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Contents

- 25 Elder abuse: a major public health problem**
N Kar
- 27 Care arrangements for persons with dementia: A review on formal care and its relevance to Indian context**
S Ganesh, S Dhanasekaran, L P Nirisha, S S Chatterjee, P T Sivakumar
- 35 How effective is a crisis resolution and home treatment team for older people at reducing the number of admissions and length of stay in mental health wards?**
R Radhakrishnan, J Ramaswamy, S Muthalif, L Head, R Butler
- 40 Sudden onset speech impairment in a patient with schizophrenia: challenges in diagnosis**
M K Shahi, S K Kar, A Patel
- 43 Carbamazepine induced Stevens-Johnson syndrome: a case report**
J A Siddiqui, S F Qureshi, A Al Duraibi
- 46 An overview of Diogenes syndrome in the context of animal hoarding: a rare disorder**
S Zahid
- 49 Existence of boredom among the elderly: the need to further explore the concept**
P Bantwal
- 51 55 not out – views of an ageing consultant geriatrician**
D Leung
- 52 A hidden dimension of avoidable patient harm?**
J Hudson
- 53 Author's response**
S Bhattacharyya
- 55 Autumnal fire**
S Middleton
- 56 News: National Award for GeriCaRe**

I Instructions for authors

Cover Inspirations



Elder abuse: a major public health problem

Nilamadhab Kar

Abstract

Elder abuse is common, but it is often under-recognised. It has wide ranging consequences in the form of physical and psychiatric morbidities, and early mortality. Most of the elder persons who experience abuse have no support or protective measures. It is extremely important to prevent elder abuse, identify it early and to intervene. Increased awareness and multidisciplinary approach involving various organisations are needed to deal with these concerns of older persons.

Key words

Elder abuse, management, prevalence, prevention, public health, risk factors

Introduction

Maltreatment of older persons is common and present in epidemic proportion; but they are not adequately reported or even recognized; and in many instances people are still simply unaware of its existence. Elder abuse is defined as: “(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship, or (b) failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm”.¹ There are many categories of elder abuse: neglect, emotional/psychological abuse, physical abuse, sexual abuse, and financial exploitation.^{2,3}

Prevalence

It is reported that abuse is common in everyday life of many older persons.⁴ Reported prevalence figures suggest that around 2.2% to 61.1% of elderly have some form of abuse.^{1,3,4} However, it is possible that the reported rates are lower than the actual prevalence of elder abuse in the society. The prevalence of different types of the abuse varies across countries. Most of the abuse occurs in the familiar context and neglect is most common type.⁶

Risk factors

Various risk factors of elder abuse have been reported. Dependence on others for physical needs, activities of

daily living, and care, along with financial constraints make the situation much worse.

Physical illness, frailty, cognitive impairment, psychiatric disorders, and past history of abuse of the older person; poor relationship with the carers, relational problem in family have also been identified as potential risk factors.⁷ In addition, carers’ burden and stress, their physical, psychiatric illness, lack of understanding, training, or skill of caring contribute to the problem. Often the carers are the family members who do not have any support for this role or respite from the responsibility leading to exertion.

Outcome

Elder abuse is associated with considerable misery, physical and psychiatric morbidities and premature mortality.⁵ A link between abuse and mortality has been reported.⁸ Depression is common in elderly with history of abuse.^{9,10} Many older persons suffer silently without any recourse to help.

Interventions

The problem of elder abuse requires multidisciplinary joint working to prevent, or to recognise early when it is happening, intervene and make it safer for the elderly people. It would involve primary and secondary health care systems, social welfare agencies, policymakers, non-governmental organisations working in the field and the general public.¹ Specifically, considering the categories of abuse a range of professionals may be needed to support the intervention process: general practitioners, geriatricians, emergency nurse, paramedics, psychiatrists, psychologists, pharmacists, occupational therapists, professional carers, community health workers, social workers, police, financial advisers, lawyers, and many others.¹¹

Public education is understandably one of the methods to improve awareness and detection; which may pave the way for prevention and intervention efforts. In addition, training of all the professionals working with older persons is essential to improve the chances of identification and effective management.

Interventions to improve knowledge and attitude of caregivers may be considered as an option, but the available evidence about its effectiveness is not robust.⁵

Family based interventions including cognitive behavioural approach has been suggested,¹² the processes may need further exploration, especially in different cultures.

Other suggested approaches include helplines, emergency shelters, protective money management systems, professional carers, etc. Legal safeguards are a must; with specific laws and departments to support elderly people and protect them from abuse. It is reassuring to observe that some countries have taken specific steps in this regard.^{7,13,14}

Support for the traditional carers is vitally important. Increasing awareness, training, respite care, and resources to support the elderly in their homes may help to decrease the risk of abuse.

Conclusion

Elder abuse is a complex issue and requires sensitive and compassionate approach. The knowledgebase on this is growing; however there is still a need for prevalence and intervention studies in different cultures; and sharing of good practice about management. There are many suggested interventions, which should be culture specific, relevant to socioeconomic situations or the elderly, acceptable and accessible. The clinical, psychosocial and cost effectiveness of the interventions need to be studied as well.

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Review

Care arrangements for persons with dementia: A review on formal care and its relevance to Indian context

Suhas Ganesh, Saranya Dhanasekaran, Lakshmi Nirisha P, Seshadri Sekhar Chatterjee, Palanimuthu Thangaraju Sivakumar

Abstract

Introduction: Population ageing and increase in prevalence of dementia in developing countries like India is occurring rapidly and has emerged as a major public health challenge. Compared to developed countries, India has poorly developed health and social care systems for chronic care in elderly. In this narrative review we summarize the literature on dementia care from India with specific focus on formal care services. **Methods:** We conducted a literature search in PubMed, google scholar, PsycINFO databases for relevant articles. We also collated information on existing services from national Alzheimer/dementia societies. **Results:** There is a sparsity of literature on dementia care in India. Dementia India Report, 2010 provides an estimate of existing formal care services in India which include day care, residential care, helplines, domiciliary care, support groups and memory clinics. Compared to the magnitude of estimated population with dementia in the country the existing resources are insufficient to meet the treatment gap. **Conclusion:** There is a great need as well as potential to improve dementia care services in India. There is a need to balance the research on novel treatments with care delivery as mandated in World Alzheimer's report 2016. This should include innovative research which is translatable to the cultural and financial situations in India.

Key words

Dementia, formal care, Alzheimer's disease, India

Introduction

As per the estimates of the World Health Organization, aging population is increasing globally with particularly rapid increase in developing countries like India. Even though the proportion of elderly population in India is lesser compared to the developed countries, the actual number of elderly population in India has already crossed 100 million and is projected to further increase rapidly.¹ Dementia is a progressive neurodegenerative disorder

characterized by decline in memory and other cognitive functions and commonly associated with significant behavioral problems. Higher risk for dementia with increasing age and population ageing has contributed to significant increase in global prevalence of dementia with more rapid increase in India and other developing countries. Dementia is emerging as a major public health problem among elderly due to the significant disability, caregiver burden and high economic impact.² There is very low public awareness about dementia in India. The clinical features of dementia are often considered as part of normal ageing. Dementia is a chronic illness with no effective disease modifying treatment available currently. Hence most of the patients with dementia spend considerable period of illness (few years) with high level of disability and dependence that requires significant assistance for daily activities from caregivers.³

Dementia care can be broadly classified into informal and formal care. Informal care refers to the care provided by an immediate relative or family member and the informal support systems in the community. Formal care refers to the care provided by a professional or paraprofessional for different aspects of care needs of persons with dementia, which is usually a paid care service.

The responsibility of caregiving for dementia in India is almost entirely on the family caregivers. Health and social care systems for dementia care is significantly less developed in India compared to many other developed countries. While studies on the aspects of dementia care are frequently published from high income countries there is definite need for such studies from developing countries like India.⁵ Care arrangements for dementia are significantly related to the sociocultural and economic factors which are likely to have significant variation across countries.

In this narrative review, we propose to provide a summary of the published literature on the dementia care in India with particular focus on the formal care systems. We also compare the dementia care model in India with the systems of care in the developed countries and other contrast these models with some of the established models

in developed world and other low and middle income countries (LAMIC). Lastly we have discussed about the future role of the formal care services for dementia in the Indian context.

Methods

Literature search was carried out in Pubmed, Google Scholar and PsycINFO databases. 'Dementia', 'Alzheimer's', 'formal care', 'care', 'India', 'LAMI' were used with Boolean operators of 'AND' or 'OR' in all combinations. All the hits were screened for relevance to the questions of interest. Citations in these publications were cross referenced. We arrived at a total of 51 publications for 'Dementia' AND 'India' which narrowed down to 8 publications on addition of term 'Care'. We also accessed additional information on the framework of dementia care in India and other developed countries from the websites of relevant Government and private organizations.

Results

Scientific publications on dementia care in India

The published literature related to dementia in India has focused mostly on the epidemiology, biology, risk factors and pharmacotherapy. Studies that focus on dementia care and resources in comparison are relatively scarce in Indian scientific literature. The literature search did not yield any review from India that has primarily focused on formal care issues in dementia. The outcomes of 10/66 Dementia Research Group's initiative,⁶ which included centres from India and other individual studies which relate to aspects of dementia care are reviewed below.

The World Alzheimer Report (2015) estimated that 94% of people living with dementia in low and middle income countries are cared for at home.⁷ The 10/66 Dementia Research Group's multicenter pilot study included 179 carers from six different locations in India (Bangalore, Chennai, Goa, Hyderabad, Thrissur and Vellore). It was noted that most of the primary carers were women (75%), majority of them were co-residents (98%) and 24% of caregivers were daughters-in-law) and surprisingly, none of the carers received any carer benefits.⁸

Among the persons with dementia from the Indian centres in the 10/66 Dementia Research Group's population-based studies, between 50 and 70% of those with dementia were rated as needing care, and most needed 'much care'. In the urban Indian center of this study, 78.5% of those with dementia needed much care. In the case of the rural Vellore, the percentage of those who needed much care was 33.3%. This discrepancy between the urban and rural centers appears to reflect the impact urbanization has on caregiving in dementia in traditional societies such as India. Rapidly declining fertility rates, the disintegration of the traditional joint family systems, increasing number of single child households, the increased participation of women in the work force, urbanization and migration are all trends conspiring to reduce the availability of traditional informal family care.⁹

Despite the growing numbers of persons with dementia needing care, the patients and their families receive little or even no support from formal care services. Scarce resources (including limited specialist healthcare services, long-term community-based and residential care, primary care services) and poor knowledge and awareness largely limit the quality of formal care provided. A large proportion of caregivers are unaware of even the available albeit inadequate resources. Currently, very few people with dementia are diagnosed, let alone receive treatment and support. Around half of those affected are not diagnosed in High Income Countries, the proportion diagnosed falling to below 10-20% in Low and Middle Income Countries.^{5,10} There is increasing demand for paid carers, more so in urban India. There is a great felt need for trained caregivers/ assistants but there is very limited availability of formal training programmes. There are agencies that help families to hire workers/nursing aids, but most of them learn to care for persons with dementia only through their experiences with caregiving.

A randomized control trial tested the effectiveness of home care program for caregivers of persons with dementia in a community setting in Goa, India. Patients with mild to moderate dementia and their caregivers were randomized to receive community based intervention by home care advisors and a supervisory team. The study found significant reduction in general health questionnaire scores and distress due to behavioral symptoms. The authors concluded that such a program was feasible, acceptable, effective and required low-cost and locally available resource.¹¹ Another study assessed the household cost of dementia care in India including patients with all stages from both urban and rural backgrounds. The authors estimated the annual cost of care to range between 45,000 to 200,000 Indian Rupees (INR) in urban areas and 20,000 to 70,000 INR in rural areas. Interesting findings from this study are that the cost of informal care accounted for fifty percent of the total cost. This study also reported increased social costs with increased severity of illness.¹² In another study the authors reviewed the ethical issues of dementia care in Kerala, India and contrasted it with the model of care in Netherlands. The authors opined that the dementia care in Kerala was influenced by limited awareness and was mostly home based. They also highlighted the absence of an advanced directive process and lack of addressing of end of life issues.¹³

A few of the other published articles have evaluated the caregiver experience,¹⁴ the caregiver burden and its predictors. These studies have demonstrated that despite the presence of extended family in many persons with dementia, there is significant burden on primary caregivers to the extent that it is comparable to the burden experienced in developed countries. Majority of the caregivers are women. The burden is more in those who had to cut down their work to manage the caregiving responsibility.

International experts in dementia research have identified the delivery and quality of care for persons with dementia and their carers as one of the important priority areas of

research to reduce global burden of dementia by the year 2025. There is clearly an urgent need for more Indian studies on caregiving arrangements for dementia and the requirements of formal care services for dementia in particular.¹⁵

Formal care services for Dementia in India – Current status

The exact details of the availability of formal care services for dementia in India are not readily available or easily accessible from any reliable and real time source. The Dementia India Report, 2010, which was compiled by the Alzheimer's and Related Disorders Society of India has attempted to compile the available resources but such information has not been updated recently.¹⁶ The Alzheimer's and Related Disorders Society of India (ARDSI), established in 1992, is a Non-Government Organization engaged in the care, support, training and research of dementia and has spearheaded the dementia movement in India. ARDSI presently has 18 chapters all across India. The ARDSI is actively involved in developing services like respite care, day care, home care, setting up memory clinic, conducting training programmes for the family members, doctors, nurses and social workers and promoting research. In addition, a few other Non-Government Organizations also provide care services either in association with ARDSI or by themselves. A majority of them however are in the South Indian States.

Memory Clinics

Memory clinics are by far the most widespread available resource in dementia formal care. Many medical colleges and specialty hospitals by the public and private agencies (with neurology and psychiatry departments) run memory clinics or specialty geriatric clinics. These are geared to provide initial diagnostic evaluation, medical management, brief advice and caregiver counselling. In 2010 it was estimated that there are around 100 memory clinics functioning all over India and this number has seen a slow but significant increase over the past six years.¹⁶ The Government Of India in its recent initiative through National Programme for Health Care of Elderly (NPHCE) 2011, has proposed setting up daily geriatric clinics at district level in 80 identified districts which will also serve as referral centers for community and rural health centers. In addition, state, regional and national level centers for aging have been proposed as part of this program. The effective implementation of this program is hoped to provide accessible care for people with dementia.^{17,18}

Support Groups

In the context of dementia care support groups play a major role for coming together of the caregivers to share their caring experiences, feelings and as learning platforms. They also provide a voice for dementia carers who are major stakeholders in the caring journey. The exact number of support groups that are helping the families of people with dementia is not clear, as they

function informally in pockets over the country.¹⁶ And there is no published literature available at this point on the utilization and effectiveness of this resource in India.

Day-care centers for dementia care

Dementia Day Care facilities are designed for persons with dementia who have a need for medical attention or supervised daytime care, but who do not require institutionalization in a nursing home or hospital. There were around ten day-care services exclusively for people with dementia in 2010.¹⁶ There are a few general day care services for the elderly where people with dementia are also looked after. The chapters of the ARDSI and a few NGOs provide day care services for persons with dementia. Our search online retrieved a list of 20 day-care centres in 2016.¹⁹ Most of the day care centers are located in cities which cater to only a small minority as 80% of the population living in rural and semi urban regions.²⁰

Residential care

Residential care assumes an important role in dementia care especially during advanced stages of illness. The major components of long term care include assistance with Activities of Daily Living (ADL), treatment of chronic diseases and disabilities and management of acute medical needs.²¹ The existing residential care system can be seen broadly as care provided by old age homes, psychiatric institutions and dementia specific centres. In 2009 there were an estimated 1018 old age homes in India.²² However not many of these care for persons with dementia considering specific and complex needs of this group. Most of the hospitals with psychiatric units are not equipped to provide long term care. According to dementia India report 2010, there were about 6 centres which provided residential services to persons with dementia which included long term care and respite care. All these provide paid services. These centres mostly run by non-profit organisations, which are funded by donations, public contributions. The centres are situated in the metropolitan cities with virtually no centres listed in the smaller cities and towns. At present one centre has been established in Thiruvananthapuram, Kerala India which is government run and provides services exclusively to persons with dementia and their caregiver, this centre is run in collaboration with the Alzheimer's Society, India and has been lauded as the first centre of its kind.¹⁶ With burden of 4.1million dementia people in India, these services are accessed by only a fraction of caregivers.

Domiciliary care or Outreach services

Domiciliary care plays a significant role by providing the required assistance by trained personnel to the patient and it reduced the caregiving burden for the caregiver. It also helps to retain the person with dementia in family which is often preferred by both the patients and caregivers. The caregivers also get an opportunity to learn the art and science of caring from a trained personnel in handling problem behaviors. Six centers provide home based care

for people with dementia. Under this scheme, the part time staff, social workers or volunteers visit families of people with dementia and provide assistance in the form of counselling, guidance and help with activities of daily living.

Help lines

Help lines and mobile applications have assumed greater relevance with advance in telecommunication services. They provide information on dementia, dementia care and resources. There are about 10 help lines mainly run by the national office of ARDSI and the various chapters which cater to the persons in the respective localities. Subsequently a national helpline has been inaugurated in 2013 which provided nationwide coverage operating from Cochin, India. Technology has been a recent respite in dissemination of dementia care exemplified by the initiative of Ministry of Science and technology introducing TIDE (Technology Initiative for Disabled and Elderly) through which information on all elderly needs and resources are provided on an online portal.²³

Most of the services noted above are provided by private institutions and non-governmental organizations. They are available only in major cities and inaccessible to the large majority of persons with dementia dwelling in rural and semi urban parts of the country. Even to the persons who can access most of the services are paid as out of pocket expenditure which further limits the universal utility of dementia formal care services in India.

Government policies related to dementia care

Past two decades have witnessed many programmes and policies of Government of India on elderly relate to some extent regarding the care for people with dementia. The National Policy on Older Persons (NPOP) was adopted in 1999 by Ministry of Social Justice and Empowerment.²⁴ This policy envisages active, productive, creative and satisfying life for people above the age of sixty. It identifies principal areas of intervention and action which includes financial security; health care and nutrition; education; welfare; protection of life and property; and other areas. With regards to healthcare the policy emphasizes healthy aging and integration of health care of the elderly with the primary health care system in India.

The 'Maintenance and Welfare of parents and senior citizens act, 2007' refers to the responsibility of children or an immediate relative and the state in the care of elderly.²⁵ One of the aspects of maintenance referred by the act includes medical treatment. It also directs all states to have old age home in each district with a minimum capacity for 150 residents. More importantly the states are directed to establish specific medical facilities, allocate doctors/hospital beds, expand treatment for chronic, terminal and degenerative diseases; and conduct research on ailments of the elderly and ageing. Though the act has been drafted with the aging population in mind and the changing trends in family dynamics in the country the act does not make a reference to old age pension or social security benefits. The implementation of the act is also

thought to be challenging from setting up of the tribunal to access to the elderly to make a case for maintenance. Specifically, people with dementia who go through significant deterioration of day to day functioning might face added challenges to benefit from this act.

The National Program for Health Care for Elderly (NPHCE) was launched in 2010-11 by Ministry of Health and Family Welfare, Government of India.¹⁸ As noted earlier this program aims to set up health care facilities for elderly at all levels of health system in phased manner. Additionally 8 regional centres and two national centres are proposed which not only serve as the tertiary referral systems but also build the required manpower for the care of the elderly.

The Mental Health Care bill, 2013 and the Rights of persons with disability bill, 2014 do not make direct reference to dementia care are but are relevant here as the definition of 'mental illness' in both acts are clearly met by persons with dementia.^{26,27} A detailed account of the specific implications of these acts on dementia care is beyond the scope of this review but it might suffice to say both the bills provide rights to persons with dementia access to health care and disability benefits.

Discussion

HelpAge international starting from 2013 has been ranking countries around the world as Global age watch index. The countries are ranked in terms of how well the older people fare in a country based on income security, health status, capability and enabling environment. In 2015 India stood 71 in overall ranking but the ranking for health status was 87. Health status ranked the lowest compared to other three domains. The health status is measured on life expectancy at 60, healthy life expectancy at 60 and psychological well-being. The countries which were listed in the top of the list do particularly well in this aspect of the index.²⁸ Here we enumerate some of the models of dementia care in developed countries.

Worldwide patterns of formal care in dementia

European countries have different policies which cater to the needs of persons with dementia, for both informal care and formal care. The policies vary from country to country. In Scandinavian countries, which are ranked highest in Age watch index, the formal care and social support provided is based on individual needs and availability of support from the municipality or the county council. In Germany costs have to be borne by the family, when family cannot afford, the government will pay for it. Formal care services vary from providing nursing care to institutionalised care for the persons with dementia.²⁹

"Right Time Place Care" project in Europe, consisting of work strategies which aimed at developing best practise strategies to provide dementia patients and their care givers at affordable cost-benefit ratio in European countries.³⁰ The commission submits reports periodically to enable reforming and monitoring dementia services, funding process and use of the services.

In Scotland 8 Pillar model in care for dementia patients, aimed at providing an integrated comprehensive approach is in place where a step by step assessment of the dementia care is planned and provided. The post diagnosis care ranges from medication, follow ups to formal care services where the case manager or the social worker continues to assist the care giver. It has been proposed to a useful model of service delivery for persons with dementia.³¹

In the USA a number of states have adopted different policies and models to provide formal and informal care services to persons with dementia. State run programs like “Kentucky Adult day care and Alzheimer’s Respite programme” provide formal care services such respite care, day care services, assisted living facilities which are either free or provided at a subsidized price depending on state policies and the income of the individual and the families.³² In UCLA the state came up with the “UCLA, Alzheimer’s Dementia Programme”: which aimed at providing high quality care, improve health and more efficient health care use. The programme developed model which uses “Dementia Care Manager” who identifies patients with dementia offers counselling to the family and also makes assessments to provide tailor made services to these individuals. The DCM provides referrals to access formal care services such as respite care, adult day care services and individualised counselling. Formal partnership with community based organisations was also carried out. The programme preliminary observations have shown the programme to be beneficial with increased caregiver satisfaction and improved care provision.³³

Costs and funding of the formal care services

As like in other countries most costs incurred in caring for patients with dementia is borne by families. In USA insurance benefits are available Alzheimer’s dementia patients through Medicare and Medicaid.

Medicare pays for medical expenses; it however does not pay for the residential/ assisted living facilities but costs incurred in the form medical expenses in while staying in these centres. Medicaid another health insurance programme is a federal funded programme for low income families for the care dementia patients. Other services such as State Non-Medicaid assistance programme provided financial assistance to the AD patients. Life insurance conversions and Alzheimer’s care loans are available to provide formal care to dementia patients.^{34,35}

Overall there are models across the developed world where the entire cost or a large share of cost of care is borne by a federal body where the satisfaction of care appears to be very high. In few other countries with hybrid financing the caregivers, insurance schemes and government share the cost of caring.

Potential opportunities for dementia care provision in India

Health care models: Specialist to community based models for dementia formal care

The World Alzheimer Report (2016) argues that current dementia healthcare services are over-specialized (care is provided by geriatricians, neurologists and psychiatrists) and that more emphasis needs to be placed on community care.³⁶ This shifting of care to the primary or community level will ensure better resource utilization and better care for people with dementia especially in developing nations like India where specialists trained in diagnosing and managing neurodegenerative illness are few and are largely concentrated in cities. As the numbers of the aging population and people with dementia increase, it is unlikely that adequate care and services can be provided using only a specialist care approach.

Community care for dementia in India has been tested in a randomized control trial as noted earlier and has been shown to be both effective and feasible.¹¹ Such studies need replication across different states as there is considerable diversity in the geography, culture and population in India. The initial phase of dementia care in terms of case ascertaining the diagnosis and provision of pharmacotherapy though requires a specialist/ tertiary care support, the after care of dementia can be effectively carried out in the community. That being said, training and education of primary care physicians can enable earlier detection and referrals of dementia in primary care. In addition to setting up accessible day care and long term care facilities there is a need to establish regional and national registries of existing facilities. Effective delivery of community based dementia care also requires active collaboration between regional and local governing bodies, non-governmental organizations working in dementia care and the caregivers.

Defining the role of specialist care

The role of the specialist needs to be better refined. Specialists need to take an active role in the training of primary care physicians in the diagnosis and management of dementia. One of the feasible solutions to better dementia care involves strengthening the primary care systems to diagnose and manage the relatively straightforward cases and refer more complex patients to specialist care. This would enable the optimal utilization of resources. The specialist roles in turn will shift more towards training and leadership.

Financing dementia care

Families and caregivers currently bear almost the entire cost of dementia care in India. As noted earlier, the estimate varies between urban and rural areas in both settings this may serve as a potential barrier to the access of care in patients with dementia and may also lead to neglect and abuse. In the absence of a uniform social security scheme persons with dementia form an extremely vulnerable population. The existing insurance systems do

not cover the costs of care for chronic degenerative illnesses like dementia. There is a need to evolve specialized insurance schemes which cater to this population.

Equitable distribution of formal care services

Most of the formal care services are run by NGOs and are concentrated in the Southern states. A more geographically equitable distribution and the provision of less expensive, government run services will help benefit a larger population.

Public awareness and education

Even with systems in place, the community needs to be aware of the symptoms of dementia and when and where to seek help. Many including non-specialist health care workers continue to think that dementia is a normal part of aging. It is only through extensive and targeted awareness programs that better utilization of services present is possible.

Research and innovation

Research into which systems work best in the Indian context both in terms of effectiveness and cost-savings is required to enable the translation of ideas into practice. We need to focus on bettering dementia diagnosis and management across the different levels of health care (primary to tertiary) and devise the best suited models to deliver formal care to persons with dementia and their families across this vast and diverse country.

The recent use of technology in bridging the treatment gap needs further innovations and effective platforms for delivery. One such innovation is the iSupport program launched by WHO which aims at supporting informal caregivers of people living with dementia through e-platforms is one such innovation with relatively low cost and high accessibility.³⁷ The platform provided education, skills training in care, assistance with necessary information while caring.

A recently initiated research project funded by Indian Council of Medical Research is evaluating the perceived need for formal care and its predictors in a 1 year prospective follow up. The findings from this study will help in improving the understanding on this issue in the Indian context.

Towards a palliative care model

Though many aspects of dementia care are congruent with the definition of palliative care given by WHO,³⁸ fewer proportion of persons with dementia worldwide access palliative care services compared to patients suffering from cancer.³⁹ There is virtually no information on access to palliative care in India. Mental Health Care bill 2013, has introduced advance directive for persons with mental illness.²⁷ This opens up an opportunity to impart advance care planning in persons with dementia from early stages of illness. This will also provide a window of opportunity

to address the medical, legal, financial and spiritual needs of persons with dementia through the journey of dementia care from early to advanced stages.

Summary

With increasing older population across the world the prevalence of dementia has assumed significant public health importance. This poses a significant challenge to LAMICs like India where the formal care services are still scarce and underdeveloped. Significant burden of dementia care is still borne by informal caregivers adding to high burden of indirect costs of care. Research in the field of dementia care becomes vital in the absence of curative treatments. Existing resources which include day care, domiciliary care, residential care, memory clinics and helplines are largely insufficient to cater to the number of persons with dementia in India. The access to these services is also mostly limited to urban population and inclusion of primary care services in dementia is limited. Moving towards community care, financing dementia care through insurance, care delivery research and effective governmental policy can address the epidemic of dementia and bridge the treatment gap.

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Research Article

How effective is a crisis resolution and home treatment team for older people at reducing the number of admissions and length of stay in mental health wards?

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Abstract

Background: One of the functions of the crisis resolution and home treatment team (CRHT) is to reduce hospital admissions of mentally ill patients. **Aims:** To compare a CRHT for adults in later life with a CRHT for adults of working age in terms of team composition, patient characteristics, interventions and outcomes measured by numbers of admissions and lengths of stay. **Methods:** Using the electronic record system (ePEX) we examined referral data for both teams for a 12 month period of January 2005 to January 2006 and the 30 month period of January 2007 to June 2009. We used a semi-structured tool to perform a retrospective electronic file review of a subgroup of 80 referrals. **Results:** The teams differed in team composition, patient characteristics, interventions and outcomes measured by numbers of admissions and lengths of stay. Later life wards showed a 9% average monthly reduction in admissions (from 33 to 30, not significant). Adult wards showed a 19% reduction (from 121 to 98 per month, $p < 0.001$), reduction in admissions to the adult wards was significantly greater than to the later life wards ($p < 0.05$). **Conclusions:** This study identified many differences between an adult and an older age crisis team in terms of composition, patient characteristics, interventions and outcomes. These differences will be important considerations as teams are developed for the increasing number of older people. This has important implications for service redesign.

Key words

Crisis resolution and home treatment team, older people, admission, outcome, service, effectiveness

Introduction

The current 'balanced' model of mental health care involves a range of service components including outpatient and ambulatory clinics, community mental health teams, community based residential care, home treatment teams, crisis resolution teams, day care,

assertive outreach teams, early intervention teams and inpatient services.^{1,2} However, inpatient care in the modern mental health service is probably the most problematic component of the system, and many service users and professionals are not satisfied with current hospital care.² In addition, it is expensive. Hence, the growth in the use of alternatives to psychiatric hospital care in recent years is an important trend which has been encouraged by the recovery movement.³ Home treatment and crisis resolution teams are mobile community mental health teams offering assessment for patients in psychiatric crisis and providing intensive treatment and care at home. They have been developed to offer an alternative to hospital admission.

UK Department of Health policy states that crisis resolution teams treat older people on the basis of need, but this may not be reflected in practice.^{4,5} Studies have shown, that in adult and older people's services, crisis resolution and home treatment teams are considered to be helpful in managing people at home, reducing the number of unnecessary admissions,^{6,9} and speeding up discharges.^{10,11} However, there are relatively few crisis teams that offer a specialist service for older people.¹² The development of such a team in East Suffolk offered the opportunity to examine its impact.

Suffolk Mental Health Partnership Trust has more adult beds available per 100,000 head of population than average UK beds (30 compared to 27) but fewer later life beds (45 compared to 75). Admissions for older adults are fewer than average at 55 per 100,000 population compared to 75 in younger adults.¹³ The later life crisis team in the east consists of an associate specialist psychiatrist, a clinical team leader, six registered mental health nurses and five support workers.

One way to assess whether older patients are receiving the appropriate standard of care is to compare the later life team with a general adult crisis team regarding the patterns of referrals, population characteristics, interventions and outcomes. Hence, this study sets out to examine the number of admissions of adult patients between 18 to 65 (adult patients) and patients above 65 (late life patients), to psychiatric inpatient units between

the periods 2005-2006 and 2007-2009. The study intended to compare the changes in rate of admissions and length of stay between adult patients and later life patients as well as before and after introduction of medical input in CRHT.

Methods

The data was collected from the electronic patient records system (ePEX) for the 12 month period of January 2005 to January 2006 and the 30 month period January 2007 to June 2009. Data for all the patients referred to the crisis resolution team and those who were admitted were collected. Those who were considered to be in crisis and admission was considered as an option were also entered for further data analysis, whether or not they were admitted to the inpatient unit.

Further data was collected for a subgroup of 80 patients through a retrospective file review from the records of patients who were referred, using semi-structured format about factors possibly responsible for variations. Data were codified to make these anonymous. The project was considered as a service evaluation.

Socio-demographic variables were analysed using descriptive statistics, including mean, standard deviation, and percentages. This was retrospective chart review and analysis was done on the available data for each variable; missing data were not included in the calculation. Fisher's exact and chi-square tests were carried out for discrete variables for comparison. The number of admission days was compared between the crisis team admissions and non-admissions as well as with the data from the previous years using the Student's t-test.

Results

The number of admissions to the later life wards was 394 in the first period and 976 in the second period. This showed a 9% average monthly reduction between the time periods (from 33 to 30, not significant). Admissions to the adult wards were 1452 in the first period and 2932 in the second period. This showed a 19% reduction (from 121 to 98 per month, $p<0.001$). The reduction to the adult wards was significantly greater than to the later life wards ($p<0.05$).

Table 1: Comparison of inpatient admissions between 2005 and 2007 to 2009.

Categories	AMH 2005	OPMH 2005	AMH 2007-9	OPMH 2007-9	Significance	
Age in years (Mean \pm SD)	42.1 ± 13.4	77.4 ± 7.3	42.1 ± 13.7	74.7 ± 12.5	AMH	NS
Females %	52.1	60.2	49.2	69.7	OPMH	$p<0.05$
Duration of inpatient stay in days (Mean \pm SD)	15.2 ± 35.4	29.9 ± 40.3	19.2 ± 40.5	36.1 ± 52.6	AMH	$p<0.01$
Mental Health Act Assessments %	24.4	13.5	28.4	29.8	OPMH	$p<0.001$

Adult Mental Health (AMH): a: There was no difference in the age group of adult mental health patients in the period compared, where there was significant reduction in age in the period 2007-9 for older adult patients.

Older people mental health (OPMH): b: Diagnoses for older adults were not available electronically between the periods compared.

c,d: Duration of inpatient stay days for both adult and older adults showed a significant increase.

e,f: There was significant increase in patients admitted under mental health act in both adults and older adults

Table 2: Patients seen by the crisis and home treatment teams

Categories	AMH 2005	OPMH 2005	AMH 2007-9	OPMH 2007-9	Significance	
Age in years (Mean \pm SD)	39.6 ± 12.5	80.9 ± 7.0	39.4 ± 13.4	79.3 ± 8.1	AMH	NS
Females %	51.6	72.1	53.1	65.8	OPMH	NS
Duration of intervention in days (Mean \pm SD)	15.6 ± 82.2	44.5 ± 41.3	8.9 ± 21.8	23.1 ± 27.1	AMH	$p<0.001$
Mental Health Act Assessments %	2.4	2.6	2.7	4.4	OPMH	$p<0.001$

a: AMH: adult mental health; b: OPMH: older people mental health; c: no difference noted between adult patients in 2005 and 2007-09; d: no difference noted between older adult patients in 2005 and 2007-09; e: there was significant reduction in percentage of females seen 2007-9 in older adult crisis team; f: duration of intervention by CRHT significantly reduced in adult patients; g: duration of intervention by LLCRHT significantly reduced in adult patients; h: No significant difference was noted in patients treated under mental health act between 2005 and 2007-09 in CRHT; j: significant difference was noted in patients treated under mental health act between 2005 and 2007-09 in LLCRHT. NS: Not significant

Table 1 shows the characteristics of inpatient population during this period. Average length of stays increased significantly in both services. In the later life wards it increased from 29 to 36 days ($p<0.001$). In the adult wards it increased from 15 to 19 days ($p<0.001$). People in the general adult population had a significantly higher

chance of being admitted involuntarily under the Mental Health Act compared to those in the later life population. The diagnostic breakup of the inpatient admissions in Adult Mental Health for 2005 (N=394) and 2007-9 (N=483) was as follows: psychotic disorders 35.5% and 9.5%, mood disorders 11.2% and 19.3%, personality

disorder 1.0% and 8.1%, adjustment disorder 1.7% and 11.6% and dementia 1.7% and 0% respectively. These figures for Older People Mental Health services were not available.

Crisis team interventions results are shown in Table 2. There were a significantly higher number of females referred to the late life crisis team compared to the adult crisis team. We compared the length of intervention in CRHT with LLCRHT. There were significantly fewer number of days of intervention by the adult CRHT compared to the late life CRHT in both periods i.e. in 2005 and between 2007 to 2009 (15.6 & 44.5; 8.8 vs 22.1; $p < 0.001$). Comparison over the study period of 2005 to 2007-09 showed a significant reduction in the number of days of intervention in both teams (15.6 & 8.9 vs 44.5 &

22.1; $p < 0.001$). In 2007-9, the diagnostic profile of the patients in LLCRHT (N=330) were: psychotic disorder 6.1%, mood disorders 46.0%, dementia 28.8% and adjustment disorders 2.4%.

Tables 3 and 4 show patient group comparison and pattern of work comparison in a subgroup of patients referred to the crisis teams. It was observed that a significantly higher number of people in the old age population lived in their own homes, were diagnosed with dementia, had treatment offered from the crisis team, had a higher amount of doctor input, had a higher number of medication prescriptions, more nursing input, more admissions to day hospital, were offered more subsequent community support and had a significantly lower past and current history of deliberate self-harm.

Table 3: Patients group comparison in a subgroup analysis of functioning of crisis teams

Variables	Adult (N=40)	Late life (N=40)	Significance
Living in own home	20.0	55.0	$P < 0.01$
Past psychiatric history	67.5	70.0	NS
Past history of DSH	25.0	5.0	$P < 0.05$
Past history of aggression	25.0	17.5	NS
Current history of DSH	47.5	7.5	$P < 0.001$
Current history of aggression	17.5	32.5	NS
Diagnosis			
• Mood disorder	40.0	42.5	NS
• Dementia	2.5	52.5	$P < 0.001$
• Schizophrenia	10.0	2.5	NS

Figures are in percentages. Fisher's exact test. NS: Not significant; DSH: deliberate self-harm

Table 4: Pattern of work comparison in a subgroup analysis of functioning of crisis teams

Variables	Adult (N=40)	Late life (N=40)	Significance
Referral by GP	25.0	42.5	NS
Urgent referrals	92.5	92.5	NS
Treatment offered by the intervention team	42.5	75.0	$P < 0.05$
Doctor input	30.0	65.0	$P < 0.01$
Medication	25.0	52.5	$P < 0.05$
Nursing input	70.0	92.5	$P < 0.05$
Admission to Inpatient ward	30.0	20.0	NS
Admission to day hospital	0.0	20.0	$P < 0.05$
Community support	10.0	47.5	$P < 0.01$
Admission to acute general hospital	12.5	7.5	NS

Figures are in percentages. Fisher's exact test. NS: Not significant

Discussion

CRHTs and admission rates – adult services

This study benefits from a large initial sample size taken over a relatively long period. The reduction in admissions to the adult wards is consistent with previous studies.^{6,14} The evidence supports the hypothesis that the development of CRHTs in the UK since 2000 has been associated with a reduction in the number of inpatient psychiatric admissions. The question remains whether this is causal. The number of inpatient beds may have reduced without the development of new teams but with different working practices from community mental health teams. It may be possible that within the context of remodelling

of services, there were closure of psychiatry beds which may have affected the admission rate. The significant increase noticed in length of stay in general adult patients could have been due to prevention of crisis admission by intervention using CRHT, resulting in more serious and complex patients getting admitted requiring more days in the hospital.

CRHTs and admission rates – later life services

A previous study by in the west of Suffolk showed a reduction in admissions in later life services,¹⁵ although our study did not show a significant reduction. Suffolk Mental Health Partnership had closed many later life beds prior to the study period. Another factor may be the

diagnosis of patients referred to late life CRHT which was predominantly dementia. Nevertheless, by finding a different effect between the adult and later life services suggests there may be other differences in patient groups or delivery of CRHT interventions. Length of stay was increased in these set of patients again showing the complexity of cases and the possibility that less complex cases were managed by CRHT. It is also interesting to note that there was a significant increase in admission under mental health act showing possible effectiveness of CRHT.

Differences in patient groups

The older people seen by crisis teams were more likely to be female and more likely to be living in their own home. They were less likely to present with deliberate self-harm and more likely to have dementia. Hence, the patients seen by the two services differ significantly in more ways than just age. Dementia is more common in older people. People with dementia are usually only admitted to hospital if there is an acute crisis at home and respite care cannot be organised or the level of risk is deemed to be too high for care in the community. These situations are unusual but they may mean admission is more difficult to prevent than in the case of a younger person who feels suicidal.

Differences in interventions

Despite a reduced availability of the late life crisis team (8 hours per day) compared to adult team (24 hours), the old age crisis team is more likely to offer an intervention. LLCRHT offered treatment and intervention for a significantly longer duration than CRHT. Treatment is more likely to have doctor involvement and medication prescribed. Older people have a higher chance to get admitted to day hospital than in patient; this might be due to a lack of a day hospital in the adult department. The finding that later life services are making more interventions suggests that differences in interventions are not the main cause of the difference in the number of hospital admissions.

Limitations

The main limitation of this study is that it is a retrospective analysis of data entered into the electronic system. It is dependent on the accuracy and adequacy of the data entered to the systems. In addition, other changes over the study period may have contributed to the results.

Conclusions

Between 2005 and 2009 there was a significantly greater reduction in the number admissions to adult wards than the later life wards. Both services saw an increase in length of stay. The results of this study suggested the difference was mainly due to differences in patient groups and not due to a lack of interventions by the later life crisis team. This has important implications for the development of later life services. It suggests that it may be more difficult to close later life beds below a certain

level. As even in services with a specialised later life crisis team that offers a lot of interventions people with dementia would still require hospital beds during mental health crises that cannot be managed in the community.

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Case Report

Sudden onset speech impairment in a patient with schizophrenia: challenges in diagnosis

Mohit Kumar Shahi, Sujita Kumar Kar, Amardeep Patel

Abstract

Speech abnormalities are commonly reported in patients with schizophrenia. Often the speech abnormalities of schizophrenia mimic with that associated with organic brain pathology. Missing the organic pathology may mislead the clinician in planning management. We present here a case of schizophrenia on stable treatment regimen, who suddenly developed aphasia without any obvious neurological deficit, following abrupt stoppage of medications. Neuroimaging revealed a large infarct involving the left temporo-parietal cortex. The diagnostic dilemma, management issues and clinical implications have been discussed along with review of literature. The mental health professionals need to see neuropsychiatric manifestations beyond the frontier of psychiatric illness.

Key words

aphasia, organic brain syndrome, schizophrenia, speech

Introduction

Schizophrenia is a severe mental illness, which produces significant disability and compromises the quality of life. Long-term follow up studies revealed that patients with schizophrenia carry higher risk of developing stroke in comparison to their healthy counterparts.^{1, 2} The risk of developing stroke was found to be more among females than males.¹ Chronicity of schizophrenia also plays a detrimental role as it further increases the risk of stroke.³ Other risk factors of stroke identified in patients with schizophrenia are – old age, obesity, smoking, hypertension, high dose of medications and polypharmacy.³ There are contradicting evidences regarding role of antipsychotics in causation of stroke and determining the mortality and morbidity related to stroke.^{4, 5} Evidences suggest that use of typical antipsychotics increase the risk of stroke than atypical antipsychotics.^{6, 7}

A patient with stroke may manifest in various forms of neurological deficits. Impairment of speech is reported in strokes involving mostly left cerebral hemisphere.⁸ Speech abnormalities are also commonly reported in schizophrenia. It is often difficult to differentiate between the speech abnormalities associated with schizophrenia

from stroke related abnormalities due to overlapping clinical features.^{8, 9}

Case history

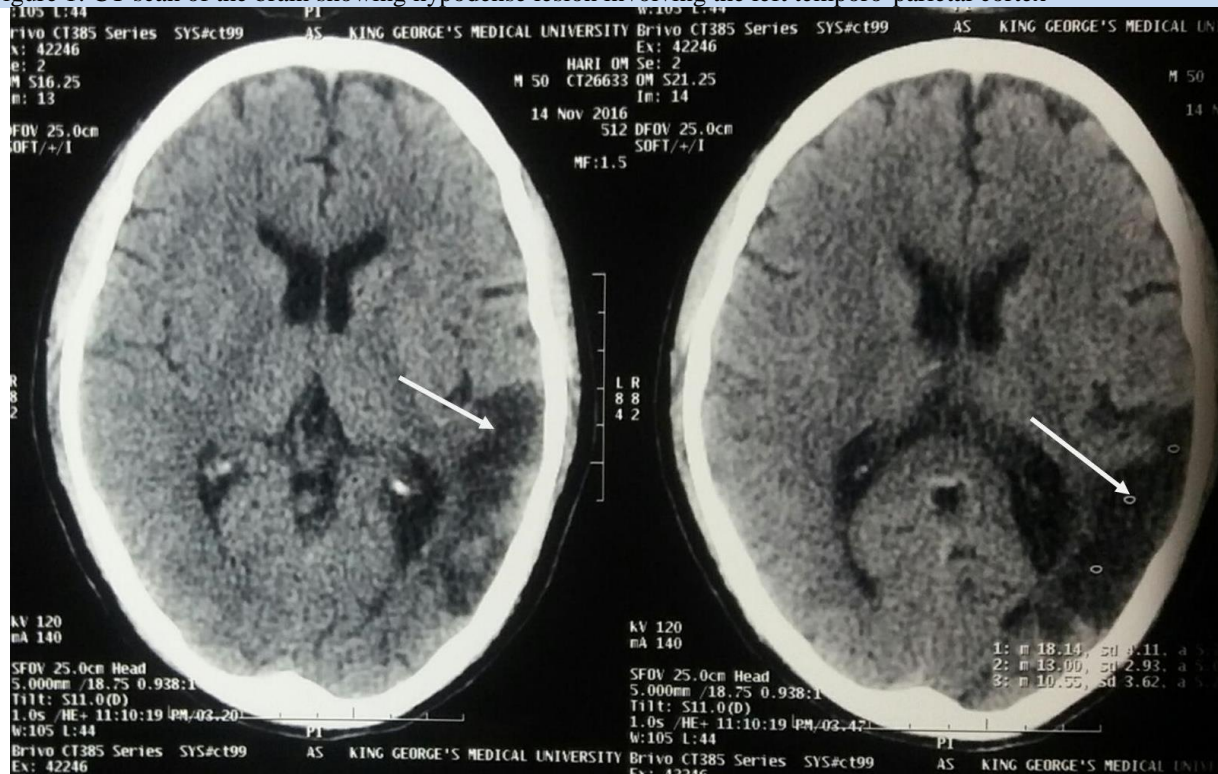
A non-diabetic, non-hypertensive male of 50 years age, from a rural background was diagnosed with schizophrenia for last 3 years. He had delusions of persecution, delusion of infidelity, delusion of reference, third person auditory hallucination with derogatory content along with disturbed sleep. He was treated with trifluoperazine 10mg/day, trihexyphenidyl 4mg/day and etizolam 0.5mg/day for more than 2 years with adequate control of his symptoms.

He presented with difficulty in speech for 3 days in the psychiatric emergency department. The speech difficulty was of sudden onset. He had stopped all his medications a day before onset of his speech difficulty. He was producing some non-comprehensible sounds, when attempted to speak. He was able to comprehend commands. There was no other difficulty except speech impairment. The patient was using gestures for communication. He had significant distress for his speech impairment. Attempts to communicate were made by writing; however, as the patient was illiterate, he was not able to write; but he could copy objects.

He had history of smoking tobacco in the form of “Bidi” for more than 10 years. He would smoke up to 20 to 30 bidis per day. However, he was abstinent for past 3 years. His past medical history was insignificant. His family history was also not contributory. Pre-morbidly, he was well adjusted to life; he was a farmer and leading a productive life.

The patient was hospitalized for detailed evaluation. There were no evidences of extrapyramidal side effects due to antipsychotic drugs. No evidence of catatonic features was found. General physical examination and cardio-respiratory system examination did not reveal any abnormality. On neurological examination, there was upper motor neuron type facial weakness involving right half of face. Aphasia was present. No other neurological deficit evident on clinical evaluation. CT scan of the brain was done, which revealed large hypodense lesion involving the left temporo-parietal cortex, suggestive of infarct (Figure 1).

Figure 1: CT scan of the brain showing hypodense lesion involving the left temporo-parietal cortex



Investigations such as blood counts, renal function test, plasma glucose, lipid profile, thyroid function test, electrocardiogram and echocardiography were within normal limits. Neurology opinion was sought, a diagnosis of ischemic stroke involving left middle cerebral artery territory was made and conservative management was suggested. He was prescribed atorvastatin 40mg/day and aspirin 150mg/day. The patient was started with antipsychotic aripiprazole (up to 15mg/day) along with clonazepam 0.5mg/day for sedation. He was maintained well and shown improvement with the above prescribed medications. There was significant improvement in aphasia by the end of third week of initiation of the treatment.

Discussion

Sudden onset isolated speech impairment in a patient with schizophrenia may be due to multiple reasons. It can be due to side effect of psychotropic medications, particularly extrapyramidal side effects (laryngeal dystonia). Catatonia, which is a well-known entity during the course of schizophrenia, can also cause mutism and other speech abnormalities like echolalia and verbal stereotypy. Even dissociative phenomenon may have a component of speech impairment.

Our patient is an adult male of fifty years of age, suffering from schizophrenia. There was no apparent change in the psycho-social milieu of the patient before the onset of speech impairment. Despite of speech impairment, the patient was following commands and trying to convey his distress through gestures. There was no evidence of extrapyramidal side effects on clinical evaluation. All these contextual findings rule out the possibilities of dissociative phenomenon, catatonia and extrapyramidal side effects. Hence, we thought of possible organic

pathology behind speech impairment and neuroimaging was done, which revealed vascular pathology involving dominant cerebral hemisphere.

Schizophrenia increases the risk of stroke directly or indirectly. Our patient had multiple risk factors for stroke, like – age (50 years), smoking history, sedentary life style (due to illness), schizophrenia and psychotropic medication (typical antipsychotic) use.² These risk factors might have attributed to development of ischemic stroke in our patient.

After hospitalization, the modifiable risk factors of stroke (smoking, sedentary life style, antipsychotic drug) were addressed. Antipsychotic drug (trifluoperazine) was changed to aripiprazole, which is an atypical antipsychotic possessing less risk of metabolic abnormalities. He was prescribed statins and aspirin as the patient had ischemic stroke. Atherosclerosis is the common cause of ischemic stroke. Statins have anti-thrombotic and anti-inflammatory property, in addition to their lipid lowering property.¹⁰ Statin is useful in prevention of stroke even in patients with normal lipid profile.^{11, 12}

The left cerebral hemisphere is mainly responsible for speech control. A large part of the brain is involved in the processing of speech. Stroke involving the left cerebral cortex involving the areas associated with speech production causes impairment of speech. Often it becomes challenging to differentiate the speech abnormality related to psychiatric illness from that of stroke.¹³ New onset speech abnormality, in a patient with schizophrenia may be due to exacerbation of the psychotic process or medication related side effects or due to damage to the brain areas involved in processing of speech. Because of this it becomes important that speech

disturbance be explained in detail in case history and examination.

It is important to differentiate schizophrenia related speech abnormality from aphasic stroke, as these psychopathologies are overlapping.¹⁴ Often such cases are cross-diagnosed. Certain clinical parameters differentiate speech abnormalities in aphasic stroke from that of schizophrenia during cross-sectional evaluation. Shorter verbal responses, intact awareness about speech impairment, substitution of language for communication purpose and non-bizarreness of the speech content are mostly suggestive of stroke related speech abnormality.¹⁴

The mental health professionals need to see neuropsychiatric manifestations beyond the frontier of psychiatric illness. The clinician need to be alert, when there is newly emergent symptoms of sudden onset in a patient with stable treatment regimen. A detailed physical examination and may be a neuroimaging may guide the clinician in making appropriate diagnosis.

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Case Report

Carbamazepine induced Stevens-Johnson syndrome: a case report

Javed Ather Siddiqui, Shazia Farheen Qureshi, Abdullah Al Duraibi

Abstract

Stevens-Johnson syndrome (SJS) is a very rare, acute, serious and potentially fatal skin reaction disease. Carbamazepine is one of its most common cause, others are antiretroviral drugs, anti-tuberculosis drugs, sulphonamides, fluoroquinolones, penicillins, non-steroidal anti-inflammatory drugs and multivitamins. Genetic susceptibility has been suggested as a possible explanation. We report a case of SJS secondary to carbamazepine in a patient with previous history of skin rashes due to carbamazepine which was given for treatment of schizoaffective disorder. We would like to highlight that carbamazepine re-administration should be avoided in the patient with a previous history of adverse skin reaction or SJS. In addition, gradual titration and observation for these side effects are recommended while initiating treatment with carbamazepine.

Key words

Adverse effects, carbamazepine, drug eruptions, drug hypersensitivity syndrome, Stevens-Johnson syndrome, toxic epidermal necrolysis

Introduction

Carbamazepine is associated with several dermatological adverse effects including rashes, urticaria, and photosensitivity reactions, whereas, severe and life threatening acute adverse cutaneous drug reactions such as erythema multiforme, toxic epidermal necrolysis (TEN) and Stevens-Johnson syndrome (SJS) are reported rarely. TEN is clinically characterized by erythematous macules and targeted lesions throughout the body along with more than 30 percent of body surface area having full thickness epidermal necrosis; whereas SJS have less than 10% body surface area affected with full-thickness epidermal necrosis with detachment along with mucous membrane involvement in two or more areas.¹ Most of the reported cases of SJS occur during first two months of antiepileptic drugs use. The estimated risk ranges between one and ten cases per 10,000 new users for carbamazepine, lamotrigine, phenytoin, phenobarbital,

whereas lower rates have been reported for valproate.² Highest rates of SJS have been reported to occur with carbamazepine around 14/10,000 users.^{2,3}

SJS is a clinical syndrome presumed to be a hypersensitivity reaction manifested initially with prodromal symptoms of fever, malaise and a sore throat. The prodromal phase is then followed up to 14 days by an acute polymorphous dermatologic syndrome manifested as erythematous maculo-papular skin lesions, target lesions, bullae, vesicle, involvement of at least two mucus membranes, conjunctivitis and associated systemic toxic state.⁴ SJS is severe, acute mucocutaneous reactions that are most often elicited by drugs and occasionally by infections. They are now considered to be differing only in the extent of body surface area involved.⁵ The drugs commonly implicated as the cause of SJS are anticonvulsants, sulfonamides, non-steroidal anti-inflammatory drugs and antibiotics.^{6,7,8} Carbamazepine is prescribed in schizoaffective disorder and bipolar disorder as a mood stabilizer, and in seizure disorders, trigeminal neuralgia and chronic pain. It is associated with hypersensitivity reactions that range from benign urticaria to life-threatening cutaneous disorders, including SJS and TEN.^{4,9,10} In psychiatry, cutaneous adverse drug eruptions are rarely noticed with atypical antipsychotics. To date, very few skin rashes and eruptions with olanzapine have been described in the literature. Dermatological side effects that have been reported with olanzapine are eruptive xanthomas, skin hyperpigmentation and purpura associated with thrombocytopenia.¹¹ Amongst other atypical antipsychotics, only two cases of erythema multiforme have been reported, one with ziprasidone,¹² and one with risperidone.¹³ The SJS carry a mortality that can be as high as 30% and require early diagnosis, with prompt withdrawal of all suspected potential causative drugs.

Case History

A 60-year-old married male patient diagnosed with schizoaffective disorder, presented with increased talk, disturbed sleep and hyperactivity for past 3 months, following treatment with carbamazepine 200mg twice daily along with olanzapine 10mg twice daily. There was no family history of any psychiatric or physical illness, or drug reactions. Further history revealed that he had

discontinued medications including carbamazepine three years back on his own due to mild rash. Then he had many psychotic and manic episodes, and had tried many mood stabilizers: lithium, sodium valproate and lamotrigine but did not get good result. In the past, he had improved with carbamazepine, so carbamazepine was restarted 200mg once daily. On his second day of medication, he had a mild fever and general weakness along with flushing of face and subsequently developed maculopapular rashes, starting from face spreading to neck then trunk and later developed to both legs, on 10th day. On physical examination the patient had pruritic and stinging erythema and red maculopapular rashes on both legs (Figure-1). Pharynx, eyes and genital mucosa were not involved. Nikolsky's sign (mechanical pressure to the skin leading to blistering within minutes or hours) was positive. Laboratory examinations revealed high erythrocyte sedimentation rate 50 mm in the first hour; leukocyte count was 8000 per cubic milliliter; and other investigations were within normal limits.

All his medications were stopped and referred to dermatology department for further management. A diagnosis of drug-induced SJS was made by dermatologist. He was treated with dexamethasone injection 4 mg twice a day, ceftriaxone injection 1 gram twice a day and topical betamethasone. After 17 days his condition improved. Patient had a satisfactory recovery; and at the time of discharge, he had generalized desquamation and incomplete peeling of the skin on the trunk and both legs. He was reviewed in psychiatric department and was started with sodium valproate 1000 mg and olanzapine 10 mg per day. After three weeks, there was complete resolution of manic symptoms. There were no adverse effects.

Discussion

Carbamazepine has been strongly associated with SJS. Although it has multiple etiologies, it is commonly triggered by viral infections (herpes simplex virus is the infectious agent more commonly involved) and neoplasias (carcinomas and lymphomas).¹⁴ However, the most common cause is the use of medications. Among the drugs implicated more often are allopurinol, antibiotics, anticonvulsants and non-steroidal anti-inflammatories.

Recently, in a seven-year study, Devi et al. concluded that anticonvulsants were implicated in most cases of SJS especially in the first eight weeks of treatment; and the main drug responsible was carbamazepine.²

Typically, the initial presentation is marked by symptoms of fever, myalgia, and general weakness for 1 to 3 days before the development of cutaneous lesions. The skin lesions are symmetrically distributed on the face and upper trunk areas. The rash spreads rapidly and is usually maximal within four days, sometimes within hours. The initial skin lesions are usually poorly defined macules with darker purpuric centers that coalesce. Diagnosis is arrived at through clinical history and examination. However, skin biopsy helps to confirm the diagnosis, usually excluding bullous diseases not related to drug therapy. The patient in this case was exposed to carbamazepine twice; had mild rash in the first exposure few years back; but the degree of his cutaneous reaction was greater with the second exposure, when he developed SJS. Adverse reactions to drugs are reported to increase with age.¹⁵ SJS is reported to affect females more frequently than males, but an Indian study showed a slight male preponderance.¹⁶ Although SJS appears in all age groups but it is more common in older people, probably because of tendency to use more drugs. Most patients are in the second to fourth decades and onwards.¹⁷ Mortality was observed more commonly in elderly patients.¹⁸ It is possible that severity of SJS is greater at extreme of ages perhaps due to poor immune response as compared to adults.¹⁹

Conclusion

Considering this case report of SJS associated with carbamazepine, it is suggested that carbamazepine re-administration should be avoided in patients with a previous history of rash or SJS. In this regard, obtaining an accurate medical history is important. In addition, it is advisable to observe for any side effects while gradual titrating the dose at the start of treatment with carbamazepine. Awareness about drugs causing serious drug reactions such as SJS and TEN will help doctors prevent such reactions by judicious use of drugs and managing them adequately, reducing associated morbidity and mortality.

Figure1: Red, maculopapular rashes



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Short review

An overview of Diogenes syndrome in the context of animal hoarding: a rare disorder

Sadia Zahid

Abstract

Diogenes syndrome, also called senile squalor syndrome as mentioned commonly. The name Diogenes is derived from the name of an ancient Greek philosopher Diogenes, who rejected worldly comforts and lived a life of shabbiness and squalor. Diogenes syndrome is a rare disorder where the persons usually elderly, have a tendency to retreat in to solitary confinement, collect and hoard objects and are unable to care for their personal hygiene and cleanliness of their surroundings or living compound. They have little insight in to their condition with a significant difficulty in normal social functioning. An extension of this disorder is called Noah syndrome, self-descriptive, aptly described as a condition where the aged people start to hoard animals of various types, as pets. The disease is characterized by extreme squalor, poor insight of the sufferer about the excessive clutter and vileness, an inability to ask for help as evident by extreme and unnatural hoarding, lack of sanitation along with the presence of several different types of animals, usually cats and dogs that can be malnourished and in poor physical health. The people suffering with the disorder are resistant to any intervention, like in other hoarding disorders. The syndrome can be associated with other co morbid psychiatric conditions like depression and dementia where a person might be hoarding other non-living objects in addition to animals.

Key words

Animals, dementia, Diogenes syndrome, elderly, hoarding, Noah syndrome, senile squalor syndrome, syllogomania,

Introduction

Diogenes syndrome as described in the Diagnostic and Statistical Manual DSM-5 is a disorder of hoarding in the elderly where there is a tendency to compulsive hoarding (syllogomania) despite little value of the objects collected and an urge to save and store items and distress associated with discarding them along with apathy and inability to seek external help.¹ A version of this disorder where the individual collects animals in large numbers is described

as Noah syndrome named after the Hebrew Patriarch and Prophet Noah.² The resultant consequences of animal hoarding can be linked to significant difficulty in social functioning and can lead to extreme physical health morbidity and mortality including serious consequences to the health and safety of the individual and the animals involved.³ The disorder has increasingly been described with organic and psychiatric conditions like dementia and untreated depressive illness in the elderly in addition to others.⁴

Clinical Manifestations

Diogenes syndrome once rarely known is becoming an increasingly common condition in the elderly.⁵ Noah syndrome being a variant of Diogenes syndrome has many characteristics in common with the disorder. The syndrome is characterized by extreme hoarding behaviour, denial of external help or intervention and social norms and a resistance to change along with social withdrawal. The sufferer is usually an elderly female, single and most commonly living alone with above-average intelligence. Individuals who are never married are at increased risk of excessive hoarding, resistance to a change or introduction of a treatment regime and are at risk of increased physical and mental health morbidity and mortality with implications on public health as well. The person starts to hoard stray animals collected from streets or may register with a charity organization for the purpose who might deliver animals unknowingly to the person. In some cases the animals' numbers might increase due to uncontrolled reproduction. The hoarding behaviour usually stems from increased loneliness that these elderly have in their life and reaches to the heights of inappropriate altruism and selflessness. The person has no insight with regards to the physical needs of themselves and the animals living with them, the living quarter is usually in a dilapidated state with animal faeces, insect infestation and piles of rubbish.⁶ The person and animals found in various case studies were malnourished with poor physical health.⁷ There is a tendency to collect animals more in such cases due to the reciprocity of a loving relationship from animals as opposed to non-living objects. The person may have little contact with friends and family and commonly estranged possibly due to their eccentric lifestyle. The whistle is usually blown by health authorities when the person is due for a mandatory check

or brought in by emergency services after deterioration of physical health; and in many cases several years may lapse before they are finally brought to the attention of psychiatric services.

Characteristics of Noah Syndrome

Animal hoarding is signified by excessive accumulation of animals (dogs, cats, birds, horses etc.) as pets more than what the individual can take care of, and a lack of understanding of the basic needs of animals (housing, food, vaccination etc.). At the same time, there is a lack of insight in informing the authorities/asking for help to look after the huge number of animals, hence making this an inappropriate and dysfunctional attachment. Animal hoarding has been described in the past, though less frequently, going as far back as the 1960s. Patients are usually described as hermits who rarely go out and mix with the wider community. There have been accounts of animal cruelty and ferociousness leading to animal welfare organizations e.g. RSPCA (Royal Society for Prevention of Cruelty to Animals) etc. being alerted prompting a forensic assessment in extreme cases. At times, local housing authorities' representatives or neighbours are alerted due to unusual clamour and noise signifying the presence of huge number of animals. This can pose a serious public health threat due to worm and rodent infestation as well as communicable diseases from animals that are collected by the individual. In many cases, police warrants are issued due to active attempts by the elderly to refuse any intervention. The animals might sometimes have been collected over several years leading to their exorbitant numbers.

There is a predilection of the condition in patients with dementia as shown by various studies with numbers reaching up to half or one thirds. One case study showed 22% prevalence with hoarding behaviour as a heralding sign of dementia; however dementia itself may not be the only risk factor associated with the disorder.⁸ Patients are shown to have marked frontal lobe deficits since its involvement with higher order functioning like reasoning, judgement, decision-making and other cognitive processes. There is some association of the condition with frontotemporal dementia (36% of cases).⁹ Other psychiatric conditions associated with hoarding disorder include bipolar disorder, schizophrenia, depressive illness and alcohol abuse. Studies have also shown personality impairment as a link to Diogenes syndrome and its subtypes. However in the absence of a particular personality disorder the patients may have various personality traits predisposing them to become squalors even though they may not come under the strict criteria as defined in diagnostic manuals. Hoarding tendency and extent can be formally assessed using questionnaires like Saving inventory-revised and Clutter image rating in some cases along with frontal lobe battery for executive functioning.¹⁰ In some of the extreme cases, mummified, starved bodies of patients have been found in piles of rubbish and filth when cases only surfaced on post-mortem examination. Extreme degree of self neglect and fatal outcome associated with the senile squalor syndrome is sometimes reported in the media.¹¹ Some of the reports in media suggested hundreds of animals been discovered

on patients' properties that they have collected over several years.¹²

Interventions

Treatment of the underlying pathology is of foremost importance. Effective cognitive behaviour therapy centred approach along with the use of Selective Serotonin Reuptake Inhibitors and antipsychotics is considered to be beneficial along with main treatment of any underlying associated condition like dementia etc.¹³ Where possible an outpatients approach is considered useful rather than in an inpatient setting and if needed patients in severe cases might need to be relocated to a higher care facility.

Unfortunately patients are seen to revert back to their original lifestyle after some time. In most of the cases they refuse to seek help from the services despite rigorous interventions from animal welfare organizations and health services and have even been seen to move addresses in a desperate attempt to avoid identification.¹⁴ Ethical issues might arise in situations where patients have capacity and are non-consenting. In almost all of the cases involvement of animal welfare organisations as well social services in addition to medical and psychiatric input is needed for acute management as well as long term rehabilitation.¹⁵

Conclusion

The variant of Diogenes syndrome in the context of animal hoarding, Noah syndrome has rarely been described in medical literature. This condition is characterized by extreme hoarding behaviour including hoarding of living animals as well as inanimate objects, excessive clutter and poor living conditions in addition to the subject's inability to recognize the condition as a hindrance to day-to-day life. This condition is commonly seen in elderly patients usually with an underlying psychiatric condition like dementia, untreated depression etc. Patients are reclusive and show reluctance to accept treatment including active attempts to avoid interaction with services. Expertly performed assessment and involvement of multidisciplinary team including social services and animal services to help the elderly is the key to success although many patients have a chance of relapse after disengagement with the services.

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Viewpoint

Existence of boredom among the elderly: the need to further explore the concept

Priyanka Bantwal

Abstract

Aging is a dynamic, universal process bringing in a whole range of challenges and experiences. Boredom has been reported as one of the top 10 concerns among elderly in India. This article aims to emphasize the need to study and understand the concept of boredom among the elderly. The negative valence in the experience of boredom, fine link between boredom and depression, changing family dynamics and social roles in old age make it all the more imperative to study this subject further.

Key words

Boredom, concept, concern, depression, elderly

American writer Gloria Pitzer rightly said, "About the only thing that comes to us without any effort is old age". With most of societal duties finished, people transiting from middle age open their arms to what mostly quote as the 'closing years of life'. Even with India having a vast youth population, it has been termed as an 'aging country' by World Health Organization. The population of people in old age i.e. above 60 years is expected to rise to 12.26% in 2025.¹ Also, while earlier planning for life post-retirement basically meant living a few years and then death, the scenario has now changed with more people living longer, up to as long as 90 plus years.

The ageing process is of course a biological reality which has its own dynamics, largely beyond human control. Aging is marked by gamut of physical changes like atrophy of tissues and organs, weakness of the regulatory systems, musculoskeletal, nervous system and sense organ changes.² They also confront the effects of the stressful and hectic midlife: faulty diet, emotional stress, inadequate rest, no exercise and physical exhaustion.

Gatz et al in their paper 'Depression in Older Adults' have mentioned about how even though depression is less prominent among older adults than young adults; it does hold serious devastating consequences for them, because of which late life depression becomes a prominent concern.³

An average Indian mostly spend their prime years in work and making a living, it's no surprise that once they retire, they may suddenly find themselves completely 'free' or nothing 'meaningful' to do, which has also been termed as disenchantment phase of retirement, which may manifest itself in the form of feelings of loneliness, uncertainty, disappointment and a sense of meaninglessness. Not that an individual will always be stuck in the phase of disenchantment. There are many who reorient and redefine their goals for life, but there are also some who may find themselves stuck in the 'existential crisis.'

Existential crises are characterized by escalating inner conflicts related to issues of purpose in life, responsibility, independence, freedom and commitment.⁴ Examples include remorse over past life choices, a feeling that one's life has no meaning, and emerging questions on one's basic values or spiritual beliefs. The fact that boredom and a sense of meaning exhibit a mutually causative relationship is also compelling.⁵

Individual and societal perceptions at large determine how individuals attend to and manage with these changes. That is probably the reason why the general myth of getting into the later years of life being dull, boring, and filled with sadness and despair is redundant; with studies showing people holding positive outlook of the same and moving towards successful aging. Nevertheless, this cannot be generalized. There is a certain part of the same graying population that always dreads the uncertainties and fears thinking, what this phase might hold for them.

Help Age India has cited boredom to be one of the top 10 problems faced by the elderly in India.⁶ It is also interesting to note that Thomas et al had developed the philosophy 'The three plagues of loneliness, helplessness, and boredom' to deinstitutionalize long term care facility for the elders,⁷ further emphasizing the importance of boredom. Boredom is a unique state, having components like emotion, cognition, perception, attribution and behavior linked to it. It is an aversive state with a negative valence attached to it, where every attempt is made to escape from it.⁸ Though a universal experience, there is lack of coherent, universally accepted definition of boredom that is theoretically sophisticated or empirically grounded. Boredom has been described as 'a complex, difficult to define construct'.⁹

Erich Fromm in his book, 'Pathology of Normalcy' has also mentioned that 'boredom is more of a normal average experience, which in pathology can be called as melancholia and depression.' Fromm's viewpoints enlighten us on how these two concepts: boredom and depression are possibly linked.¹⁰

Individuals may experience boredom in their day to day life. It may act as an indication that what one is currently pursuing does not hold much meaning, thereby motivating them to find other alternatives. Trouble arises when an individual stays in this state for a prolonged time. The world may seem uninteresting and non-stimulating for the person. They may not find meaning in anything around them or with their existence, making a pathway for negative emotions and falling into a downward spiral of thoughts. This may make them vulnerable to depression.

Boredom as a concept is not new to the domain of research. It has been studied under variety of contexts and set ups like: job, leisure, school, sexual, crime, eating and consumer behavior etc. and is now also being studied under the categories of Trait Boredom and State Boredom. However, it is noteworthy the enlightening details it has given in this short span. Goldberg et al have highlighted the aspect that boredom is very different from depression and is worthy of examination in its own right. Though highly related, there is something about the experience of boredom that is not fully captured in any of the concept like depression, apathy and anhedonia.¹¹

Boredom may be easily misinterpreted as depression, for both the terms carry similar connotations. However, the experience that entails the two is different. When one is depressed, there is anxiety, feelings of worthlessness and helplessness, fatigue, loss of appetite, social isolation and complete loss of interest in previously pleasurable activities; whereas boredom is an aversive state characterized by feelings of dissatisfaction, restlessness and weariness. An individual always attempts to escape this state. However the entities may co-exist at the same time and it may be a challenge to differentiate.

Not only is studying boredom especially in the Indian context important, how a person copes with it is of equal importance as well. Even if one is aware of being in the state of boredom, one may not be well acquainted with the appropriate strategies to overcome it. There are various types of coping mechanisms one can engage in and their effects on an individual in the long run. One possible solution that is frequently suggested is distracting oneself. However, it may only relieve the boredom for a while. There is a need to go for strategic, individual-centered, long-term interventions. There are studies to indicate that the elderly do not often engage in strategies that may possibly help them in dealing with boredom in a healthier way, thereby having a negative impact on their mental health.

There is a strong need to familiarize the concept of boredom and its effects on elderly amongst clinicians, carers and the older persons. It is also important to develop culture appropriate strategies to help the older

person deal with boredom. These efforts may lead to a healthy and successful aging.

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Insight

55 not out – views of an ageing consultant geriatrician

Daryl Leung

In charge of very little but responsible for everything when it goes pear-shaped

I qualified in 1984. At 55 now I am a greying old man with a dodgy back and aching knees from getting down to explain to patients what is wrong. I find myself at a funny age and a funny stage in life. Should the hospital Trust I work for replace me with a newer model? I have been Clinical Director of my Care of the Elderly Department for over a decade, the longest serving departmental Clinical Director in the hospital. I have not however been promoted in management any further. I find myself amid suggestions of being replaced by someone with only 2 years' experience in the job. The NHS is a strange beast. However, it still remains an organisation I would and have given my life to.

New ideas appear but really just recycled old practices that have been forgotten or not experienced by new clinicians and managers too young to remember.

My FY1 House Officer or my Specialist Registrar for that matter could be my son or daughter; my Divisional Lead and Line Manager, my younger sibling.

Thousands of pounds have been spent on external reviews purchased by management or commissioning groups to explain what is barn door obvious to the foot soldier weary at the front line.

Huddles rather than multidisciplinary team meetings, discharge co-ordinators rather than bloody good ward clerks. Electronic typed discharge letters still written by the most inexperienced and newly qualified junior doctor. Perhaps now legible instead of the old fashioned unreadable carbon copy even though it still contains questionable content.

But despite all this I am proud to work for my Trust and the NHS. I have seen mind blowing improvements in clinical care. I have seen wonderful developments of new services and a much more slick (not sick) organisation than when I joined over 30 years ago.

I used to feel sorry for our pre-registration House Officers with no formal teaching sessions left to struggle on the wards. As a medical registrar I devised a teaching programme for them and delivered it myself on a weekly basis. Now it has all been taken over by the

educationalists. I am forced to do e-portfolio, evidence based discussions and reflections on the computer system. Once I chose to do this voluntarily now I am forced to comply.

The backbone of our service on a daily basis is delivered by good, honest, relatively low paid clinicians, ward clerks, Health Care Assistants, Medical Secretaries and newly qualified Staff Nurses - people who go the extra mile to keep the service afloat.

I want, I must stay positive, up for it as they say. I have tens of thousands of hours of experience which I have gained and must use this to continue to improve our NHS service. Yes, I consider the NHS a service, that's what in my eyes it is, rather than a system, there for the local population, region and country. I am proud to be part of it. Over the years it has been my life's blood, developing my skills as a Consultant Physician and Geriatrician, as an educator. It has placed me in such a privileged position professionally, socially, educationally and most definitely given me an insight into the understanding of life and death itself.

55 not out. I am an ageing geriatrician in charge of very little but responsible for everything when it goes pear shaped. Us old'uns need to keep batting. We have much to give, experience, wisdom, honesty and still much to learn. I am privileged to work in my own NHS Trust. It may be the end of an "over". I must change ends and keep batting for the team, there is still much to be gained.

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A hidden dimension of avoidable patient harm?

John Hudson

Regarding a recent article which appeared in the Journal of Geriatric Care and Research¹ concerning the use of antipsychotic medications for patients with dementia, a few observations may be offered. It is re-assuring to observe a more cautious approach to the prescribing of antipsychotic medications for persons with dementia, based on repeated alerts in the literature concerning the potential risks to patient safety and wellbeing; many of which are acknowledged in the author's overview of the subject.

A non-clinician's observation

This might be a useful opportunity to raise one further level of concern, which appears to have been largely missed in the guidelines on antipsychotic prescribing (and, indeed, in all but a few of the relevant systematic reviews)? A potential oversight in the clinical guidelines, and to a lesser extent in the professional literature more widely, may have arisen as a result of the implicit search for a broadly generalisable "one size fits all" procedural set of algorithms offering a solution to dilemmas in trading-off risks versus benefits for patients.

The title of the article duly reflects (re: plural dementias, as opposed to singular dementia or Alzheimer's disease alone) that there are numerous clinical sub-types of dementia. It is surprising therefore that clinical guidelines on the subject tend to strive for a "monolithic" approach in their directives (perhaps inadvertently), albeit with in-built regular medication reviews and "tapers"² to reflect individual progress. Typically the guidelines, perhaps in a misguided search for "simplicity" or "uniformity" of approach, appear to deliberately waive any deliberately more nuanced - and therefore potentially more precise - differentiation in their guidance, which might be capable of being "tuned" more suitably to reflect the underlying diversity of the patient population.

A thought experiment

Imagine, purely hypothetically, if there were one or more broad patient groupings which had been demonstrated to be affected in a disproportionately adverse manner by antipsychotic prescribing, even at the lowest level of dosage? Consider, again hypothetically, if such prescribing had been shown to result in undue loss of independence, mobility and wellbeing (not to mention greater risk of falls, cardiovascular side-effects such as

stroke, and avoidable premature mortality) on the part of those susceptible patients? Should the guidelines not reflect these problems explicitly, loud and clear, with a view to minimising these harms? The recent drift in NHS culture is avowedly strict on striving for greater patient safety, with an emphasis on a "zero-harm" culture.

So far, so sensible?

In fact, there *does* appear to be at least one (possibly two) such patient groups, which have been demonstrated to display a pronounced and extreme degree of neuroleptic sensitivity; and therefore for whom one would expect clinicians and the clinical guidelines to be particularly cautions about the commencement of antipsychotics prescribing (perhaps at all), the levels of dosage, and the desirability of the swift discontinuation of such medication. In contrast, it is likely you will search in vain, across all of the various international guidelines, for any such explicit mention of the need for any specially cautious and careful treatment of patients falling into such groups.

Which patient groups are at particularly high risk?

There has been an accumulating amount of evidence, reported sporadically in the literature over recent decades,³⁻¹¹ indicating that patients suffering from Dementia with Lewy Bodies (DLB) suffer from particularly adverse medication side-effects arising from extreme neuroleptic sensitivity when exposed to antipsychotics. Patients with another clinical sub-type of dementia, namely Parkinsonian Dementia, are likewise affected in a disproportionately adverse way, due to their severe neuroleptic sensitivity; particularly in more advanced stages of the disease. (These two conditions - DLB and Parkinson's disease Dementia (PDD) - may well be connected, in terms of a shared condition termed synucleinopathy, although this detail need not detain the reader here). Both conditions are characterised by distressing cognitive fluctuations and hallucinations (psychosis loosely termed, with associated disruptive and inconvenient BPSD). Patients with either condition are, accordingly, particularly likely to attract the attention of well-intentioned mental health teams, psychiatrists, psycho-geriatricians etc. with their potentially inappropriate (if applied without due care and informed discrimination) armoury of atypical-antipsychotics.

Time to refine the guidelines (or add explicit caveats at least)?

There may well be other clinical sub-types deserving special attention, but two - DLB and PDD - are enough to make the point for now. The clinical guidelines, as they currently stand, may be in need of further refinement to cater better for the specific needs of persons with particular dementia sub-types (mentioned above) and who are therefore at heightened risk of harm.

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Author's Response

Sarmishtha Bhattacharyya

Thank you for the thoughtful response on the editorial.¹ Your letter to the Editor titled 'A Hidden Dimension of Avoidable Patient Harm?' in the *Journal of Geriatric Care and Research*² highlights important aspects of a non-clinician's perspective. Person centred care should be the basic premise for management of any behavioural and psychological symptoms in dementia and may undoubtedly reduce the use of both physical and chemical restraints.³

It is important to remember also that guidelines are there to advise and there is no doubt that 'one size does not fit all'. Any treatment and management based on any guidelines should satisfy a particular person's needs and

should be done after assessing risks and benefits of a particular treatment.

Older adults with dementias are often neuroleptic naïve and in particular types of dementias such as Lewy body the use of antipsychotic medication is highly risky. Often individual patient centred interventions and advice are needed to manage such distressing behavioural and psychological symptoms of dementia (BPSD). There is also evidence for other medications such as antidepressants to be used for BPSD such as agitation, delusions, aggression although most available evidences are usually for Alzheimer's dementia.^{4,5}

Clinicians should therefore be cautious on prescriptions of antipsychotics and base it on an individual basis after due consideration to risks mentioned in the editorial and related correspondence.^{1,2}

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2. Hudson J. A Hidden dimension to avoidable patient harm. Journal of Geriatric Care and Research, 2016; 3(2): 52-53.
3. Andrews GJ. Managing challenging behaviour in dementia: A person centred approach may reduce the use of physical and chemical restraints. BMJ. 2006; 332(7544): 741.
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5. Schneider LS, Frangakis C, Drye LT, Devanand DP, Marano CM, Mintzer J *et al*, Heterogeneity of Treatment Response to Citalopram for Patients With Alzheimer's Disease With Aggression or Agitation: The CitAD Randomized Clinical Trial. Am J Psychiatry. 2016; 173(5):465-72.

Creative Expressions

Autumnal Fire

Susan Middleton



This is my latest painting, which was done in an all-day workshop "Painting in Penn" run by the well-known artist John Connolly. Medium I used is acrylic paint. Inspired by the sea, moors and woods, John's work is full of drama and emotion and observers often experience a feeling of remoteness and a sense of the place. In my painting, inspired by John's work and techniques, I have tried to create a realistic forest scene with an intriguing, winding path; and vibrant colours which should immediately pull you in to the scene. I have been painting as an amateur for a couple of years now and I have found that this hobby can relieve the stresses and strains of my every-day life.

For a few hours I can relax in a world of my own as I focus only on the subject before me. I have yet to name this painting but as it represents an autumnal scene with a wealth of colour, which seems both relaxing and exciting, I am leaning towards calling it "Autumnal Fire".

Artist information: Susan Middleton. Painting in Penn, St Bartholomew's Church Hall, Penn, Wolverhampton, WV4 5JB, England. Email: susanmiddletonart@gmail.com.

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Citation: Middleton S. Autumnal fire. Journal of Geriatric Care and Research, 2016, 3(2): 55.

News

National Award for GeriCaRe

Geriatric Care and Research Organisation (GeriCaRe) has been conferred the Indian National Award for Senior Citizens, 2016 (*Vayoshreshtha Samman*) as the 'Best Institution for Research in the Field of Ageing'.



Organized by the Ministry of Social Justice & Empowerment of Government of India, this award was presented as part of the celebration of the International Day of Older Persons on 1st October. Union Minister for Social Justice & Empowerment Shri Thawarchand Gehlot presided over the function. Ministers of State for Social Justice & Empowerment Shri Vijay Sampla and Shri Krishna Pal Gutjar, and Secretary, Ministry of Social Justice & Empowerment Smt. Anita Agnihotri were present in the function.



Shri Harish Chandra Kar, President of GeriCaRe and Dr Brajaballav Kar, Associate Professor of School of Management, KIIT University, Bhubaneswar received the award from the Honourable President of India, Shri Pranab Mukherjee, in Vigyan Bhawan, New Delhi.

Established in 1999, GeriCaRe is involved in the care of older persons and has completed many multi-disciplinary projects on the health and psychosocial issues of older persons. GeriCaRe is trying to improve the utilisation of scientific, evidence based research findings by the general public while taking care of the older persons. GeriCaRe has been involved and supported many research projects in wide variety of areas which have been published in international medical and professional journals and appreciated. GeriCaRe has pioneered a Health Passport approach to improve awareness about health risks and to take appropriate actions. Journal of Geriatric Care and Research is published by GeriCaRe which is now distributed free and reaches many individuals and institutions around the world. GeriCaRe has also been instrumental in publishing Handbook of Dementia which has gone into two editions.



In a statement GeriCaRe dedicates this award to the older persons and highlights that its volunteers, researchers and experts supporting its various activities are the real winners of this award.

Instructions for authors

Introduction

The *Journal of Geriatric Care and Research (JGCR)* is the official publication of Geriatric Care and Research Organisation (GeriCaRe). The *JGCR* publishes original work in all fields of geriatrics, contributing to the care of elderly. Theme based special issues focusing one aspect of care are also published periodically. Manuscripts for publication should be submitted via email <jgcr.gericare@gmail.com>.

The *JGCR* is not responsible for statements made by authors. Material in the *JGCR* does not necessarily reflect the views of the Editors or of GeriCaRe.

Editorial process

Contributions are accepted for publication on the condition that their substance (whole or part) has not been published or submitted for publication elsewhere, including internet. If there are other papers from same database, then the authors must send all details of previous or simultaneous submissions.

All submitted articles are peer reviewed. At the first step, the articles are assessed by the editorial board for its suitability for the formal review.

If found suitable, the manuscripts undergo a double-blind peer review. The suggestions received from reviewers are conveyed to the corresponding author. When appropriate, the author is requested to provide a point by point response to reviewers' comments and submit a revised version of the manuscript.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with *JGCR* style.

Authorship

Authorship credit should be based only on substantial contribution to:

- conception and design, or analysis and interpretation of data
- drafting the article or revising it critically for important intellectual content, and
- final approval of the version to be published.

All these conditions must be met. Participation solely in the collection of data or the acquisition of funding does not justify authorship. In addition, the corresponding author must ensure that there is no one else who fulfils the criteria but has not been included as an author.

Group authorship is permitted, but in this case individual authors will not be cited personally.

If a professional medical writer was used for manuscript preparation, their name and contact details must be given in the acknowledgement and any conflicts of interest must be disclosed.

The corresponding author must sign the contributors form on behalf of all the authors, once a manuscript has been accepted. This author must take responsibility for keeping all other named authors informed of the paper's progress.

Unless otherwise stated corresponding author will be considered as the guarantor of the article. However one or more authors/contributors can be guarantor. The guarantor accepts full responsibility for the work and/or the conduct of the study, had access to the data, and controlled the decision to publish.

Declaration of competing interest

All submissions to the *JGCR* (including editorials and letters to the Editor) require a declaration of competing interest. This should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, at any time over the preceding three years, an organisation whose interests may be affected by the publication of the paper.

Ethics approval of research

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 a locally appointed ethics committee or institutional review board.

Every research article must include a statement that the investigators obtained ethical approval for the study (or an explanation of why ethical approval was not needed) in

the methods section of the manuscript with the name and location of the approving ethics committee(s).

Patient consent and confidentiality

A statement regarding informed consent must be included in the methodology. Studies involving humans must have written informed consent from the patients. Where the individual is not able to give informed consent for lack of mental capacity, 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 legal representative or other authorised person as a matter of medical ethics. The authors 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; and must archive the signed informed consent form.

The process used to assess the subject's capacity to give informed consent and safeguards included in the study design for protection of human subjects should be mentioned.

Publication Ethics

Authors should consider all ethical issues relevant to publication. This includes (but not restricted to) avoiding multiple submission, plagiarism and manipulation of figures/data. Any concerns in this regard must be brought to the attention of the Editor and these will be investigated by procedures recommended by the [Committee on Publication Ethics \(COPE\)](#). If conclusive evidence of misconduct is found, the *JGCR* undertakes to publish a correction or retraction of article as necessary.

Clinical trial registration

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

Qualitative research

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

Type of manuscripts

Research article

The research article should normally be between 3000 and 4000 words in length (excluding references, tables and figure legends). Only the essential references should be given, preferably not more than 25 beyond those describing statistical procedures, 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.

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, and Conclusions.

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

Article should have Introduction, Method, Results and Discussion sections. Authors may use relevant subheadings under these sections. Introductions should normally be no more than one paragraph; longer ones may be allowed for new and unusual subjects. The Discussion should always include limitations of the paper to ensure balance. A paragraph of practical implications of the observations is encouraged.

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 abstract of one paragraph, not exceeding 100 words. The report should not exceed 1500 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 1000 words (excluding references, tables and figure legends). The written informed consent of the individuals must be obtained and submitted with the manuscript. 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, as expert opinion or as general letters to

the Editor. Letters may be up to 400 words in length with a maximum of 5 references.

Viewpoint

These are personal opinion pieces which may reflect an individual perception, involvement, or contribution to geriatric care. These articles may be up to 2000 words excluding references and should contain an unstructured abstract of around 100 words. Use of subheadings is encouraged.

First person account

In first person accounts *JGCR* publishes experiences of older persons or their care providers about the care and concerns of 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.

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, paintings, photographs, quotations, important internet links, etc.

Preparation of Manuscripts

Prepare article in Word, A4 size page, with 1 inch margin, double spaced throughout.

Article information page

1. Type of manuscript:
2. Title of the article: Brief and relevant
3. Running title: not more than 50 characters;
4. Name of the authors: (underline Last name)
5. Details of authors: academic degrees and institutional affiliations, professional address, email
6. Corresponding author: name, address, phone, fax, and e-mail
7. Contributions of each author:
8. Word count for abstract:
9. Word count for the text (excluding references):
10. Number of photographs/images (to be provided separately in JPEG files):
11. Acknowledgement:
12. Competing interests:

No identifiable details beyond this page.

Article Text pages

The article text pages do not contain any identifiable information, for a blind review. It should contain: Title of the article, Abstract and Key words (depending upon the article type) and the Text of the article.

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, Pfaffler 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.

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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.

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.

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.

Proofs

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

Copyright/ contributors form

On acceptance of the paper for publication, all authors should submit a contributor's form 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.



Donate to GeriCaRe

GeriCaRe (Geriatric Care and Research Organisation) is involved in the care of older persons, trying to improve their quality of life. Sharing knowledgebase and making the research evidence utilisable in the community is a key focus of GeriCaRe. It conducts and supports various research and development projects in various disciplines including health, psychology, sociology and other allied fields. It endeavours to provide evidence based information for caregivers and elderly about age related issues, and to support life-long-learning through educational programmes for professionals and carers. In the process, it prepares and distributes public-education materials. Journal of Geriatric Care and Research (JGCR) is one of its flagship endeavours. The JGCR is free to readers and authors and is distributed worldwide. For its activities, GeriCaRe has been received an Indian National Award in 2016 as the 'Best Institution for Research in the Field of Ageing'.

GeriCaRe is supported by its members, a number of experts and volunteers who contribute their time and expertise freely.

GeriCaRe requires financial support to carry on its activities. It depends upon the contribution from the individuals and organisations. You will be able to help by sponsorships.

You can sponsor any of the activities, e.g. Health Camps, Health Care Initiatives, Journal of Geriatric Care and Research, or Research and Development Projects.

If you are a business organisation, you can support GeriCaRe as one of your corporate social responsibility (CSR) activities. Considering the wide ranging issues that GeriCaRe addresses you will be able find many reasons to support.

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As a token of appreciation of your donation, GeriCaRe will send you the e-copies of JGCR. If requested it will also provide the donors an annual review of health with action plans for a chosen older adult, if the clinical details are shared.

Preferably, please consider setting up a direct debit at least yearly (or more frequently if you wish) which will help GeriCaRe in planning its activities; however onetime payments are also welcome. For payment instructions or further information on donation, please contact org.gericare@gmail.com or jgcr.gericare@gmail.com.

