

to socialise with the extended family and the wider community and, finally, how to cope with their deteriorating biological functioning (sleep, appetite, bowel/bladder). As the burden of caring directly correlates with the level of independent functioning of the patient (Ryden, 1998), it was understandable that the carers were worried about the future ability of patients to care for themselves.

Gender sensitivity is required in understanding carers' problems in dealing with an ill relative. We found that male and female carers had different requirements and concerns in caring for a spouse with geriatric problems. The specific concerns of female spouses centred on the burden of increased responsibility, the difficulty in understanding erratic behaviour, the loss of the family's breadwinner, a loss of sense of protection and security, their increased dependence on adult children and the extended family, and being blamed by society for their spouse's condition. The specific concerns of male spouses who were carers included difficulties with household chores, a loss of routine, difficulty understanding erratic behaviour and increased dependence on adult children and the extended family. Among the wider group of carers, the needs of children of patients differ from those who are spouses. Programmes should be developed to address different needs, depending upon the gender of the carer and the relationship to the patient.

The results need to be understood in the light of certain limitations to the study, such as the short duration of the group sessions (30–45 minutes, due to limited resources and lack of infrastructure). Further, as it was an open group session for out-patient carers, the group composition varied, and not all carers were able to attend all three group sessions.

In conclusion, the geriatric group programme was acceptable to the carers of out-patients with geriatric ailments. Further development and distribution of group intervention

materials, such as handouts on the various topics discussed, could be helpful for carers. Future programmes need to deal with gender-specific issues in taking care of patients with geriatric disorders before the efficacy of these group sessions is tested in a larger, controlled intervention study.

Memoriam

The primary researcher in this study, Dr Udaya Kumar GS, passed away in June 2007. The authors dedicate this paper to him.

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THEMATIC PAPER – CARE FOR ELDERLY PEOPLE WITH MENTAL ILLNESS

Twenty-five years of expectation: where are the services for older people with mental illness in Africa?

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Mental health disorders account for about 14% of the global burden of disease. Neuropsychiatric disorders may be responsible for more than 1.2 million deaths annually (Prince *et al*, 2007). Around 80% of those affected live in low- and middle-income countries. Yet, despite the fact that older persons carry a disproportionate burden of non-communicable disease and mental disorder, they are not seen as priority issues for healthcare provision in these countries. Logically and ethically, older persons should be prioritised for targeted interventions,

alongside the generic strengthening of primary and community health provision. African governments, spurred on by the specific agendas of non-governmental and parastatal organisations, continue with more urgent tasks; their healthcare provision is oriented towards the 'younger generations' (maternal and child healthcare, and infection). In most African countries, the expenditure specifically targeted for mental health is below 1% of the total healthcare budget, that is, effectively non-existent (Saxena *et al*, 2007).

Should the mental health of older persons receive a higher priority?

Some 8–18% of older adults live alone in Africa, and the probability of living alone is greater for older women than it is for men (Bongaarts & Zimmer, 2002). Today, approximately 3–5% of Africans are aged 60 years or more and are, in broad terms, widowed females with little or no formal education who live in relative rural poverty. Urbanisation, the transforming effect of wage-based economies on rural extended families and their subsistence lifestyles, and migration will increase the tendency for older Africans (especially women) to be left alone and unsupported within rural areas.

Although the proportionate rise in the population aged 60 and over in Africa in coming decades will be relatively modest, the absolute number of individuals in this age range is predicted to rise from 48 million in 2005 to 207 million by 2050 (Ferreira, 2008). This increase poses dramatic prospects for African healthcare planners. As population ageing progresses, the number of older persons with mental health problems will proportionately increase too.

The next four decades will witness more than 150 million newly recruited older Africans without adequate provision of mental healthcare. More than 20 million older Africans may be living alone by 2050. As informal care inevitably erodes, the prospects for the older person with a mental illness must be poor. In today's world of rapid demographic transition, there is no certainty that the care of older persons, previously taken for granted within the informal social system of the extended family, will be sustained (Levkoff *et al*, 1995). Indeed, all evidence points to the contrary: in order to survive, most older Africans need to be economically active to the end, as informal financial support and retirement pensions are available to only a tiny minority. With no parallel increase in the provision of formal social or health services to cater for the associated increased need, evidence points to increasing numbers of premature and avoidable deaths among older persons with treatable mental health conditions (Clausen *et al*, 2007).

The demographic change towards benefits that accrue from increased life expectancy will be transient in Africa. An opportunity now exists for countries to experience 'the longevity dividend', but this will be short-lived. An increase in healthy life expectancy will initially provide a national economic benefit and, beyond this, it could also lead to a better fulfilment of life and to an increase in the older person's meaningful participation in the community. Countries in which this capacity to capitalise on longevity is not achieved, however, will experience an increase in the gap between healthcare demand and their capacity to deliver healthcare to the ageing population.

Is mental illness in older Africans different from that elsewhere?

Literature from Africa is scant, and even regular monitoring of mental illness and mental healthcare delivery is non-existent in most African countries. There may be variation in the distribution of causal mechanisms that contribute to risk of mental illnesses, such as dementias, in Africa compared with high-income countries (Hendrie *et al*, 2001). While there is little evidence that older Africans experience Alzheimer's disease,

vascular dementias or other degenerative dementias, cognitive impairment is relatively common, although it is typically observed to be at a lower prevalence than in Europe and the USA. In Botswana, cognitive impairment has been found in 9% of those aged 60 years and over, and the prevalence increases with age (Clausen *et al*, 2007). In addition, older Africans experience a higher risk of depression, of hereditary, nutritional and infective dementias, and, especially, of alcohol dependence (Prince *et al*, 2007). In Botswana, up to 25% of older persons experience one or more of these three common patterns of mental illness. The afflictions render them vulnerable to ostracism, social isolation, elder abuse and reduced physical function (Gureje *et al*, 2007). When they are accompanied by institutional prejudice and neglect, and an increased burden of other non-communicable disorders and physical disabilities, it is easy to see why the perceived need for provision of care may be low. Affected people simply die, and often do so alone (Clausen *et al*, 2007).

Thus, although the prevalence of a range of mental illnesses may be somewhat differently distributed across cultures, mental disorders of the elderly are potentially common in Africa. They may be relatively unrecognised because of the high attrition rates from these illnesses, which are due to a total lack of care provision.

In high-income countries, ageing and the loss of function in older citizens are addressed through the provision of targeted health and social care. Social care systems may differ between nations, but they always require central financial support. Governments usually provide a mix of cash transfers and formal care services, such as pension schemes, meals, home-based care and, ultimately, institutionalisation. It is likely that culturally sensitive approaches and systems will be required in Africa, but currently the only 'systematic response' to the needs of older Africans with a mental illness is near total neglect, in terms of formal service provision (Saxena *et al*, 2007).

What has been promised?

It is necessary to review and assess the effect of all the statements, resolutions, promises and commitments from a succession of international fora on this subject. On the part of the World Health Organization and the United Nations they include the First World Assembly on Ageing (Vienna, 1982), the Year of the Older Person (1999), the *World Health Report* (2001), entitled *Mental Health: New Understanding, New Hope*, and the Second World Assembly on Ageing (Madrid, 2002); there was also the African Union's *Policy Framework and Plan of Action on Ageing* (2003). Together these amount to an enormous quantity of work and expertise. But to what end?

How has Africa benefited? Can Africa meet the challenge?

On the face of it, there has been scant, if any, tangible benefit for older Africans with mental illness in the past quarter century. Of course, it is always possible to cite individual projects that have been notable and effective, but these invariably were local and driven by particular individuals. They

often withered as time passed. At governmental policy and planning levels, if the problem of mental health remains unrecognised and unacknowledged, then there is little that can be achieved. However, if a commitment to the implementation of carefully constructed and targeted community-based interventions were possible, harnessing the rich tradition of community support (*ubuntu*) that persists in rural Africa, a transformation is viable. Hope for the new cohorts of older Africans rests on those brave policy-makers who acknowledge the need to allocate resources to mental health.

If, instead, African governments continue to fail to meet this challenge, there is little point in rehearsing the specifics of appropriate interventions. The intentions, guidelines and suggested interventions already exist in thick documents carefully constructed by numerous international experts (United Nations, 2002; Patel *et al*, 2007). African countries can still prepare to meet the challenge of increasing numbers of dependent older persons with mental illness, by training personnel and preparing adequate health service systems, before these problems reach overwhelming proportions. Health service improvement cannot be cost free, but the provision of appropriate community care services and the training of lay persons who could assist older persons in maintaining independent function for as long as possible would be a cost-effective starting point.

We do not need more good intentions; older Africans now deserve commitment and action.

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THEMATIC PAPER – CARE FOR ELDERLY PEOPLE WITH MENTAL ILLNESS

Elderly people with mental illness in South-East Asia: rethinking a model of care

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The report *World Population Ageing 1950–2050* (United Nations, 2002) estimated that in 2005 there were 37.3 million elderly people (i.e. aged 65 years or more) in South-East Asia (a region incorporating Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam). There are only a few epidemiological studies on mental disorders among elderly people in this region and the published data are mainly from Singapore, Malaysia and Thailand. Using Singapore's prevalence rate of 3% for dementia and 5.7% for depression, the numbers of elderly people with dementia in this region would be 1.2 million and with depression 2.12 million (Kua, 1992; Kua & Ko, 1995). However, even in Singapore, we have identified only 10% of all potential cases of dementia and depression – meaning that the large majority of elderly people with mental disorders are not detected, although they may be known, for other reasons, to the health services.

The under-diagnosis partly arises because most doctors are not taught geriatric psychiatry in the undergraduate curriculum, and even those with some training have difficulty recognising the early signs and symptoms. Medical students are often given clinical teaching in the context of a general hospital or mental hospital, where cases of dementia or depression are of moderate to severe degree. However, within primary care the clinical presentations are usually mild and may not yet fulfil the criteria (DSM or ICD) that apply to the diagnosis of more advanced disorders.

Access to services

In most South-East Asian countries there is a dearth of mental health services and human resources (Tasman *et al*, 2009). Unfortunately, the priority accorded to geriatric care is often low; geriatric psychiatry is never a popular