USA:**
- Depression is an important issue because it often goes untreated.
- Social stigma on mental illness.
- Consistency of assessment tools and medical management
- Shortage of Nurses in the mental health sector
- Untreated depression can lead to impaired cognitive ability & increased risk of serious medical issues *(NAMI, 2016).*

**Thailand:**
- Increased lifespan of Thailand pop = increased risk for depression.
- Family dynamics are changing in elderly caregiving.
- Increased health care costs for treatment of depression and increased risks of health problems related to depression such as dementia. *(WHO, 2016; Wongpakaran, 2012 )*
USA Elderly Growth

Population age 65 and over and age 85 and over, selected years 1900–2010 and projected 2020–2050

NOTE: These projections are based on Census 2000 and are not consistent with the 2010 Census results. Projections based on the 2010 Census will be released in late 2012.

Reference population: These data refer to the resident population.

Thailand Elderly Growth

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision
## Comparative Analysis

<table>
<thead>
<tr>
<th>UNITED STATES OF AMERICA</th>
<th>THAILAND</th>
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<tbody>
<tr>
<td>Projected growth = 72 million in 2030</td>
<td>Projected growth = to exceed 15% by 2020</td>
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<tr>
<td><strong>Prevalence of Depression:</strong></td>
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<tr>
<td>An estimated 11.19% over age 70 diagnosed with major depression And over 12% over age 80 diagnosed with depression (Federal Integracy Forum on Aging-rated statistics, 2012).</td>
<td>One study of 74 older adults between ages of 63-94, found that 61% has clinical characteristics of MDD (Wongpakaran, et. al, 2014)</td>
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<td>White Males &gt;85 y/o have the highest suicide rate in U.S. related to depression (NIMH, n.d.).</td>
<td>Depression ranks first in Mental health among psychiatric illnesses (Wongpakaran, 2011)</td>
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<td><strong>Gender Depression Rates:</strong></td>
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<tr>
<td>Male: 11% reported depressive symptoms Suicide = 19.4 per 100,000</td>
<td>Male: recent data unavailable Suicide = 19.1 per 100,000</td>
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<tr>
<td>Female: 16 % reported depressive symptoms Suicide = 5.2 per 100,000</td>
<td>Female: recent data unavailable Suicide = 4.5 per 100,000</td>
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Depression in the Elderly

- Episode period greater than 2 weeks
- Depressed mood or the loss of interest or pleasure in nearly all activities.
- Four of the following symptoms must be also be present.
  - changes in appetite or weight, Sleep, psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation or suicide plans or attempts.
- Depression must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Chronic major depression disorder’s (Dysthymia) criteria is two of the symptoms present over a span of at least two years.
Signs & Symptoms

- Somatic complaints (e.g., bodily aches and pains) rather than reporting feelings of sadness.
- Increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, an exaggerated sense of frustration over minor matters).
- Loss of interest
- Reduction or increased appetite
- Psychomotor changes – unable to sit still, pulling of skin, slowed speech or thinking, etc.
- The sense of worthlessness or guilt which may include unrealistic negative evaluations of one’s worth.
- Thoughts of death, suicide ideation, or attempts.
### Comparative Depression Screening

<table>
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<tr>
<th>USA</th>
<th>THAILAND</th>
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<tr>
<td><strong>Noticing SS</strong> – Caregiver/Family/Nurse</td>
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<tr>
<td><strong>Mental Status Examination (MSE):</strong> objective data about the patient.</td>
<td><strong>Village Health Volunteer:</strong> Tell results + give Psychoeducation</td>
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<td><strong>Psychosocial assessment:</strong> assessing the patient as a whole.</td>
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</table>
| **PHQ-2:** Ask two questions: 1) Little interest or pleasure in doing things 2) Feeling down, depressed or hopeless. | **Primary Care:** Screening in primary setting for risk group:  
  • Give Psychoeducation  
  • 9Q; >7 assess 8Q (Suicide) |
| **Geriatric Depression Scale (GDS):**  
  Long form contains 30 questions  
  Short form contains 15 questions | **Secondary Care: 2Q/15Q: Community Hospital in risk group.**  
  • 9Q; if > 7 assess 8Q (Suicide)  
  • Diagnose by Dr.  
  •  
    - Mild (7-12): Csg + Ed. Relative  
    - Moderate (13-18): Rx + Csg + Ed. Relative  
    - Severe (>19): Rx + Csg + Ed. Relative  
  • If no MDD, evaluate for psychosocial problem, if +, give Csg  
  • In no psychosocial problem, give education. |
|  | **Tertiary Care:** if 8Q is >17 or if 9Q is >19:  
  • Referred to Psychiatric doctor  
  • Treated by the protocol  
  • Follow-up until 9Q <9 every month  
  • After that reduce dose until stop drug |
Protective vs Risk Factors for Depression

- **Socioeconomic**: Higher education, SES
- **Spiritual/Cultural**: Religious or spiritual involvement
- **Environmental**: Healthy, Safe, Clean
- **Psychologic**: Effective coping skills, exercise, healthy eating
- **Social Support**: Healthy family dynamics and support, engaged in valued activities
# Treatment Factors for the Elderly

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<tr>
<th>Factors for Treatment</th>
<th>Challenges/Treatment &amp; Diagnosis Barriers</th>
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<tr>
<td>Depression Severity</td>
<td>Perceived stigma</td>
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<tr>
<td>Co-morbidities &amp; medications</td>
<td>Length of treatment needed</td>
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<td>Treatment side effects</td>
<td>Program expectations</td>
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<tr>
<td>Prior history of treatment response</td>
<td>Efficacy of treatment and treatment side effects</td>
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<td>Recurring symptoms</td>
<td>Accessibility</td>
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<td>DSM V criteria</td>
<td>Cost of treatment (U.S.)</td>
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<td></td>
<td>Inaccurate assessment</td>
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<td>Pre-existing cognitive impairment</td>
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<td>Transportation needs.</td>
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<td>Cultural differences</td>
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<td>USA</td>
<td>Thailand</td>
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<td>Medications</td>
<td>Psychotherapy</td>
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<td>ECT</td>
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<td>Light Therapy</td>
<td>Traditional Thai Medicine (Alternative)</td>
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<td>Alternative Therapies</td>
<td>Exercise : Elderly club</td>
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<td>Self-management strategies &amp; education</td>
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<td>Mind/Body/Spirit approaches</td>
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<td>Exercise</td>
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Thailand Case study: male in his 60’s currently diagnosis of: heart failure, hypertension, acute Kidney failure, and depression. Patient was diagnosed with depression after he stated that he wanted to die because of his quality of life and being a burden to caregiver. Patient was provided counseling and medication therapy.

US case study: veteran male in his 60’s, who after multiple surgeries and complications was experiencing issues with pain, anxiety, stress, and insomnia. There was previous history of treatment for depression. After assessments and offering referral to mental health professional, the patient declined any services.
Economic analysis has indicated that treating depression in primary care is feasible, affordable and cost-effective (WHO); therefore the nursing role can incorporate measure to lower rates and risk factors:

- Develop patient care plan: use the nursing process of Assessments, diagnosis/analysis, planning, implementation, and evaluation.
- Increased screening in the elderly
- Medication monitoring
- Incorporating cognitive-behavioral therapies in individual and family
- Evaluating family dynamics
- Advocacy
- Medical and emotional support – promote involvement of support groups, etc.
- Suicide prevention
- Educate patient and family on signs and symptoms of depression
- Teach coping skills
- Depression Health Awareness
Conclusion

Future Studies:
– Effects of interventions for depression
– Medication effects and improvements

What we have learned:
– Healthcare system protocols to treat mental health
– The nursing role at each level of care
– That Thai society upholds strong traditional values, which embrace the family support in caring for their parents as an expression of gratitude, as well as a society that has high regard for their elders.


Do you have any questions?