

Depression and Anxiety in the Elderly: Formulation and Development of Preventive Model through Community Participation

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The objective of this research was to formulate and develop a caregiving model for the elderly with depression and anxiety, using collaborative action research. The research was done in 6 provinces from 4 regions in Thailand (Northern, Central, Northeastern and Southern). There were three parties involved in the action research: (a) researchers from Srinakharinwirot University; (b) nurses and healthcare officers, Village Health Volunteers (VHV) or Eldercare Volunteers; and (c) in-home caregivers. From the study, the findings found that the development of caregiving model and mechanism for depression and anxiety prevention could be varied into 6 approaches according to the areas where the studies were conducted. Nevertheless, the formats and mechanisms often shared common characteristics in terms of the way they were operated or driven by an individual, group of individuals and agencies through different activities. They shared the same objective in providing proper mental health care for the senior citizens to continue leading a happy and comfortable life. In conclusion, each community has its own specific format of eldercare. Moreover, elderly care relies on strengthening collaborations and continuum.

Keywords: caregiving, senior citizens, prevention, depressive, community

Thailand has entered into the period of aging society since 2005 as a result of dramatic decrease of Thai population's birth rate and the development of medical technology and healthcare, consequentially resulting in the population's improved health and longer life. In 2014, the report on situation of Thai elderly by the Foundation of the Thai Gerontology Research and Development Institute (FTGRDI) together with the Institute for Population and Social Research, Mahidol University, Thailand, revealed that there are over 10 million Thai senior citizens, which account to 15% of the country's population while the ratio of Thai citizens in the working age (15-59 years) and senior citizens is 4.3 to 1, respectively. In 2021, Thailand will become a "complete aging society" with 20% of the population being over 60 years of age. The current average life expectancy of Thai population is 75 years (Prasartkul, 2015).

Thailand's transition into aging society has intensified the importance of elderly care as a key to improve the senior citizens' quality of life, including their physical and mental health. The physical health of elderly people is in the deteriorating stage where indications of illness are observable, allowing immediate help and treatment or proper medical care that needs to be provided. Changes in mental and emotional conditions may be harder to observe or understand. Additionally, some senior individuals still feel the connection of friendship with those who may live in different places and times. On the contrary, some people look at the past with a sense of despair, regretting the mistakes they have done. The feeling of

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despair also involves anger, which may be expressed as hatred and insults towards others as a way to hide their own low self-esteem (Kroger, 2016; Wrightsman, 1994). As a result, elderly people may suffer from a great sense of despair that can affect their psychological well-being and lead to outcomes such as depression and anxiety. Equally important to a healthy physical condition is a good mental health, and people in the elderly's life can help prevent such symptoms from causing any harm to their lives.

Effectiveness and quality of elderly care therefore depend on a network of the family members of and individuals who are close to the elderly. However, when considering the living condition where elderly people share accommodation with family members today, it is found that the size of the family is smaller, with approximately three members per one household with increasing rate of senior individuals living alone. In 2002, the number of senior people living alone account to 6.3%, while 15.9% living with partner or spouse. Nevertheless, in 2014, the number of elderly living alone increased to 8.7% with 18.8% living with partner or spouse (Prasartkul, 2015). Such statistical data reflects the tendency of present and future eldercare and its reliance on community participation, particularly the group of elderly people who live alone without any assistance from in-home caregivers. The research is, therefore, interested to study the formulation and development of eldercare model to prevent depression and anxiety among elderly people through community participation. By utilizing Ecological Framework in the study of today's elderly care such as General Ecological Model of Aging by Lawton and Nahemow (1973) and Bioecological Systems by Bronfenbrenner and Morris (2006). Both ecological concepts explain diverse, interactive and dynamic relationships between people and their environmental contexts, which lead to the facilitation of continual elderly care. Bronfenbrenner's Bioecological Systems emphasize the explanation of human development as a result of how a person exists in an environmental context called bio-ecological environment whose superimposed layers is systematically organized. Bio-ecological environment comprised of five systems: (a) Microsystem, the interactive system between the environment and an elderly person, possessing immediate effects on senior individuals such as family, income, neighbors, caregivers; (b) Mesosystem is essentially the connections within the Microsystem with another level of impact on the elderly's life such as the connection between a family and neighbors, collaborations between community and family members to nurture the elderly's mental health; (c) Exosystem, the external system, which can contribute indirect effects on senior citizens' way of life such as activities organized by community, healthcare and social services; (d) Macrosystem is the outermost layer and encompasses social values, traditions, laws, beliefs, resources, economic and social conditions; and (e) Chronosystem involves chronological periods and their connections with the elderly's environment such as the differences of technological context with today's progressive methods of communication as well as networks of online community that could not be found in the past. The eco-biological model highlighted three areas: (a) relationships between different environments in each layer of context; (b) the way in which such environments influence the elderly's physical, mental and social conditions; and (c) the way in which the elderly adjust or acknowledge these different contexts of environment for their own self-development. Bio-ecological framework is, therefore, a suitable choice for this study for it encompasses the roles and responsibilities of various groups and levels of caregiver and community, the way the elderly interact with caregivers, community and eldercare agencies, as well as the effects such eldercare management brings to the elderly's change of behaviors and awareness in their physical and mental health.

As previously stated, caring of the elderly people' mental health is extremely important. That being the case, the research team is interested in the formulation and development of mental health service model for the elderly by the involved stakeholders from different levels of operating community healthcare team, as well as the caregivers' way of life. Collaborative action research is incorporated to formulate and develop a preventive caregiving model for depression and anxiety in the elderly. The study was done in central, northeastern, northern and southern region of Thailand while the findings are expected to become additional sources of knowledge of the areas. Such contribution can be beneficial for future planning and implementation of policies and operations concerning local and regional eldercare by the local agencies such as Provincial Administrative Organization, health promoting hospitals, district hospitals, provincial hospitals, and provincial public healthcare offices. Furthermore, the research findings could be used as a model for future actions and learning in other areas.

Research Objectives

To formulate and develop a model of caregiving for the prevention of depression and anxiety in the elderly people through community participation.

Research Methods

Areas and Target Groups

The areas and target groups of the research comprised of nurses/ public health technical officers, Village Health Volunteers (VHV) / Eldercare Volunteers (5-10 members per area), in-home caregivers (8-12 members per area). The target groups are operating in different areas in four regions of Thailand under the following local authorities: (a) one community medical center (Medical Center 2 Wat Pasalawan, Nakhon Ratchasima); (b) three sub-district health promoting hospitals (San SHPH, Nan, Prongakat SHPH, Chachoengsoa, and Bann Mad SHPH, Sakon Nakhon); and (c) two district community hospitals (Bang Pae Hospital, Ratchaburi and Ranode Hospital, Songkla).

Data Collection and Research Tools

This research employs the methodology of collaborative action research that is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. Collaborative action research begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community (health), which comprises of processes, activities, data collection and utilization of research tools as follows:

1. Interviewing the specified target groups to collect data for environmental scanning in different areas to understand both external and internal environmental conditions and prevent depression and anxiety among elder people in local communities.

2. Organizing group discussion to formulate community's mechanism for present and future prevention of depression and anxiety among elderly people. The discussion offers the

researchers a chance to propose a primary model for each group to confer and exchange opinions before adjusting and finalizing the model for present and future use.

3. Interview caregivers to learn about elderly people's physical and mental conditions as well as caring methods for elderly patients who suffer from depression and anxiety in different communities. Assistant researchers and researchers conduct interviews of in-home caregivers in each community using the storytelling technique.

4. Organization of learning bases to provide knowledge and methods about elderly care using storytelling, roleplaying, exchange of knowledge and screening of videos about eldercare. Assignments are given to in-home caregivers where they are asked to document impressive stories about senior people they care for. Village Health Volunteers (VHV) / Homecare Volunteers are asked to document 10 stories about the care of elderly people in their families.

5. Brainstorming and group discussions about the organization of 3 following activities: (a) the exchange and learning of "stories" to reexamine the results of how the knowledge has been used; (b) the effects they have brought after the target groups (nurses/VHV/homecare volunteers and in-home caregivers) participated in the activities and storytelling session; and (c) AAR activity is organized to obtain the information about the next round of planning in each province as well as the assessment of the Bangkok project. Once the data from all the five activities are collected, the researchers conduct data analysis using content analysis method. By acquiring the analyzed data, mechanisms are formulated to oversee and prevent depression and anxiety in elderly people using participative approach that incorporates roles of family as well as governmental and people sector.

Research Findings

The format and mechanism of care and prevention of depression and anxiety in elderly people is facilitated from the participative process with contribution from families, people and governmental sector in the communities in all the six provinces. The process starts with surveys of local communities, which reveal that the team of care providers consisting of nurses, Village Health Volunteers (VHV), Homecare Volunteers and caregivers had different experiences and opinions about elderly people's stress and anxiety while the details vary for each community and province as well. The involved parties in the research team organize workshops to formulate formats and mechanisms for elderly care for each province using group activity to materialize future depiction about the community care for the elderly. The obtained results are exhibited in 6 models as follows:

1. Algorithm of community care for the prevention of depression and anxiety among elderly people: Prongakat Sub-District Health Promoting Hospital, Chachoengsao Province.

The Figure 1 shows that the current algorithm of community care for the prevention of depression and anxiety among elderly people on the family level relies on caregivers (FP2) and family members (FP3) with activities such as daily conversations, family gatherings, religious events, traveling. On the community level, there are two groups of caregivers. The organizational level comprises of sub-district health promoting hospitals (CO2), provincial hospital (CO3), Sub-district Administrative Organization or SAO (CO4), Community Health

Fund (CO5). The individual level includes Village Health Volunteers (VHV), Homecare Volunteers (CP1) and personnel from Local Administrative Organization (CP2). There are activities organized directly by SAO and Non-Formal and Informal Education (NFE) as well as the ones organized by other groups. Activities most provided by the community are elderly welfare budget and funds. On the social level, the main care providers are the Government (SO1), Ministry of Education (SO2), Provincial Public Health Office (SO3) and National Health Security Office (NHSO) (SO4). Most of the activities in this level are operated through the format and mechanism in the community level, and involve the provision of future budgets and benefits. The Prongakat team is determined to increase the incorporation of social organizations such as Ministry of Social Development and Human Security (SO5), which is expected to be responsible for the distribution of benefits and budgets for SAO (CO4) to initiate vocational workshops as a way for the elderly to generate additional income, as well as to expand the network of organizations in the community level namely Wat Yanransaram School (CO1), which supervises massage class for the elderly's family members. This activity will be an addition to the caring program facilitated by Village Health Volunteers (VHV)/Homecare Volunteers (CP1), caregivers (FP2) and family members (FP3).

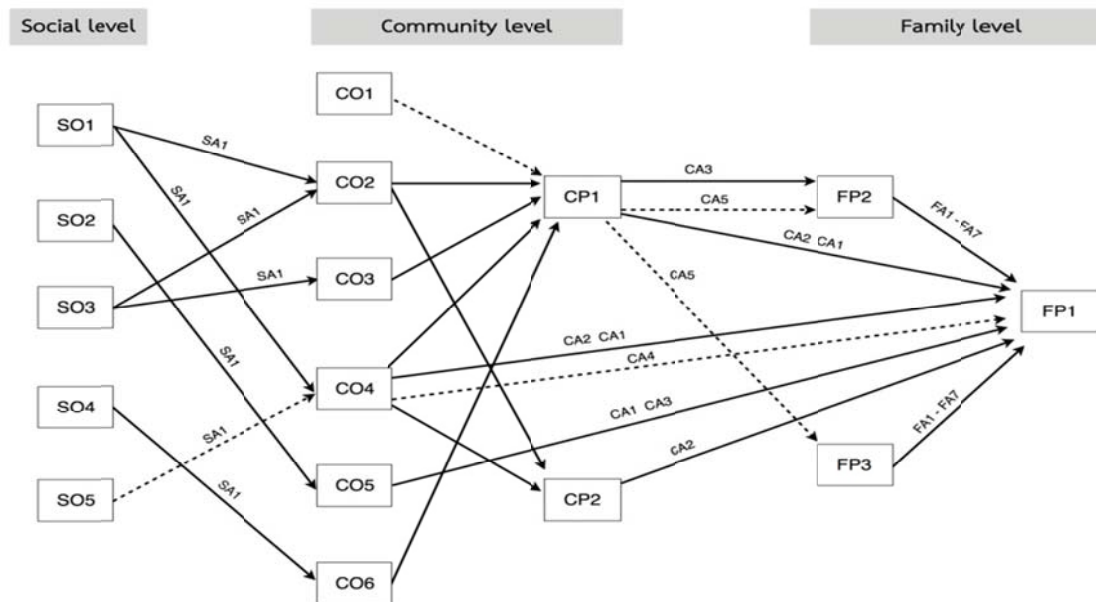


Figure 1. Algorithm of Community Care for the Prevention of Depression and Anxiety among Elderly People: Prongakat Sub-District Health Promoting Hospital, Chachoengsao Province.

2. Algorithm of community care for the prevention of depression and anxiety among elderly people: Community Medical Center 2 Wat Pasalawan, Nakhon Ratchasima Province.

Figure 2 exhibits the algorithm of community care for the prevention of depression and anxiety among elderly people. On the family level, the care providers include caregivers/family members (FP2) with activities ranging from family gatherings, religious events, spending time with grandchildren, etc. On the community level, organizational care providers are Community Medical Center 2 Wat Pasalawan (CO1), Healthcare Volunteers (CO2), volunteers (CO3), senior citizen club (CO4) with activities initiated and operated on

both family and community level such as eldercare workshops, home visits, religious promotional activities. On the social level, the care providers include Nakhon Ratchasima Municipal Office (SO1), Ministry of Social Development and Human Security (SO2), Mahanakhon Ratchasima Hospital (SO3), Non-Formal and Informal Education Centre (SO4). Activities operated directly with the elderly are facilitated by Nakhon Ratchasima Municipal, Ministry of Social Development and Human Securities (SO2), ranging from workshops providing knowledge and aiding tools for effective assistance in the elderly's everyday life. There are also activities operated using formats and mechanisms on the community and family level such as home visits, knowledge workshops and finding solutions for the elderly's serious dilemmas. In the future, the team of Community Medical Center 2 Wat Pasalawan intends to build a network of collaboration with local schools (CO6) for the organization of activities such as inviting senior citizens to be instructors in subjects and issues such as art and culture, life skills, self-employment as well as the exchange of technological knowledge between students and the seniors.

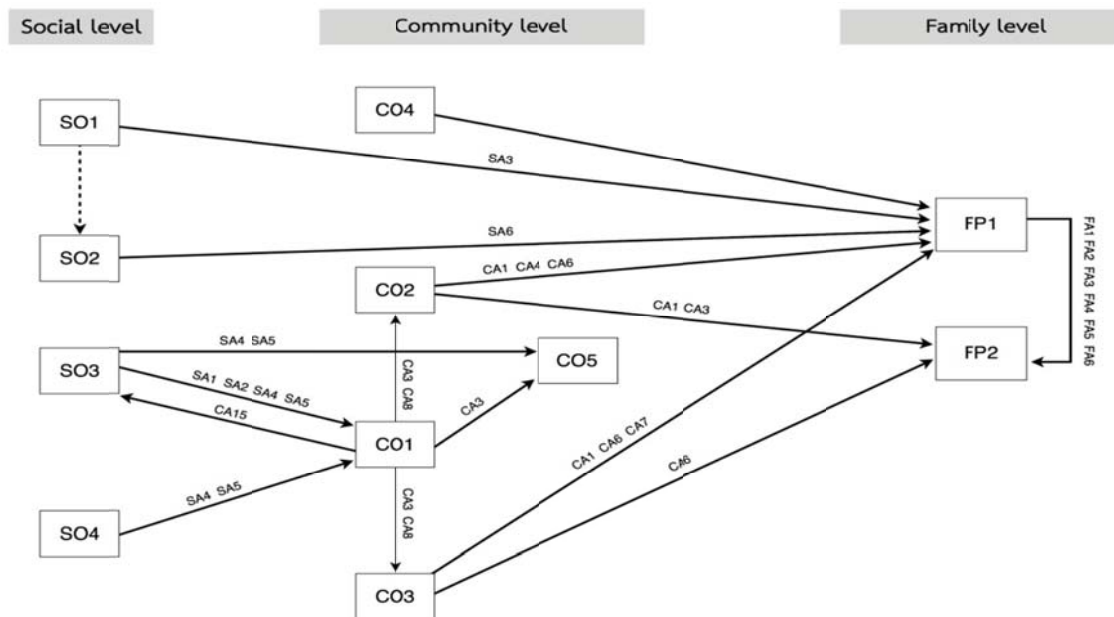


Figure 2. Algorithm of Community Care for the Prevention of Depression and Anxiety among Elderly People: Community Medical Center 2 Wat Pasalawan, Nakhon Ratchasima Province.

3. Algorithm of community care for the prevention of depression and anxiety among elderly people: Bann Mad Sub-District Health Promoting Hospital, Sakon NaKhon Province.

Figure 3 illustrates the algorithm of community care for the prevention of depression and anxiety among elderly people. On the family level, the care providers include caregivers (FP2) and family members (FP3) with activities such as tree planting campaign, religious events where the senior individuals are encouraged to participate in activities and community the live in. On the community level, care providers are mostly personnel and agencies from the organizational levels such as sub-district health promoting hospitals (CO1), public

healthcare volunteers (CO2), SAO (CO3), temples (CO5) schools (CO6), social development and human security volunteers (CO7). The activities operated directly with the elderly are facilitated by sub-district health promoting hospitals (CO1), public healthcare volunteers (CO2), SAO (CO3), temples (CO5) and social development and human security volunteers (CO7).

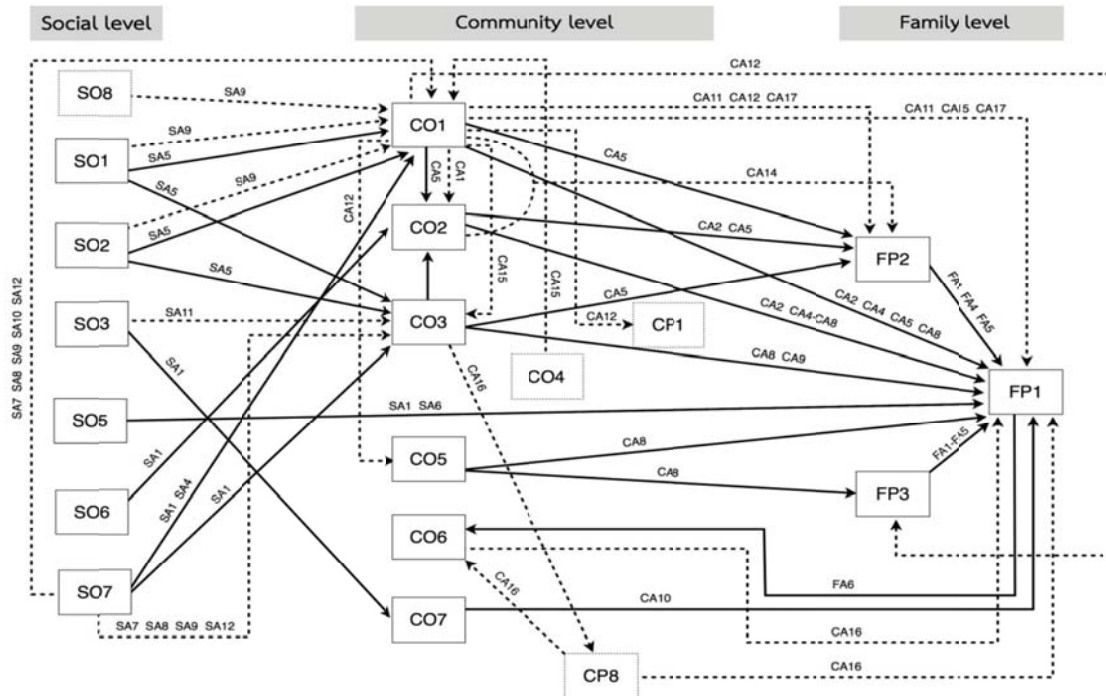


Figure 3. Algorithm of Community Care for the Prevention of Depression and Anxiety among Elderly People: Bann Mad Sub-District Health Promoting Hospital, Sakon NaKhon Province.

Activities operated on family and community level encompass knowledge workshops, cultural and traditional activities, provision of loans, etc. On the social level, the care providers include Provincial Public Healthcare Office (SO1), district public healthcare offices (SO2), Ministry of Social Development and Human Security (SO3), Rotary Club (SO5), Office of Health Promotional Funds (SO6), National Health Security Office (NHSO) (SO7). Rotary Club initiates activities directly with the local senior citizens such as provision of funds for elderly care and acupuncture sessions. Other groups organize activities, which are operated on community level, such as knowledge workshops for the elderly, eldercare budget management course, provision of free eye exam and eyeglasses, etc. In the future, the team from Bann Mad Sub-District Health Promoting Hospital intends to expand the network of collaborations through provincial hospital (SO8), which acts as a social organization that will be holding seminars and providing consults to volunteers and sub-district health promoting hospitals (CO1) while increasing the role of other groups on the social level such as Provincial Public Healthcare Office (SO1), district public healthcare offices (SO2), National Health Security Office (NHSO) (SO7) and Ministry of Social Development and Human Security (SA3). These collaborators will be the initiators of activities such as workshops for

public healthcare volunteers. On the community level, village headmaster group (CO4) and Children Council (CO8) will be integrated as parts of the network. Village headmaster group will be asked to form plans and assessment methods as well as increase the number of activities operated by SAO through the Children Council such as the promotion of positive attitudes towards elderly care. In the individual level, Dr. Yao (CP1) will formulate plans and assessment methods for sub-district health promoting hospitals (CO1), including elevating activities in other community groups such as sub-district health promoting hospitals (SHPH) together with public healthcare volunteers to explore the ongoing problems and demands. The activity sub-district health promoting hospitals together with elderly's family members will be participating in knowledge workshops.

4. Algorithm of community care for the prevention of depression and anxiety among elderly people: San Sub-District Health Promoting Hospital, Nan province.

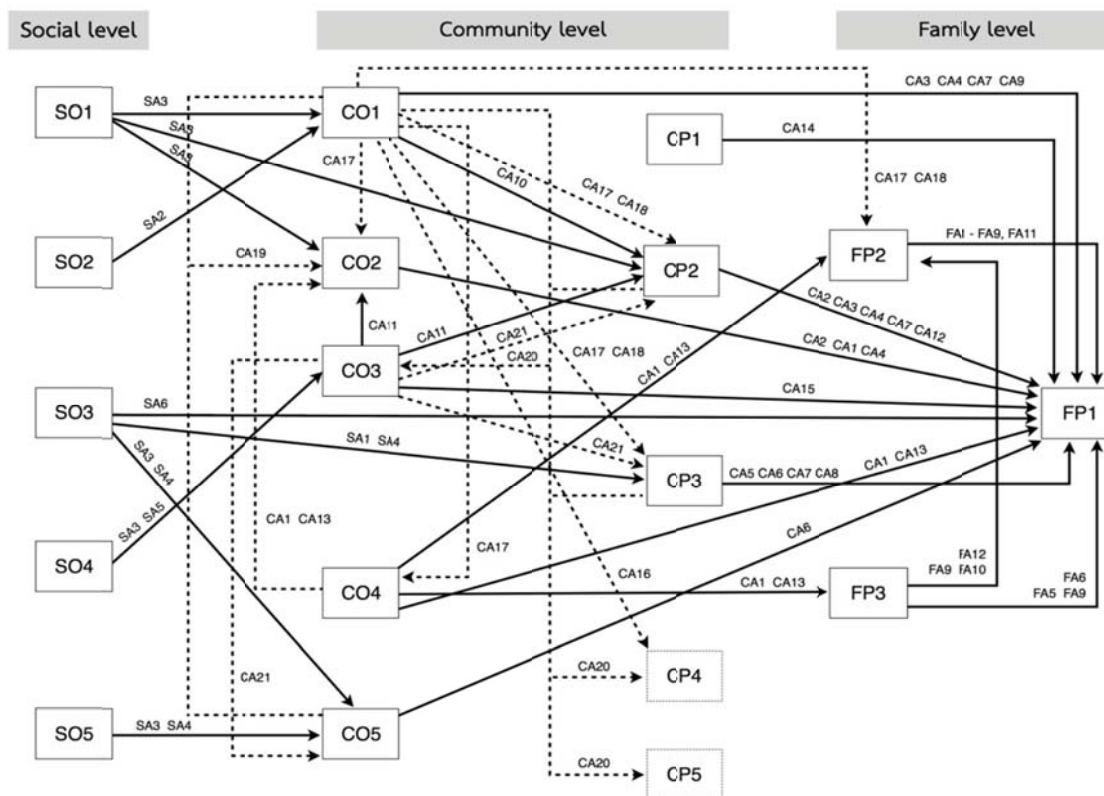


Figure 4. Algorithm of Community Care for the Prevention of Depression and Anxiety among Elderly People: San Sub-District Health Promoting Hospital, Nan Province.

Figure 4 exhibits the community's current algorithm of community care for the prevention of depression and anxiety among elderly people. On the family level, the care providers include caregivers (FP2) and family members (FP3) with activities for elderly care such as exchange of knowledge between peers, religious event, showing of support for the elderly, etc. Additionally, family members (FP3) also provide financial support and facilities as well as encouragement to motivate the elderly's self-worth. On the community level, there are two groups of caregivers. The organizational level includes community hospitals (CO1), senior citizen clubs (CO2), SAO and municipal offices (CO3), temples (CO4) and Foo Hug

Sann Network (CO5), while the individual level encompasses community members (CP1), Public Healthcare volunteers (CP2) eldercare volunteers/ social development and human security volunteers (CP3). All activities are operated directly with the elderly, ranging from seminars where basic knowledge about elderly healthcare is provided, home visits, cultural and religious events, sporting, traveling and recreational activities, etc. On family and community level, initiated activities are such as preventive home visits to observe and oversee the elderly's mental and physical health, provision of budget and welfare. On the social level, the elderly's care providers include Health Fund by NHSO (SO1), Ministry of Public Health (SO2), Ministry of Social Development and Human Security/ Provincial Social Development and Human Security Office (SO3), Ministry of Interior (SO4) and private agencies such as Office of Health Promotional Funds, Earth Funds and other foundations such as Xavier House (SO5). On this particular level, activities are operated directly with the elderly by Ministry of Social Development and Human Security (SO3) such as interest-free loan. Activities operated by other groups on community and individual level are mostly distributions of budget.

In the future, San Sub-District Health Promoting Hospital intends to integrate two groups of individuals: the village headmasters (CP4) and volunteers in the communities (CP5). The network of activities may be expanded to other groups such as SHPH and community hospitals through the organization of workshops and seminars that provide basic knowledge about depression and anxiety to village headmasters. Knowledge and skills in providing proper mental aid for elderly people who suffer from depression and anxiety can be passed on to public healthcare volunteers, elderly care volunteers/social development and human security volunteers and caregivers as well as members of senior citizen clubs and temples. Training sessions can also be conducted for public healthcare volunteers, elderly care volunteers/social development and human security volunteers and caregivers to keep them physically and mentally healthy. Sub-district health promoting hospitals/community hospitals and Fu Hag San Network can help find potential leaders for local elderly community to oversee the members' physical and mental health. Temples can also appoint potential leaders who can collaborate in bringing members of elderly community to participate in religious activities as a way to socialize with others. SAO can distribute budgets to public healthcare volunteers, elderly care volunteers/social development and human security volunteers and caregivers to help initiating and supporting activities for elderly patients who suffer from depression and anxiety.

5. Algorithm of community care for the prevention of depression and anxiety among elderly people: Bang Pae Hospital, Ratchaburi province.

Figure 5 exhibits the community's current algorithm of community care for the prevention of depression and anxiety among elderly people. On the family level, the care providers are caregivers/the elderly's families (FP2) and family members/ relatives (FP3) with activities ranging from the exchange of knowledge, organizing trips to temples and make merit, going to medical appointments, etc. On the community level, there are two groups of care providers: the organizational level includes temples (CO1), senior citizen clubs (CO2), district hospitals (similar role to SHPH) (CO3), municipal offices (CO4) and community hospitals (CO5) while the individual level encompasses public healthcare volunteers/eldercare volunteers (CP1), psychiatric nurses (CP2) and public health technical officers (CP3). The activities are operated directly with the elderly with temples (CO1), senior citizen clubs (CO2) district hospital (CO3) and community hospitals (CO5) as the

facilitators. There are also activities initiated from the collaborations between two groups (temples and senior citizen clubs and district hospitals and psychiatric nurses). There are also other activities operated through other groups on the community level such as religious and social activities, training courses, etc. On the social level, the care providers are medical unit from Princess Mother's Medical Volunteer Foundation (SO1), Provincial Red Cross Office (SO2E), Thai Red Cross Central Office (SO2A), Ministry of Public Health (SO3), Ministry of Social Development and Human Security (SO4), Damrongdhama Centre (SO5) and Elderly and Wisdom Collective Association (SO6). The activities are operated directly with the elderly by medical unit from Princess Mother's Medical Volunteer Foundation (SO1), Provincial Red Cross Office (SO2E) and those operated through the community's model and mechanism such as home visits, provision of welfare and necessary everyday-life items, helping community members reconciling urgent dilemmas, etc.

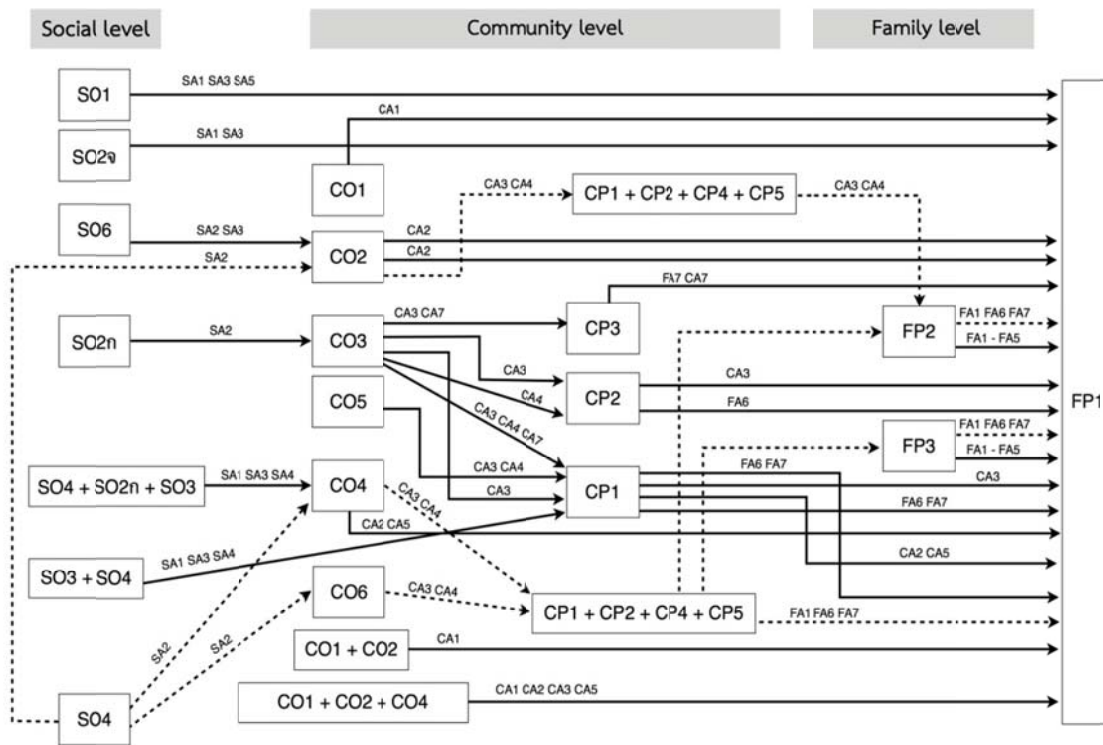


Figure 5. Algorithm of Community Care for the Prevention of Depression and Anxiety among Elderly People: Bang Pae Hospital, Ratchaburi Province.

In the future, the team of Bang Pae Hospital intends to incorporate two operators into its caring network. The Ministry of Social Development and Human Security (SO4) from social level will provide knowledge training for agencies in the community level as follows: senior citizen clubs (CO2), municipal office (CO4), and schools (CO6). The operators in the community level include 1 organization and 2 individual groups as follows: schools (CO6), house doctors (CP4) and teachers/students (CP5). The local schools (CO6) will provide training and knowledge in triage for public healthcare volunteers/eldercare volunteers (CP1), psychiatric nurses (CP2), house doctors (CP4) and teachers/students (CP5) before passing on

the knowledge to the elderly in the community. In addition, there is also an intention to increase the number and frequency of activities such as maximizing the role of senior citizen club (CO2), facilitating knowledge training as well as triage and transferring process for public healthcare volunteers/eldercare volunteers (CP1), psychiatric nurses (CP2), house doctors (CP4) and teachers/students (CP5). These agencies will be the mediators of knowledge that will be passed on to caregivers/the elderly's families (FP2) and senior individuals in the community (FP1).

6. Algorithm of community care for the prevention of depression and anxiety among elderly people: Ranode Hospital, Songkla Province.

Figure 6 illustrates the current algorithm of community care for the prevention of depression and anxiety among elderly people. On the family level, the care providers include caregivers (FP2) and family members (FP3) with activities including social activities, exercises, religious events, etc. On the community level, there are two groups of care providers: the organizational level includes SHPH (CO1), medical clinics (CO2), senior citizen club (CO3), municipal office's public healthcare unit (CO4), whereas the individual level encompasses public healthcare volunteers/eldercare volunteers (CP4), social development and human security officers (CP5). The activities range from those operated

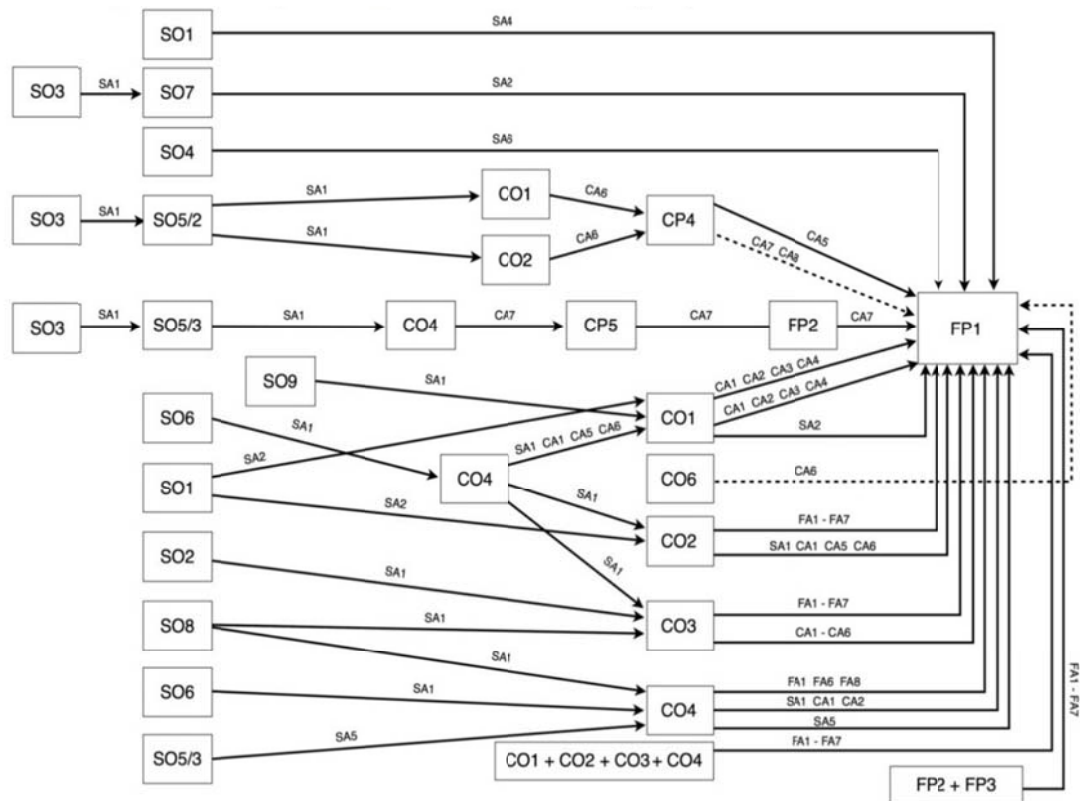


Figure 6. Algorithm of Community Care for the Prevention of Depression and Anxiety among Elderly People: Ranode Hospital, Songkla Province.

directly with the elderly, for instance, the collaboration between SHPH, medical clinics, senior citizen club and municipal office's public healthcare unit ranging from social activities, exercises, religious events, etc. On the social level, the care providers include royal medical unit (SO1), Office of Health Promotional Funds (SO2), Government's policies (SO3), Department of Transportation (SO4), the Thai Government (SO3), Ministry of Public Health (SO52) and Ministry of Social Development and Human Security (SO53), National Health Security Office (NHSO) (SO6), Provincial Administrative Organization (SO7), private agencies (SO8), Provincial Public Healthcare Office (SO9). The activities operated directly with the elderly are facilitated by the Royal medical unit where selected patients are taken under Royal patronage as well as the Department of Transportation who initiates the half-price bus fee campaign. Other activities are operated through other formats and mechanisms on social, community and family level. For instance, the Royal medical unit (SO1) organizes mobile medical examination through the collaboration with SHPH (CO1) before the hospitals carry out the activity further to the elderly.

In the future, the team of Ranode Hospital intends to increase the number of staff with direct expertise in elderly care such as psychiatrists (CO6) with the plan for these personnel to provide the proper knowledge concerning mental and physical care for elderly patients with depression and anxiety. The plan also includes the facilitation of platform for knowledge exchange and friends for friends group by public healthcare volunteers/eldercare volunteers (CP4).

Discussion and Conclusion

The formulation of community's format and mechanism for the prevention of depression and anxiety among elderly people through participation of people and governmental sector is a study conducted using collaborative action research method. There were three groups of collaborators in this research: (a) Researchers from Srinakharinwirot University, Thailand; (b) Nurses, village health volunteers or in-home caregivers; and (c) caregivers who are family members. The study found that each community has its own specific format of eldercare with individuals, organizations/groups and activities encompassing different roles and operations as follows:

Table 1 illustrates the mechanisms developed to stimulate the exchange of knowledge between caregivers on a community using storytelling techniques. The narratives generated from such process depict anxiety and depressive symptoms in elderly people as well as the methods employed to provide proper and effective care. The quality of life of citizens is the key element of the society's human resource development, particularly those of the elderly people who have the highest tendency for health problems. The research finding indicates that by using the format and mechanism generated by the society, the care and prevention of depression and anxiety among the elderly render both direct and indirect depictions of the relationships between the senior citizens and other groups of individuals. The research categorizes the connection into two levels, individual and community. To further elaborate, the individual level depicts the relationships between the elderly and members of the family and caregivers such as daily conversations and interactions, participation in activities such as going to temples. Furthermore, there are also the relationships between families and caregivers that may have certain influences on the elderly. The community level reflects the

relationships between groups of individuals or organizations within a community and their direct roles in elderly care through different activities such as religious events, exercising sessions, etc. The indirect involvements of these groups include distribution of budgets, management of learning resources from individuals inside and outside the community. The system, which brings together different types of relationships, is formulated though the combined levels of all-encompassing connections are there the aspect of health, culture or others that can potentially affect the elderly's physical and mental health. The theory of Bioecological Systems by Bronfenbrenner and Morris proposes the framework, which can be utilized to explain the changes on individual and community level in a broader sense and various aspects from physical, behavioral, social to environmental. The complexity of these combined dimensions influences approaches and methods of care provided for the growing number of elderly population, of different ages, sexualities, nationalities and social statuses (Satariano, 2006). The algorithm illustrates four types of Bioecological Systems: (a) Microsystem exhibits direct relationships between an individual and the environment; (b) Mesosystem is the connection of micro relations or relationships between the environment and the individual living in it; (c) Exosystem is the expansion of Mesosystem, which involves other institutions, both official and non-official ones; and (d) Macrosystem is the level that encompasses the formats of institutions such as religion, law, etc. The research done by Wangmo (2011) studied the behaviors and health awareness of Tibetan elderly living in India and Switzerland, using Bronfenbrenner's theory of Bioecological Theory to analyze the systems of relationships. That is to say, the Microsystem consists of individual factors such as attitudes, behaviors whereas Mesosystem comprises of relationships between the elderly and their families. Exosystem is made up of community, place of residence, healthcare system provided within the community whereas Macrosystem encompasses Tibetans' religions and effects caused by eldercare policies implemented by both countries. It is found that the health of elderly citizens living in Switzerland, which offers superior financial freedom as seen from the citizens' health insurance, pension, or other benefits, is better than those in India. The research by Huangtong, Piaseu, and Kaveevivitchai (2013) showed the similar tendency through their study about behaviors and obstacles affecting the control of blood pressure in elderly people in communities using Bronfenbrenner's theory of Bioecological Systems as the analytical tool. The study finds that the key problems are caused by the stakeholders and social system. Improper knowledge about eating habits, lack of interactions with others and unstandardized health service system within a community are among the causes.

Table 1

Personnel and Activities Initiated to Improve Elderly People's Mental Health

Involved Stakeholders	Mental Health Activities
- Caregivers	- Conversations between family members/ family gatherings
- Family members	- Exercise
	- Makin merit/ dharma practice
	- Gardening/ Planting trees
	- Babysitting grandchildren/spending time with young offspring such as walking them to school
	- Travelling
	- Telling funny stories / watching entertaining television programs
	- Earning extra income by working at home

Table 2

Personnel, Organizations and Activities Initiated to Improve Elderly People's Mental Health

Groups of individuals/ Organizations	Mental Health Activities
-Sub-district health promoting hospitals	- Distribute budget and welfare
-Provincial hospitals	-Workshops and trainings about eldercare and discussion groups where knowledge about elderly care is exchanged
-Medical centers	- Conduct screening for illness and mental health
-Senior citizen clubs	- Facilitating the transfer of elderly patients with physical illness and severe symptoms of depression to receive further treatments at hospitals
-Temples	- Home visits
-SAO/Municipal offices	- Religious and cultural activities such as praying, meditation, making merit
-Public healthcare volunteers/eldercare volunteers	- Fieldtrips
-Local Administrative Organization officers	- Visiting elderly nursing homes
-Volunteers	- Traditional activities
-Social development and human security volunteers	- Provision of loans
	- House repairs

Differences between eldercare models are derived from each community's distinctive surrounding context. It is also observable that the main structure of each model exhibits the important role of family, which can be linked to other systems in the society. In addition, each community's acknowledgment of and active response towards the eldercare issue can affect the roles of family and the well-being of its senior members. The finding is in the same direction with the research by Srithamrongsawat, Bundhamcharoen, Sasat, and Amnatsatsue (2009), which studies the format of long-term eldercare by the community. From the qualitative research done on the 4 specified areas where healthcare services are provided (4 provinces in Thailand: Payao, Yasothon, Supahnburi and Nakhonsrithammarat), it is found that family still plays a significant part as a care provider. In the meantime, the provision of healthcare services in each area also encompasses different levels of intensity. Additionally, the results of such format also reflect the important role of healthcare system in a community, which is linked to the more expansive external network, especially those provided by social groups outside of hospital such as senior citizen clubs, SAO/municipal office, volunteer groups, Ministry of Social Development and Human Security, etc. These agencies and organizations can effectively facilitate collaborations and expand the network of eldercare with hospitals and medical centers in a community.

This eventually brings about a collective network of elderly care as Artsantia and Kumprao (2014) propose in their research on the holistic management and provision of services for elderly that proper network of care outside of the hospital should be facilitated

such as senior citizen clubs, daycare center, homecare supervised by a team of knowledgeable individuals. The proposition is complemented by the finding from the study on eldercare in different areas of Thailand done by Wongpraparat et al. (2014), which explores the format of the promotion of health of the elderly in Sansai District, Chiang Mai. The study finds that the format puts great emphasis on community's participation through 5 methods: analysis of elderly's needs, consumption of healthy and nutritious food, exercise, practicing dharma and other integrative activities. Nevertheless, the development of the community's potential to progress and provide support needs reinforcements from expansive network of hospitals, municipal offices, senior citizen clubs, etc. The collaboration will eventually lead to the development of every aspect of the elderly's well-being in the long run. It is also found that the long-term elderly care in facilities can be categorized into two different types. The first is the basic-level care such as nursing homes, which essentially focuses on the social aspect of elder care and assistance on the elderly's everyday living. Advanced level care is the provision of continuing care on elderly patients with chronic illnesses who need close assistance and monitoring from professional providers such as, doctors, nurses, social workers, psychologists, etc. The services in this category include elderly care centers, long-term service during hospitalization, palliative care facilities, etc.

Suggestions

From the research findings, the formulated models exhibit the approaches to mental health care for elderly people in communities, which comprise of roles of different service providers from social, community and individual levels. As a result, to achieve effective and successful outcome, elderly care relies on strengthening collaborations and continuum. As an agency under the Ministry of Public Health, Department of Mental Health's role is to oversee mental health of Thai population of all genders and developmental ages. Its responsibility includes future implementation of policies that can effectively prevent the country's senior citizen from depression and anxiety. The process can be operated by: (a) formulating a model for eldercare for local communities to follow with all-encompassing aspects of both ongoing and future operations through the roles and contributions of community's healthcare providers from public healthcare volunteers, eldercare volunteers to nurses and other involving agencies such as SAO and social development and human security volunteers; (b) community's healthcare personnel and other involved agencies are assigned to conduct surveys inquiring the staff's needs for additional knowledge and skill developments. Through storytelling technique, a specific body of knowledge of a community is formed while the stories may involve individuals or activities included in the model; (c) experts should be invited to provide useful knowledge and skills; (d) the healthcare personnel should employ the activities from the model to actual practice and formulate narratives. The narratives then should be passed on to a wider audience through roleplaying technique or as an exchange of knowledge among the healthcare providers; and (e) documentation of stories and experiences from the individuals who personally involve in elderly care should be done systematically and consistently.

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