

Clinical Family Trace Service on Depression for Primary Care Basis

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The aging population with neurotic disorders and personality disorders in Taiwan has approached 1.2 million people in 2012. Genetics reflected by the family history is an important factor in predicting recurrence of depression, anxiety and insomnia, and the analysis of occurrences in the families. The family trace is also important for older patients with chronic diseases. Depression and chronic diseases are often correlated in clinical diagnosis. The purpose of this study was to examine the relationship between family traces and the treatment rate of older patients suffering from elderly depression and other chronic diseases (Lee, 2011). We would also provide clinic staff more effective analyzed treatment information of depressive older patients to trace patients' continuing treatment. We also supported the information associated with other common elderly chronic diseases, such as anxiety, insomnia, diabetes, hyperlipidemia, and hypertension to medical staff for their diagnosis concern and health service.

In the current study, sample data was collected from a local clinic in Taipei, Taiwan from 2006 to 2011. We obtained information on the outpatients' gender, age, clinical diagnosis and visits. This was the input of a relational database to manage and analyze clinical elderly depression data. Classification was applied to family trace and age groups---the older people(> 65), the baby boomers(47-64), and the general(< 46). The type of depression and chronic diseases was classified according to the internationally accepted standards, ICD-9 (International Classification of Diseases, 9th Revision). An evaluation by a clinical specialist was carried out to assess the quality of the patients' family tracing and depression treatment completeness. The latter was defined as monthly visits for at least 6 months. Distributions, relation and differences between depressive older patients with and without a family trace were analyzed with regard to gender, routine visits and other chronic diseases by means of SPSS 18.

There were 6,204 family identifications assigned to 52,813 patients. We analyzed 1,105 depressive patients' data from three age groups: > 65, 47-64 and < 46. Family links were found for 157 patients from these three groups (Table 1). The lower percentage of depressive older patients with family trace had a failure in treatment than without (47.06%; 57.81%) (Table 2). Among the 206 depressive older patients in the current study, 40(20%) visited the clinic merely for elderly depression without other elderly chronic diseases while 160 depressive older patients (80%) did so also for elderly chronic diseases, e.g., anxiety, insomnia, diabetes (94/47.24%), hyperlipidemia, and hypertension (65/32.66%). 6 depressive older patients were not involved since they didn't have their first visit until August, 2011. With family traced, more depressive patients visited the clinic for anxiety or insomnia (64/46.38%; 30/49.18%) than for merely depression (25/18.12%; 15/24.59%) or for other common chronic diseases (49/35.51%; 16/26.23%) (Table 3).

Family trace service would help clinic staff to follow up depressive patients' continuing treatment efficiently. In general, depressive older patients without family traced would less likely complete their treatment. Clinic staff should take suitable actions to remind them of revisit, such as telephone calls or messages, appointment sheets, and appointment packs in which national health insurance cards, appointment sheets, patient instructions and medicine are put.

However, this study had limitations. First, our study subjects were only from a local clinic in Taipei, Taiwan from 2006 to 2011. Second, at least 6 monthly visits might not be qualified enough to access the real treatment completeness because of various severances of depression. Therefore, further

study with suitable treatment completeness and with larger samples, especially those chosen from other clinics, general hospitals and multi-centers in different regions, are warranted.

Table 1. Data of depressive population collected from a local clinic in Taipei, Taiwan from 2006 to 2011

		Total Heads (Ratio%)	Older Heads (Ratio%)	Baby Boomer Heads (Ratio%)	General Heads (Ratio%)
		1,105 (100)	206 (18.64)	423 (38.28)	476 (43.08)
Family traced	With	626 (56.65)	139 (67.48)	244 (57.68)	243 (51.05)
	Without	479 (43.35)	67 (38.20)	179 (42.32)	233 (48.95)
Gender	Male	278 (25.16)	59 (28.64)	111 (26.24)	108 (22.69)
	Female	827 (74.84)	147 (71.36)	312 (73.76)	368 (77.31)

Table 2. Treatment style data of depressive older patients with and without a family trace

Treatment Tyle		Family traced		
		n(%) (N=200)	With	Without
Completed	Male	51 (25.50)	38 (27.94)	13 (20.31)
	Female	41 (20.50)	30 (22.06)	11 (17.19)
		48 (24.00)	34 (25.00)	14 (21.88)
Not completed	Male	17 (8.50)	12 (8.82)	5 (7.81)
	Female	31 (15.50)	22 (16.18)	9 (14.06)
		101 (50.50)	64 (47.06)	37 (57.81)
Failed	Male	29 (14.50)	19 (13.97)	10 (15.62)
	Female	72 (36.00)	45 (33.09)	27 (42.19)

Note: Patients who took continuing treatment for 6 months were regarded as “completed treatment”; those who only took continuing treatment less than 6 months were regarded as “not-completed”; and those who only showed less than 3 times were regarded as “failed”. Patients who took treatment after August 1, 2011 weren't counted in this study.

Table 3. Data of other common elderly chronic diseases among depressive older people (N=200)

Family traced	Treatment styles	Depression	Depression with Anxiety or Insomnia	Depression with (Anxiety or Insomnia) and Chronic Diseases
		n (%)	n (%)	n (%)
		40 (20.00)	97 (48.50)	63 (31.50)
With (N=136)	Completed(N=38)	4 (10.53)	15 (39.47)	19 (50.00)
	Not completed (N=34)	3 (8.82)	14 (41.18)	17 (50.00)
	Failed (N=64)	19 (29.69)	34 (53.13)	11 (17.19)
Without (N=64)	Completed(N=38)	2 (15.38)	7 (53.85)	4 (30.77)
	Not completed(N=34)	1 (7.14)	7 (50.00)	6 (42.86)
	Failed (N=64)	11 (29.69)	20 (54.05)	6 (16.22)

Note: Patients who took continuing treatment for 6 months were regarded as “completed treatment”; those who only took continuing treatment less than 6 months were regarded as “not-completed”; and those who only showed less than 3 times were regarded as “failed”. Patients who took treatment after August 1, 2011 weren't counted in this study.

References

- Lee, I. C. (2011). The Emotional issues and mental health of the elderly. *Taiwan Journal Of Gerontological Health Research*, 7(1), 1-32.