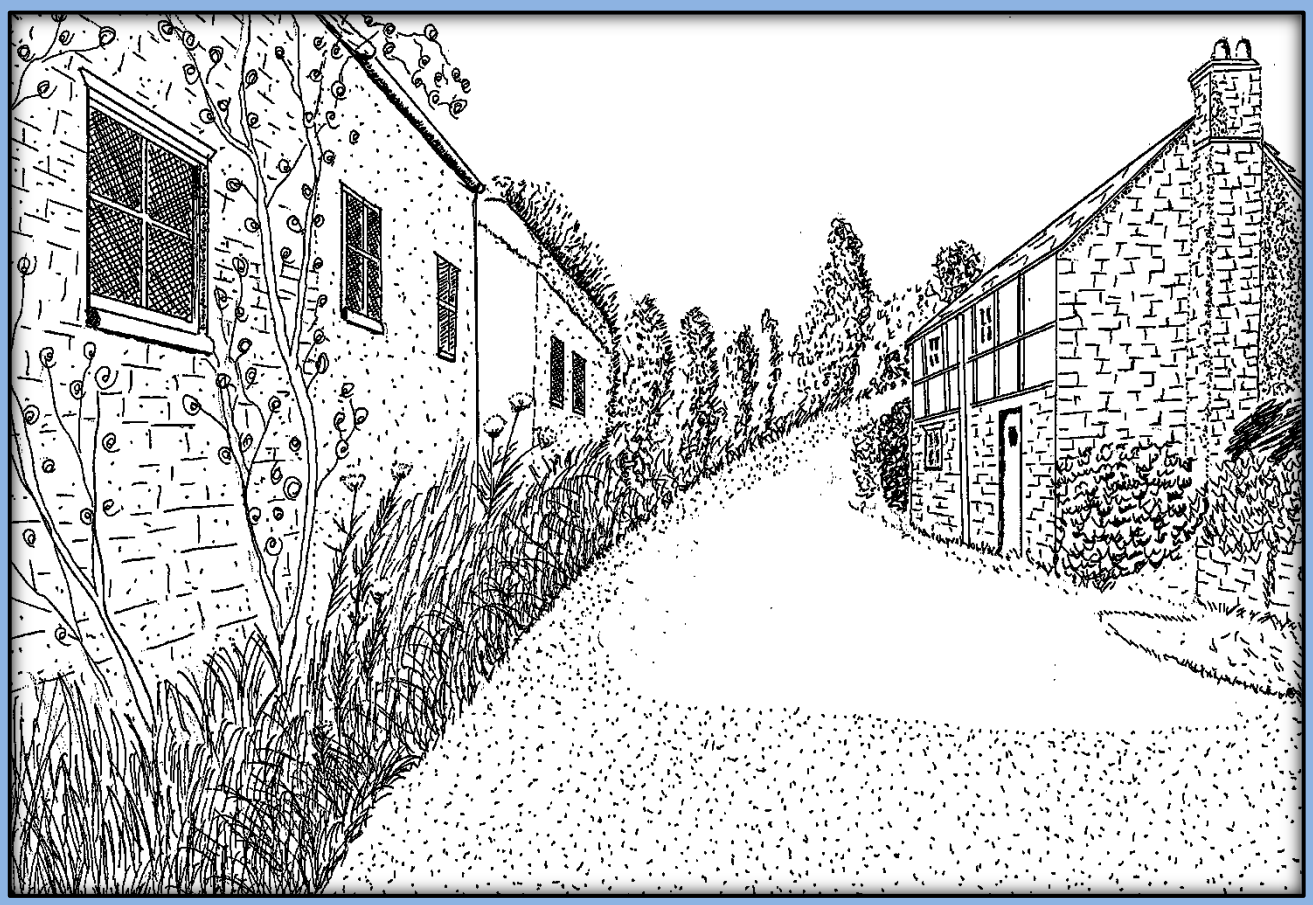
# JOURNAL OF GERIATRIC CARE AND RESEARCH



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Editorial

# Care needs of older persons

Nilamadhab Kar

## Summary

Older persons have a range of care needs beyond the health and basic needs for daily living. Social care, safety and security, companionship, love and respect are some of the needs which need to be addressed adequately. It seems there are many unmet care needs of the older persons in different societies. These needs should be identified and supported through appropriate measures.

With increase in age, the functional capabilities dwindle gradually. From an absolutely independent life, the dependency upon others begins, initially for more complex activities to relatively simpler activities of daily living, until the very basic ones fade. The age at which that happens differs individually considering many factors including mostly physical and mental illnesses. However it may also differ in different cultures and societies. It is interesting to observe the opinions about 'when does old age start'?[1]

Dependency upon others becomes prominent when the skills for day to day activities become deficient. Matching with the decreasing abilities, care needs of the elderly increase. These needs are not just health related, which is most often highlighted; there are also needs for companionship, security, social belonging, and many more. In specific circumstances and societies priorities may be completely different. These could be very basic needs for life for poor people, where deficient diet and poor living conditions influence massively the quality of life of older people. In many trouble-torn societies and following massive man-made or natural disasters the needs of older people are often neglected when the resources are scarce. Safety and security of elderly with failing health and disabilities are a concern in almost all societies. Atrocities and abuse against them are common and are often not recognised or not reported.

Inadequacies in the support systems are observed everywhere. Facilities and supports designed for the young, able-bodied people do not fit well to the needs of the elderly. These difficulties result in restrictions in their movements, decreasing social engagements, lesser personal contact and gradual confinement to their houses. Often there is a sense of being left out and no longer being in the mainstream of society. With rapid changes in the societal norms and behaviour the generation gap becomes evident, faster than anticipated. Feelings of social belonging dissipate; and gradually loneliness and detachment ensue. Although there is still love and respect for the elderly in many cultures, the lack of these are being felt more and more.

Specific needs of the elderly with particular disability or illness deserve a specific mention. These kinds of needs are present in most elderly people; and in fact, many of them could be already dependent upon others for their care needs before old age because of specific disabilities. Support for these requires additional input; some of them could be possible only through continuing clinical or professional care. Understandably, these involve high cost, availability of expertise locally and other factors which are beyond the reach of individual families. Even the states feel stretched meeting these needs as their priorities differ.

A few examples of unmet care needs of the older adults may illustrate the issues better. Almost a quarter of older adults in France did not have their health care needs met,[2] whereas in the Netherlands, while the health care needs were met for most older adults in primary care, the emphasis was on psychosocial needs.[3] In the UK, concerns have been raised regarding the social care, where unmet needs are at significant levels for certain activities.[4] There are many other examples of unmet care needs in specific areas.[5,6,7,8]

These issues are well recognised across countries; however the remedial actions are not adequately evident. When the care of the elderly is discussed, emphasis is usually given to the basic needs for living and the health related issues which are obviously important. However, it is true that most countries struggle to meet even these basic needs effectively.[2] As a result, the care needs of most elderly people are not met; and the situation is particularly dire for people in the poorer section of society. There are issues of poor planning, infrastructure, socio-political and legal frameworks, bringing in constraints on the care provisions for the elderly. There are many unmet needs of the elderly at different levels; and this is ubiquitous. The care needs of the elderly should be delineated at individual and community level and should be addressed. Besides expertise and finances, these require a change in societal and cultural attitude and political will.

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Review

# Use of restraints in elderly with mental illness: to be or not to be?

Raveesh BN, Anil Kumar M Nagaraj, Narendra Kumar MS, Vijay Danivas, Soumithra Pathare, Joske Bunders

## Abstract

Elderly people are one of the most vulnerable populations in society. Those with psychiatric illness and/or physical debilitating illness are doubly disadvantageous. Coercion in psychiatric practise is a concept much talked about in the recent years in the perspective of maintaining the rights of the patients. Coercion in elderly is an issue with regards to common geriatric disorders like dementia. However, few published data exists amongst the Indian population on this newer aspect of coercion in elderly population. Western literature suggests that bedrails, belts and covert medications are the common coercive practices amongst elderly. They also suggest alternative measures to minimise coercion as well as modest coercion as a transient option to prevent harm out of problem behaviours in dementia. The existing laws in developed nations address coercion along with elderly abuse where as in India it is predominantly focussed on elderly alone. The current review gives an account on these dilemmas involved in coercion and alternative practices that can minimise the same.

## Key words

abuse, coercion, dementia, elderly, mental illness, restraints,

## Introduction

Reducing the use of seclusion and restraint has been identified as a major practice change initiative across globe. Despite moves to enhance the autonomy of clients of health care services, the use of a variety of physical restraints on the freedom of movement of frail, elderly patients continues in nursing homes in western countries.[1-3] The situation is not very different in India. Despite the fact that family and friends are often intimately involved in patients' care in India, standards of coercion and restraint have not been defined. With a lack of international comparisons it is all the more important to be aware of patients' individual rights and preferences regarding the necessity, mode and place of psychiatric treatment and also to recognise the legitimate interests and wishes of family members.

Restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour.' In this context, 'behaviour' means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is 'stopping a person doing something they appear to want to do'.[4]

## Indian context

Mental health policies and laws in low- and middle-income countries often fail to incorporate current international human rights and best practice standards to prevent violation of human rights.[5] Article 21 of Indian constitution (Right to life) defines that 'No person shall be deprived of his life or personal liberty except according to procedure established by law'.[6] The right to life is interpreted as more than mere existence and includes the right to live with human dignity and decency.

In the *Chandan Kumar vs. State of West Bengal*,[7] the Supreme Court heard of the inhuman conditions in which mentally ill persons were held in mental hospital at the Mankundu Hospital in the Hooghli district of West Bengal state. The Court denounced this practice and ordered the cessation of the practice of tying up the patients who were unruly or not physically controllable with iron chains and ordered medical treatment for these patients.

In India, refusal to consent and incompetency to consent are included in the section on 'admission under special circumstances' in the Mental Health Act (MHA) 1987.[8] It has been strongly criticized that 'competence' has not been defined in the purview of the MHA. In the MHA, 1987 there is no separate provision for forced treatment. The act delineates the procedure and the circumstances under which a person with mental illness can be admitted to a hospital against his wish; however there is no mention on the treatment process. It assumes that person is treated against his wish in good interest of the patient. The new Mental Health Care Bill 2013 brings about a rights-based protection of mentally-ill persons. This was never the focus of the MHA 1987 and the 2013 Bill fills this requirement of the UN Convention on the Rights of Persons with Disabilities by guaranteeing to all persons the right to access to mental healthcare, and a range of services for persons with mental illness including shelter homes, supported accommodation, community based

rehabilitation; the right to community living, the right to live with dignity, protection against cruel, degrading and inhuman treatment, the right to equality and non-discrimination, the right to information, confidentiality and access to medical records; right to personal communication, legal aid and the right to make complaints about deficiencies in provision of services in addition to other similar legal remedies. It is for the first time that any law has guaranteed such rights to equality, non-discrimination and the positive rights for provision of basic services to persons with mental illness. However, the recent draft proposal to amend the Indian Mental Health Act has not brought certainty to issues of coercion.[9]

The common forms of coercion in India are chemical, physical and mechanical restraint. These are described below.

## Types of restraint

There are different types of restraints. Restraint, whether it is chemical, physical, or environmental, is a limitation of a person's autonomy and freedom of movement.[10]

**Physical restraint:** direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual.[11] Broadly speaking, the need to use restraint, particularly physical restraint, arises from two distinct circumstances: those which are *planned* and those which are *unplanned*. *Unplanned physical restraint* refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. Under these circumstances immediacy does not allow time to plan ahead. Staff are guided by best practice guidelines and training. *Planned physical restraint* refers to restrictive physical interventions which have been planned via risk assessment and where there is an expectation that predicted circumstances are likely to occur. There is time for planning and restraint plans are structured and documented in health care records.

**Chemical restraint:** It involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control undesirable behaviour.

**Mechanical restraint**: It involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop a person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

**Environmental restraint:** It involves buildings designed to limit peoples' freedom of movement, including locked doors, electronic keypads, double door handles and baffle locks. Seclusion is an important sub-type of environmental restraint. It is defined as 'placing of a person, at any time and for any duration, alone in an area with the door(s) shut in such a way as to prevent free exit from that area'.

**Psychological restraint**: It includes constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up. It might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example removal of walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of preventing them from leaving.

Though there has been discussion about the restraint and coercion in patients with psychiatric disorder, there is a significant void when it comes to geriatric population. At present, to the best of our knowledge, there has been no publication from India in indexed journals focussing on coercion in elderly. There are some western studies throwing light on this issue.[2,3,12,13] But our day-to-day practise definitely indicates coercion in both psychiatric and medical settings either due to behavioural and psychological symptoms associated with dementia or as a result of delirium secondary to any medical causes. Though this is done with harm reduction (to prevent elderly from having falls and sustaining injuries) to patient as a primary motive, there has been no research looking at the extent of coercion, practices used as part of coercion and guideline for use in India.

A recent study done in Norway, which involved interviewing the nursing home staff infers that in Europe, patients suffering from dementia are subjected to different coercive practices like bedrails, belts and covert medication. The two main reasons being: the patients' incompetence to give consent for treatment and prevention of harm to patient.[12]

There have been acts and bills in place in the developed nations like the United Kingdom and United States of America. Protection of vulnerable adults (POVA) recognised the extent of elderly abuse and the need to prevent them. As part of that, no one previously involved in the abuse of the recipient of care/ sexual act with persons with learning disability/mental retardation are allowed to work in institutions where caregiving for elderly is involved. Similarly in the USA, an act to address the issue of protection of elderly - Older Americans Act is in place. All these acts mention restraint (physical or chemical) as a form of abuse. It is predominantly in the context of care of elderly in institutions and not in hospital settings when they are ill. Even in India, there exists a "The Senior Citizen's Bill 2005" which address the issue of elderly neglect as a social issue and not talk about the coercion or restraint in treatment settings.

## Legal and ethical dilemma

In mental health, there is a delicate balance between the need to prevent and manage aggressive behaviour so that

staff, consumers and visitors are safeguarded, and the need to promote the health and welfare of consumers in the least restrictive manner.[14] Medicating people with disabilities and elderly people is a contentious issue, particularly in situations that involve aggression. Some experts argue that medication can have a calming effect, and may help to "normalize" the individual (which means absence of aggression or problem behavior).On the other hand, critics argue that medication only masks the symptoms; it does not address them.[15] The issue becomes even worse when the evidence suggests that mental health workers may be over medicating their patients. Manyexperts challenge the assumption that use of restraints is necessary to protect the welfare of frail, elderly patients by drawing on a range of data indicating the limited efficacy of restraints. They argue that the duty to respect individual autonomy extends to a duty to respect the autonomy of patients who are elderly, frail and living in nursing homes.[16]

Here is a case illustrating the medico-legal implications. A patient with Alzheimer's disease was hospitalized and within 24 hours, after she was restrained, found dead. The county coroner called her death an accidental asphyxiation. A lawyer was obtained by the family to represent the family in a 'wrongful death suit'.[17] In addition, the Department of Justice alleged that the hospital violated the False Claims Act by collecting Medicare payments without "following federal rules on the use of chemical and physical restraints." The hospital agreed to pay the government $200,000 and to hire a consultant to review restraint usage at the hospital as part of the agreement. The settlement focused upon financial fraud of government funding rather than the actual harm/danger to the patient.[18]

A balance has to be struck between patients' autonomy and the suffering that absence of treatment may cause. The Hawaii declaration of the World Psychiatric Association provided guidelines for treating a patient who cannot express his or her own wishes regarding treatment and cannot see what is in his or her best interest because of their psychiatric illness. A compulsory treatment may or should be given provided it is done in the best interests of the patient. Patients should be encouraged to participate as fully as possible in all decisions about their care.[10]

## Strategies to minimise the use of restraint

A recent qualitative study explains the strategies to prevent and avoid the use of coercion in elderly. Strategies like 'deflection and persuasion', 'limiting choices by conscious use of language', 'flexibilities' like trying later, change of personnel and one-to-one care with respect to patient's temperaments and 'seclusion' have been explained in detail. The study also lists some prerequisites to avoid coercion. These include knowing the patient, resources in nursing home, adequate staffing and competence of staff. These are discussed exclusively in case of elderly patients.[12]

Another European study has tried to answer some critical questions in relation to coercion in dementia patients. These questions include: When should people with dementia be submitted to coercive care? Who should decide about this? Within what legal framework should the medical personnel who are practicing coercive care operate? The study indicates coercion as a mode of treatment when it is modest. The study explains that 'modest' coercion is one which is exerted where the patient is incapable of autonomous decisions for his treatment. It also discourages 'meddlesome' coercion which is imposed even when the patient is capable of autonomous decision. The author concludes that one has to choose between two options: a law giving too much licence to health care personnel and a hypocritical system that gives no licence at all, but takes for granted that they will take action when they should do so, but not otherwise.[13]

Mental health clinicians should be trained in skilled communication that is two-way, open, repeated, empathic, and accommodative. Along with communication, detailed documentation is necessary to explain why a particular action (e.g. involuntary treatment, seclusion or restraint, etc.) was felt necessary under the specific circumstances. Facilities should be available for advanced planning for the possibility of future incapacity, for example, by the use of joint crisis plans and advance directive. This can help reduce compulsory admissions and treatment in patients with severe mental illness, and may affect the amount of perceived coercion.[11]

The doctrine of the 'least restrictive alternative' ('least' in terms of modality, severity, and duration of the action taken) should be used. Positive approaches, such as persuasion, should be the strategies of choice and negative approaches, such as threats should be avoided. Professionals should be explicit about what they are doing and why, should allow patients to tell their side of the story, and should seriously consider this information.

## Conclusion

Elderly people with mental disorders are one of the most vulnerable populations in society. They often end up in unhygienic and inhumane living conditions either in the community or in the mental hospitals with increased likelihood of human rights violation. Mental health legislation acts as an important means of protecting the rights and dignity of persons with mental disorders. However, mental health care providers and hospitals should implement strategies for adequate staff, infrastructure and effective staff training on management of aggression and violence safely for staff and patients. This needs to include evidence base and safe de-escalation, as well as restraint techniques that have to be implemented only when alternative strategies like persuasion and one-to-one care fail.

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Case Report

# Improvement of tardive dyskinesia with quetiapine: a case report

Sujata Sethi, Pankaj Sheoran

## Abstract

Evidence suggests that second generation antipsychotics are expected to cause less tardive dyskinesia than first generation antipsychotics. We present a case of a woman who developed tardive dyskinesia with risperidone, a second generation antipsychotic but the same was alleviated by quetiapine, another second generation antipsychotic. This finding is discussed in the light of different pharmacodynamic properties of second generation antipsychotics.

## Key words

quetiapine, risperidone, tardive dyskinesia

## Introduction

Tardive dyskinesia (TD) is well known side effect associated with chronic use of first generation antipsychotic drugs, with a prevalence ranging from 30-40%.[1] As TD can be permanent and disfiguring, it has been a major limiting factor in the use of antipsychotic drugs.[2] It was hoped that because of different mechanism of action second generation antipsychotics (SGA) or atypicals would be free from this debilitating side effect. However reports suggest that annual incidence of TD in patients taking risperidone (7.6-9.4mg/day) is at the range of 0.3-0.5% suggesting that SGA are also not as safe as hoped.[3,4] Our case is unusual in a way that TD induced by one SGA is relieved by another SGA suggesting thereby the differential propensities of different second generation antipsychotics for TD.

## Case report

Mrs. A, 59 years old married Hindu female was brought with 7 months duration of bizarre delusions, delusions of persecution and of reference, somatic passivity and commanding auditory hallucinations with no evidence of substance abuse or of organic pathology and no contributory family history. A diagnosis of paranoid schizophrenia was made based on Diagnostic Criteria for Research (ICD-10).[5]

Physical examination and routine investigations including MRI scan of brain were within normal limits. The illness started at the age of 25. She was hospitalized four times till the age of 48 and was treated with a number of first generation antipsychotics. Mrs. A responded well to antipsychotics with almost complete inter-episodic recovery. She was lost on follow up and reportedly had kept well without any medication till the index episode.

At the time of contact with our services, she was already taking oral risperidone 2mg/ day for the previous 10 days so the same was continued and was gradually increased to 6mg/day over the next seven weeks. She showed improvement in her symptoms but developed extrapyramidal symptoms in the form of rigidity and fine tremors of both hands. Trihexiphenidyl 4mg/day was added and within 8-10 days extrapyramidal symptoms subsided. It could not be discontinued as extrapyramidal symptoms re-emerged as and when dose of trihexiphenidyl was reduced. After about 10 months she was noticed to have choreiform and athetoid buccolingual masticatory movements. Mrs. A was not aware of these movements and these movements disappeared during sleep. However over the next 2 months these movements progressed to involve both upper limbs. Diagnosis of TD was made according to Schooler-Kane diagnostic criteria for TD.[6] Risperidone was discontinued. However there was no change in TD movements. As the symptoms started to reappear quetiapine 150mg per day divided in three doses was introduced. The dose of quetiapine was gradually increased to 350mg per day over the next few weeks. Quetiapine not only controlled the psychotic symptoms but also alleviated tardive dyskinetic movements completely over the next 3 months. Mrs. A continues to do well without any TD movements.

## Discussion

Tardive dyskinesia is not a common side effect associated with SGA drugs. The incidence of TD in patients treated with risperidone for at least one year has been estimated to be around 0.5%.[4]

Our patient had some of the well documented risk factors associated with the development of TD i.e. increasing age (>55 years) and female gender. Development of EPS early in the treatment as well as use of THP are other associated risk factors.[7] There was no family history of any movement disorder. Though our patient was exposed to first generation antipsychotics earlier but she did not have any dyskinetic movements. Further she did not

receive any antipsychotic drugs for many years until this episode when risperidone was started. It seems the TD was induced by risperidone.

At a dose of 6 mg/day, risperidone is known to lose the balanced 5HT2/D2 blockade, resulting in more affinity for D2 receptors just like first generation antipsychotics. When given for long period, this dose can lead to supersensitivity of D2 receptors in the nigro-striatal system resulting in TD. However, if D2 receptor blockade is removed early enough, TD may reverse. This reversal is theoretically due to a "resetting" of these D2 receptors in the nigro-striatal pathway by an appropriate decrease in the number or their sensitivity once the antipsychotic drug that had been blocking these receptors is removed early.[8] However, after long-term treatment, the D2 receptors apparently cannot reset back to normal, even when antipsychotic drugs are discontinued.

This argument however, does not explain the reversal of TD movements with quetiapine. Second generation antipsychotic drugs differ in their affinity for D2 receptor at a high affinity state. Quetiapine ($K_D$ = 122nM) has much lower affinity than risperidone ($K_D$ =1nM).[9] Atypical antipsychotic drug with a low affinity for D2 and fast dissociation from the receptors (high $K_{OFF}$) would interfere less with physiological dopamine transmission, permitting antipsychotic efficacy without motor side-effects.[10] This hypothesis explains why TD induced by risperidone improved with quetiapine. A similar case has been reported by Bressan et al wherein TD induced by olanzapine was alleviated by quetiapine; and while augmentation of risperidone made the TD relapse, its withdrawal led to remission of TD.[11] This case and the case we report alert us to the fact that atypical antipsychotic drugs with high D2 receptor affinity carry the risk to cause TD. Quetiapine, because of its low striatal D2 occupancy and fast dissociation from receptors, makes it a better choice amongst atypical antipsychotics.

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JOURNAL OF GERIATRIC CARE AND RESEARCH

Insight

# Older lesbian, gay, bisexual and transgender persons in UK: Reviewing issues and concerns

Rahul V Chandavarkar, Maryam S Khan

## Background

Since time immemorial heterosexual culture has been the norm in human society and most people know little about the culture and experiences of Lesbian, Gay, Bisexual and Transgender (LGBT) people. 'LGBT' is a commonly used acronym that encompasses all people whose sexual orientation, gender identity or sex differ from heterosexual or male/female sex and gender norms, regardless of the identity labels people use.

Considerable proportion of the general population is known to be LGBT people. In the UK, the Integrated Household Survey, 2013 reported that 1.6% of adults identified their sexual identity as gay, lesbian or bisexual.[1] London had the highest percentage of adults identifying themselves as gay, lesbian or bisexual at 3.2%. Aspinall, estimated the numbers of elderly lesbian and gay men in the UK may be up to 1.2 million people.[2] In the United States, there are an estimated 1.75 to 4 million people aged 60 and over who class themselves as LGBT.[3]

The LGBT community is a vulnerable and marginalized segment of the population due to the stigma and discrimination experienced by them over the years. The older LGBT people especially of today are of a generation when they had very few rights or protection in law, as homosexuality was criminalised and pathologised in many societies. Consideration needs to be given to some salient factors and historical issues, to understand the vulnerabilities of today's LGBT elderly population and to address their needs.

## Historical discrimination in the UK: its potential impact on the present day elderly LGBT

Male homosexuality had been illegal in England since the Buggery Act of 1533 (female homosexuality was not specified in those days).[4] The law became even more strict in 1885 with the Criminal Law Amendment Act, which made all homosexual acts illegal. Perhaps the most famous prosecution was that of the writer Oscar Wilde in 1895.[5] After World War II, arrests and prosecutions for homosexuals increased. The government set up a Departmental Committee under Sir John Wolfenden, to consider both homosexual offences and prostitution. The Wolfenden Report,[6] published by the Government in 1957, began the process of decriminalisation of gay men by recommending that sexual relations in private between consenting adults of the same sex should no longer be a criminal offence. Ten years later, the Sexual Offences Act 1967 implemented the Wolfenden proposals.[7] The 1967 Act exempted gay men from criminal prosecution if consensual sex took place in private between two consenting males aged 21 or over.

## The psychosocial complexities of the older LGBT persons

The older LGBT population of today are not a homogenous group. Diversity exists in gender, ethnicity, educational attainment, income and many other characteristics; all of which would underpin their needs and influence their ability to access help and support. It should not be too hard to imagine that faced by such a lifetime of hardships, discrimination, social isolation, inability to express themselves openly and risk of verbal even physical attacks, most of these people have preferred to remain closeted; and with these continuing stresses, they have a risk of developing significant mental health problems. Fenaughty and Harre identified coming out (disclosure particularly) as one of the most stressful experiences for gay people.[8] These life experiences and evolved coping strategies of avoidance could have an impact on how these present day older LGBT individuals seek help for their psychosocial problems.

## Older LGBT adults and economic hardships

While specific data related to the educational qualifications of older LGBT population in the UK is hard to come by , the Integrated Household Survey, 2013 reported that over half of the population aged 65 and over (52.9%) in the UK had no qualifications.[1] This was the only age group with a higher proportion of people reporting no qualifications. Up to the age of 50, there were a higher proportion of men with no qualifications than women, whereas for those aged 50 to 64 there were more women (27.0%) than men (23.2%) with no qualifications. This information could potentially be extrapolated to older LGBT in the UK.

In the United States, research shows that one in six American's aged 65 and older are living in poverty.[9,10]

Poverty among lesbian, gay and bisexual people has been shown to be as high, or higher, than among the heterosexual population. According to a 2009 report led by UCLA's Williams Institute, 24% of lesbians and 15% of gay and bisexual men were poor, compared to 19% and 13% of heterosexual women and men, respectively. For LGBT older adults, a lifetime of employment discrimination, among other factors, contributed to disproportionately high poverty rates. Transgender people faced high levels of employment and housing discrimination, and consequent economic and housing instability. Many had lost jobs and homes due to discrimination. The economic and personal impact of this discrimination could have accumulated over a lifetime and had an impact on earnings and savings. Even those who transitioned in mid-life and started out financially secure were often devastated by discrimination.

Lack of employment, poverty, homelessness, lack of family support and social isolation over the years are some of social factors which could compound the economic difficulties faced by the older LGBT persons today, further impacting on their mental health and highlighting a need for greater support in the present day.

## Mental health in the older LGBT persons

King et al reported that both gay men and lesbians reported more psychological distress than heterosexual men and women.[11] Violence and bullying were very commonly reported by lesbians. Bullying was reported by both gay men and women, but men felt their sexual orientation was the main provocation for being bullied.

The San Francisco LGBT Aging Policy Task Force reported their findings in March 2014.[12] Most of the elderly surveyed had college degrees but 40% lived below national poverty levels. The most needed services included - housing, transportation, delivered meals, social events, in-home health services, support groups and assisted living options. One in three was reported as being clinically depressed and up to 41% of LGBT older adult participants had seriously contemplated taking their own life at some point. Many had experienced victimization and discrimination, mostly in the form of verbal assaults. Transgender and bisexual seniors reported higher levels of discrimination and abuse. One in three reported losing a life partner and over half of the surveyed elderly individuals lived alone. There was also a prevalence of upto 20% HIV/AIDS among those surveyed. There is a need for similar focused study on older LGBT population in the UK to ascertain the current state and the needs.

A systematic review and meta-analysis of studies of mental disorders by King et al reported a higher risk of alcohol and substance dependence in LGB people compared to their heterosexual counterparts.[13] However, the risk of dependence was particularly high in lesbian and bisexual women who had a four- fold relative risk of alcohol dependence over a twelve month period. In a study in the UK, Hunt & Fish, reported that about 40% of lesbian and bisexual women drink alcohol three or more times a week compared with a quarter of women in general.[14]

## Conclusion

There are a range of factors which influence the experiences, mental health and well-being of the ageing LGBT individuals. They constitute a vulnerable, ever increasing sexual minority within the general population. The impact and consequences on their mental health of negative reactions stem from a lifetime of experiencing discrimination, bullying and violence associated with their sexual orientation and gender identity, potentially even from family and friends following 'disclosure', making them uniquely vulnerable and at risk of significant mental illness. It seems common that this group of vulnerable elderly people lead lonely lives in isolation and poverty, important predictors for a myriad of mental illnesses, also putting them at further risk of self-harm and alcohol dependence.

There are gaps in knowledge about the older LGBT population in relation to their physical and mental health issues, use and experience of health and social services. Further research is needed, exploring these issues impacting the wellbeing of the elderly LGBT. There is a need for increasing awareness, providing training to care givers and improving available resources to support the elderly LGBT. Finally, it may be through advocacy that awareness of the unmet needs of the elderly LGBT can be raised, which could then lead to the development and provision of care pathways for this vulnerable population.

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JOURNAL OF GERIATRIC CARE AND RESEARCH

Insight

# Physical activity in older adults: importance re-emphasized

Physical inactivity is common in older adults. Its negative impact on physical health is well known. In a recent study Souza et al have reported that that physical inactivity is associated with various adverse issues, e.g. poor self-rated health, activities of daily living, vision and depression and neglected self-care.[1] Universally, physical inactivity increases with age, however interestingly there are variations of activity level of older persons in different parts of the world. Contributing factors are many; e.g. besides physical fragility, availability of transport, different easy means of communication, changes in occupation, availability of social interaction for the older persons, motivation, interest and many more. To some extent, lack of awareness about its effect on health and illness contributes too. Considering the impact of physical inactivity it is important that this is highlighted to older adults and their carers.

World Health Organisation has recommended levels of physical activity and has given various examples of activities that can be undertaken.[2] The benefits of physical activity are manifold: lower rates of heart disease, hypertension, diabetes, certain types of cancer e.g. breast and colon, and overall mortality. It improves cognition, functionality and prevents various ailments. In addition, it helps preventing falls in older adults.[3] There are many research findings highlighting various benefits of the physical activities in older adults.

The message for the older adults is clear: It is important to check whether you are having enough physical activity and to remain active! It is also imperative for the carers to encourage and support older persons to achieve adequate level of physical activities.

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# Dignity of older people

It is a concern to observe that the dignity of the older persons is in jeopardy. It is observed in different situations from within their home, to health care set ups, care homes and society.[1] Dignity involves multiple facets, e.g. independence, self-respect, human rights and many more.[2] Self-esteem of the older people are affected when they are excluded from the decision making, patronised, not trusted and ignored. It is an irony to observe that in many societies they are no more respected or valued for their contribution to the society. Maintaining dignity while caring for older people is essential; and should not be compromised. This is of paramount importance for all who are involved in the care of the older persons, including professionals. Practices that may preserve the dignity while caring include sensitive listening, involving older person in the discussion regarding their care, respecting their views, individualized care, involving independent advocacy when appropriate etc;[3] and in some cases, it may need addressing the attitudes of the carers. However, it also involves social values and sense of responsibility of the carers.

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JOURNAL OF GERIATRIC CARE AND RESEARCH

## Creative Expressions

JMW Turner's Rock near St David's (2003) by Jim Laceby, England.

Creative pursuits are extremely important in healthy aging. There are many benefits of cognitively and socially stimulating activities in old age. It has been suggested that creativity may promote resilience and protect against cognitive decline. Out of many creative activities, painting and drawing are common and more importantly can be initiated at any age. Irrespective of the cognitive status painting may still be enjoyable. There are many examples of people who have taken up painting later in life and continued it long. It provides opportunity for meaningful expressions, interactions and personal satisfaction.

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Review

# Elderly mental health in North West Province of Pakistan: An overview in the context of violence and trauma

Amina Rashid

## Abstract

Older persons are known to have increased vulnerability for mental health related morbidity following sever traumatic events affecting masses. In this review, the situations of elderly people in Khyber Pukhtunkhwa Pakistan, which has been affected by violence and aggression for the past three decades, are highlighted. Evidently there is inadequate literature available on the subject which makes it difficult to portray the extent of the problem precisely. However, based on information at hand it is clear that the mental health related morbidities are wide-spread and intense. There is a need to have focused research in this area, to evaluate the extent of the problem and to reflect on the appropriate intervention measures. Scarcity of resource, availability of mental health professionals and a supportive system is evident. It can be stressed that joined effort of different professionals and organizations including media, voluntary and government organizations might be helpful to improve the situation.

## Key words

Elderly, mental health, morbidity, Pakistan, trauma, terror, violence

## Background

The North West province of Pakistan (Khyber Pukhtunkhwa Pakistan – KPK) bordering Afghanistan is one of the most ravaged regions affected by continuous violence and conflict for the past three decades.[1] The situation was aggravated by Afghanistan war, military operations, drone strikes, along with different local groups involved in violence and terror. There are now a huge population of Internally Displaced Persons, refugees and militants. The tension and stress in this region is at an extremely high level.

The nature of traumatic events includes kidnapping, torture, death, bombing, mass shooting, drone strikes, etc. In the last few years the incidence of kidnapping for ransom has been on constant rise in these regions of Pakistan.[2] Many kidnapped individuals return only after months and years in captivity and some unfortunately do not. In this situation, often one does not know whether the kidnapped person is alive or dead. There is further stress because of deteriorating economic situation in the area. Understandably people live in constant fear and despair.

## Mental health morbidity of elderly

It is well known that older persons are one of the most vulnerable groups in the events of mass trauma. However there is hardly any information about the mental health morbidity of elderly people in KPK. The psychological impact of this ongoing violence in the tribal regions of Pakistan upon the elderly has not been well-documented. The traumatic effect of the stresses and the unnatural and violent deaths of young family members on the elderly people are unspeakable. Yet, older people usually do not seek help nor is it provided to them proactively. There is a need to explore their mental health morbidity.

It is understandable that the population affected by these traumatic events would have greater mental morbidity. A clinic based study conducted in this region reported that 36% females had adjustment disorder and 21% males had post-traumatic stress disorder as most common besides depression and anxiety disorders.[3] It may be highlighted that in Pakistan approximately 10–16% of the population suffers from mental disorders.[4] Reported rates of depression in elderly in Pakistan is considerable, with ranges around 22.9%, 40.6% to as high as 66%.[5,6,7] A systematic review suggested that the mean overall prevalence of anxiety and depressive disorders in the community population of Pakistan was 34% (range 29-66% for women and 10-33% for men).[8]

It can be expected that the prevalence may be more in disturbed areas, among the victims of traumatic experience. Information from Federally Administered Tribal Areas (FATA) which is affected by violence and terror suggests massive number of people having psychiatric illness.[9] However, information specific to elderly victims of violence and terror are not available.

## Difficulties in providing mental health care

There are many challenges in providing mental health care particularly in KPK. Because of the stigma around mental illnesses and belief in supernatural causation

which are commonly present, many do not attend psychiatric services. However, other specific factors also play a role in this region. Following few incidences, there is fear of kidnapping of health professionals. There is a perception of inadequate security. In addition there is scarcity of mental health facilities and professionals in this region and patients may have to travel long distances to avail services. The other issue is lack of financial resources to fund for the treatment. Systems of support for elderly population are grossly deficient in Pakistan; [10] and specific mental health care of elderly is rather nonexistent.

## Conclusion

It appears that the traumatic experience and resultant psychiatric and physical morbidity of the elderly population in KPK has not been focus. It is probable that there is a considerable concern in this area. With an increase in ageing population, it means a large population are affected and need adequate care and attention. The extent of the problem should be evaluated and appropriate remedial measures should be put in place. It would involve collaborative work among various government and non-governmental organisations, social and public health professionals, including media. Physicians, psychiatrists and other mental health professionals can play a key role in the process supporting the affected communities and individuals. It may be easier to incorporate mental health care within primary care medical services already available there which can be supported by specialist services when needed.[1]

The efforts need long term vision, ensuring training of health care and other professionals, facilitating research, appropriate planning of services and community support systems and public education. Concerted efforts from all involved are essential which may be helpful in the process of recovery.

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Insight

# Predicting and preventing cardiovascular risk

Cardiovascular diseases (CVD) are a major cause of morbidity and mortality all over the world. Many risk factors for these diseases are well known and it is possible to predict the risk for heart attack or stroke. There are many CVD prediction scores;[1] however two commonly used resources in this regard are QRISK2-2011 (www.qrisk.org) and Framingham heart study (www.framinghamheartstudy.org). Based on large data bases involving huge patient population and cardiovascular events these methods provide reliable estimates of risks within a certain period of time.[2,3] The information used in calculating the risk can be easily used in primary care. The risk factors are also understandable to most people and can motivate to take actions on the modifiable ones. The usual risk factor considered for these are age, smoking, diabetes, hypertension, treated and untreated systolic blood pressure, total cholesterol, HDL cholesterol, body mass index (BMI). In addition, associated kidney disease, family history of early cardiovascular events, atrial fibrillation and rheumatoid arthritis are some of other factors that are taken into account while calculating some of the risk scores.

While knowing the risks are essential, it is important to take action regarding these to prevent cardiovascular diseases. There are major initiatives in this regard in many countries.[4-8] It needs to be emphasized that the prevention efforts are concentrated at population level. Actions are to be taken by various organisations including primary care and public health, however individuals themselves should remain aware and contribute to the preventive process through specific health actions.

Advice on strategies for preventing cardiovascular diseases at individual level is easily available; which are based on the greater understanding of the risk factors.[9-11] There are no surprises regarding the advices for individuals, which commonly include: healthy eating, being physically active, with regular physical exercise, keeping a healthy weight, no smoking, regular screening for hypertension, diabetes and high cholesterol and taking appropriate measure to keep these under control, getting good quality sleep, etc. However, the importance is in following these advices and practicing them regularly.

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Manuscript Preparation

# Instructions for authors

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The *JGCR* expects authors to follow the World Association's Declaration of Helsinki and base their article on researches conducted in a way that is morally and ethically acceptable. The research protocol must have been approved by the locally appointed ethics committee and informed consent must have been obtained from subjects (or their guardians).

Authors must explicitly state in the covering letter (on the first page of submission) that any necessary ethics committee approval was secured for the study. This fact should also be explicitly stated in the manuscript with the name and location of the approving ethics committee(s). The editors may request research ethics committee approval papers and may contact the ethics committee chair directly, where there is doubt about research ethics approval.

## Patient consent and confidentiality

Studies involving humans must have written informed consent from the patients. A statement regarding this must be included in the methodology. Where the individual is not able to give informed consent, it should be obtained from a legal representative or other authorised person. If consent cannot be obtained because the patient cannot be traced then publication will be possible only if the information can be sufficiently anonymised. Anonymisation means that neither the patient nor anyone could identify the patient with certainty. Such anonymisation might, at an extreme, involve making the authors of the article anonymous. If the patient is dead, the authors should seek permission from a relative as a matter of courtesy and medical ethics. They should check the specific laws in their country. Contributors should be aware of the risk of complaint by individuals in respect of breach of confidentiality and defamation.

## Structure of manuscripts

### Research article

The title should be brief and relevant.

A structured abstract not normally exceeding 150 words should be given at the beginning of the article, incorporating the following headings: Background; Aims; Method; Results; Conclusions.

Key words: Up to six key words should be provided.

Introductions should normally be no more than one paragraph; longer ones may be allowed for new and unusual subjects. This should be followed by Method, Results and Discussion sections. The Discussion should always include limitations of the paper to ensure balance. Use of subheadings is encouraged.

A subheading of practical implications of the observations is encouraged at the end of the article.

The article should normally be between 2500 and 3500 words in length (excluding references, tables and figure legends) and normally would not include more than 25 essential references beyond those describing statistical procedues, psychometric instruments and diagnostic guidelines used in the study. Authors are encouraged to present key data within smaller tables in the appropriate places in the running text. This applies also to review articles and short reports.

### Review

Systematic and narrative review articles should be structured in the same way as research articles, but the length of these may vary considerably, as will the number of references. It requires a structured abstract like that of research articles.

### Short report

Short reports require an unstructured summary of one paragraph, not exceeding 100 words. The report should not exceed 1000 words (excluding references, tables and figure legends) and contain no more than one figure or table and up to 10 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study.

### Case report

Case reports and series require up to 100 word abstract, and the length should not exceed 750 words (excluding references, tables and figure legends). The written informed consent of the individuals must be obtained and submitted with the manuscript. The individual should read the report before submission. Please refer to patient consent and confidentiality paragraph for further detail. In general, case studies are published in the *JGCR* only if the authors can present evidence that the case report is of fundamental significance and it is unlikely that the scientific value of the communication could be achieved using any other methodology.

### Editorial

Editorials require an unstructured summary of one paragraph, not exceeding 50 words. Editorials should not exceed 1000 words and may contain no more than one figure or table and up to 10 essential references.

### Letters to the Editor

Letters may be submitted either as responses to published articles, to inform about particular situation or raise pertinent issues, for expert opinion or as general letters to the Editor. Letters may be up to 400 words in length with a maximum of 5 references.

### First person account

In first person accounts *JGCR* publishes carers' or patients' own experiences in the care or the elderly, that can be considered significant and provide learning points for others.

### Insight

This section includes reviews on recent research findings, book, film or web resources as short articles up to 400 words. Authors can include good practice examples, inspirational experiences, and highlight neglected areas. Essays up to 1500 words in descriptive prose can be submitted on any topic related to geriatric care.

**Viewpoint**

These are personal opinion pieces which may reflect an individual perception, involvement, or contribution to geriatric care and should be prepared like a Review.

**Filler**

Fillers are published at the end of articles where space allows. These comprise a wide range of material considered to be of interest to readers of the *JGCR*. Examples include news regarding developments that can influence the care of elderly, poems, painting, photographs, quotations, important internet links, etc.

## References

Authors are responsible for checking all references for accuracy and relevance in advance of submission. All references should be given in superscripted number in the order they appear in the text. Place superscript reference number after commas and full stops, unless the superscript is attached to authors name or title of book/database. At the end of the article the full list of references should follow the Vancouver style. If there are more than six authors, the first six should be named, followed by 'et al'.

Example of journal articles:

The authors' names are followed by the full title of the article; the journal title abbreviated according to the PubMed; the year of publication; the volume number; (issue number in bracket); and the first and last page numbers.

1 Singh SP, Singh V, Kar N, Chan K. Efficacy of antidepressants in treating the negative symptoms of chronic schizophrenia: meta-analysis. Br J Psychiatry. 2010; 197(3): 174-9.

References to books should give the names of any editors, place of publication, editor, and year. Examples are shown below.

2 Murray PR, Rosenthal KS, Kobayashi GS, Pfaller MA. Medical microbiology. 4th ed. St. Louis: Mosby; 2002.

3 Meltzer PS, Kallioniemi A, Trent JM. Chromosome alterations in human solid tumors. In: Vogelstein B, Kinzler KW, editors. The genetic basis of human cancer. New York: McGraw-Hill; 2002. p. 93-113.

4 Foley KM, Gelband H, editors. Improving palliative care for cancer [Internet]. Washington: National Academy Press; 2001 [cited 2002 Jul 9]. Available from: http://www.nap.edu/books/0309074029/html/.

5 Cancer-Pain.org [Internet]. New York: Association of Cancer Online Resources, Inc.; c2000-01 [updated 2002 May 16; cited 2002 Jul 9]. Available from: http://www.cancer-pain.org/.

Personal communications need written authorisation (email is acceptable); they should not be included in the reference list. Unpublished doctoral theses may be cited (please state department or faculty, university and degree). No other citation of unpublished work, including unpublished conference presentations, is permissible.

Further information about the references can be availed from
http://www.nlm.nih.gov/bsd/uniform_requirements.html

## Tables

Tables should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information. The heading of the table, together with any footnotes or comments, should be self-explanatory. The table should be placed at the desired position of the manuscript.

Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

## Figures

Figures should be clearly numbered and include an explanatory legend. All figures should be mentioned in the text and the desired position of the figure in the manuscript should be indicated.

Authors must obtain permission from the original publisher if they intend to use figures from other sources, and due acknowledgement should be made in the legend.

## Statistics

Methods of statistical analysis should be described in language that is comprehensible to most readers. Raw data for the studies may be asked at any time up to 5 years after publication of research in the *JGCR* and the authors are suggested to keep these safe.

## Qualitative research

The *JGCR* welcomes submissions of reports of qualitative research relevant to the scope of the care of elderly.

## Registration of clinical trials

The *JGCR* recommends that all clinical trials are registered in a public trials registry.

## Abbreviations, units and footnotes

All abbreviations must be spelt out on first usage and only widely recognized abbreviations will be permitted. Abbreviations usage should be consistent throughout the article. Use abbreviations sparingly; consider using one if it is repeated more than three times.

The generic names of drugs should be used.

Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses.

Footnotes are not allowed, except table footnotes.

## Proofs

A proof will be sent to the corresponding author of an article which should be sent back within 7 days.

## Copyright

On acceptance of the paper for publication, all authors should transfer copyright to the Geriatric Care and Research Organisation (GeriCaRe).

## Open access

There is no submission or publication fee at present for papers published in the *JGCR*. All papers published in the *JGCR* become freely available.

## Clinical trial registration

All clinical trials must be registered in a public trials registry. This is a requirement for publications of the trials.

## Ethical considerations

Authors should consider all ethical issues relevant to their research, and briefly address each of these in their articles. Authors of reports on human studies, especially those involving placebo, symptom provocation, drug discontinuation, or patients with disorders that may impair decision-making capability, should consider the ethical issues related to the work and include detailed information on the informed consent process in the Methods and Materials section of the manuscript) including the method or methods used to assess the subject's capacity to give informed consent, and safeguards included in the study design for protection of human subjects. Approval from an institutional review board (IRB)/ ethics committee should be mentioned in the methods. In organizations where IRB is not available; the authors must include a statement that research was conducted in accordance with the Helsinki Declaration.

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