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Geriatric Mental Health Care in India: Issues and Challenges

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ABSTRACT

The boundary of old age cannot be defined because it does not have the same meaning in all societies. People are considered old due to certain changes in their activities or social roles. Most definitions of aging indicate that it is a progressive process associated with declines in structure and function, impaired maintenance and repair systems, increased susceptibility to disease and death, and reduced reproductive capacity. Geriatrics simply refers to the medical care of the elderly people. Geriatric care has attracted unprecedented attention and rightly so as the world is witnessing the phenomenon of global ageing. India is also not an exception as the elderly population is steadily increasing. India has acquired the label of "an ageing nation" with 8.6% of its population being more than 60 years old in 2011; and has been projected to increase to 19% by the year 2050. Over the past decades, India's health program and policies have been focusing on issues like disease control, maternal and child health, and population stabilization. However, current statistics for the elderly in India gives a prologue to a new set of medical, social and economic problems. As a result of dramatic demographic and socio-economic shifts, India's growing elderly population needs quality social and medical care. This paper focuses on mental health issues of elderly population in India. Most common psychiatric illnesses in the Indian elderly population are dementia, depression and anxiety disorders. However, current literature suggests that lack of awareness, inadequate training opportunities, inequitable distribution of health resources, and virtual absence of chronic mental health care are some of the challenges that baffle the geriatric mental health services in India. This paper attempts to highlight the problems of elderly in Indian context including demographics, government health policies and programmes, available geriatric mental health care services, and challenges encountered by the concern stakeholders. The paper also tries to suggest the strategies for bringing about an improvement in mental health care services for the elderly and their quality of life in general.

Key Words : Geriatric, Elderly, Anxiety, Depression, Dementia, Mental health care

INTRODUCTION

The boundary of old age cannot be defined because it does not have the same meaning in all societies. People can be considered old due to certain changes in their activities or social roles. Government of India adopted 'National Policy on Older Persons' in January, 1999 which defines 'senior citizen' or 'elderly' as a person who is of age 60 years or above (Ministry of Statistics and Programme Implementation, Government of India, 2016). Most definitions of aging indicate that it is a progressive process associated with declines in structure and function, impaired maintenance and repair systems, increased susceptibility to disease and death, and reduced reproductive capacity (Cabo and Le Couteur, 2015). Geriatric care has attracted unprecedented attention and rightly so as the world is witnessing the phenomenon of global ageing. Geriatrics simply refers to the medical care of the elderly people. Gerontology on the other hand refers to the "study of physical and psychological changes which are incident to old age". Experimental gerontology is concerned with research into the basic biological problems of ageing, into its physiology, biochemistry,

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pathology and psychology (Park, 2015). Clinical gerontology is concerned with research which characterizes physiological changes across human life span that influence the risk of age related conditions. Ageing populations have brought with them a myriad of socio-economic and medical problems, tackling which has become a major concern of governments all around the world.

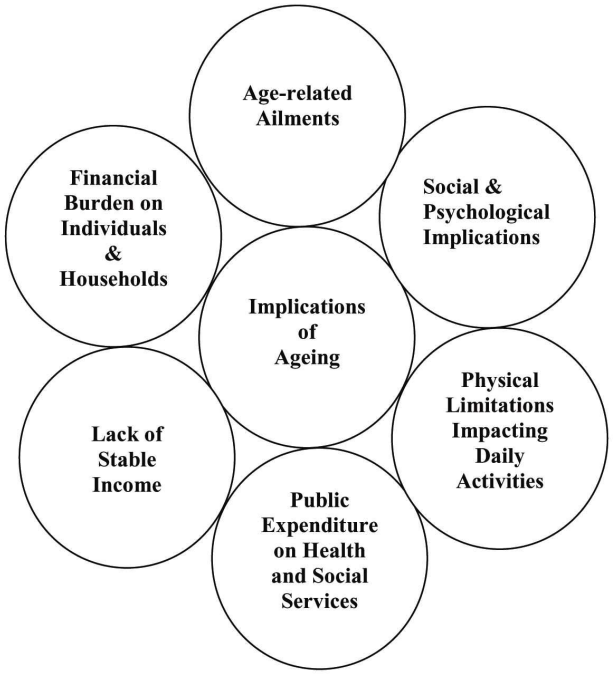
Demographic profile:

Globally, demographers predict that for the 65 years and older age group, it will take only another 25-30 years to reach double the number of children under 5 years of age. This means that future populations might require more geriatricians than paediatricians. The demographic profile depicts that during the years 2000–2050, the overall population in India will grow by 55%, whereas the aged population of 60 years and above will increase by 326 % and those in the age group of 80 years and above will increase by 700 % (Population Division of United Nations, 2015). This has resulted in an increased proportion of older people in the total population, termed as the "greying of population".

India is in a process of demographic transition. There is a downward shift from a high mortality/high fertility scenario to a low mortality/low fertility scenario. The expectancy of life at birth has almost doubled from 32 years in 1947 to 63.4 years in 2011 (Ministry of Statistics and Programme Implementation, Government of India, 2011). The elderly population (aged 60 years or above) in India accounted for 7.4% of the total population in 2001, 8.6% (104 million –53 million females and 51 million males) in 2011 and has been projected to increase to 19% by the year 2050. About 48.2% of elderly persons were women, out of whom 55% were widows. India is one of the few countries in the world in which the sex ratio of the aged favours males. This could be attributed to various reasons such as under-reporting of females, especially widows and higher female mortality in different age groups (Sudha and Rajan, 1999).

In the year 2011, it was observed that as many as 71% of elderly persons were living in rural areas. In rural areas, 66% of elderly men and 28% of elderly women were working, while only 46% of elderly men and about 11% of elderly women were working in urban areas. Around 73% of elderly persons were illiterate and dependent on physical labour, and about 90% of the elderly were from the unorganized sector. They have no regular source of income and 66% of older persons were in a vulnerable situation without adequate food, clothing, or shelter (Ministry of Statistics and Programme Implementation, Government of India, 2011).

State-wise data on economic independence tells us that in rural areas, the proportion of elderly males who are fully dependent on others is highest in Kerala (43%) and is lowest in Jammu and Kashmir (21%).



Adapted from *Ensuring care for the golden years – Way forward for India*, FICCI 7th Annual Health Insurance Conference, 2014

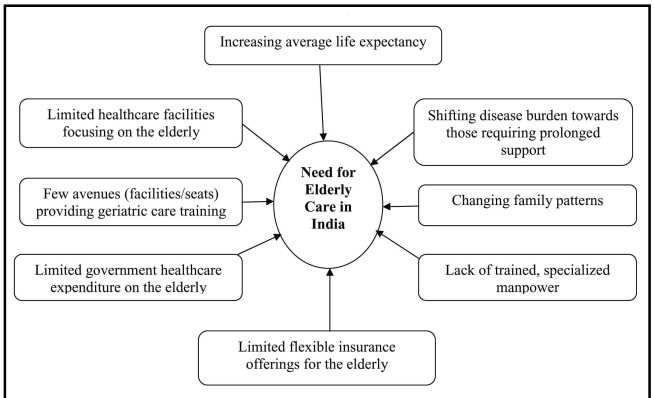
Fig. 1 : Implications of an increasing ageing population

As a result of dramatic demographic and socio-economic shifts, India's growing elderly population needs quality medical and social care. However, current literature suggests that lack of awareness, inadequate training opportunities, inequitable distribution of health resources, and virtual absence of chronic mental health care models are some of the challenges that baffle the geriatric mental health services in India. There is a need to highlight the medical as well as socio-economic problems that are being faced by the elderly people in India. This paper focuses on mental health issues of elderly population in India. Most common psychiatric illnesses in the Indian elderly population are dementia, depression and anxiety disorders. This paper, based on

secondary sources, attempts to highlight the problems of elderly in Indian context including demographics, available geriatric mental health care services and challenges encountered by concern stakeholders, and government health policies and programmes. This paper also tries to suggest the strategies for bringing about an improvement in mental health care services for the elderly and their quality of life in general.

Problems of Elderly in India:

Over the past decades, India's health program and policies have been focusing on issues like population stabilization, maternal and child health, and disease control. However, current statistics for the elderly in India gives an idea about the new set of medical, social and economic problems. In addition to the medical problems, the apparent success of the medical science is invariably accompanied by several social, economic and psychological problems in older persons. It needs to be understood that many of these problems require lifelong drug therapy, physical therapy and long-term rehabilitation (Yeolekar, 2005). Depending on the nature of the clinical problems, the elderly tend to be cared for in a variety of settings— home, nursing home, day-care centre, geriatric out-patient department, medical units or intensive care unit. Care of elderly necessitates addressing several social issues. The needs and problems of the elderly vary significantly according to their age, socio-economic status, health, living status and other such background characteristics. Their social rights are neglected and they are profusely abused and mostly go unreported.



Adapted from *Ensuring care for the golden years – Way forward for India*, FICCI 7th Annual Health Insurance Conference, 2014

Fig. 2 : The Need for Elderly Care in India

The socio-economic problems of the elderly are aggravated by factors such as the lack of social security and inadequate facilities for health care, rehabilitation and recreation. The rapid urbanization and societal modernization has brought in its wake a breakdown in family structure and values. Lack of family support, economic insecurity, social isolation, elderly abuse, etc. is leading to a host of psychological illnesses. Women especially widows are prone to face social stigma and ostracism (Jamuna and Reddy, 1997). In addition, in most of the developing countries including India, pension and social security programmes are restricted to those who have worked in the public sector or the organized sector of industry (Kartikeyan *et al*., 1999). Many surveys have shown that retired elderly people are confronted with the problems of financial insecurity and loneliness (Goel *et al*., 1999).

According to National Sample Survey Organization, the old age dependency ratio was found to be higher in rural areas (125/1000) than in urban areas (103/1000). With regard to the state of economic development, a higher number of males in rural areas (313/1000) were fully dependent as compared with males in urban areas (297/1000). For the aged female, an opposite trend has been observed – a higher number for females in rural areas (706/1000) were fully dependent as compared with 757 for females in urban areas (757/1000). Overall 75% of the economically dependent elderly are supported by their children and grandchildren (NSSO, 2006). Despite this, the elderly still tend to suffer from psychological stress as was found in a survey conducted for a middle class locality in New Delhi (Bose, 1997). Over 81% of the elderly confessed to having increasing stress and psychological problems in modern society, while 77.6% complained about mother-in-law/daughter-in-law conflicts being on the increase.

The elderly are also vulnerable to abuse in their own families or in institutional settings. This includes physical abuse like infliction of pain or injury; psychological or emotional abuse like infliction of mental anguish and illegal exploitation; and sexual abuse. A study that examined the extent and correlation of elder mistreatment among 400 community-dwelling adults aged 65 years and above in Chennai found the prevalence rate of mistreatment to be 14% (Chokkanathan and Lee, 2005). Chronic verbal abuse was the most common followed by financial abuse, physical abuse and neglect. It is also found that the prominent perpetrators were adult children, daughters-

in-law, spouses, and sons-in-law. A significantly higher number of women faced abuse as compared with men (Chokkanathan and Lee, 2005).

Geriatric Mental Health Problems in India:

Elderly people are highly prone to mental morbidities in India. The burden of mental morbidities is increasing among the Indian elderly due to ageing of the brain, problems associated with physical health, cerebral pathology and socio-economic factors such as breakdown of the family support systems, social isolation and decrease in economic independence (Guha, 1994). Epidemiological data about the elderly population is still scarce in India. Most of these studies are part of general population studies or hospital based or primary care geriatric patients' studies rather than community based. Dube (1970) reported the prevalence of mental illnesses in the elderly to be 2.23 %, while Nandi *et al*. (1975) found it as 33.3 % in rural India. Ramachandran *et al*. (1979) found this prevalence as 35 %. Another research group led by Tiwari (2000) found it to be much higher (43.32 %) in the geriatric group as compared to 4.66 % in the non-geriatric group. The reported prevalence of geriatric psychiatric morbidity in the community varied from 8.9% to 61.2 % (Shaji *et al.*, 2010). The mental disorders frequently encountered in the Indian elderly include dementia, mood disorders and depression in particular. Other disorders include anxiety disorders, drug and alcohol abuse, delirium and psychosis (Khandelwal, 2003; Prakash *et al*., 2009). Low education, poor socio-economic status, being a widow/widower/divorcee, medical co-morbidities, and disability are all well-established factors playing significant roles in psychiatric illnesses among the elderly in India (Guha *et al*., 2000; Harris *et al*, 2003). From the studies conducted in hospital clinics, community as well as old age homes, it is found that depression as the most common psychiatric disorder in the geriatric population with prevalence ranging from 22.2 % to 55.2 % of elderly psychiatric patients (Tiple *et al*., 2006; Rajkumar *et al*., 2009; Seby *et al.*, 2011; Sureshkumar *et al*., 2012). Suicide, especially due to depression, occurs more frequently in the elderly (Rao and Madhavan, 1983). But, wrong or improper diagnosis of depression is very common among the elderly patients. Prakash and his colleagues in their study found that 23 % of patients having depressive symptoms and 18 % having a definite depressive disorder among geriatric clinic attendees. Surprisingly, none of the geriatric physicians even from a tertiary clinic setting had made a diagnosis of depression (Prakash *et al*., 2009). Dementia is going to be the next silent epidemic in the country. The major independent risk factors for dementia are –diabetes, depression, hyperlipidaemia, urban living and lack of exercise. Living in joint families and increased intake of polyunsaturated fats conferred protection against dementia (Tripathi *et al*., 2012). The prevalence of dementia in Indian studies has been shown to vary from 0.84 % to 6.7 % (Prasad *et al*., 2009; Prince, 2009; Shaji *et al*., 2010). The prevalence of anxiety disorders has been reported to range from 5.34 % to 21.35 % among elderly psychiatric patients (Tiwari and Srivastava, 1998; Prakash and Rajkumar, 2009).

State of Geriatric Mental Health Care Services and Challenges in India:

Emphasis on geriatrics in the public health system is limited, with the focus areas of public health expenditure being issues such as maternal and child health and communicable diseases. Apart from it, the issues of the public health system, such as lack of infrastructure, limited manpower, poor quality of care, overcrowding of facilities, etc. are exacerbated for geriatrics due to insufficient focus on elderly care. For example, India has 7 physicians and 17.1 nurses per 10,000 people, while global density of physician and nurse is 14.1 and 29.2 per 10,000 people respectively (World Health Statistics 2014, World Health Organization). This lack of availability of health personnel is even more acute for geriatric people, as gerontology remains an ignored field in the Indian medical education system. Therefore, few doctors are qualified to assess and treat geriatric conditions in the country. As a result, dedicated geriatric service offerings through the public system are very much limited.

India is a multicultural, pluralistic society with enormous socio-economic disparities. Therefore, it is a daunting task to provide care to the heterogeneous population with variable knowledge of attitude and practices. Most of the time, symptoms of illness are disregarded both by the patient and his/her family as part of the 'normal aging process' or something 'not serious' due to the prevailing socially sanctioned roles for elderly in India. Even if it is acknowledged as a problem, some choose to self-medicate or use home remedies. Alternative healing practices, especially religious healing, are still the first choice for many people. Those reaching to mental health care professionals have to be contended

with for the misconceptions about mental disorders and the stigma attached to them. A study was conducted to assess the unmet needs of the geriatric population in rural areas observed that as many as 46.3 % of the study participants were unaware of the availability of any geriatric services near their locality and 96 % had never used any geriatric care services. About 59 % of them stated that the nearest government facility was 3 kilometres from their homes (Goel *et al*., 1999). Lack of awareness surrounding mental illness makes it more stigmatised. In India, treatment seeking behaviour is very poor due to financial constraint and poverty (Agrawal and Arokiasamy, 2010).

The available resources for providing geriatric mental health care services in India can be classified into four categories – (i) state funded government psychiatric hospitals; (ii) private psychiatric hospitals and nursing homes; (iii) non-government organisations; and (iv) family caregivers as most important informal source. The country has limited numbers of mental health professionals, around 4000 psychiatrists catering to the 21 million geriatric populations in need of mental health services (Thirunavukarasu and Thirunavukarasu, 2010). According to the Union Ministry of Health and Family Welfare, the number of mental health professionals including clinical psychiatrists, psychologists, psychiatric social workers and psychiatric nurses required is 54,750 but we only have 7,000. Moreover, the requirement of psychiatrists in the country is 11,500 as opposed to 3,500 available presently. In the case of psychiatric social workers, the count is 400 against the requisite of 23,000. Similarly, 500 clinical psychologists are available where the estimated need is of 17,250 (ePsyclinic, 2016).

In terms of infrastructure, very few Indian hospitals have geriatric units and most elderly patients are treated in general medical/psychiatry wards. At present, most of the geriatric outpatient department (OPD) services are only operating at the tertiary care hospitals in big cities. Public sector hospitals suffer from problems of inaccessibility, inequitable distribution, lack of staff, drugs and equipment, while the private sector is largely unregulated with serious complaints regarding high cost, poor quality of health care and unethical practices. In general, less than 26 % of Indians have some form of health insurance; and the health insurance sector in India doesn't cover mental illnesses (www.deloitte.com/in).

Several indigenous systems of medicine also operate in India amidst the formal public and private systems and offer treatments which may be more accessible, affordable or acceptable to the rural elderly. However, as per the recent study, graduates of indigenous medical programmes often lack the clinical training required to utilize diagnostic tools, conduct basic procedures and handle primary care emergencies (Patwardhan *et al*., 2011). A large portion of the population is forced to bypass free public services to pay out-of-pocket (OOP) in private institutions (Shaji *et al*., 2010).

The focus of mental health care in India is still on acute management and tertiary care instead of developing primary care and rehabilitative services. Though new initiatives such as day care centres, old age residential homes, memory clinics, helplines, counselling and recreational facilities are being developed, most of them are urban based and concentrated mainly in southern part of India. Non-governmental organisations like Help Age India, the Age well Foundation and the Dignity Foundation too are actively contributing, but still efforts are far from reaching to the masses (Krishnaswamy *et al*., 2008). The support of families is undoubtedly the only option left considering the meagre geriatric mental health resources available. Family members, irrespective of their financial status, deem it their responsibility to care for

Table 1 : Mental Health Human Resources in India

Types of Mental Health professionals	Health professionals working in the mental health sector Rate per 100,000	Training of health professions in educational institutions Rate per 100,000
Psychiatrists	0.301	0.0364
Medical doctors, not specialized in psychiatry	UN	2.893
Nurses	0.166	0.016
Psychologists	0.047	0.010
Social workers	0.033	0.003
Occupational therapists	UN	UN
Other health workers	UN	NA

Source: Mental Health Atlas 2011, Department of Mental Health and Substance Abuse, World Health Organization

their elderly mentally ill relatives. But, in the current era of modernisation, globalization and eroding social values, there is an apparent weakening of joint family systems. The younger generation is trying to find out their new identities and redefining new social roles within as well as outside the family. The changing economic structure has reduced the dependence of rural families on agriculture, which had earlier provided strength to bonds between generations. The Indian elderly generation is caught between the decline in traditional values on the one hand and the absence of an adequate social security system, on the other (Bhat and Raj, 2001). Among the younger generation, the traditional sense of duty and obligation towards their older generation is being eroded. This has led to the increasing incidences of the elderly being abandoned as homeless by their own family members. The government has provided facilities for day care centres and respite care that are very scarce. There is a sheer absence of any home based rehabilitation measures or benefits accorded by the government to families to address caregiver burdens (Gupta, 2009).

Geriatric psychiatry is a neglected branch. In terms of manpower training and research for geriatric care, opportunities are very limited in India. Geriatric medicine training is offered only in a college in Chennai. The Medical Council of India (MCI) offers this super speciality training only in Lucknow and Bangalore. Out of these handful psychiatrists available, the brain drain of psychiatrists towards the Western countries is another problem. Advocacy and research activities are confined to a few organisations like Geriatric Society of India, the Indian Association for Geriatric Mental Health, Indian Academy of Geriatrics and the Association of Gerontology (Gupta, 2009).

Role of Government:

The well-being of senior citizens is mandated in the Constitution of India under Article 41: "The state shall, within the limits of its economic capacity and development, make effective provision for securing the right to public assistance in cases of old age". However, health is not the priority for the government including mental health and geriatric care services. It is the least appealing, non-productive negligent bunch of all, when it comes to budgetary allocation (National Health Account, GOI, 2004-05). When compared with BRICS, the UK and the US, India has the highest share of private spending on health and the lowest share of government spending. The government contributes just 29% of the total health spending in India, while the government's share is 83% in the UK. For others, this figure ranges between 45% and 55%. Indian government spends just 1.1% of its GDP on health; and National Health Policy of 2017 set a goal of raising this figure to 2.5% of GDP by 2025.

Overall health insurance coverage in the country is estimated to be 26%. However, insurance coverage among the elderly under public and private insurance schemes is significantly lower and estimated to be 1.6% (www.deloitte.com/in). This low insurance penetration amongst the elderly is further exacerbated by inadequate coverage provided to the insured, in terms of both amount and type of services covered. Private health insurance includes a combination of insurance products to target specifically elderly people or general insurance plans that have a flexible entry age. While these products cover a wider range of medical care services including emergency care and long-term treatment, the issue of their affordability makes them unavailable to a majority of the elderly population. Most of these insurance products in India unfortunately do not provide coverage for non-medical services such as home-health or palliative care. While the government has not developed specific insurance schemes or financing policies for the elderly; social insurance schemes such as Rashtriya Swasthya Bima Yojana (RSBY) cover elderly care as they do not have an age limit for eligibility. However, limited coverage and low reimbursement amounts restrict the effectiveness of these schemes for the elderly people.

It is estimated that households with only elderly members incur a monthly per capita health expense that is 3.8 times that of households with no elderly members (*Out-of-pocket Expenditure on Health Care among Elderly and Non-elderly Households in India*, Social Indicators Research). Hence, elderly households spend a disproportionate amount of their total monthly consumption on healthcare needs when compared to other households. New data from the National Health Accounts (NHA, 2014-15) published by the Union Health Ministry reveals that medicines are the biggest financial burden on Indian households. Out-of-pocket spending (OOP) is the money individuals pay on their own rather than being covered by insurance or health benefit schemes. OOP constitutes 62.6% of the total health expenditure in India — including all government and private sources. Out of more than 3.0 lakh crores rupees that households spent on health in 2014-15, around 42% of the total OOP

spending went in buying medicines. Indian households spent around 28% of the OOP spending in private hospitals. Experts say that high OOP spending for health brings a financial burden on families and discourages people from seeking timely care. India has one of the highest private OOP expenditures in the world. "OOP, when catastrophic, results in 7.0 crores people falling back into poverty line," former Union health secretary CK Mishra said at a conference organised by the National Institute of Public Finance and Policy (NIPFP) in December 2017 (*The Hindustan Times,* 2017).

The Central and State governments have already made efforts to tackle the problem of economic insecurity by launching policies such as the National Policy for Older Persons (1999); the National Initiative on Care for the Elderly (2004); and the Maintenance and Welfare of Parents and Senior Citizens Act (2007). The most recent effort is the National Programme for the Health Care of the Elderly (NPHCE), initiated in early 2011. Other social security programmes include National Old Age Pension Program, Annapurna Program, etc. Social security provisions for pension, income tax benefits, provident fund, gratuity, and medical assistance have been strengthened. Focus is shifting more on capacity building by: (i) expanding infrastructure to include Regional Geriatric Centres in district hospitals and opening community-based geriatric clinics; (ii) establishing specialized geriatric training programs and research institutes; and (iii) utilizing mass media to educate the public. The program also includes provision to promote strong inter-organizational linkages and referral mechanisms, training and support for informal caregivers. The program is being implemented in phases beginning with 100 districts in 21 states of India. (National Health Account, GOI, 2004-05).

However, the benefits of these programs have been questioned several times in terms of the meagre budget, improper identification of beneficiaries, lengthy procedures, and irregular payment. Increase in government spending is crucial but accountability and utilisation of allotted find is also equally important. Despite the low budgetary allocation to health, Yamini Aiyar, President and Chief Executive of Centre for Policy Research, said that the government is unable to spend the relatively little it does have. "The system is so deeply broken that even some of the basic things like moving money and spending money become a complicated task," Aiyar said at the NIPFP conference, pointing to the inefficiencies and systemic problems in how public finances are managed in the country. Bihar, for instance, spent just 54% of its approved budget in 2016-17. Health issues in Bihar require massive expenditure, yet the state is able to spend remarkably little (*The Hindustan Times*, 2017).

Despite the policies being in place, the crude reality is that policies are not implemented in their true sense. On the other hand, most of the policies talk about social benefits for the elderly in general, but showing least concern for geriatric mental health. Policy makers should not neglect the role of caregivers and families and at the same time they should ensure adequate support for the caregivers from health professionals. Therefore, efforts in place for geriatric care are noteworthy but highly inadequate.

Recommendations:

In spite of the growing requirement for mental health services for older persons, there is substantial unmet need. Since the elderly segment does not actively contribute to the productive population, so then it often fails to receive its due attention from policy makers. The elderly people not only make important contributions to the society via the formal workforce (primarily in agriculture), but also involve in raising grandchildren, resolving conflict and offering counsel, and translating rich heritage. If in a low resource setting, improving life span and decreasing mortality was an achievement of the 20th century, then ensuring good quality geriatric care is going to be the challenge of 21st century. Therefore, there is an urgent need for developing appropriate and effective health services directed towards this population. Following are some of the ways that are to be considered and incorporated for providing better health care services to the senior citizens of our country *vis-a-vis* for improving their quality of life in general:

Increasing awareness:

An important prerequisite to improving care for elderly people is to create a climate that fosters such improvement. Awareness generation regarding mental health problems, specific needs of the geriatric population and availability of existing services among all stakeholders is need of the hours. The existing framework should allow for positive engagement between clinicians, researchers, caregivers and elderly people with mental illness.

Training and Manpower Development:

There is a felt need to expand the teaching curriculum to include geriatric care components across all the disciplines including general physicians, psychiatrists, psychologists, psychiatric nursing and psychiatric social work. There is also a need to increase the number of seats in geriatric medicine, geriatric psychiatry and super speciality courses. Suitable programmes must be developed for sensitising general physicians and health workers for screening and appropriate referral. AYUSH (*Ayurveda, Yoga, Unani, Siddha and Homaeopathy*) system is notably strong in terms of the first dimension as it has rich potential to promote health of the elderly, besides the scope of rejuvenation and promotion of longevity. There is an urgent need to set up geriatric centres of excellence. Catering to A multidisciplinary approach can also play a crucial role in geriatric health care.

Home based care programmes:

In the current scenario where training a health professional is a time and resource-consuming affair, countries like India can develop adequate training programmes for family members—the major current task force in the service of the elderly in country. Supporting, educating and advising family caregivers is a cost effective strategy for developing countries as it requires only one tenth of resources as invested in residential care.

Rehabilitation services:

Proper and adequate services for continuity of care beyond hospitals in the community needs to be arranged. It may be done by establishing day care centres, respite care facilities, half-way homes, and old age homes. There is an urgent need of a paradigm shift in the care model beyond the current preoccupation with simple curative interventions to encompass long-term support and chronic disease management.

Need for research:

In general, the literature reviewed adequately answers the "what" and the "why" of aging and poor geriatric care in India, but more research is needed to understand "how" to make improvements. The paucity of population-based research calls for more good quality epidemiological and health services research that will help to generate awareness, shape health and social policy and encourage the development of better services for patients and their caregivers.

Conclusion:

The current trends in demographics coupled with rapid urbanization and changed lifestyle have led to an emergence of a host of problems faced by the elderly in India. Geriatric care has two distinct facets—first, promotion of health and longevity and second, management of diseases which are specifically incident in old age for sustaining a comfortable and healthy aging. Geriatric mental health is a neglected issue due to poor sensitivity amongst patients, caregivers and administrators. The challenge is to develop culturally sensitive services designed for the poor people and spreading more community awareness. There is also a need to raise awareness among health and health-related professionals about unmet needs of geriatric mental health, developing adequate human resources and strengthening inter-sectoral collaboration. There is an urgent need to implement national policies, programmes and legislation targeting geriatric mental health and promoting advocacy and empowerment. Serious efforts should be made for making treatment accessible, available and affordable in community. Although this paper has mainly focused on the mental health problems of the elderly and strategies for improving mental health care services, it must be remembered that improving the quality of life of the elderly calls for a holistic approach and concerted efforts by the health and health-related sectors with strong backing by the government.

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