UNIT 18 GERIATRIC PROBLEMS AND DISORDERS

Structure

18.1 INTRODUCTION

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. This population ageing can be seen as a success story for public health policies and for socioeconomic development, but it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security.

India is home to more than 76 million people older than sixty years as per Census India 2001. This age group, currently 7.4% of the population, is expected to grow dramatically in the coming few decades. Low public awareness and low priority for health care of older people allows even conditions like dementia remain hidden problems. Depression is much more prevalent than dementia and can have profound negative effects on the quality of life of an older person. There is a growing realization of the need for interventions aimed at improving the mental health and well being of older people.

Health problems in general and mental health problems in particular are important determinants of quality of life in late life. Many seniors live active and healthy

lives. But as we age, our bodies and minds change. Some changes may just be part of normal ageing, while others may be a warning sign of a medical problem. It is important to know the difference. This Unit will make an attempt to introduce the health care and related issues of people above the age of sixty years and will summarize the interventions which are helpful for people who experience mental health problems in late life.

Objectives

After studying this Unit, you will be able to:

- Understand the public health aspects of demographic ageing;
- Describe the common health problems of late life;
- Describe the common mental health problems of late life;
- Recognize clinical features of delirium, dementia and depression;
- Provide emotional support to older people with health problems;
- Recognize the need for assistance in activities of daily living;
- Recognize the caregiver issues in care of older people;
- Recognize the burden of care and its implications;
- Inform and educate caregivers of older people;
- Support the families who provide home-based care;
- Provide emotional support to caregivers; and
- Provide tips for better care by families engaged in home-based care.

18.2 DEMOGRAPHIC AGEING

Reduced birth rates with increasing life expectancy is leading to an increase in the proportion of older people in our population and this phenomenon is called demographic ageing. This will result in a sharp increase in the number of older people with neuropsychiatric disorders. Many of them would require some kind of assistance in daily living. Demographic changes occur along with rapid social restructuring and economic turbulence in developing countries. These are difficult times for the region as we have to meet the health care needs of the growing number of older people in our society.What is most remarkable about the demographic ageing in developing countries is the rapidity with which this is occurring here. In the developed world the demographic transition occurred over a period of many decades and allowed these societies enough time to make adjustments.

There are many interesting facts about ageing. The World Health Organization (WHO) has listed 10 facts on ageing and the life course (http://www.who.int/features/factfiles/ageing/en/index.html).

These are summarized here. Let us go through each one of these:

Fact 1

Ageing is a global phenomenon. The world's elderly population ─ people 60 years of age and older ─ is the fastest growing age group. By 2050 about 80% of the elderly will be living in developing countries. Population ageing is occurring in parallel with rapid urbanization: in 2007 more than half of the world's population lived in cities. By 2030 that figure is expected to rise to more than 60%.

Fact 2

Population ageing is a triumph of modern society. It reflects improving global health, but also raises special challenges for the 21st century in both developing and developed countries. In 2005, life expectancy in countries like Japan and France was already more than 80 years. Life expectancy is also rising in developing countries.

Fact 3

Vast health inequalities persist, as is clear from differences in life expectancy at birth. For example, while Japan has the highest life expectancy in the world at 82.2 years, in several countries in Africa the figure is as much as 40 years lower.

Fact 4

Within countries, health inequalities are also significant. For example, in the United States of America higher socioeconomic groups can expect to live up to 20 years longer than those from lower socioeconomic groups.

Fact 5

By 2050, close to 80% of all deaths are expected to occur in people older than 60. Health expenditure increases with age and is concentrated in the last year of life — but the older a person dies, the less costs are concentrated in that period. Postponing the age of death through healthy ageing combined with appropriate end-of-life policies could lead to major health care savings.

Fact 6

Healthy older people also represent a resource for their families, communities and economies. Investing in health throughout life produces dividends for societies everywhere. It is rarely too late to change risky behaviours to promote health: for example, the risk of premature death decreases by 50% if someone gives up smoking between 60 and 75 years of age.

Fact 7

Effective, community-level primary health care for older people is crucial to promote health, prevent disease and manage chronic illnesses in dependent and frail patients. In general, training for health professionals includes little if any instruction about care for the elderly. However, they will increasingly spend time caring for this section of the population. WHO maintains that all health providers should be trained on ageing issues, regardless of their specialism.

Fact 8

Disasters and emergencies severely impact the most vulnerable, including older people. As examples: the highest percentage of fatalities in Indonesia caused by the 2004 Indian Ocean tsunami was in people 60 years of age and older, and the majority of the 2003 heat wave victims in Europe were people 70 years of age and older. Policies to protect older persons during emergencies are urgently required.

Fact 9

In older age, the risk of falls increases and consequences of injuries are far more serious. This leads to significant health, human and economic costs.

Fact 10

Elder abuse is on the increase as the population ages and social dynamics change. WHO estimates that between 4% and 6% of older persons worldwide have suffered from a form of elder abuse - either physical, psychological, emotional, financial or due to neglect. Elder abuse is an infringement of human rights.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. What do you mean by demographic ageing?

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18.3 COMMON HEALTH PROBLEMS IN LATE LIFE

The world is ageing fast. It is of paramount importance that health care workers are well versed with the diagnosis and management of the so called “four giants” of geriatrics (memory loss, urinary incontinence, depression and falls / immobility) as well as the chronic diseases that are common in later life and that can often be prevented or delayed. They include hypertension, diabetes, arthritis, chronic obstructive airway diseases etc. However, prevention requires reaching the individual before the disease takes hold. Most preventative health care and early disease screening takes place in Primary Health Care (PHC) centres within health systems. These centres play a critical role in the health of older people worldwide at the local level.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided.

b) Check your answers with those provided at the end of this Unit.

1. Which are the so called "four giants" of geriatrics?

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2. Which health care facility should ideally play a crucial role in health care of older people?

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18.4 AGEING AND DISABILITY

Neuropsychiatric disorders are more prevalent in older age groups and these disorders tend to be chronic in nature and usually lead to functional impairment. The Global Burden of Disease (GBD) report indicates that dementia is one of the main causes of disability in later life. Older people are particularly likely to have multiple health conditions. Chronic physical diseases affecting different organ systems can coexist with mental and cognitive disorders .These multiple pathologies will interact in complex ways to create difficulties in performing important tasks and activities (disability), and in determining needs for care (dependence). Dementia probably has a disproportionate impact on capacity for independent living. Presence of disability often results in the individual needing assistance for personal activities of living, which would then be qualified as dependence.

The experience of limitations or disability happens in the contexts of partners, family and friends. Comprehensive health and social care systems prevalent in the economically developed countries to a great extent compensate for the less prominent role played by the family. However, even in these societies, most of the care for older people are provided by families, a fact often overlooked. Facilities for assisted living are not widely available in India and these can be very expensive. Almost all disabled older people are being cared at home by co-resident caregivers in India.

Disability increases with age. We have limited information on the proportion of older people with disability in India. The ability to carry out activities of daily living can be compromised in late life due to a number of neuropsychiatric conditions including dementia .Everyday Abilities Scale for India (EASI) was developed to assess cognitive disability (REF).This scale with 12 items looks at disability arising from possible cognitive problem among older people. Functional impairment (defined as inability to carry out four or more activities) was found to be more prevalent in older age groups.

18.5 AGEING AND MENTAL HEALTH

Ageing is also associated with decline in physical and mental health. Declining memory is a common complaint. There is reduction in muscle strength and stamina. Exercise tolerance becomes less. Sensory systems usually has reduced ability in late life in many older people. Vision and hearing may get affected due to age related changes or degenerative conditions. As age advances the incidence and prevalence of many diseases increase. Medical illnesses are very common in later years of life.

Social isolation, loss of spouse, close relatives and friends due to death is also more frequent in late life. Reduced birth rates with increasing life expectancy is leading to an increase in the proportion of older people in our population and this phenomenon is called demographic ageing. Loneliness, reduced social support and need for assistance in activities of daily living are common stressors in later years of human life. Depressive symptoms are common in late life. Old age increases the risk for cognitive disorders especially progressive conditions like degenerative dementias .

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. List important stressors in late life.

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18.6 MENTAL HEALTH PROBLEMS OF OLDER PEOPLE

Doctors and policy makers are responsible for shaping the health care system of the country. Health care services should meet the requirements of all sections of the society. Medicine must change itself to serve the increasing number of older people in the society .Though this appears perfectly logical, there seems to be little take up in this direction. For older people, mental health conditions are an important cause of morbidity and premature mortality (Prince et al., 2007). Dementia and depression are common mental health conditions of late life and are emerging as major public health challenges in ageing societies like ours. India with its huge population probably need to cater to the needs of a very large number of older people with mental health problems than most other countries. Delirium is less frequent, but is a medical emergency which could be mistaken for another psychiatric problem. Delay in diagnosis could be fatal though many cases are reversible if detected early. Most often these are due to an underlying medical problem.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

Say whether the following statements are true or false:

i) Mental health conditions are an important cause of morbidity and premature mortality for older people. .....

ii) Dementia and depression are two important mental health problems in late life. .....

iii) Delirium is a medical emergency and early detection is important. .....

18.6.1 Delirium

Delirium or acute confusional state is a common medical emergency in older people. This is caused by a transient, usually reversible, cerebral dysfunction characterized by clouding of consciousness. Delirium usually occurs in association with a physical illness. It could well be the presenting feature of a medical problem. Common medical conditions like pneumonia , urinary tract infection or electrolyte imbalance may present as delirium. Delirium has to be considered and ruled out in all cases of sudden onset behavioural disturbance in older people. The diagnosis of delirium is often missed. Misdiagnosis as psychosis is also common. People with preexisting dementia can develop delirium and may present with recent sudden worsening of cognitive function and behavioural disturbance. Delirium in elderly is often caused by multiple causes. Delirium in late life is a medical emergency and needs prompt identification, detailed evaluation and intensive care.

Delirium should be considered as the first possibility in all late onset acute behavioural problems in older people. It is treatable and reversible in many instances if detected early in the course. Identification of the cause and prompt management is critical for good outcome. Untreated delirium is associated with increased morbidity and mortality rate. Patients who develop delirium during hospitalization have a mortality rate of 22-76% and a high rate of death during the months following discharge.

Risk factors for delirium in elderly are:

- Advanced age (especially >80 years)
- Severe illness (especially cancer)
- Dehydration
- Dementia

Signs and symptoms of delirium are:

- Clouding of consciousness
- Difficulty maintaining or shifting attention

- Disorientation
- Illusions
- Hallucinations
- Fluctuating levels of consciousness — Symptoms tend to fluctuate over the course of the day, with some improvement in the daytime and maximum disturbance at night.
- Reversal of the sleep-wake cycle
- Neurological symptoms like Dysphasia, Dysarthria, Tremor

Disorientation to time and place and memory impairment are the classical symptoms. Person has inability to recall the time of the day, he might mistake day for night time or think he/she is at home when he/she is in the hospital. Incontinence of urine, motor restlessness, especially more at night time and sleep disturbance could also be present. Abnormalities in perception, especially visual hallucinations or illusions also can be seen. The person is noted to be less alert and could be less responsive and drowsy at times.This is usually accompanied by the symptoms and signs of the primary illness which causes delirium.

Check Your Progress Exercise 5

Note: a) Read the following questions carefully and answer in the space provided.

b) Check your answers with those provided at the end of this Unit.

1. What is the first possibility to be considered if an otherwise normal older person suddenly develops abnormal behaviour?

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2. What is the most prominent symptom in delirium?

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18.6.2 Dementia

Dementia is a syndrome which is usually chronic, characterized by a progressive, global deterioration in intellect including memory, learning, orientation, language, comprehension and judgement due to disease of the brain. It mainly affects older people; about 2% of cases start before the age of 65 years. After this, the prevalence doubles every five years. Dementia is one of the major causes of disability in late-life.

The dementia syndrome is linked to a number of underlying causes and diseases in the brain. The common causes accounting for 90% of all cases are Alzheimer's disease, Vascular dementia, Dementia with Lewy bodies and Frontotemporal dementia. Alzheimer's disease and Vascular dementia are two most common

causes and together they account for more than 50% of dementia cases in the community. Less common causes of dementia (like hypothyroidism, chronic infections, brain tumours, subdural haemorrhage, normal pressure hydrocephalus, metabolic conditions, and toxins or deficiencies of vitamin B12 and folic acid) are particularly important to identify as these conditions may be treated partially by timely medical or surgical interventions and the dementia syndrome could be reversed fully or partially. These are sometimes referred to as "Reversible Dementias".

Symptomatic treatment may delay the relentless course of the disease and ameliorate the troublesome behavioural symptoms in Alzheimer's disease, Vascular dementia and other dementias. Timely support can help people with dementia and carers alike.

The standard treatment goals of dementia management include:

- Early diagnosis
- Optimization of physical health, cognition, activity and well being
- Detection and treatment of Behavioural and Psychological Symptoms of Dementia (BPSD)
- Educating carers and providing long term support to carers

People who suffer from dementia need to be treated with patience. Their dignity and personhood should always be respected. The carers require support and guidance. Their needs should be determined and attended to. Carers have to be educated about the course and symptoms of dementia. They could also be trained to manage many symptoms including behavioural symptoms at home.

Partially effective treatments are available for most core symptoms of dementia. These treatments are all symptomatic. They often help to reduce the severity of symptoms, but do not alter the progressive course of the disease. Importantly, psychological and psychosocial interventions (sometimes referred to as 'non-pharmacological' interventions) may be as effective as drugs, but have been less extensively researched, and much less effectively promoted.

Cholinesterase Inhibitors (ChEIs) and NDMA receptor antagonists can lead to useful improvements in cognitive function, behavioural symptoms and daily functioning but their cost-effectiveness has not yet been established (National Institute for Health and Clinical Excellence, 2007). Recommendations regarding their use will depend upon affordability and availability of specialist support. These drugs are less expensive in India when compared to other countries. However, poorer sections in India may not be able to buy them. Hence, there must be an attempt to make these drugs available through the public run health care services along with other psychotropic drugs.

Behavioural and Psychological Symptoms of Dementia (BPSD)

For BPSD, antipsychotic drugs are effective minimally, although they may be very helpful for some patients, particularly amongst those with aggression as a main problem. There are serious concerns about their safety with an increased risk of death (Schneider, Dagerman & Insel, 2005) and cerebrovascular adverse events (Schneider, Dagerman & Insel, 2006). For these reasons, a brief duration of anti-psychotic drugs may be recommended with specialist input, particularly

when severe and distressing behaviour is troublesome and there is an imminent risk of harm. Physical health assessment, carer training and support are all indicated.

A large literature is available regarding the wide-ranging potential benefits of carer interventions in dementia (Sorensen, *et al*. 2006). There are several systematic reviews and meta-analyses which have shown the benefit of carer interventions in preventing or delaying hospitalization or institutionalization. Psycho-educational interventions require the active participation of the carer. Studies on carer education and training intervention indicate much larger treatment effects on carer psychological morbidity and strain (e.g. Dias et al., 2008).

The caregiver needs continuous help and support from other family members. Those who received support from others seem to cope better. Poorer families also need financial support to compensate them for the financial losses incurred. The government should consider providing financial assistance to those families and this can take the form of monthly income support for the carer as well as payments towards medical expenses of the patient.

Ideally, we should aim at improving the understanding about dementia. It is easy to name the condition as Alzheimer's Disease or other dementias. Failure to intervene, defeats the purpose. This can happen if we fail to acquire a scientific understanding of the condition. Naming is important and necessary for identification, but understanding is the key to management and improving care. Carers, the families and the civil society need to know more about dementia. We should be aware of the fact that there are several ways of helping people with dementia. We all need to have a better understanding about the meaning of having dementia and its implications. A lot can be done to improve the quality of life of the person with dementia and the lives of people who provide home-based care. It is essential to realize the importance of early intervention strategy and use a public health model for dementia care.

There is some evidence from studies with other chronic diseases like hypertension and diabetes mellitus that intervention programmes for vascular disorders and risk factors would possibly help in dementia prevention too. Greater integration of care and increased use of chronic disease prevention and management approach is desirable.

18.6.3 Depression

Depressive disorders are common in late life. Prevalence rates for depression in a community sample of elders have varied widely. Recent Indian studies suggest higher prevalence of depression (Rajkumaret et al. 2009; Jain & Aras, 2007).

Determinants of Geriatric Depression

The determinants of late life depression are definitely multiple. The major factors associated with depression are:

- Genetic factors
- Biological factors
- Physical factors

- Psycho-social factors
- Economic factors

There is evidence of specific relationship between physical illness and depression in at least three areas:

1. Depression presenting as physical illness
2. Physical illness presenting as depression
3. Influence of physical disease on the course and outcome of depression

Depression can be physically disabling. Fatigue, sleep disturbance and loss of appetite may be compounded by self-neglect, inactivity, and a reduction in patient's motivation to take treatment for physical illness. Depression is a common reaction to a physical disability. The fact that depression is apparently reactive does not mean that the patient may not benefit from appropriate antidepressant therapy in addition to treatment for physical disorder.

Five possible reasons leading to presence of depression in physical illness are as follows:

1. Depression may be a consequence to treatment
2. Depression may be a consequence of organic brain diseases
3. Depression may be a psychological reaction to physical illness
4. Depression may predispose the individual to onset of physical disease
5. The behavioural consequences of depressed mood may cause or complicate physical ill health through starvation, self neglect and self harm.

Moreover, the physical disorder and disability may increase the individual's vulnerability to other adverse life events that predispose to depression and also inhibit recovery from depression.

Concurrent symptoms of co-morbid physical illness and cognitive impairment can lead to under-diagnosis of depression. Emergency room visits are usually due to suicidal behaviour, refusal to eat, intense agitation, or due to severe fear and paranoia. Antidepressants may be precribed by medical specialists to ameliorate depression.

Agitation is a state of restlessness. It is experienced by the patient as inability to relax and is seen by the observer as restless activity. When agitation is severe, patient cannot sit for long time and usually paces up and down. It is a common in older patients with psychosis and depression. It can also occur in dementia and akathisia.

Severe psychomotor agitation is often relieved by small doses of antipsychotics. However, drugs have to be used judiciously in older people. Suicidal rates are high in this age group and suicidal behaviour should lead to detailed psychiatric evaluation. Early identification and prompt management of depression can be life saving.

Counselling, psychotherapy and family therapy is very important. Information and education about depression will help. Emotional support is important. Removing negative cognitions, arousing hope and dealing with pessimistic

thoughts and low self esteem can be achieved through counselling and family therapy. Frequent sessions are important.

18.6.4 Other Psychiatric Disorders

Psychosis in late life could be broadly classified into two groups based on the onset of the illness. There are many individuals who have psychotic illness with onset in adult life and is at present older than sixty years. Late onset psychotic illness is rather rare and would require careful evaluation to rule out brain or related organic pathology.

18.6.5 Suicide and Suicidal Behaviour

Older adults have the highest risk of death by suicide of all age groups. Suicidal behaviour in elderly is more planned and deliberate, and means are more lethal. All older people with history of suicidal ideation or attempt are at very high risk for suicide. Evaluation for psychiatric morbidity is very important. Depression should be treated aggressively if present. Undetected, untreated depression is the most important cause for suicidal behaviour in older people. This has to be explained to the patient, caregivers and family members. Identification and adequate treatment of depression can indeed prevent a number of suicides in older people. Depression could be missed especially when it is present along with disabilities and medical problems in an older person. Clinician should never ever dismiss depressive symptoms and suicidal behaviour as insignificant in an older person.

18.7 CAREGIVER INTERVENTIONS

Women are more likely to be carers than men. Provision of sustained personal assistance carries its own burden. The provision of intensive informal care to frail older people can have profound consequences for the carer. This is particularly so if the older person has a cognitive impairment. The responsibilities of caring often constrain social participation and necessitate withdrawal from the work force. Intensive caring can have adverse effects on the psychological health of carers. There is consistent evidence that carers are more at risk of mental health problems, particularly stress and depression, than other adults of the same age. It has been well recognized that ‘carers’ also require support and assistance. One of the aims in providing services to carers is to reduce these negative effects of carer stress by supporting carers.

All caregiver interventions should focus on three ingredients :

1. Information and education
2. Caregiver support
3. Guidance for home-based care

Caregiver support is important in management of late life mental health problems. Management of disabled older people with behavioural disturbance can be very stressful for the families. Identifying and managing behavioural symptoms of dementia and provision for caregiver support are important. Care can be delivered by trained primary care teams, with a paradigm shift towards chronic continuing care and community outreach. Care delivery will be more efficient when integrated with that of other chronic diseases, and more broadly based

community support programmes for the elderly and disabled. To be successful, all efforts in psychogeriatric service development need to be supported by a clearly spelt out policy on long-term care and political commitment.

Future directions

Care provision for mental health problems of late life is less than adequate. Major conditions like dementia remain as hidden problems. There are no accurate estimates for the treatment gap for dementia in India in general, but this is likely to be huge. There are several major barriers to closing this treatment gap including the low levels of awareness about dementia and depression as medical disorders. The most significant barrier is the very low human resource capacity for the care of people with mental disorders. This scarcity of resources is true for all mental disorders across the continuum of life and has been systematically documented in the recent Lancet series on Global Mental Health (Saxena, et al. 2007). We lack the economic as well as the human resources to achieve widespread coverage of specialist services. Moreover, specialist services which tend to focus mostly on medical interventions may have only a limited role in the long-term care of older people with mental health problems, especially those with conditions like dementia. When we develop services, we should cater to the requirements of home-based care and address the diverse medical and psychosocial health needs of the affected persons and their caregivers. This bottom up approach is necessary for better acceptance of mental health care by the community. To be sustainable the services should meet the needs and aspirations of the communities they serve. Development of culturally appropriate interventions at affordable costs is important. Public and low-cost service providers have an important role in services provision.

It is important to note that mental illness is seldom an isolated event among elderly people; thus , co-morbidity with other mental illnesses and physical health problems is typically the rule. The most common problems include deficits of vision and hearing, hypertension, diabetes mellitus, arthritis and cardiovascular disorders. Thus, an ideal model of care for mental disorders in older people must fully address their physical health needs as well. There is a need to raise awareness about mental disorders in late-life in the community and amongst health professionals, and to improve access to appropriate health care for the elderly with mental illness. Health education should aim at educating health workers and the community to recognize the common symptoms of mental disorders and, in particular, to stress that depression and dementia are real disorders and not just the natural consequences of ageing.

Integration with other services

In India there is a large network of government run primary health centres and hospitals which work side by side with extensive private health care and not-for-profit providers. Manpower shortage and poor infrastructure are common in the government system. Implementation of decentralized planning under the new *panchayathi raj* system of governance has opened up opportunities to develop and test models for dementia care. One such initiative began at the Talikulam Rural Development Block in the Thrissur District of Kerala that (Shaji et al., 2002 & 2003) involved working closely with the *anganwadi* workers and the community leaders and developing a service for older people as well as running a monthly mental health clinic to address problems of the older people. The community based dementia care module developed can be useful for training health voulunteers.

Palliative care and care of older people

Indian Association of Palliative Care has formally declared its resolve to provide services for older people with disabling conditions like dementia through their community care network. The palliative care model in community care is unique by the partnership between health activists, health care professionals and specialists in palliative care. Clinicians with special interest/ training in dementia care or psychogeriatric care can also consider linking with similar community care initiatives. An alliance between the clinician, caregiver and the health worker can help. Health workers like, Accredited Social Health Activists (ASHA) or other community health workers can be trained to identify people with dementia and other unmet mental health needs (Shaji *et al.*, 2002). They could then be trained to deliver simple interventions at home as part of their community work.

Community care for older people with mental health problems

There are three important steps in the development of responsive community-based services. The first is to identify people with dementia or other mental health problems needing help.The second step is the assessment of identified cases and the needs of the caregiver. Then health workers after receiving more training can provide simple home-based interventions. The focus should be on improving the quality of life of the patient and the caregivers. The ingredients of the intervention should include educating the family and the caregivers about the illness and its management, and assisting the caregiver in manageing distressing symptoms. Special attention should be given to the assessment and management of behavioural symptoms as well as impairment in basic activities of daily living. Simple cost-effective intervention strategies will have the potential for wider application in the community.

Attention needs to be directed towards the development of age-appropriate long-term care policy. There have to be mechanisms for ensuring the social protection of older persons. Conditions like dementia are important causes of dependency among older people. Community based services can address the needs of people affected by a wide variety of disabling and incurable conditions. A network of nurses and doctors with expertise can supervise and support such initiatives. Dementia care can be delivered as part of such initiatives (Prince, et al., 2009).

Depression is more prevalent than dementia and is eminently treatable. There is a need to equip primary care to identify and manage depression and other mental health problems of late life. Outreach services need to include health care of older people as a priority. Linking of outreach services with primary care and specialist psychogeriatric care should be attempted . Well informed community health workers can play a key role in scaling up of services.

18.8 LET US SUM UP

This Unit has focussed on the concept of demographic ageing and the common health problems; particularly mental health issues during old age. Delirium, dementia and depressive disorders are common in late life, as are sucidal tenderncies. A concorted effort needs to be made at the individual, family commiunity and public health service provision levels to address these problems, and to foster the physical and mental health of the elderly.

18.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Reduced birth rates with increasing life expectancy is leading to an increase in the proportion of older people in our population and this phenomenon is called demographic ageing.

Check Your Progress Exercise 2

1. Memory loss, urinary incontinence, depression and falls/immobility.
2. Primary Health Care centres

Check Your Progress Exercise 3

1. Loneliness, reduced social support and need for assistance in activities of daily living are common stressors in later years of human life.

Check Your Progress Exercise 4

1. (i) True, (ii) True, (iii) True

Check Your Progress Exercise 5

1. Delirium
2. Clouding of consciousness

18.10 UNIT END QUESTIONS

1. With the help of examples, discuss ageing and mental health in the Indian sociocultural context.
2. How can the mental health problems in old age be addressed effectively? Analyse, giving examples.

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