GERIATRIC SOCIAL WORK

COURSE OBJECTIVES

 Develop an understanding of the scope of Gerontology and Geriatrics.
 To develop an ability to see and explore the factors contributing to the growing problems of Older persons.
 To develop an attitude of becoming responsible for taking care of the elderly by family members.
 To sensitize the students about the debilitating impact of ageing on older persons.
 To inform the students of the policies and welfare programmes meant for the older persons

UNIT- I GERONTOLOGY AND GERIATRICS:

Concept and Growth: History and Growth of gerontology; Scope and Fields of Gerontology; Geriatric Care : History of Geriatric care in India; Home & Community-Based Care; Fields of Geriatrics; Theories of Aging; Role and Functions of Gerontologist.

UNIT -II FACTORS CONTRIBUTING TO GROWING PROBLEMS OF THE ELDERLY:

Problems of the Elderly in India; Aging and Risk Factors for Diseases and Disabilities; Elder Abuse and Neglect; Elder Abuse – Causes; Factors and Forms of Elder Abuse; Elder Abuse in India; Medications, Substance Abuse and Older Adult.

UNIT- III ROLE OF FAMILY AND CARE GIVERS:

Role and Importance of Family and Care givers in Elder Care; Role and Importance of Younger Generations in the Care of Old Persons; Old Age Homes – Types and Services; Need and Importance of Old Age Homes; Services of Old Age Homes; Quality of Life of the Elderly in Old Age Homes.

UNIT- IV WORKING WITH THE ELDERLY:

Aging and the Body/Body Systems; Effects of aging; Common health problems; Care of the patient and symptoms to report; Aging and the Mind: Mental and personality changes; Temporary changes in mental functioning and causes; Permanent changes in mental functioning and common problems; Caring for clients with memory loss or confusion.

UNIT -V POLICIES AND PROGRAMMES FOR THE ELDERLY IN INDIA:

Legislations for the Elderly in India; Statutory provisions for the elderly; National Policy on Older Persons; United Nations Organization and the Elderly; International Initiatives for Elderly Care; Gerontological social work practice.

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UNIT-1

Introduction

Gerontology

With an understanding of gerontology, an individual can make plans for her or his own life course and needs, and communities and legislators can make necessary public policy choices. Public policy decisions are critical because of the tremendous growth of our population aged 65. Georgia's older adult population is the fourth fastest growing in the nation and currently numbers 1.2 million. The South added nearly 2.5 million older adults between 2000 and 2010. Nationally, it is projected that the older population will double to 89 million by 2050 – a rate of growth that is twice as fast as the under age 50 population. The demand for professionals with expertise in gerontology will mirror these increases.

Definition of Gerontology

Gerontology is the study of aging and older adults. The science of gerontology has evolved as longevity has improved. Researchers in this field are diverse and are trained in areas such as physiology, social science, psychology, public health, and policy. A more complete definition of gerontology includes all of the following:

- Scientific studies of processes associated with the bodily changes from middle agethrough later life;
- Multidisciplinary investigation of societal changes resulting from an aging populationand ranging from the humanities (e.g., history, philosophy, literature) to economics; and
- Applications of this knowledge to policies and programs.

Gerontology is the study of aging. It comes from the Greek words *geron*, meaning "old man", and *-ology*, a suffix meaning "the study of". Gerontology is a multidisciplinary field. It involves the scientific study of physical, mental, and social changes that occur in older people, the investigation of societal changes from an economic, historical, and

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philosophical standpoint, and the carrying out of policies and procedures to aid older people with information from gerontology in mind. Gerontologists in the field of biology study the biological changes that occur in older individuals. Gerontology is not to be confused with geriatrics, which specificallyrefers to the medical care and treatment of older people.

History of Gerontology

People have been fascinated with aging since ancient times. Of course, many ancient cultures, much like today's society, were highly interested in slowing the aging process or reversing it. The earliest known recipe for an anti-aging ointment is from an Egyptian papyrus dating back to 2800-2700 B.C. called "The Book for Transforming an Old Man into a Youth of Twenty". It claimed to beautify the skin and remove any disfiguring signs of age. Another ancient papyrus from 1550 B.C. describes some of the biological changes that can occur with aging, such as heart pain, deafness, blindness, and what would later be known as cancer.

Gerontology research, and other forms of scientific research, really took off during the 19th Century, when the use of the compound microscope became widespread. Many scientists at first began to study bacteria under the microscope in order to study senescence, or aging, but this proved difficult because bacteria reproduce by dividing themselves into two cells and do not become senescent in the way that the cells of multicellular organisms do.

Multicellular animal models had to be used instead, and this is one reason why the use of mice became so ubiquitous in research. With the use of the microscope, scientific knowledge advanced a great deal. For the first time, researchers could examine the processes of aging at the cellular level, and really begin to understand the specific changes that take place in the cells of older people.

People began to develop theories about why aging occurs; August Weissman, a German embryologist, proposed that lifespan was related to an evolutionary selective advantage, and that species with different body sizes, intelligence, and ecology had different lifespans. The term gerontology was

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coined in 1903 by Élie Metchnikoff, a Russian zoologist who did immunology research and won the Nobel Prize in Physiology or Medicine for his work.

In the mid-20th century when the structure of DNA was uncovered, another paradigm shift occurred in gerontology research. Scientists could now study genetics relating to aging; for example, they looked at unique mutations in abnormally long-lived or short-lived fruit flies.

Other ways of extending an organism's lifespan were also found, like putting mice on calorie- restricted diets or putting fruit flies in very small cages so that they couldn't fly as much. Further progress was made when age-related decline in certain hormones, like growth hormone, thyroid hormone, and estrogen, was discovered. More recently, genome sequencing has been used to identify genes associated with aging.

A New Concept:

Ageing is not an event but a process. For the development theorists and practitioners ageing is one of the most neglected issues mainly because aged people are considered as disempowered and non-resourceful persons. They are not considered as a class category or status group neither by economists nor by sociologists. Though ageing is universal, till a decade back ageing is considered as natural and evolutionary process and hence it is not taken seriously. Till 1980s the problems of the old were not known to the state in the developing countries and therefore they were not attended. There are many ways to reduce the child population whereas the old population cannot be stopped as the developing countries like Asian countries methodically ignored the structure of the population.

Ageing can generally be described as the process of growing old and is an intricate part of the life cycle. Basically it is a multi-dimensional process and affects almost every aspect of human life. Introduction to the study of human ageing have typically emphasized changes in demography focusing on the ‗ageing of population'- a trend, which has characterized industrial societies throughout the twentieth century but in recent decades, has become a worldwide phenomenon.

Population ageing is the most significant result of the process known as

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demographic transition. Two dimensions of demographic transition are:

a) Reduction of fertility that leads to a decline in the proportion of the young in the population.

b) Reduction of mortality which means a longer life span forindividuals.

Jean Bourgeois Pichat (1979) has called attention to two process in ageing which reflects the twodimension of demographic transition.

Ageing at the base occurs when fertility falls, thus decreasing the proportion of children and ageing at the apex occurs when the proportion of aged persons increases presumably due to declining mortality at older ages.

Population ageing involves a shift fromhigh mortality / high fertility to low mortality / lowfertility and consequently an increased proportionof older people in the total population (Prakash,1999).

Dimensions and definition of Ageing

Ageing has been defined in various ways by different scholars and it is measured in manyways according to the academic background of the person who study them. Some have regarded ageing as period of physiological deterioration, others regard it as simply the advancement of years and still others have emphasized that ageing involves a restriction on cultural roles.

According to Bhatia (1983) the term ‗ageing' is a broad one and can be studied under three types

– Biological, Psychological, and Socio-cultural.

In the broadest sense, Charles S Becker (1959) defines ageing ‗as those changes occurring in an individual, which are the result of the passage of time'. These may be, according to him, anatomical, physiological, psychological and even social and economic. He further adds: Ageing consists of two simultaneous components – anabolic building up and catabolic breaking down. In the middle years there is an essential balance between expansion and decay, while growth predominates in youth; degenerative changes which start occurring very clearly in life pre-dominate in the late life span. Edward J. Stieglitz (1960) defines ageing as ‗the element of time in living'. According to him, ‗ageing is a part of living. Ageing begins with conception and terminates with death. It cannot be arrested unless we arrest life.

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According to Tibbitts (1960) ageing may be best defined as the survival of a growing number of people who have completed the traditional roles of making a living and child rearing and years following the completion of these tasks represent an extension of life. He also says, ageing is an inevitable and irreversible biological process.

According to Hooyman and Kiyak (1994), the gerontologist view ageing in terms of the following four distinct process or dimensions:

Four dimensions of ageing are commonly identified: chronological, biological, psychologicaland social ageing.

Chronological ageing refers to the number of years since someone was born Chronological age also provides individuals with a means of distinguishing roles and relationships in terms of the behaviour and expectations that are linked to different chronological groupings. But it is generally not recognised as an adequate measure of the extent of ageing because, as a process, it is thought to vary between individuals.

Biological ageing, often known as senescence (declines of a cell or organism due to ageing) and sometimes functional ageing, refers to biological events occurring across time which progressively impair the physiological system so that the organism becomes less able to withstand disease, ultimately increasing its susceptibility to death. From this perspective, the ageing process stems from several physiological factors, and is modified throughout the life course by environmental factors (such as nutrition), experiences of disease, genetic factors and life stage. This is usually associated with decline in the regulation and proper functioning of the vital organs of the body. However, not all people experience decreased organ function in the same proportion. Some individuals have healthier hearts at age 80 than others do at age 60.

Psychological ageing focuses upon changes that occur during adulthood to an individual‘s personality,mental functioning (e.g. memory, learning and intelligence) and sensory and perceptual processes. Jegede (2003) stated that the indices of psychological ageing include feelings, motivation, memory, emotions, and experience and self-identify. For instance, people who had intention of

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traveling abroad may decide to drop the idea and contribute to the growth of their own economy. Psychological ageing is heterogeneous and continuous as an individual passes through life.

Social ageing refers to the changing experiences that individuals will encounter in their roles and relationships with other people and as members of broader social structures (such as a religious group) as they pass through different phases of their life course. In sociological ageing, personal or attitude and interaction within the community are used to assess a person‘s maturation and ageing. As a person ages socially, he/she calculates his/her utterances, limits the use of vulgar language, prunes relationship to mature friends, changes his/her mode of dressing, reduces nocturnal clubs. As a person ages socially, he/she tends to be guided by the norms of the society to which the person belongs.

As an individual experience, social ageing affects perceptions of who we are, but can also be shaped or _constructed‘ by social and cultural contexts which dictate the normative expectations about the roles, positions and behaviour of older people in society.

While all three dimensions of biological, social and psychological ageing generally interact, the pace at which each dimension is experienced may be different for the same individual. This is usually how a person relates with others in the society.

Strehler (1962) has proposed four criteria for ageing, reported in Tyagi (1999). They are: Ageing is universal, which means it occurs in all members of population.

- Ageing is progressive, a continuous process. Ageing is intrinsic to the organism
- Ageing is degenerative

Thus, ageing is an inevitable, ubiquitous and universal phenomena of human life because it is a natural process. Finally, population ageing, sometimes referred to as societal ageing, is a process whereby a group (such as a country or an ethnic group) experiences the progressive increase in the actual numbers and proportion of older people within its total population.

This change, brought about largely by socio-economic improvements in health

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and living standards, progressively reduces mortality and fertility, resulting in increased life expectancy and fewer births, and ultimately, an increase in the older population in relation to younger age groups. Population ageing has long-term implications for governments in terms, for example, of the cost of health and social care for an increasingly important number ofolder people.

Cavanaught (1993) in Osunde and Obiunu (2005) divided ageing into three types, the primary ageing, the secondary ageing and the tertiary ageing.

The Primary Ageing: Primary ageing is considered as the normal process which has nothing to do with illness. It simply involves changes in the biological, social and psychological domains. These occur due to tear and wear of vital organs of the body

The Secondary Ageing:

This process is associated with different kinds of terminal illness which prevent normal functioning of the individual.

The Tertiary Ageing: This occurs when there are loses brought about by death or disasters like war(s) on a family member or close friends that could lead to a gradual decline in the proper functioning of the individual.

History of Geriatric care in India

In India, the elderly suffer from dual burden of communicable and non-communicable diseases besides impairment of special sensory functions like vision and hearing and other degenerative diseases. Poor geographical access and high cost of treatment also lead to poor utilization of health care especially among the elderly.

The elderly are also prone to abuse in their families or in institutional settings. A study in Chennai among 400 community-dwelling elderly aged 65 years and above found the prevalence rate of mistreatment to be 14%. Chronic verbal abuse was the most common followed by financial abuse, physical abuse and neglect.

Geriatric care is conspicuously missing from the medical education

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curriculum. Similarly the nursing and other paramedical staff members are not formally trained in providing care for elderly patients. There is no specialized training in geriatrics in most medical schools in India. Geriatrics is a low-profile specialty that lacks visibility in academia and finds least favor among the medical students.

Only selected facilities have a dedicated geriatric unit, but concentrated in urban areas and highly expensive. Very few hospitals provide inpatient geriatric care. Although, there are hundreds of old-age homes, day-care centers and mobile medicare units that provide care to the elderly population, these facilities are managed by NGOs or funded partially by government, but are urban-based, expensive or focused on tertiary as opposed to primary care.

Recently, the Government of India has taken significant strides towards securing the rights of the elderly. In 2007, Indian parliament passed a bill known as Maintenance and Welfare of Parents and Senior Citizens Act, which made maintenance of parents or senior citizens by children or relatives obligatory and justifiable and also provided penal provision for their abandonment.

Government of India formulated the National Program for the Health Care of Elderly in 2011 to provide easy access to preventive, promotive, curative and rehabilitative services to the elderly at all levels of health care delivery system along with specialized long-term and short-term training of health professionals to address the growing health needs of the elderly.

The National Policy on Senior Citizens in 2011 recognizes senior citizens as a valuable resource for the country and ensures their full participation in society. It aims at providing socio-economic support through income-generating activities, insurance and pension schemes, and promoting care of senior citizens within the family.

With a strong network of public health infrastructure in place, focus should be on building human resource capacity through specialized education and training opportunities. There are few broad areas in aging research that need immediate attention in the Indian context.

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These include etio-pathological mechanisms of aging, socio-economic support mechanisms for aging, mechanisms to promote healthy and active aging process, efficient models of geriatric health care delivery, research in alternative medicine and the study of age-related disorders.

While we depend on domiciliary model of elderly care, we lack scientific models of care in different settings. We should look for cost-effective feasible models of geriatric care that is acceptable and based on our cultural practices and traditions. We should also build new models for long-term medical care.

Apart from medical care models, we should also explore innovative models of economic support and insurance. Although health insurance sector is on a rise in India, the insurance policies tend to exclude those who need the most, especially the elderly. A comprehensive preventive package should be delivered, including knowledge and awareness regarding common geriatric problems and their prevention, healthy nutrition, physical exercise, yoga and meditation, and promotion of mental well-being.

Laws and policies cannot teach us family values and respect for elders. Thus, parents have a major role to play toward fostering respect for elders at a tender age. The government should focus on raising the capacity of health professionals in geriatric care through specialized courses and trainings and develop socio-economic support mechanisms for the elderly in the community.

Specialization in the gerontology careers:

- Research Gerontologists perform research on the aging process.
- Applied Gerontologists or Gerontologist Counselor work directly with the elderly.
- Administrative Gerontologists develop and coordinate programs and services for the elderly.

Role of Gerontologists

- Counseling older adults
- Challenging common misconceptions about the aging
- Researching the effects of aging or diseases that affect older adults

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- Teaching in a university setting
- Advocating better services and care for the aging

Skills of Gerontologists

Compassion: Gerontologists work with elderly people they must have compassion and empathy for them.

Listening skills: Gerontologists should listen to their clients about challenges in their lives to effectively help and understand their clients' needs.

Organizational skills: Helping and managing multiple clients, often assisting with their paperwork or documenting their treatment, requires good organizational skills.

Problem-solving skills: Gerontologists need to develop practical and innovative solutions to their clients' problems.

Scope of Gerontologist in India:

There is a demand for gerontologist professionals as people are becoming more aware of this field. Many gerontologists work directly with older adults as caregivers or advocates. Others work behind the scenes in medical research, education or administration.

These graduates can expect a job as a gerontologist in non-profit sectors, nursing home, hospitals, government agencies, community service organisations, private practices, veterans affairs facilities and home-care services. These graduates also take their career as research, policy development and education.

THEORIES OF AGING

BIOLOGIC THEORIES OF AGING :

- Biologic theories are concerned with answering basic questions regarding the physiologic processes that occur in all living organisms as they chronologically age.
- These age related changes occur independently of any external or pathologic

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influence. The primary question being addressed relates to the factors that trigger the actual aging process in organisms.

- These theories generally view aging as occurring from a molecular, cellular, or even a systems point of view. Additionally, biologic theories are not meant to be exclusionary. Theories may be combined to explain phenomena (Hayflick, 1996).

The foci of biologic theories include explanations of the following:
(1) deleterious effects leading to decreasing fur,~~ion of the organism;

(2) gradually occurring agerelated changes that are progressive over time; and
(3) intrinsic changes that can affect all members of a species because of chronologie age.

The decreasing function of an organism may lead to a complete failure of either an organ or an entire system. (Hayflick, 1996). In addition, according to these theories, all organs in anyone organism do not age at the same rate, and any single organ does not necessarily age at the same rate in different. individuals of the same species.

Stochastic Theories Error Theory

As a cell ages, various changes occur naturally in its deoxyribonucleic acid (DNA) and ribonucleic acid (RNA), the building blocks of the cell. DNA, found in the nucleus of the cell, contains the fundamental genetic code and forms the genes on all 46 human chromosomes (Black, Matassarin-Jacobs, 1997).

In 1963, Orgel proposed the Error Theory, sometimes called the Error Catastrophe Theory. The hypothesis of this theory is based on the idea that errors can occur in the transcription in any step of protein synthesis of DNA, and this eventually leads to either the aging or the actual death of a cell.

The error would cause the reproduction of an enzyme or protein that was not an exact copy of the original. The next transcription would again contain an error. Asthe effect continued through several generations of 22 Part One Introduction to

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Gerontologic Nursing proteins, the end product would not even resemble the original cell and its functional ability would be diminished. (Sonneborn, 1979).

In recent years, the theory has not been supported by research. Although changes do occur in the activity of various enzymes with aging, studies have not found that all aged cells contain altered or misspecified proteins, nor is aging automatically or necessarily accelerated if rnisspecified proteins or enzymes are introduced to a cell (Hayflick, 1996; Goldstein, 1993; Schneider, 1992).

Free Radical Theory

Free radicals are byproducts of fundamental metabolic activities within the body. Free radical production can increase as a result of environmental pollutants such as ozone, pesticides, and radiation. Normally, they are neutralized by enzymatic activity or natural antioxidants. If, however, they are not neutralized, they may attach to other molecules.

These highly reactive free radicals react with molecules in cell membranes, in particular cell membranes of unsaturated lipids such as mitochondria, lysosomes, and nuclear membranes. This action monopolizes the receptor sites on the membrane, thereby inhibiting the interaction with other substances that normally use this site; this chemical reaction is called lipid peroxidation.

Therefore the mitochondria, for example, can no longer function as efficiently, and their cell membranes may become damaged, resulting in increased permeability. If excessive fluid is either lost or gained, the internal homeostasis is disrupted and cell death may result. There are other deleterious results related to free radical molecules in the body. Although these molecules do not contain DNA themselves, they can cause mutations to occur in the DNA-RNA transcription, thereby producing mutations of the original protein.

In nervous and muscle tissue, to which free radicals have a high affinity, a substance called lipofuscin has been found and is thought to be indicative of chronologie age. Lipofuscin, a lipid- and protein-enriched pigmented material, has been found to accumulate in older adults' tissues, and is commonly referred to as "age spots." As the lipofuscin's presence increases, healthy tissue is slowly being deprived of oxygen and nutrient supply. Further degeneration of surrounding tissue

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eventually leads to the actual death of the tissue. The body does have naturally occurring antioxidants or protective mechanisms. Vitamins C and E are two of these substances that can inhibit the functioning of the free radicals or possibly decrease their production in the body.

Harman (1956) was the first to suggest that the administration of chemicals terminating the propagation of free radicals would extend the lifespan or delay the aging process. Animal research has demonstrated that administration of antioxidants did increase the average length of life, possibly due to the delayed appearance of diseases that may have eventually killed the animals studied.

It appears that administration of antioxidants postpones the appearance of diseases such as cardiovascular disease and cancer, two of the most common causes of death. It appears that antioxidants also have an effect on the decline of the immune system and on degenerative neurologic diseases, both of which affect morbidity and mortality (Hayflick, 1996; Yu, 1998, 1993).

Cross-Linkage Theory

The cross-link theory of aging hypothesizes that with age some proteins become increasingly cross-linked or enmeshed and may impede metabolic processes by obstructing the passage of nutrients and wastes between the intracellular and extracellular compartments.

According to this theory, normally separated molecular structures are bound together through chemical reactions. Primarily this involves collagen, which is a relatively inert long-chain macromolecule produced by fibroblasts. As new fibers are created, they become enmeshed with old fibers and form an actual chemical cross-link.

The end result of this cross-linkage process is an increase in density of the collagen molecule but a decrease in the capacity to transport nutrients 'to, and to remove waste products £Tom, the cells. Eventually, this results in a decrease in the function of the structure. An example of this would be the changes associated with aging skin. The skin of a baby is very soft and pliable, whereas the aging skin losses much of its suppleness and elasticity.

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This aging process is similar to the process of tanning leather, which purposefully creates cross-links (Bjorkstein, 1976; Hayflick, 1996). Cross-linkage agents have been found in unsaturated fats; in polyvalent metal ions like aluminum, zinc, and-- magnesium; and in association with excessive radiation exposure. Many of the medications ingested by the older population contain aluminum (antacids and coagulants), as does the common cooking ingredient baking powder.

Some research supports a combination of exercise and dietary restrictions in helping to inhibit the cross-linkage process, as well as the use of vitamin C prophylactically as an antioxidant agent (Bjorkstein, 1976). Cerani has shown that blood sugar reacts with bodily proteins to form cross-links.

He has found that the crystallis of the lens of the eye, membranes of the kidney, and blood vessels are especially susceptible to cross-linking under the conditions of increased glucose. Cerani suggests increased levels of blood glucose cause increased amounts of cross-linking which accelerate lens, kidney, and blood vessel diseases (Schneider, 1992).

Cross-linkage theory proposes that as a person ages and the immune system begins to decrease in its efficiency, the body's defense mechanism cannot remove the cross-linking agent before it becomes securely established. Cross linkage has been proposed as a primary cause of arteriosclerosis, a decrease in efficiency of the immune system with age, and the loss of elasticity often seen in older adult skin.

The cross-link theory has emerged from deductive reasoning and other than the previous examples, there is little: empirical evidence to support its claims (Hayflick, 1996). Chapter Two Theories of Aging 23 Wear and Tear Theory This theory proposed that cells wear out over time because of continued use.

When this theory was first proposed in 1882 by Weisman, death was seen as a result of tissues being worn out because they could not rejuvenate themselves in an endless manner (Hayflick, 1988). Essentially, the theory reflects a belief that organs and tissues have a preprogrammed amount of energy available to them and eventually wear out when the allotted energy is expended. Eventually, this leads to the death of the entire organism.

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Under this theory, aging is viewed as almost a preprogrammed process-a process thought to be vulnerable to stress, or an accumulation of injuries or trauma, which may actually accelerate it. "Death," said Weisman, "occurs because a worn out tissue cannot forever renew itself" (Hayflick,1996). Proponents of this theory cite microscopic signs of wear and tear that have been found in striated and smooth muscle tissue and in nerve cells.

Researchers question this theory with research demonstrating increased functional abilities in individuals that participate in daily exercise. This effect occurs even in persons with chronic limiting states such as rheumatoid arthritis. If exercise has been found to increase a person's level of functioning rather than decrease it, critics challenge, how can the wear and tear hypothesis be correct? The time frame for the development of this theory was during the Industrial Revolution, when people were attempting to explain and make sense of events in their world.

Thee people were trying to equate men with the marvelous machines they were producing. It eventually became clearly evident just how different man was from these machines.

Nonstochastic Theories Programmed Theory or Hayflick Limit Theory One of the first proposed biologic theories is based on a study completed In 1961 by Hayflick and Moorehead. This particular study included an experiment on fetal fibroblastic cells and their reproductive capabilities.

The results of this landmark study changed the way scientists viewed the biologic aging process. Hayflick and Moorehead's study showed that there are functional changes that do occur within cells and are responsible for the aging of the cells and the organism. The study further supported the hypothesis that a cumulative effect of improper functioning of cells and eventual loss of cells in organs and tissues is therefore responsible for the "aging phenomenon."

This study contradicted earlier studies by Carrel and Ebeling in which chick embryo cells were able to be kept alive indefinitely in a laboratory setting; the conclusion from this 1912 experiment was that cells do not wear out, but continue to function normally forever. An interesting aspect of the 1961 study was

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that freezing was found to halt the biologic cellular clock (Hayflick, Moorehead, 1961).

Based on this 1961 study, unlimited cell division was not found to occur; the immortality of individual cells was found to be more an abnormal than a normal occurrence. Therefore this study seemed to support the HayfIick limit Theory. Life expectancy was generally seen as preprogrammed, within a species-specific range; this biologic clock for humans was estimated at 110 to 120 years (Gerhard, Cristofalo, 1992; Hayflick, 1996).

Based on the conclusions of this experiment, the Hayflick Limit Theory is sometimes called the "Biological Clock," "Cellular Aging," or "Genetic Theory."

Immunity Theory

The immune system is a network of specialized cells, tissues, and organs that provide the body with protection against invading organisms. Its primary role is to differentiate self from non-self, thereby protecting the organism from attack by pathogens. It has been found that as a person ages, the immune system functions less effectively.

The term immunosenescence has been given to this age-related decrease in function. Essential components of the immune system are T cells, which are responsible for cell-mediated immunity, and B cells, the antibodies responsible for humoral immunity. Both T and B cells may respond to an invasion of the organism, though one may provide more protection in certain situations.

The changes that occur with aging are most apparent in the T-lymphocytes, although changes also occur in the functioning capabilities of B-lymphocytes. Accompanying these changes is a decrease in the body's defense against foreign pathogens, which manifests itself as an increased incidence of infectious diseases and an increase in the production of autoantibodies, which lead to a propensity to develop autoimmune-related dis-- eases (Hayflick, 1996) (Box 2-3).

The changes occurring in the immune system cannot precisely be explained by an exact cause-and-effect relationship, but they do seem to increase with advancing age.

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These changes include a decrease in humoral immune response, often predisposing older adults to: (1) a decreased resistance to a tumor cell challenge and the development of cancer, (2) a decreased ability to initiate the immune process and mobiliie the body's defenses in aggressively attacking pathogens, and (3) a heightened production of autoantigens, often leading to an increase in autoimmune-related diseases.

Immunodeficient conditions, such as the human immunodeficiency virus (HIV) and the immune suppression of organ transplant recipients, have demonstrated a relationship between immunocompetence and cancer development. HIV has been associated with several forms of cancer, such as Kaposi's sarcoma. Recipients of organ transplants are 80 times more likely to contract cancer than the rest of the population (Black, Matarassian-Iacobs, 1997).

Emerging Theories Neuroendocrine Control or Pacemaker Theory

The neuroendocrine theory examines the interrelated role of the neurologic and endocrine systems over the life-span of an individual. The neuroendocrine system regulates arid controls many important metabolic activities. It has been observed that there is a decline, or even a cessation, in many of the components of the neuroendocrine system over the life span.

The reproductive.system, and its changes over the life of an individual, provides an. interesting model for the functional capability of the neuroendocrine system. Research has shown that there are complex interactions between the endocrine and the nervous systems. It appears that the female reproductive system is governed not by the ovaries or the pituitary gland but by the hypothalamus.

Men do not experience a reproductive event such as a menopause, though they do demonstrate a decline in fertility. The mechanisms that trigger this decline may offer a template for understanding the phenomena of aging (Hayflick, 1996). .

Another hormone that has been receiving attention is dehydroepiandrosterone (DHEA). This hormone, secreted by the adrenal glands, diminishes over the lifetime of an individual. Administration of this hormone to

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laboratory mice showed it increased longevity, bolstered immunity, and made the animals appear younger.

These mice also ate less, so there is some question of whether DHEA-fed mice exhibit the effect of calorie restriction (Cupp, 1997; Guardiola-Lemaitre, 1997; Hayflick, 1996; Kendler, 1997) Melatonin is a hormone that is being investigated for its role as a biologic dock. Melatonin is produced by the pineal gland, the function of which had been a mystery until recent times.

Melatonin has been found to be a regulator of biologic rhythms and a powerful antioxidant that may enhance. immune function. The level of melatonin production in the body declines dramatically from just after puberty until old age.

The belief that melatonin has a role in aging comes not only from its effect on the immune system and its antioxidant capability, but also from studies on rodents that demonstrated an increased lifespan when melatonin was administered to these animals. In this instance as well it was found that rodents fed supplementary melaton~ restricted their calorie intake, More research needs to be performed regarding the safety and efficacy of melatonin.

However, in the United States melatonin can already be sold as a dietary supplement, so ther~ is little financial benefit in conducting research. In Europe melatonin is considered a neurohormone, so there would be more financial gain to determining its role in the aging process. At this time, no individual should take melatonin without their primary health care provider's knowledge (GuardiolaLemaitre, 1997; Hayflick, 1996).

Metabolic Theory of Aging/Caloric Restriction This theory proposes that all organisms have a finite amount of metabolic lifetime and that organisms with a higher metabolic rate have a shorter lifespan. Evidence for this theory comes from research that has shown that certain fish, when the water temperature is lowered, live longer than their warm water counterparts. Extensive experimentation on the effects of caloric restriction on rodents has demonstrated that caloric restriction increases the lifespan and delays the onset of age-dependent diseases (Hayflick, 1996; Schneider, 1992.

SOCIOLOGICAL THEORY:

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Disengagement Theory :

When the disengagement theory was introduced by Cumming and Henry in 1961, the theory sparked immediate controversy. These two theorists viewed aging' as a developmental task in and of itself, with its .own norms and appropriate patterns of behavior. The identified appropriate patterns of behavior were conceptualized as a mutual agreement between older adults and society on a reciprocal withdrawal.

Individuals would change from being centered on society and interacting in the community to being selfcentered persons withdrawing from society, by virtue of becoming "old." Therefore social equilibrium would be achieved as the end result {Cumming, Henry, 1961}. The idea that older adults preferred to withdraw from society and to voluntarily decrease their interactions with others was not readily accepted by the general public, much less the older population.

Although the theory oversimplified the aging process, the lasting benefit of the theory relates to the controversy it created. The theory itself is no longer supported, but the discussion and the research stemming from its premise continue today.

Activity Theory or Developmental Task Theory:

With one group of theorists proposing the concept that older adults need to disengage from society, other sociologists proposed that people needed to stay active if they are to age successfully. In 1953, Havighurst and Albrecht first proposed the idea that aging successfully meant staying active. It was not until 10 years later that the phrase "activity theory" was actually coined by Havighurst and his associates (Havighurst, Neugarten, Tobin, 1963).

Activity is viewed by this theory as necessary to maintain a person's life satisfaction and a positive self-concept. By remaining active, the older person stays young and alive and does not withdraw from society because of an age parameter. Essentially, the person actively participates in a continuous struggle to remain "middle-aged."

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This theory is based on three assumptions:

(1) it is better to be active than inactive,
(2) it is better to be happy than unhappy, and
(3) an older individual is the best judge of his or her own success in achieving the first two assumptions (Havighurst, 1972).

Within the context of this theory, activity can be viewed very broadly as physical or intellectual. Therefore, even with illness or advancing age, the older person can remain "active" and achieve a sense oflife satisfaction {Havighurst, Neugarten, Tobin, 1963}.

Continuity Theory

The continuity theory dispels the premises of both the disengagement and activity theories. According to this theory, being active, trying to maintain a sense of being middIeaged, or willingly withdrawing from society does not necessarily bring happiness. Instead, the continuity theory proposes that how a person has been throughout life is how that person will continue through the remainder oflife (Havighurst, Neugarten, Tobin, 1963).

Old age is not viewed as a terminal or final part of life separated from the rest of life. According to this theory, the latter part of life is a continuation of the earlier part and therefore an integral component of the entire life cycle. When viewed from this perspective, the theory can be seen as a developmental theory. Simply stated, the theory proposes that as persons age, they try to maintain or continue previous habits, preferences, commitments, values, beliefs, and all the factors that have contributed to their personalities {Havighurst, Neugarten, Tobin, 1963}.

Age Stratification Theory Beginning in the 1970s, theorists on aging began to focus more broadly on societal and structural factors that influenced how the older population was being viewed. The age stratification theory is only one example of a theory addressing societal values. The key societal issue being addressed in this theory is the concept of interdependence between the aging person and society at large (Riley, Johnson, Foner, 1972).

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This theory views the aging person as an individual element of society and also as a member, with peers, interacting in a social process. The theory attempts to explain the interdependence between older adults and society and how they are constantly influencing each other in a variety of ways.

Riley (1985) identifies the five major concepts of this theory:

(1) each individual progresses through societyin groups of cohorts that are collectively aging socially, biologically, and psychologically;
(2) new cohorts are continually being born, and each of them experiences their own unique sense of history;
(3) society itself can be divided into various strata according to the parameters of age and roles;
(4) not only are people and roles within every stratum continuously changing, but so is society at large; and
(5) the interaction between individual aging people and the entire society is not stagnant but remains dynamic.

Person-Environment Fit Theory

One of the newer aging theories relates to the individual's personal competence within the environment in which he or she interacts. This theory was proposed by Lawton (1982) and examines the concept of interrelationships among the competencies of a group of persons, older adults, and their society or environment.

Everyone, including older persons, has certain personal competencies that help mold and shape them throughout life. Lawton (1982) identified these personal competencies as including ego strength; level of motor skills, individual biologic health, and cognitive and sensory-perceptual capacities. All of these help a person deal with the environment in which one lives.

As a person ages, there may be changes or even decreases in some of these personal competencies. These changes influence the individual's abilities to interrelate with the environment.

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If a person develops one or more chronic diseases, such as rheumatoid arthritis or cardiovascular disease, then competencies may be impaired and the level of interrelatedness may be limited.

The theory further proposes that, as a person ages, the environment becomes more threatening and one may feel incompetent dealing with it. In a society constantly making rapid technologic advances, this theory helps explain why an older person might feel inhibited and may retreat from society.

PSYCHOLOGIC THEORIES OF AGING

The basic assumption of the psychologic theories of aging is that development does not end when a person reaches adulthood, but remains a dynamic process that occurs over the lifespan. As a person passes from the middle to the later life roles, abilities, perspectives, and belief systems enter a stage of transition. The nurse, by providing holistic care, seeks to employ strategies to enhance clients' quality of life (Hogstel, 1995).

The psychologic theories of aging are much broader in scope than the previous theories because they are influenced by both biology and sociology. Therefore psychologic aging cannot readily be separated from biologic and sociologic influences.

As a person ages, various adaptive changes occur that assist the person to cope with or accept some of the biologic changes. Some of the adaptive mechanisms include memory, learning capacity, feelings, intellectual functioning, and motivations to perform or not perform particular activities (Birren, Cunningham, 1985).

Psychologic aging, therefore, includes not only behavioral changes but also developmental aspects related to the lives of older adults. How does behavior change in relation to advancing age? Are these behavioral changes consistent in pattern from one individual to another? Theorists are searching for answers to questions such as these.

Maslow's Hierarchy of Human Needs Theory

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According to this theory, each individual has an innate internal hierarchy of needs that motivates all human behaviors (Maslow, 1954). These human needs have different orders of priority.

These human needs are often depicted as a pyramid, with the most elemental needs at the base. The initial human needs each person must meet relate to physiologic needs, needs for basic survival. Initially, a starving person worries about obtaining food to survive.

Once this need is met, the next concern is about safety and security. These needs must be met, at least to some extent, before the needs for love, acceptance, and a feeling-- of belonging become concerns.

According to Maslow (1968), as each succeeding layer of needs is addressed, the individual is motivated to look to the needs at the next higher step; Maslow's fully developed, self-actualized person displays high levels of all of the following characteristics: perception of reality; acceptance of self, others, and nature; spontaneity; problem-solving ability; self-direction; detachment and the desire for privacy; freshness of peak experiences; identification with other human beings; satisfying and changing relationships with other people; a democratic character structure; creativity; and a sense of values (Maslow, 1968.

Jungis Theory of Individualism

The Swiss psychologist Carl Jung (1960) proposed a theory of personality development throughout life: childhood, youth and young adulthood, middle age, and old age. According to this theory, a person's personality is visualized as oriented either toward the external world (extroverted) or toward subjective, inner experiences (introverted).

A balance between these two forces, which are present in every individual, is essential for mental health. Applying jung's theory to individuals as they progress through life, it is at the onset of middle age that the person begins to question values, beliefs, and possible dreams left undone. The phrase "midlife crisis" became popular based on this theory and refers to a period of emotional, and sometimes behavioral, turmoil that heralds the onset of middle age.

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This period may last for several years, with the exact time and duration varying from person to person. During this period, the individual often searches for answers about reaching goals-questioning whether a part of their personality or "true self" has been neglected and whether time is running out for the completion of these quests. This may be the first time that the individual becomes aware of the effects of the aging process and the fact that the first part of the adult life is over.

This realization does not necessarily signal a time of trauma. For many people, it is just another "rite of passage." As the person ages chronologically, the personality often begins to change from being outwardly focused, concerned about-establishing oneself in society, to becoming more inward, as the individual begins to search for answers from within. .Successful aging, when viewed from Jung's theory, is when a person looks inward and values oneself for more than just current physical limitations or losses.

The individual 'accepts past accomplishments and limitations Oung,l96Q). Eight Stages of life Theory Erikson (1993) proposed a theory of psychologic development that reflects cultural and societal influences. The major focus of development in this theory is with an individual's ego structure, or sense of self, especially in response to the ways in which society shapes its development. In each of the eight stages identified by Erikson, a "crisis" occurs that impacts the development of the person's ego.

. When .considering older adults, attention needs to be focused on the developmental tasks of both middle and older adulthood. The task of middle adulthood is resolving the conflict between generativity and stagnation. In 1968, Peck expanded Erikson's original theory regarding the eighth stage of older adulthood. Erikson grouped all individuals together into" old age" beginning at age 65 and did not anticipate that a person may potentially live for another 30 to 40 years beyond this identified milestone.

Since people were living longer, there became an obvious need to identify additional stages for older adults. Peck (1968) expanded the eighth stage, ego integrity versus despair, into three stages: ego differentiation versus work role preoccupation, body transcendence versus body preoccupation, and ego transcendence versus ego preoccupation (Ignatavicius, Workman, Mishler, 1999).

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During the stage of ego differentiation versus work role preoccupation, the task for older adults is to achieve identity and feelings of worth from sources other than the work role. The onset of retirement and termination of the work role may reduce feelings of self-worth. In contrast, a person with a well-differentiated ego, who is defined by many dimensions, can replace the work role as the major defining source for self-esteem.

The second stage of body transcendence versus body preoccupation refers to the older person's view of the physical changes that occur as a result of the aging process. The task is to adjust to or transcend the declines that may occur-- in order to maintain feelings of well-being. This task can be successfully resolved by focusing on the satisfaction obtained from interpersonal interactions and psychosocial related activities.

The third and final task of ego transcendence versus ego preoccupation involves acceptance of the individual's eventual death without dwelling on the prospect of it. Remaining actively involved with a future that extends beyond a person's mortality is the adjustment that must be made to achieve ego transcendence.

Selective Optimization with Compensation :

Baltes (1987) has conducted a series of studies on the psychologic processes of development and aging from a lifespan perspective and formulated a psychologic model of successful aging.

. Schroots (1996) used the famous pianist, Rubinstein, to illustrate an application of these elements that the pianist applied in later years. First, Rubinstein said he reduced. his repertoire and played a smaller number of pieces (selection); second, he practiced these more often (optimization); and third, he slowed down his speed of playing prior to fast movements, thereby producing a contrast that' enhanced the impression of speed in the fast movements (compensation).

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UNIT -II

FACTORS CONTRIBUTING TO GROWING PROBLEMS OF THE ELDERLY

Elder abuse:

Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.

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Geriatric Diseases: Age-Related Medical Conditions & Illnesses

The elderly population in the United States is rapidly growing. In fact, the number of people over age 85 is set to triple by the year 2050. And because older adults are more likely to develop one chronic condition or another, it is important that families and the overall health care system are prepared to handle this growing need for healthy aging.

Many age related changes are common, such as a minor decline in vision and hearing, high blood pressure, muscle weakness, or a weakened immune system. But some health problems are not considered a part of the normal aging process for older adults. Chronic conditions affecting kidney function, leading to cognitive impairment, or otherwise undermining the quality of life of an elderly person need to be treated with geriatric medicine.

Geriatric Diseases

Geriatric medicine specializes in treating the conditions commonly experienced by older adults. There are numerous variables that make treating older adults different from their younger counterparts, including polypharmacy, vague presentation of symptoms, and challenges with attribution in cases where multiple health conditions are present at once.

Older adults are also more prone to developing age related diseases that younger people do not typically develop. High blood pressure might be an intergenerational problem, but issues like cardiovascular disease, ischemic heart disease, urinary incontinence, vascular dementia, multiple sclerosis, and other diseases are far more common among older adults**.**

Examples of Chronic Disease

While this is by no means a comprehensive list of ailments experienced by older adults, these and other chronic diseases are among the more common:

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- Arthritis
- Cancer
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Dementia, Alzheimer's, and Parkinson's
- Diabetes
- Osteoporosis
- Stroke

Arthritis

This chronic disease is one of the most common age related conditions older adults experience. Arthritis causes joint pain and chronic inflammation. The two types are osteoarthritis and rheumatoid arthritis. Osteoarthritis, the more common of the two, is a result of normal wear and tear. Rheumatoid arthritis is an autoimmune disease in which the immune system attacks the lining of the joints.

There is no cure for arthritis, but it can be managed with painkillers and corticosteroids.

Symptoms include:

- Pain, stiffness, and tenderness of the joints
- Inflammation around joints
- Limited or restricted movement

Cancer

With over 200 different forms of cancer — prostate cancer, breast cancer, and lung cancer just to name a few — this is one of the most common issues that older people face. Cancer occurs through the rapid and abnormal replication of cells in the body, forming tumors than can spread via the bloodstream.

While cures have been discovered for many types of cancer, cancer treatment can be extremely invasive and takes a major toll on the body. However,

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the earlier it is detected, the better the chance of beating it. It is a good idea to consider conducting a periodic cancer screening.

Here are the common symptoms:

- Discovery of an unexpected lump or mass
- Inexplicable weight loss
- Blood in a person's stool, urine, vomit, or when coughing

Chronic Kidney Disease

Kidney infections, kidney inflammation, high blood pressure, and diabetes can all lead to chronic kidney disease. This condition affects the kidneys and can lead to kidney failure, and there is presently no cure. Another unfortunate reality is that early symptoms do not commonly appear — instead, the condition is usually identified through urine tests ordered for other medical conditions.

Older adults must therefore be diligent in reporting the following later-stage symptoms to their doctor as soon as they discover them:

- Bloody urine
- Shortness of breath
- Swollen ankles, hands, or feet
- Tiredness or a feeling of sickness

Chronic Obstructive Pulmonary Disease

The best known condition under this category of illness is chronic bronchitis. Bronchitis is caused by an infection affecting the lungs and airways, contributing to a buildup of excessive mucus. The body tries to displace this buildup through coughing.

Smoking is one of the biggest contributing factors to the development of chronic bronchitis, which means that quitting is the best way to overcome it. A healthy diet is also important — as are rest, hydration, and the treatment of headaches.

Symptoms of bronchitis include:

- Chest pain

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- Fatigue
- Hacking, productive cough
- Headaches
- Runny nose or congestion
- Sore throat

Dementia, Alzheimer's Disease, and Parkinson's Disease

Dementia is an umbrella term used to describe a syndrome — or a collection of chronic conditions — in older adults that lead to problems with memory and cognition. This occurs when there is damage to brain cells or a loss of connection between cells that causes them to die.

Symptoms of dementia include:

- **Memory loss**
- **Difficulty with verbal expression**
- **Struggles with visual or spatial abilities**
- Trouble with problem-solving or reasoning
- Difficulty managing complex tasks, critical thinking skills, planning, and organization
- Decline in coordination with motor functions
- Confusion and disorientation
- Personality changes
- Inappropriate behavior
- Depression, anxiety, paranoia, and agitation
- Hallucinations

Alzheimer's disease is a specific type of dementia, accounting for up to 70% of cases. Caused by disruptive build ups of proteins in the brain,

Symptoms of Alzheimer's include:

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- Trouble remembering details about people, places, or events
- Difficulty concentrating
- Changes to one's personality like disinterest, suspicion, or aggression
- Apathy and depression
- Mood changes
- Confusion
- Impaired judgement or decision-making abilities
- Difficulty with speaking, swallowing, or walking

Parkinson's disease is another type of dementia. This progressive disease is caused by a loss of nerve cells in the brain, which reduces the amount of dopamine necessary for normal cognitive functioning. While there is no cure, the symptoms can be treated.

Here is what to look out for:

- Involuntary shaking of particular parts of the body
- Muscles that are stiff and inflexible
- Slow movement

Diabetes

Diabetes can develop during middle age — and sometimes even younger. But it most commonly develops among older adults, and it has to be managed as a lifelong condition. This disease occurs when the body is not able to produce enough insulin to ensure normal functioning.

The most common type of diabetes is Type II diabetes. This is when the pancreas is no longer capable of producing the appropriate amount of insulin.

A person's chance of developing diabetes can be reduced through lifestyle changes, including:

- A healthy diet
- A healthy weight

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- Regular exercise

Type I diabetes accounts for about 10% of overall cases. It is an autoimmune disease, in which the body attacks the cells that produce insulin.

Osteoporosis

Osteoporosis is one of the most common conditions among older adults. This condition presents as a reduction in bone density, and it often goes undetected until a fall causes a break or fracture. Like losing muscle mass, losing bone strength is part of the normal aging process, but people with osteoporosis experience this decline more quickly than most people.

Osteoporosis can be treated with medication and supplements like calcium and vitamin D. Weight-bearing exercises and exercises designed to increase muscle strength can also help older adults manage the condition.

Stroke

A stroke occurs when the brain's vital blood flow is cut off. This causes brain cells to die, it can lead to permanent disability, and it can be life threatening. Strokes are very common among older adults, so it is important to know the signs and symptoms so you can seek medical attention as soon as possible.

- **Face:** Is the face drooping on one side?
- **Arms:** Is the person unable to lift both arms
- **Speech:** Is their speech slurred?
- **Time:** If so, do not waste time — seek medical attention immediately.

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Forms of abuse Of Elder

The common forms of abuse of elderly persons are as follows.

- ***Physical abuse***
    - Hitting, pushing, kicking
    - Inappropriate use of drugs or restraints

- ***Psychological or emotional abuse*** - Insults, threats, humiliation, controlling behavior, confinement and isolation.
- ***Financial abuse*** - Misusing or stealing a person's money or assets
- ***Neglect or abandonment*** - Not providing food, housing, or medical care
- ***Sexual abuse*** - Sexual contact without consent
- ***Abusive acts in institutions*** - physically restraining patients, depriving them of dignity (for instance, by leaving them in soiled clothes) and choice over daily affairs; intentionally providing insufficient care (such as allowing them to develop pressure sores); over- and under-medicating and withholding medication from patients; and emotional neglect and abuse.

People responsible for elder abuse

People who commit elder abuse are often in a position of trust.

- ***At Home*** : Family members - mostly adult children, spouses and partners.
- ***Health care workers*** : Nursing homes, Long-term care facilities

Risk factors

Risk factors that may increase the potential for abuse of an older person

Individual

Risks at the individual level include poor physical and mental health of the victim, and mental disorders and alcohol and substance abuse in the abuser. Other individual-level factors which may increase the risk of abuse include the gender of the victim and a shared living situation. While older men have the same risk of abuse as women, in some cultures where women have inferior social status, elderly women are at higher risk of neglect and financial abuse (such as seizing their property) when they are widowed. Women may also be at higher risk of more persistent and severe forms of abuse and injury.

Relationship

A shared living situation is a risk factor for elder abuse. It is not yet clear whether spouses or adult children of older people are more likely to perpetrate abuse. An abuser's dependency on the older person (often financial) also increases the risk of abuse. In some cases, a long history of poor family relationships may

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worsen as a result of stress when the older person becomes more care dependent. Finally, as more women enter the workforce and have less spare time, caring for older relatives becomes a greater burden, increasing the risk of abuse.

Community

Social isolation of caregivers and older persons, and the ensuing lack of social support, is a significant risk factor for elder abuse by caregivers. Many elderly people are isolated because of loss of physical or mental capacity, or through the loss of friends and family members.

Socio-cultural

Socio-cultural factors that may affect the risk of elder abuse include:

- depiction of older people as frail, weak and dependent;
- erosion of the bonds between generations of a family;
- systems of inheritance and land rights, affecting the distribution of power and material goods within families;
- migration of young couples, leaving elderly parents alone in societies where older people were traditionally cared for by their offspring; and
- lack of funds to pay for care.

Within institutions, abuse is more likely to occur where:

- standards for health care, welfare services, and care facilities for elder persons are low;
- where staff are poorly trained, remunerated, and overworked;
- where the physical environment is deficient; and
- where policies operate in the interests of the institution rather than the residents.

Risk factors for committing elder abuse

- Using or abusing drugs or alcohol
- High stress levels

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- Depression
- ack of social support
- Lack of training in how to care for older people
- Emotional or financial dependence on the older person

Prevention

Many strategies have been implemented to prevent elder abuse and to take action against it and mitigate its consequences. Interventions that have been implemented – mainly in high-income countries – to prevent abuse include:

- public and professional awareness campaigns
- screening (of potential victims and abusers)
- school-based intergenerational programmes
- caregiver support interventions (including stress management and respite care)
- residential care policies to define and improve standards of care
- caregiver training on dementia.

Efforts to respond to and prevent further abuse include interventions such as:

- mandatory reporting of abuse to authorities
- self-help groups
- safe-houses and emergency shelters
- psychological programmes for abusers
- helplines to provide information and referrals
- caregiver support interventions.

Ageing and Disabilities

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The global population aged 60 years or over numbered 962 million in 2017. The number of older persons is expected to double again by 2050, when it is projected to reach nearly 2.1 billion.

Ageing can be viewed as a societal accomplishment, but it also poses a challenge in terms of health care and continuing healthy functioning for this rapidly growing population. As a result, it's critical to ensure that these extra years are not only free of chronic disease or disability but also that mental and physical functionality is maintained. This will lessen the population's massive economic and social responsibilities. Nearly half of all healthcare spending occurs after the age of 65, according to estimates.

Successful aging can be defined as "adding life to the years.". There is a growing recognition among biomedical experts that the quality of life may be just as significant as the number of years added to life. While a specific definition of successful ageing has yet to be agreed upon, it is widely agreed that it comprises the freedom from chronic disease and the ability to operate well in old age, both physically and cognitively.

Ageing is a multifaceted phenomenon influenced by genetics, constitution, lifestyle, and environmental factors. There are distinct phases of growth in human life: there is a progressive increase in functioning (from infancy to adolescence), there is a type of plateau during adult life, and then there is a physiological drop in functioning as one becomes older.

Disability

Disability is viewed in a dynamic way and as a process, according to International Classification of Functioning, Health and Disability (ICF), World Health Organization, and other conceptual models of disability and approved by the United Convention of the Rights of the People with Disabilities According to this vision, disability is the consequence of the relationship of the person, with his/her health conditions, and the environment.

There is also an international agreement in the view that “health and active ageing” is not without disorders or without diseases, but it refers to well-being from a biopsychosocial point of view: so it refers to well-being and quality of life, even in the presence of a disease or a disorder.

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From the more recent conceptual models of ageing and disability, the aim of each kind of intervention is to prevent pathological to reduce the risk of age-related health conditions and their consequences, to promote active and healthy ageing, and to prevent the change from usual to pathological ageing.

People with disabilities and people who are ageing with disabilities are on the rise all around the world. According to a report on disability published by the World Health Organization and the World Bank, roughly 15.3 per cent of people had disabilities in 2004 and about 15% of people had disabilities in 2010, with about 2-4 per cent of these persons with disabilities having severe functional difficulties.

Age has a significant impact: the older you get, the more likely you are to become disabled. For these reasons, the relationship between ageing and disability has become extremely important, both in terms of its implications for ageing people's involvement, inclusion, and quality of life, as well as its implications for socio-sanitary organizations.

1. Disability with ageing- which refers to ageing people that become people with a disability only during his/her ageing process, mainly due to age-related conditions.

Consequences between ageing and disability

Three kinds of consequences between ageing and disability.

1. Disability-related secondary conditions- People with disabilities are more likely to develop secondary conditions, either directly or indirectly (any additional physical or mental health conditions that may arise as a result of a primary disabling condition but are not a specific feature of it), which are similar to those that ageing people experience in general, but they occur 20-25 years earlier and are often referred to as premature or atypical.

2. Age-related conditions—these conditions are related to ageing and the long-term consequences of exposure to environmental risks, as well as the effects of poor health behaviours—that may be experienced by ageing persons and also by ageing people with disabilities.

3. Hypertension, high cholesterol, diabetes, osteoarthritis, heart disease, gait and mobility issues, falls, respiratory infections/chronic obstructive pulmonary disease, urine Urinary

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Incontinence, osteoporosis, skin disease, hearing and vision loss, and dementia are examples of these conditions.

4. Multiple Chronic Conditions- the risk of having two or more chronic conditions at the same time, either in dyads (hypertension and diabetes) or in triads (cholesterol, hypertension, and diabetes**).**

Anatomical and Physiological changes with Ageing

Muscle Strength

Muscle strength and Postural alignment plays an important role in an effective functioning in older adults. Loss of muscle strength has been documented in individuals as young as 50 to 59 years old. Reductions in muscle strength is closely associated with an increase in age.

Normal changes in the ageing musculoskeletal system include reduced muscle mass, and loss of bone density and can be compounded by physical inactivity. After discontinuing resistance training for almost 2 weeks, more than 5% of the benefits gained are greatly diminished.

On recommending the older adults to spend days or weeks exclusively on bed rest due to illness or injury, muscle strength swiftly declines, it is lost at approximately twice the rate it takes to regain it. Reduction in muscle mass leads to an increased rate of disability. For example, quadriceps strength is necessary to rise from a chair or toilet seat. At worst, reduced muscle strength leads to loss of function preventing an older adult from carrying out daily activities independently, assistance either in the home or a care center is warranted.

Bones and Joints

More peripheral sites, such as the radius, experience relative stability in density until menopause, whereas the spine and neck of the femur show bone loss 5 to 10 years earlier.

Intake of vitamin supplementation by men and women aged 65 years and older can reduce fracture risk and bone loss. Moreover, focusing on weight-bearing exercises can reduce bone loss and diminish the decrease of bone density commonly seen with advancing age.

Wear and Tear on the joint are also associated with aging due to loss of joint fluid. Joint changes seem almost inevitable with advanced age in fact osteoarthritis

is one of the conditions nearly all aged individuals experience. With ageing, the intervertebral discs lose water, flatten and undergo other deleterious changes.

These changes leads to loss of disk height and compression of spinal column. Therefore, increased thoracic spine curvature leading to thoracic kyphosis commonly seen in elder individuals due to loss of height of spinal column.

Psychomotor and Psychological functions

In general, there is a slowing in psychomotor performance in older adults, although difference in cognitive processing during the aging process are different among individuals on the basis of intelligence, health and years of formal education.

Examples of some of the commonly observed changes in cognition with aging are as follows:

1) Reduced choice reaction time

2) Increase in processing time for working memory for complex tasks

3) Fluid intelligence

Behavioural risk factors

Physical and social exposures, including behaviors, during the life period, have a significant impact on disabilities that appear later in life, resulting in an accumulation of risks as one gets older.

The four main behavioral risk factors:

1. Smoking,
2. Excessive consumption of alcohol
3. Poor diet
4. Low levels of physical activity

Behavioral risk factors in midlife have been linked to good ageing and the primary prevention or delay of disability, according to research

Elder Abuse in India

Medications

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Prescription drug abuse is when people misuse prescribed medicines. They may abuse their own medicine in a way that is not instructed by the doctor. This includes taking more medicine than they need or taking it when they don't need it. Or they may abuse a prescription that is meant for someone else. Prescription drug abuse also can occur when people mix medicine with alcohol or other drugs.

Prescription drug abuse is a term that refers to the improper use of medicines that are categorized as "controlled substances" by the Drug Enforcement Administration. Examples include medicines that doctors prescribe to treat pain, anxiety, or sleep. This can lead to serious problems, such as drug interactions, addiction, or even overdose. A drug interaction occurs when two or more drugs react with each other. It could make drugs less effective or cause harmful side effects.

Why are older adults at risk for prescription drug abuse

Most older adults who suffer from prescription drug abuse do so by accident. They take more medicine than other age groups. According to the National Institute on Drug Abuse, 50% of people between the ages of 57 to 85 take more than 5 medications or supplements daily. This increases the risk for mistakes and drug abuse.

Growing older also slows down your body's ability to absorb and filter medicines. This means that an older adult might become addicted to or have side effects from a prescription drug at a lower dose than a younger adult.

Path to improved health

A person can abuse any type of prescription drug. Elderly adults commonly take 2 types of medicines that have a high potential for addiction.

- Opioids are used to control pain. Examples include oxycodone (OxyContin), oxycodone with acetaminophen (Percocet), and hydrocodone with acetaminophen (Vicodin). A person can become addicted if they take an opioid for a long period of time or take too much of an opioid.
- Benzodiazepines are used to treat anxiety, panic attacks, or insomnia. Examples include diazepam (Valium), alprazolam (Xanax), clonazepam (Klonopin), and lorazepam (Ativan). A person can become addicted if they take the drug for a long period of time.

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Symptoms of prescription drug abuse can be hard to recognize in older adults. This is because they are similar to symptoms of aging. For instance, confusion and memory loss are symptoms of both.

If you care for or spend time with an older adult, be aware of their medicines and behavior.

The following are warning signs that someone may be abusing prescription drugs. If they:

- Get a prescription for the same medicine from two different doctors.
- Fill a prescription for the same medicine at two different pharmacies.
- Take more of a medicine than they used to or take more than is instructed on the label.
- Take the medicine at different times or more often than is instructed on the label.
- Become more withdrawn or angry.
- Appear confused or forgetful.
- Often talk about a medicine.
- Are afraid to go somewhere without taking a medicine.
- Are defensive when you ask about a medicine.
- Make excuses for why they need a medicine.
- Store “extra” pills in their purse or in their pocket.
- Sneak or hide medicine.
- Have been treated for alcohol, drug, or prescription drug abuse in the past.

Substance Abuse and Older Adult

Older Adults and Substance Use Disorder

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Substance abuse, particularly of alcohol and prescription drugs, among adults 60 and older is one of the fastest growing health problems facing the country. Yet, even as the number of older adults suffering from these disorders climbs, the situation remains underestimated, underidentified, underdiagnosed, and undertreated.

There is a lack of attention to substance abuse in older adults. One reason is older adults disapproval of and shame about use and misuse of substances and a reluctance to seek professional help for what many in this age group consider a private matter. Many relatives of older individuals with substance use disorders, particularly their adult children, are also ashamed of the problem and choose not to address it.

There is an unspoken but pervasive assumption that it's not worth treating older adults for substance use disorders. There is an impression that alcohol or substance abuse problems cannot be successfully treated in older adults, there is the assumption that treatment for this population is a waste of health care resources.

There are three reasons why aging Baby Boomers are more likely to use illicit drugs.

One is cultural: Baby boomers grew up in an era when illicit drugs were widely available, and their use had a certain allure. Another reason is economic: Boomers are increasing their use of illicit drugs because the recession and its aftermath have heightened their anxiety about job security and retirement savings. A third reason is emotional: Aging boomers may turn to illicit drugs to cope with grief and loss issues such as the death of a spouse or the end of a career.

National data indicates:

Of the 2.2 million adults age 50 and older:

- 54 % used marijuana.
- 28 % misused prescription drugs.
- 17 % used other illicit drug.

Here is a list of characteristics of older adults with substance use issues:

- Older adults are grossly underserved.

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- Older adults do not seek services in traditional service settings.
- Lack of awareness by professionals, society, family, and older adults prevent detection and treatment.
- "Baby Boomers" have less hesitation about using substances recreationally and for coping with the aging process.
- Alcohol is the drug of choice for older adults. One of the most damaging drugs to the human body, alcohols effects on physical health and cognitive functioning can be devastating to a body already facing changes in mobility and cognition as a part of the aging process.
- People age 50 and older have lower tolerance for alcohol and a heightened response to over the counter and prescription medication.
- More patients 65+ are admitted to hospitals for alcohol problems than for heart attacks.
- About 1/4 of nursing home admissions occur because the patient is unable to manage their medications.
- This misuse of prescription drug use indirectly causes up to 14% of hip fractures in seniors 60+.
- 85% are currently taking at least one prescription drug.
- 20% use tranquilizers daily.
- Largest consumers of psychoactive drugs.
- 70% use OTC medications daily.
- Adults 65+ use 3 times as many medications as those under 65.
- Older patients average 2 - 3 serious medication errors per month.
- Even patients who understand and agree with treatment are only 75% compliant.
- At least 40% don't follow prescription directions.

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UNIT- III

ROLE OF FAMILY AND CARE GIVERS

Responsibility of Family Caregivers:

When older adults are no longer capable of independent functioning, relatives step in. Family members who serve as the primary caregiver to elderly parents are known as family caregivers. These individuals are charged with carrying out five primary duties that affect seniors' everyday lives.

The demand on family caregivers can lead to severe emotional stress, especially when the family member cares fulltime for a relative with advanced dementia. Not all family caregivers are well suited for caregiving, making it important to consider supplemental assistance from home care agencies.

Family caregivers have multiple roles when caregiving for an aging adult. Caregivers may start out helping a parent intermittently and then progress toward greater responsibilities as the senior becomes frailer, cognitively impaired, disabled or ill with advanced cancer, Parkinson's or dementia.

The family caregiver might notice a loved one having trouble with routine activities, such as balancing a checkbook. Minimal assistance at this point is necessary. On the other hand, a family caregiver may suddenly assume caregiving duties when the senior undergoes a hip fracture or stroke.

Consequently, the responsibilities of a family caregiver depend on the extent and nature of support needed. It is worth noting that the level of caregiving duties may wax and wane. A stroke patient may require intense support at first; and, as the senior regains function, caregiving gradually decreases.

Responsibility : Assistance with ADLs

Most, if not all, family caregivers, however, provide a range of essential support with routine life tasks. Assistance with the activities of daily living (ADLs) and instrumental activities of daily living (IADLs), like managing finances, laundry, household chores, home maintenance, bill payments, transportation, and meal preparation, are expected duties of family caregivers.

Seniors also require help with self-care tasks, such as bathing, grooming, toileting, and dressing. Just under 20 percent of family caregivers provide assistance with self-care tasks either every day or most days. Family caregivers help care recipients with medication management and doctor's appointments.

Responsibility: Emotional and Social Support

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Emotional changes in the care recipient may develop gradually, as frailty increases, or symptoms of cognitive decline begin to emerge. The relationship with a family caregiver is thus impacted. Conversely, the emotional impact on the relationship may swerve suddenly in the event of an unanticipated health crisis.

Providing emotional support to an elderly individual who has suffered a stroke, for example, will be the most time-consuming aspect of the caregiving role. The senior's bouts of depression or sadness, feelings of worthlessness, loneliness, anxiety, and worry require intense emotional support.

Responsibility : Medical Tasks

The family caregiver will perform simple healthcare duties at home. Medications may be administered not only orally but also via patches, injections and intravenously. In instances of severe illness, the family caregiver will manage equipment, such as feeding tubes or catheters.

Symptom management and monitoring the senior's condition are the family caregiver's responsibilities. The caregiver will manage fever, dehydration, delirium, and complex medication regimens. Hands-on procedures, like infusion pumps and wound care, are also increasingly in the realm of family caregivers.

Responsibility: Care Coordination

Family caregivers will find themselves making doctor's appointments for their elderly care recipients. The caregivers accompany the senior to the doctor's office, speak to the doctor and order prescription medications. They also change or otherwise handle the senior's medical insurance.

As advocates, the family caregiver is responsible for identifying and procuring resources to facilitate the senior's healthcare. They may deal with potential payers, like Medicare, Medicaid and Medigap. The caregiver may even help the senior transition to a new care setting, like an assisted living facility.

Responsibility : Decision Making

Seniors with mild cognitive impairment have the ability to express their wishes. When cognitive decline is severe, the family caregiver will be responsible for making decisions on the senior's behalf. Frail individuals may require the assistance from family caregivers to execute their decisions.

Several aspects influence decision making. These include the senior's and family caregiver's values, preferences, abilities, goals, and perceptions. Caregivers

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and care recipients may not always agree. For support, both parties may utilize living wills, power of attorney and personal care agreements.

Making healthcare decisions is crucial. An elderly parent who is cognitively able to make decisions but refuses medical care, risks death. In such cases, the family caregiver is not responsible or liable for the senior's death, since the senior has a right to make medical decisions, however unwise.

Remember, the family caregiver who assumes the role of caregiver is responsible for the senior's health. This creates a duty of care. If the aging senior requests medical intervention but the family caregiver fails to provide care, it would be considered a violation of the duty of care.

When decision-making capabilities are lost, most seniors prefer to involve family caregivers as surrogate decision makers. In other cases, decisions are made after a caregiver is appointed via power of attorney, advance directive or when the courts formally appoint a guardian.

Role and Importance of Younger Generations in the Care of Old Persons:

Connecting young people (children and teenagers) and seniors can be extremely beneficial in fostering understanding between the two generations and helping to promote *senior care* in St. Louis. It doesn't matter if the connection is made through organized intergenerational programs or activities at home – ultimately the benefits for connecting these two groups will:

- Strengthen the community
- Encourage positive exchanges between the generations

AGEISM AFFECTS EVERYONE

Ageism, or discrimination based on age, can affect anyone. According to statistics, seniors are more likely to face discrimination more often than any other age group. In both daily life (including interactions with their peers) and the media, they are mocked for having "senior moments," like lapses in memory or physical deterioration.

Young people can also be faced with ageism. Seniors may see them as haughty and disrespectful. This most often occurs when both groups fail to effectively communicate. Young people can perceive the reaction for the senior as "lecturing," while seniors perceive it as offering valuable advice.

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Children may feel frightened by seniors, who can look very different from the people the children are used to seeing and being around. In addition, adults may also feel uncomfortable because they are reminded that they too will grow old.

THE BENEFITS OF BRINGING GENERATIONS TOGETHER

To say that one generation cannot understand the other is false. Each has much to learn from the other. Intergenerational programs bring these two age groups together to participate in activities and cultural exchanges.

By requiring socialization during the programs, both groups can help each other:

- Understand and embrace their similarities and differences
- Encourage learning about the other group

Strengthen Communities through Mutual Understanding

With increased communication, stereotypes are dismissed and both groups feel less alienated and more comfortable. Seniors who live in St. Louis senior care communities and the young people who visit their senior loved ones also get the benefit of enhanced socialization.

With more positive views of seniors, young people will be more likely to take greater care and treat them with more respect. With an increased interest in community, both age groups will be more receptive to volunteering and seeking to improve the area in which they live.

Encourage Learning through Mentoring

Each generation can learn from the other. Despite popular misconceptions, seniors are capable of learning new skills. By interacting with and learning from youth, they can have a better grasp of new technologies and expand skills they already have.

Seniors can also mentor younger people, which can give the senior a sense of purpose and accomplishment. Young people who have positive role models in their lives have a positive self-image and are less likely to drop out of school. Being taught by an older generation could help children develop greater comprehension and empathy skills.

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Parents are concerned only about the education of their children. They have forgotten that it is also their duty to impart social and family values in the minds of children," said Additional Commissioner of Police-Crime, Greater Chennai, Abhay Kumar Singh.

Different Types of Senior and Elderly Care Living Options

Old age is a very varied time of life – for some, they remain in great health and it is an active and vibrant period. Others find it more challenging due to health conditions or physical issues. Whatever the case, as we get older the needs of our living conditions can change and that's why there are various different types of senior and elderly care to help get the right choice.

Independent living communities

Independent living communities are for singles and couples who can look after themselves but want to live in a community with others of their own age group. It is a slight step from living in your own home and offers a sense of community and togetherness that can help combat one of the big problems of the elderly – loneliness.

Assisted living

Assisted living is the next step and can be varied in what it offers. It is for people who want some backup if they have problems or the reassurance that someone is around. It can be a single old age residential care home with a few residents or a large complex of apartments with on-site medical facilities and recreational centres.

Nursing or care homes

Residential care in Wolverhampton and around the UK is also very varied to suit the needs of people. They can offer general old age care and respite care as well as special care for people with particular needs such as:

- Dementia care
- Mental health condition care
- Physical disability care
- Sensory impairment care

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In-home care

This is the type of care where either a family or friend or a professional carer spends part or all of the day in the home of the elderly person to support them. This can be done with many people who have sometimes complex health issues as long as treatment can be successfully given in the home. It is often the most expensive care option.

Temporary or day care

Temporary or day care often involves a residential care home where the person stays for a short period of time, known as respite care, or where they visit during the day when a carer is at work. It is also a good way to get particular care after an operation or a period of ill health.

Continuous or hybrid care

This is more of care plan than a specific option because it involves using a range of different care options to best suit the needs of the period. For example, it may involve using outpatient day medical care and independent living facilities as well as short periods in a full-time care home.

Palliative care

Palliative care is specialist care for those with serious long-term illnesses, untreatable or terminal conditions. It offers help with pain management and the various issues that affect people with the most serious conditions.

A hospice is a type of palliative care where people stay for the last stages of their lives to provide comfort and support in their final time and is often a dedicated centre for this purpose.

Need and Importance of Old Age Homes:

Parents are the most important people in our whole life. They are the only reason due to which we exist in this universe. They are our first teachers as we spend our most childhood time with them learning all the activities be it from routine work to manners and etiquettes or any other special talent. In India, parents are treated next to God.

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They keep their young ones protected from every kind of unauthorized and unlawful act and nourish them so that they can lead a successful life in future.

However, the parents do not receive adequate attention from their children. The reason for this expression stands as the increase in old age homes in our country.

First of all, let us know what is an old age home?

An old age home refers to a place where the old people are kept and taken care of which includes facilities like meals, gatherings, recreational activities and also providing medical assistance.

It is different from a nursing home and also from retirement homes. According to the Directory of Old Age Homes in India, HelpAge India, 1998 there are 728 old age homes in India till the present day.

Out of these 325 are free and 95 offer pay and stay services. 116 homes offer free stay and paid stay facilities and 11 are such of which no information is available.

278 homes are available for sick people and 101 are exclusively for women. Kerala has the maximum number of old age homes standing at a number of 124.

Old age homes despite offering many facilities are still not as home but still there emergence in India is at a greater rate.

Reasons for such increase are as follows:

1. The basic reason for an old person going to an old age home is due to the reason that their children or grandchildren move to metropolitan cities or abroad as well for pursuing higher studies and they are also capable enough to adapt themselves for new lifestyle but unlikely, the old people may find it harder to adapt such lifestyle and choose to remain back to their original place due to sentimental feelings.

2. Another reason also stands that the elderly people are sometimes prone to chronic health issues which are not taken care of by their children and as a reason for that they are also not allowed to live at their homes and sent to such homes.

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3. The mindset and values differences are also one of the reasons for emergence of such old age homes because many elderly people find it difficult to remain with their only daughter at her in laws place or due to their ego clashes with their grandchildren or other people and staying in old age homes make them connect with their age groups and have a like minded community.

4. The most important reason for such an increase is that the old people only strive for peace during these days and some also leave their homes so that they can get peace in these homes by not having conflicting situations arising at any time.

5. Due to an increase in the crime rate in India, most elderly people find it easy and secure to live in old age homes when their children are not living with them or if they are working abroad. The stay in these homes provides them security by surveillance through CCTV cameras or anything.

Benefits

There are many benefits living in old age homes like companionship of their age groups, safety, security and medical assistance but there are many cons available as well:

1. Some old age homes charge money for rendering services. Most old aged people are pensioners and are not having so much money which is a challenging problem because the better the payment the better the services.

2. Limited choices are available for food as it is based for the whole community and also in living space and it also lacks privacy.

3. The foremost hardship is the impersonal relationship as some people miss their family, grand children and relatives and often feel depressed.

Considering all the facts it can be said that home is only the best place to live and nothing can even match the comfort level of living in our own home with our family.

Old age homes are often spoken of as a shameful consequence of uncaring and callous children because family is the only support a person can get and if he has the support of his family; it is always possible for him to win each and every kind of battle.

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Services of Old Age Homes

How home care services to help you age in place

While it may be hard to accept, most of us will require some type of care assistance after the age of 65. You may be used to handling everything yourself, dividing up duties with your spouse, or relying on family members for minor help around the home.

But as you get older and your circumstances change, getting around and taking care of yourself can become more and more difficult.

If the idea of moving to a retirement community, assisted living facility, or nursing home doesn't appeal, home care services may be able to help keep you living in your own home for longer.

Home care services include:

Household maintenance:

Keeping a household running smoothly takes a lot of work. If you're finding it hard to keep up, you can look into laundry, shopping, gardening, housekeeping, and handyman services. If you're having trouble staying on top of bills and appointments, financial and healthcare management may also be helpful.

Transportation:

Transportation is a key issue for older adults. Maybe you're finding it hard to drive or don't like to drive at night. Having access to trains, buses, rideshare apps, reduced fare taxis, and senior transportation services can help prolong your independence and maintain your social network.

Home modifications:

If your mobility is becoming limited, home modifications can go a long way towards keeping your existing residence comfortable and accessible. Modifications can include things such as grab bars in the shower, ramps to avoid

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or minimize the use of stairs, or even installing a new bathroom on the ground floor.

Personal care:

Help with the activities of daily living, such as dressing, bathing, or meal preparation, is called personal or custodial care. Home health aides can provide personal care services that range from a few hours a day to around-the-clock live-in care. They may also provide limited assistance with things such as taking blood pressure or offering medication reminders.

Health care:

Some healthcare services can be provided at home by trained professionals, such as occupational therapists, social workers, or home health nurses. Check with your insurance or health service to see what kind of coverage is available, although you may have to cover some cost out of pocket. Hospice care can also be provided at home.

Day programs:

Day programs or adult daycare can help you keep busy with activities and socialization during the day, while providing a break for your caregivers. Some daycare programs are primarily social, while others provide limited health services or specialize in disorders such as early stage Alzheimer's.

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UNIT- IV

WORKING WITH THE ELDERLY

Biological Changes That Occur During Aging

Young adulthood:

The period of young adulthood begins from the age of twenty years onward. The major concerns of young adults in 20s are to establish themselves in life, job, and family. The young adult wants to seek social and economic security in preparing for a role of greater independence and responsibility in society.

Middle Age:

From the period of his twenties and thirties, the individual arrives at middle age in the forties and fifties. Middle age is characterized by competence, maturity, responsibility and stability. These are the important characteristics formiddle-aged adults. This is the time when one wants to enjoy the success of job, satisfaction derived from family and social life.

The individual looks forward to the successes of children. Attention gets more focussed on health, the fate of children, aging parents, use of leisure time and plans for old age. For women, menopause occurs between the age of forty-five and fifty. Menopause is sometimes accompanied by some distressing physical and psychological symptoms in women.

Men during this period show greater amount of concern towards their health, strength, power, and sexual potency.

Old Age:

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The period of old age begins at the age of sixty. At this age most individuals retire from their jobs formally. They begin to develop some concern and occasional anxiety over their physical and psychological health. In our society, the elderly are typically perceived as not so active, deteriorating intellectually, narrow-minded and attaching new significance to religion.

Many of the old people lose their spouses and because of which they may suffer from emotional insecurity. **'**Nobody has ever died of old age'**,** is a true statement. Since old age is close to the end point of life, death has been associated with old age. Death is actually caused by disease, pollution, stress, and other factors acting on the body.

In the biological sense, some organs and systems of the body may start deteriorating. In the psychological sense, there may be measurable changes in the cognitive and perceptual abilities. There are also changes in the way a person feels about him/ herself.

You must have come across old people who are very active in life and socially very particiaptive. Such persons seem to be productive and stable and happy. Mental or physical decline does not necessarily have to occur. Persons can remain vigorous, active, and dignified until their eighties or even nineties. In fact, the older persons have vast reservoir of knowledge, experience, and wisdom on which the community can draw.

In view of increase in life expectancy increasingly greater proportion of society is joining the group of aged people. Hence they need greater attention in national planning and making them feel as an integral part of society.

PHYSICAL AND COGNITIVE CHANGES

DURING ADULTHOOD AND AGING

Normally people see old age as a period of decline in physical and mental health. This section deals with physical and psychological aspects of aging. With advancing age, there are certain inevitable and universal changes such as chemical changes in cells, or gradual loss of adaptive reserve capacity. There are also certain

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cognitive changes taking place from middle adulthood onwards. These changes are slow and gradual. They become more prominent among the elderly people.

(a) Physical Changes

It has been found that the organ system of most persons show a 0.8 to 1 percent decline per year in functional ability after the age of 30. Some of this decline is normal, some is disease related and some are caused by factors such as stress, occupational status, nutritional status and various environmental factors.

Major physical changes with ageing are described as

(1) external changes
(2) internal changes, and
(3) changes in sensory capacities.

1. External Changes

External changes refer to the outward symptoms of growing old. The more observable changes are those associated with the skin, hair, teeth, and general posture. There are changes in the skin. The most pronounced change is wrinkling. Wrinkling process begins during middle years. Skin also becomes thick, hard and less elastic.

It becomes brittle and dry. With advancing age, the hair of the person continues to turn white and loses its luster. It continues to thin. By the age of fifty-five, about 65 percent of men become bald. It is estimated that at age 65, fifty percent people have lost all their teeth.

For many, dentures become a way of life. Over the time, the production of saliva is diminished. This increases the risk of tooth decay.

Physical strength

Begins to decline from age 30 to age 80 and above. Most weakening occurs in the back and leg muscles, less in the arm muscles. There is a progressive decline in energy production. Bones become increasingly brittle and tend to break easily. Calcium deposits and disease of the joints increase with age.

Muscle tissue decreases in size and strength. Muscle tone becomes increasingly difficult to maintain with age because of an increase in fatty substance

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within the muscle fibres. This is often caused by the relative inactive role thrust on the elderly in our society. Exercise can help maintain power and sometimes even restore strength to the unused muscles.

Changes in the general posture become more evident in old age. The loss of teeth, balding and greying of the hair, wrinkling of the skin, and lack of physical strength all have a potentially negative effect on an individual's self-concept and confidence.

2. Internal Changes

Internal changes refer to the symptoms of growing old that are not visible or obvious. We shall examine some of the changes taking place with increasing age in the respiratory system, gastrointestinal system, cardiovascular system, and central nervous system.

The Respiratory System:

With increasing age, there is reduction in breathing efficiency. The lungs of an old person do not expand to take in as much air as the lungs of a young person. Decreased oxygen supply makes the old person less active, less aware and less strong. This decline seems to be part of normal aging process.

The Gastrointestinal System :

With increasing age there is decreased capacity for biting and chewing, decrease in the production of digestive enzymes, decreased gastric and intestinal mobility and lack of appetite.

The Cardiovascular System:

Cardiovascular system which includes the heart and the blood vessels show the effects of normal aging rather slowly. With the aging process there is a decrease in the elasticity of blood vessels and blood cell production also.

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Increase-in time required for heart to return to rest and arterial resistance to the passage of blood is also found. Many old individuals are found to be suffering from high blood pressure. However, healthy old individuals are found to have blood pressure similar to those of young healthy indiciduals.

The Central Nervous System (CNS) :

The CNS shows certain universal changes as a function of age. There is decreasing rate of arterial and venous flow. Beginning at about age 60, there is a reduction of cerebral blood flow. There is also a decline in oxygen and glucose consumption. Number of cells and cell endings are found to be decreasing. The most definite change is the slowing down of responses.

3. Changes in Sensory Capacities

With advancing age, there is gradual slow down in the sensory abilities. We communicate with the outer world through our senses. Losses in any senses can have profound psychological consequences.

Vision:

Increasing age brings in several problems in vision. The lens continues to lose elasticity. The pupils become smaller, irregular in shape. The eyelids have a tendency to sag. Colour vision becomes less efficient. Cataract and glaucoma are commonly found among the elderly. People with cataracts have blurred vision. This also interferes with normal vision.

Hearing:

Hearing seems to be at best around the age 20. From then onwards there is a gradual decline. Most hearing loss is not noticed. However, in the case of hearing problem, it can be improved by a hearing aid.

Other senses:

The senses of taste and smell decline with old age. This decline affects appetite and nutritional requirements of the elderly. You must have noticed that many old persons demand food that is overly sweet or spicy. This is because the four basic tastes, sweet, bitter, sour, and salty, all generally diminish in sensitivity.

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Sensitivity to touch appears to increase from birth to about 45 and then decreases sharply.

COGNITIVE CHANGES DURING ADULTHOOD AND AGING

The term 'Cognition' refers to the processes by which information is acquired, stored, and used. In this section, four major aspect of cognition-memory, learning, attention and intelligence will be discussed in relation to adulthood and aging.

a) Memory

Memory is one of the most central aspects of cognition. Memory has been defined as 'the mental processes of retaining information for later use and retrieving such information'. No significant age differences may be found in short-term memory task like forward digit span or word span.

Older subjects do not perform as well on the tasks that demand repeating numbers in reverse order. Old persons are found to perform poorer than young ones on long-term memory tasks which require processing of information and organization of material.

b) Memory of the Elderly

Memory performance with advanced age is affected by several factors. Some of the important factors are given below.

(i) Beliefs about Memory

Old persons' beliefs and attitudes about their memory ability affect their memory performance. Research shows the role of beliefs, perceptions, attitudes, and knowledge in memory abilities.

Questionnaires typically ask respondents how frequently they forget names and events, how anxious they are about forgetting, what they know about how to improve memory and what strategies they employ in remembering.

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Older adults have been found to have more difficulties with their memory than do younger adults. The common expression among elderly has been 'I am getting old'. Elderly persons are often found to be complaining about their memory failures.

(ii) Use of Memory Strategies

Memory requires the use of strategies. Memory performance would be better for those who can use effective memory strategies. An example of memory strategy is repeating to yourself over and over again the items you want to buy is connected with something that is familiar. For example, if you want to remember the name of somebody, you may associate that person with some popular figure. You can also use memory aids such as a diary or writing out a list of items you want to buy at the grocery store.

Most of us use some such strategies every now and then but we are not aware of using them. In their everyday lives, the elderly persons are more likely to use diaries, making lists of things to buy, etc. than using rehearsal or association strategy.

(iii) Life Styles of Elderly

The type of daily activities in which elderly persons engage determines their memory performance. The elderly persons who engage in daily activities like playing chess or bridge, their performance on some of the memory and reasoning tasks is found to be better than elderly non-players.

Another aspect of lifestyle determining cognitive performance is regularity in the structure of daily life. Regularity of sleep patterns, daily exercise, following regular schedule of every day activities helps to maintain everyday cognitive functioning.

b. Learning

Learning involves formation of new association. It means acquisition of general rules and knowledge about the world. It is believed that learning

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performance tends to be poorer during late than early adulthood. Can older people acquire new information and skills? Can they try new careers? Such questions are difficult to answer.

We must note that the ability to learn may be relatively unchanged in old persons. Factors such as poor motivation, lack of confidence, test anxiety, etc. may lower performance on learning tasks. Old persons' learning performance maybe very close to that of young persons if older persons are allowed more time or can self-pace the tests.

They were found to perform better when there is no time pressure and the material is presented very distinctly and in a simplified manner.

c. Attention

The term attention refers to the manner in which we focus on what we are doing. People vary in how wide their attention span is. If attention span is too narrow, one looses a lot of information.

Old people may not differ from young people in terms of their attention span as such. However, they get easily distracted by any kind of interference. With training, attention can be improved.

d. Intelligence

As has been pointed out earlier many of our impressions of old age originate from inaccurate knowledge or misconceptions. How do elderly persons perform on intelligence test? Most of the intelligence tests require speed of performance.

We have already discussed that old persons are slower on reaction time. Thus lower performance on intelligence tests may be due to slower reaction time than due to a decline in intellectual functions. General knowledge does not decline with age. Among the elderly, we often find reduced abilities for complex decision making and slowing of performance. Hardly any losses in verbal comprehension,

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social awareness and the application of experience may be noticed among the older people.

Intelligence in adulthood and aging maybe viewed as enabling the individual to cope with a variety of demanding everyday tasks and events. Everyday intelligence of the elderly maybe determined by their ability in reading road maps, understanding labels, filling out forms, understanding charts, conversations, TV programmes, doing shopping, driving during rush hours, and performing many other daily jobs.

You may remember that we have already discussed that elderly work best when they are away from pressure and can set their own pace. Moreover, the factor of general health is very important to be considered. Healthy individuals and those who lead happy and active life generally show no or little loss of intellectual abilities during old age.

Many changes occur during normal aging. Genetics and lifestyle both play a role in signs of aging exhibited by the body. Skin becomes dryer and less elastic, leading to lines and wrinkles. Hair thins, and gray hair increases. High-pitched sounds become harder to hear, and vision declines; most people need reading glasses when they're in their 40s.

Changes in sleep patterns also occur, with older people generally needing less sleep and waking up more during the night. Bones may become less dense, height decreases, metabolism slows, and blood flow to the brain decreases. Sexual functioning also decreases. Men produce fewer sperm, and women go through menopause and stop ovulating (and menstruating), which means that they can no longer get pregnant.

All of these changes are found to some extent in older people, but the choices a person makes—such as eating healthy and exercising—can help moderate the effects of aging. In individual cells, senescence occurs when a cell can no longer divide. Cells at first divide quickly, then more slowly, until eventually mitosis stops. The size and shape of the cells changes, and debris accumulates inside them.

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In addition, genetic damage can accumulate in cells over time through exposure to sunlight and radiation, and through free radicals that are cell by-products. Telomeres, which are regions of DNA at the end of a chromosome, are ultimately responsible for the stopping of mitosis. Telomeres shorten with each cell division, and over time when they become very short, the cell can no longer divide.

Behavior & Personality Changes

Behavioral symptoms like moodiness, apathy, changes in personality, unsocial behaviors and language difficulty can be part of the disease. Behaviour and personality often change with dementia. People with dementia often act in ways that are very different from their "old self," and these changes can be hard for family and friends to deal with.

Behavior changes for many reasons. In dementia, it is usually because the person is losing neurons (cells) in parts of the brain. The behavior changes you see often depend on which part of the brain is losing cells.

For example, the frontal lobes are the area of the brain right behind the eyes that controls our ability to focus, pay attention, be motivated and other aspects of personality. Therefore, when cells in the frontal lobes of the brain are lost, people are less able to plan and stay focused. They are often less motivated and become more passive. The frontal lobes also control our impulses. Someone with frontal lobe deficits may act rudely or insensitively.

Dementia also alters how a person responds to their environment. A person with Alzheimer's disease may be forgetful and have trouble following conversations. They may become angry and frustrated because they cannot follow what is going on. Noise, conversation, crowds and activity may be over-stimulating and too difficult to process or understand. Also, many people with dementia rely on others for emotional cues. For example, if you are anxious and worried, many people with dementia will mirror your emotions and become anxious and worried.

Behavior can also change due to medical issues, such as pain or infection. A person with dementia may have a painful condition but may be unable to explain

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it or describe it. Instead, they may act out in an angry way or be less active. Urinary tract infections, constipation and poor sleep are examples of conditions that can cause sudden changes in the way a person behaves. Finally, some medications may cause changes in the way a person behaves.

1. **Consider an evaluation by the person's health care provider.** Sudden changes could be a sign of an infection, pain, or side effect of a medication. Do not assume that behavior and personality changes are always due to dementia.

2. **While there are medicines that may help soften some behavior changes, medicines are not always the answer.** Some behaviors cannot be "fixed" using medicine. For example, no medicine will prevent a person from pacing or wandering. Some medicines can also cause negative side effects and actually make things worse.

3. **Think of behavior as a form of communication.** If the person with dementia acts out in an angry or irritated way, it's a way of telling others that they may be overwhelmed, in pain, confused or frightened.

4. **Try to identify what is causing the behavior change.** Was there a trigger or something that happened right beforehand? For example, was there an unexpected visitor that disrupted the person's normal routine? Does the behavior occur at bath time?

5. **Consider whether the behavior is risky and hazardous, versus annoying and frustrating.** Risky and hazardous behavior might be when the person gets angry and tries to walk out of the house in an unsafe manner. You may have to respond in an active way, such as walking with them, distracting them and then installing locks on the door. Annoying and frustrating behavior may require a softer response. For example, if the person paces about the house but is calm and doesn't try to leave, it may be best to work on accepting that the pacing is okay.

6. **Try to create a daily routine that is structured and predictable for the person with dementia.** Routine is an important source of comfort.

7. **Foster an attitude of acceptance.** The behavioral changes are due to real issues and are not because the person is deliberately trying to be difficult.

8. **Try to be calm and patient.** This means you will need to take breaks. Walk into a different room. Count to 10.

9. **Talk to other caregivers.** Consider a support group where you might learn

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about helpful strategies that other caregivers have used.

Aging and the Mind: Mental and personality changes

Mental Illness in the Elderly

Elderly behavioral problems can stem from a decline in mental health. In seniors, these issues frequently go undiagnosed or unaddressed. In fact, about 20% of U.S. adults age 55 or older experience some type of mental health concern, but nearly one in three of those seniors do not receive treatment.Data from CDC. The statistics on mental illness in seniors are sobering, but with knowledge and vigilance, caregivers can stay aware of the emotional and mental health of their older loved ones and make sure they are properly treated if they are experiencing a problem.

You might not be surprised to read that the most common mental health issue among the elderly is severe cognitive impairment or dementia. An estimated 5 million adults 65 and older currently have Alzheimer's disease — about 11% of seniors, according to the Alzheimer's Association. Depression and mood disorders are also fairly widespread among older adults, and disturbingly, they often go undiagnosed and untreated. The CDC reports that 5% of seniors 65 and older reported having current depression and about 10.5% reported a diagnosis of depression at some point in their lives.

Often going along with depression, anxiety is also one of the more prevalent mental health problems among the elderly. Anxiety disorders encompass a range of issues, from hoarding syndrome and obsessive-compulsive disorder to phobias and post-traumatic stress disorder (PTSD). About 7.6% of those over 65 have been diagnosed with an anxiety disorder at some point in their lives, says the CDC.

Assessing Common Areas of Elderly Behavior Problems

A number of issues may arise as a result of elderly behavior problems. A Place for Mom medical expert geriatrician Dr. Leslie Kernisan recommends 5 areas to assess when visiting your loved ones and some tips on what you can do when elderly loved ones resist help.

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Risk Factors for Mental Illness :

One of the ongoing problems with diagnosis and treatment of mental illness in seniors is the fact that older adults are more likely to report physical symptoms than psychiatric complaints. However, even the normal emotional and physical stresses that go along with aging can be risk factors for mental illnesses, like anxiety and depression.

The Geriatric Mental Health Foundation lists a number of potential triggers for mental illness in the elderly:

- Alcohol or substance abuse
- Change of environment, like moving into assisted living
- Dementia-causing illness (e.g. Alzheimer's disease)
- Illness or loss of a loved one
- Long-term illness (e.g., cancer or heart disease)
- Medication interactions
- Physical disability
- Physical illnesses that can affect emotion, memory and thought
- Poor diet or malnutrition

Symptoms of Mental Illness

As our loved ones age, it's natural for some changes to occur. Regular forgetfulness is one thing, however; persistent cognitive or memory loss is another thing and potentially serious.

The same goes for extreme anxiety or long-term depression. Caregivers should keep an eye out for the following warning signs, which could indicate a mental health concern:

1. Changes in appearance or dress, or problems maintaining the home or yard.
2. Confusion, disorientation, problems with concentration or decision-making.
3. Decrease or increase in appetite; changes in weight.
4. Depressed mood lasting longer than two weeks.
5. Feelings of worthlessness, inappropriate guilt, helplessness; thoughts of suicide.
6. Memory loss, especially recent or short-term memory problems.

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7. Physical problems that can't otherwise be explained: aches, constipation, etc.
8. Social withdrawal; loss of interest in things that used to be enjoyable.
9. Trouble handling finances or working with numbers.
10. Unexplained fatigue, energy loss or sleep changes.

Depression

Depression is a type of mood disorder that ranks as the most pervasive mental health concern among older adults. If untreated, it can lead to physical and mental impairments and impede social functioning. Additionally, depression can interfere with the symptoms and treatment of other chronic health problems.

Common symptoms of depression include ongoing sadness, problems sleeping, physical pain or discomfort, distancing from activities previously enjoyed, and a general "slowing down."

Seniors suffering from depression generally visit ERs and doctors more frequently, take more medications, and experience longer hospital stays than their same-age peers. Women are more likely to be affected than men.

Late-Onset Depression Risk Factors to Watch Out For

- Physical Illness
- Widowhood
- Lack of education (below high school level)
- Diminished functional status
- Heavy drinking

On the bright side, depression can typically be successfully treated in older adults. If you suspect a loved one or client is showing signs of depression, seek help immediately.

Dementia symptoms

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The most common form of dementia is Alzheimer's disease, which causes cells in the brain that control memory to die. It is an irreversible condition that occurs in severe and moderate stages in three million people over the age of 65.

While dementia does affect all individuals differently, the main symptoms of dementia include:

 Difficulty communicating.
Dementia patients often have a difficult time completing sentences or finding the right words. Also, words can get mixed up or used incorrectly.

 Increased memory issues.
Forgetfulness will start to occur more and more often, along with problems remembering how to do daily activities like cooking, cleaning and dressing.

 General confusion.
Those with dementia begin getting confused about what time of day it is, or even what year they're living in. They also have a hard time recognizing friends and family members or think they are someone else entirely. Dementia patients may also start losing or misplacing items, even accusing others of stealing their belongings.

 Personality and emotional changes.
Dementia will cause personality changes to individuals, and can affect their moods as well. Those with dementia are often fearful or depressed and experience severe mood swings.

Common Mental Illnesses in the Elderly

If a senior is displaying signs of mental illness, it's important to recognize the symptoms and seek treatment as soon as possible.

Some of the common mental illnesses the elderly experience are:

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 Depression.

Depression is considered the most common mental disorder among seniors. Social isolation plays a major role in emotional wellness, so when a senior spends long periods alone because they are unable to drive or live far away from friends and family, depression can easily set in. It is also a symptom of dementia and tends to get overlooked as a treatable ailment.

 Late onset bipolar.

Most bipolar patients are diagnosed in early adulthood. Late onset bipolar can be difficult to diagnose because of its similarities to dementia symptoms like agitation, manic behavior and delusions.

 Late onset schizophrenia.

This disorder also presents a challenge to diagnose. It can manifest in adults after age 45 and appears as the patient ages. Symptoms are similar to dementia, once again, with hallucinations and paranoia the most common, but these symptoms are milder than when this illness appears in younger adults.

Mental illnesses are treatable, but the trick is a correct diagnosis. Even if a senior had good mental health throughout their entire life, the risk of mental illness in later years is still there. Seek medical treatment as soon as possible if there are any noticeable changes beginning to occur.

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Temporary changes in mental functioning and causes

Loneliness is a painful universal phenomenon that has an evolutionary basis. Loneliness reminds us of the pain and warns us of the threat of becoming isolated.

Loneliness is the absence of imperative social relations and lack of affection in current social relationships. Loneliness is one of the main indicators of social well-being. Loneliness is caused not by being alone, but by being without some definite needed relationship or set of relationships.

Research addressing loneliness has increased dramatically over the past 2 decades; however, despite the mental health risks associated with being lonely, the relationship between loneliness and psychiatric disorders has not been sufficiently explored. In India very little research has been done on psychological and physical affect of loneliness.

There are just a few studies in India, in which relationship of loneliness with other psychiatric disorders has been studied .However most of these studies were done in elderly patients only.

Loneliness is a common experience with 80% of population below 18 years of age and 40% of population above 65 years of age report loneliness at least sometimes in their life. Loneliness is generally reported more among adolescents and young children, contrary to the myth that it occurs more in elderly.

The reason for this is that elder people have definite copying skills and can adjust accordingly to solitude, while as adolescents lack definite copying skills and adolescent period is the time of life when being accepted and loved is of such major importance to the formation of one's identity.

However elderly who have physical illness and disability report higher prevalence of loneliness, compared to elderly without physical illness and disability. In India elderly patient population is increasing and their psychological problems are on a rise.

India is destined to become the second largest population of elderly people in the coming years. Therefore it is necessary to intervene at the right time to prevent the psychological problems and physical disorders arising due to affects of loneliness in elderly population. Further loneliness gradually diminishes through the middle adult years, and then again increases in old age (i.e., ≥70 years) .

Risk factors:

The risk factors associated with loneliness include being female, being widowed, living alone, being aged, health factors, material resources and a limited number of 'social' resources .

Types of loneliness

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There are 3 types of loneliness i.e. situational loneliness, developmental loneliness and internal loneliness .

1. **Situational Loneliness:** The various factors associated with situational loneliness are environmental factors (unpleasant experiences, discrepancy between the levels of his/her needs), migration of people, inter personal conflicts, accidents and disasters, etc .

2. **Developmental Loneliness:** The various factors associated with developmental loneliness are personal inadequacies, developmental deficits, significant separations, poverty, living arrangements, and physical/psychological disabilities .

3. **Internal Loneliness:** The various factors associated with internal loneliness are personality factors, locus of control, mental distress, low self-esteem, guilt feeling , and poor coping strategies with situations .

Further Weiss et al., reported 2 types of loneliness i.e. emotional and social loneliness. Emotional loneliness defined by the absence of an attachment figure and social isolation, characterized by the absence of a social network .

Psychiatric Disorders and Loneliness

1. **Depression :**

Lonely people suffer from more depressive symptoms, as they have than been reported to be less happy, less satisfied and more pessimistic . Further loneliness and depression share common symptoms like helplessness and pain. There is so much similarity in between loneliness and depression that many authors consider it a subset of depression. However the distinction can be made by the fact that loneliness is characterized by the hope that all would be fine, if the lonely person could be united with another longed for person .

In patients, who are both lonely and depressed, loneliness is positively correlated with negative feelings and negative judgment of personality attributes and negatively correlated with it .It has been seen that there is an association between insecure attachment styles and depression.

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Several studies further suggest insecure attachment styles increases vulnerability to depression. The vulnerability to depression can be due to the fact that insecurely attached have tendency to develop low self esteem, difficulty or inability in developing and maintaining relationships with others, poor problem solving skills, and an unstable self- concept .

1. **Alzheimer's disease :**

Loneliness is associated with more then two fold risk of dementia, as loneliness is associated with loss of cognition in old age. In fact some authors signal it as prodromal stage of dementia.

In loneliness, there is more rapid decline in global cognition, semantic memory, perceptual speed, and visuospatial ability. The basis of association of loneliness with Alzheimer's disease (AD) can be attributed to two possibilities.

First possibility is that loneliness is a consequence of dementia, perhaps as a behavioral reaction to diminished cognition or as a direct result of the pathology contributing to dementia.

Second possibility is that loneliness might somehow compromise neural systems underlying cognition and memory, thereby making lonely individuals more vulnerable to the deleterious effects of age-related neuropathology and thereby decreasing neural reserves. In one study, the incidence of AD was predicted by degree of baseline loneliness, after adjusting for age, sex, and education.

It was found that those in the top deciles of loneliness scores were 2.1 times more likely to develop AD than those in the bottom deciles of loneliness scores. The prevalence of AD is lower in India compared to other countries.

There are wide variations in the incidence rates in community based as well as urban based studies in India. Various risk factors have been identified in the causation of AD in India. However, to the best of the knowledge of the author, there are no studies which assesses relationship of loneliness with AD.

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Anxiety Disorders

Like depression, anxiety is a very common mood disorder among the elderly. In fact, these two problems often appear in tandem. Statistics from the CDC show that nearly half of older adults with anxiety also experience depression.

Anxiety in seniors is thought to be under diagnosed because older adults tend to emphasize physical problems and downplay psychiatric symptoms. Women in this age group are more likely to be diagnosed with an anxiety disorder than men.

Risk Factors for Anxiety Disorders in Old Age

Anxiety in the elderly is linked to a number of risk factors, including but not limited to:

- General feelings of poor health
- Sleeping problems
- COPD, certain cardiovascular diseases, diabetes, thyroid disease, and related chronic conditions
- Side effects caused by certain medications
- The abuse/misuse of alcohol, street drugs, or prescription drugs
- Physical impairments limiting daily functioning
- Stressful events like the death of a spouse, serious medical condition, or other life-altering event
- Traumatic or difficult childhood
- Perseveration on physical symptoms

There are several different types of anxiety disorders, with the most common being generalized anxiety disorder and phobias.

Here is a list of anxiety disorders you may observe:

Generalized Anxiety Disorder

This form of anxiety presents a state of constant worry with little to no cause. Older adults with GAD have difficulty relaxing, sleeping, concentrating, and startle easily.

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Symptoms include fatigue, chest pains, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, nausea, lightheadedness, having to go to the bathroom frequently, feeling out of breath, and hot flashes.

The effects of generalized anxiety include persistent worry or fear, which can get progressively worse with time.

These symptoms eventually interfere with socialization, job performance, and day-to-day activities. Seniors with anxiety tend to become more withdrawn and reclusive.

Symptoms and Signs of Generalized Anxiety Disorders in Seniors

Elderly individuals with generalized anxiety may experience the following symptoms:

- Excessive, uncontrollable worry/anxiety
- Edginess, nervousness, or restlessness
- Chronic fatigue or tiring out easily
- Become irritable or agitated
- Poor quality of sleep or difficulty falling/staying asleep
- Tense muscles

In addition to generalized anxiety disorder, seniors can be diagnosed with the following related disorders including:

Phobia: An extreme, paralyzing fear of something that usually poses no threat, phobias can cause individuals to avoid certain things or situations due to irrational fears. Examples can include fear of social situations, flying, germs, driving, etc.

Panic disorder: This disorder is characterized by periods of sudden, intense fear that can be accompanied by heart palpitations or pounding, rapid heartbeat, shaking, sweating, difficulty breathing, or experiencing feelings of doom.

Symptoms of Panic Disorder

- Sudden, repeated bouts of intense fear
- Feeling powerless or out of control
- Persistent worry about the “next” attack

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 Avoiding situations where past panic attacks have occurred

Social Anxiety Disorder:

This social phobia causes individuals to fear being in certain social situations where they feel they might be judged, embarrassed, offensive to others, or rejected.

Social Phobia Symptoms

 Extreme anxiousness about being with others
 Difficulty talking to others in social situations
 Self-consciousness in social settings
 Fear of being judged, humiliated, or rejected
 Fear of offending others
 Worrying about attending social events long before they take place
 Avoiding social situations
 Difficulty with friendships
 Feeling queasy around other people
 Sweating, blushing or shaking around others

Post-Traumatic Stress Disorder:

PTSD is a disorder that usually manifests following a traumatic event that threatens a person's safety or survival, greatly impacting his or her quality of life.

Symptoms of PTSD

 Emotional numbness
 Flashbacks to the event
 Nightmares
 Depression
 Irritability
 Easily distracted or startled
 Anger

Obsessive-Compulsive Disorder:

Those who suffer from OCD experience uncontrollable recurring thoughts (obsessions) or rituals (compulsions). Examples of rituals include washing hands, checking if appliances are on or off, counting, or other behaviors typically done to

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quell obsessive thoughts (e.g. washing hands repeatedly to remove germs and avoid getting sick).

Treatments for Anxiety Disorders

A variety of techniques, supports, and treatments, including medication, psychotherapy, or a combination of both, are available to address various anxiety disorders in seniors. If you suspect someone you care for has symptoms of an anxiety disorder, get in touch with their care team as soon as possible.

3. Bipolar Disorders

Bipolar disorders, or manic-depressive illnesses, are often marked by unusual mood shifts and are frequently misdiagnosed in senior citizens because the symptoms presented are typical with the aging process, especially related to dementia and Alzheimer's. Bipolar disorder occurs equally among women and men in this age group.

While younger people in the manic phase of bipolar disorder will show classic signs like elation and risky behavior, seniors are likely to become more agitated or irritable.

Late-Onset Bipolar Disorder Symptoms

- Confusion
- Agitation
- Irritability
- Hyperactivity
- Psychosis
- Cognitive issues including memory problems, trouble problem solving, loss of judgment, and loss of perception

It is worth noting that the effects of certain medications and some types of illnesses show similar symptoms. The individual should be seen and diagnosed by a medical professional to determine the root cause of any symptoms as well as the best options for treatment.

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Panic disorder

Panic disorder occurs when you experience recurring unexpected panic attacks. The DSM-5 defines panic attacks as abrupt surges of intense fear or discomfort that peak within minutes. People with the disorder live in fear of having a panic attack. You may be having a panic attack when you feel sudden, overwhelming terror that has no obvious cause. You may experience physical symptoms, such as a racing heart, breathing difficulties, and sweating.

Most people experience a panic attack once or twice in their lives. The American Psychological Association reports that 1 out of every 75 people might experience a panic disorder. Panic disorder is characterized by persistent fear of having another panic attack after you have experienced at least one month (or more) of persistent concern or worry about additional panic attacks (or their consequences) recurring.

Even though the symptoms of this disorder can be quite overwhelming and frightening, they can be managed and improved with treatment. Seeking treatment is the most important part of reducing symptoms and improving your quality of life.

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UNIT –V

POLICIES AND PROGRAMMES FOR THE ELDERLY IN INDIA LEGISLATIONS

Maintenance and Welfare of Parents and Senior Citizens Act, 2007

- The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, to ensure need based maintenance for parents and senior citizens and their welfare. Section 19 of the Maintenance and Welfare of Parents and Senior Citizens Act,2007 envisages provision of at least one old age home for indigent senior citizens with a capacity of 150 persons in every district of the country.

The objectives of the Act are:

- Revocation of transfer of property by senior citizens in case of negligence by relatives.
- Maintenance of Parents/senior citizens by children/ relatives made obligatory and justiciable through Tribunals.
- Pension provision for abandonment of senior citizens.
- Adequate medical facilities and security for senior citizens.
- Establishment of Old Age Homes for indigent Senior Citizens.
- The Act was enacted on 31st December 2007. It accords prime responsibility for the maintenance of parents on their children, grand children or even relatives who may possibly inherit the property of a senior citizen. It also calls upon the state to provide facilities for poor and destitute older persons.
- The Act has to be brought into force by individual State Government. Himachal Pradesh is the first state and Punjab is the fifth state where old parents can legally stake claim to financial aid from their grown-up children for their survival and a denial would invite a prison term. As on 03.02.2010, the Act had been notified by 22 states and all UTs.

National policies and programmes for elderly

The problems of the elderly in India were not serious in the past because the numbers were small and the elderly were provided with social protection by their family members. But owing to relatively recent socio-economic changes,

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ageing of the population is emerging as a problem that requires consideration before it becomes critical.

However a few studies indicate that family and relatives still play a dominant role in providing economic and social security for the elderly. But still the majority of elderly need social, economic and health support. Over the years, the government has launched various schemes and policies for elderly persons. These policies and schemes are meant to promote the health, well-being and independence of elderly people around the country.

Some of these provisions have been discussed in this chapter as follows:

I Relevant Constitutional Provisions
II Legislations
III Various policies and programmes of Central Government for Elderly People
IV Some other important activities

I Relevant constitutional provisions

(i) Article 41 of the Constitution:

Article 41 of Directive Principles of State Policy has particular relevance to Old Age Social Security. According to Article 41 of the constitution of India, "the state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and is ablement and in other cases of undeserved want."

(ii) Article 47 of the Constitution:

Article 47 of the constitution of India provides that te state shall regard the raising of the level of nutrition and the standard of living of its people and improvement of public health as among its primary duties.

Some Other Constitutional Provisions:

Entry 24 in list III of schedule VII of constitution of India deals with the welfare of labour, including conditions of work, provident funds, liability for

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workmen's compensation, invalidity and old age pension and maternity benefits. Further, item 9 of the state list and item 20, 23 and 24 of concurrent list relates to old age pension, social security and social insurance, and economic and social planning. The right of parents, without any means, to be supported by their children having sufficient means has been recognized by section 125(1) (d) of the Code of Criminal Procedure 1973, and section 20 (1 & 3) of the Hindu Adoption and Maintenance Act, 1 956. Among the administrative setup, the Ministry of Social Justice and Empowerment focuses on policies and programmes for the elderly in close collaboration with State Governments, Non- governmental Organisations and Civil Society. The programmes aim at their welfare and maintenance especially for indigent elderly, by supporting old age homes, day care centers, mobile medical units etc.

II VARIOUS POLICIES AND PROGRAMMES OF CENTRAL GOVERNMENT FOR ELDERLY PEOPLE

Several initiative steps for various policies and programmes for the elderly have been taken by the government. Some of them have been discussed as below:

National Policy for Older Persons (NPOP) 1999

The National Policy on older Persons was announced by the Central Government of India in the year, 1999 to reaffirm the commitment to ensure the well-being of the older persons. It was a step to promote the health, safety, social security and well-being of elderly in India. The policy recognizes a person aged 60 years and above as elderly. This policy enables and supports voluntary and nongovernmental organizations to supplement the care provided by the family and provide care and protection to vulnerable elderly people. It was a step in the right direction in pursuance of the UN General Assembly Resolution 47/5 to observe 1999 as International Year of Older Persons and in keeping with the assurances to elderly people contained in the Constitution. The policy envisages state support in a number of areas – financial and food security, healthcare and nutrition, shelter, education, welfare, protection of life and property etc. for the well being of elderly people in the country.

The primary objectives of this policy are to:

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- ensure the well-being of the elderly so that they do not become marginalised, unprotected or ignored on any count.
- encourage families to take care of their older family members by adopting mechanisms for improving inter generational ties so as to make the elderly a part and parcel of families.
- encourage individuals to make adequate provision for their own as well as their spouse's old age.
- provide protection on various grounds like financial security, health care, shelter and welfare, including protection against abuse and exploitation.
- enable and support voluntary and non-governmental organizations to supplement the care provided by the family and recognising the need for expansion of social and community services with universal accessibility.
- provide care and protection to the vulnerable elderly people by ensuring for the elderly an equitable share in the benefits of development.
- provide adequate healthcare facility to the elderly.
- promote research and training facilities to train care givers and organizers of services for the elderly.
- create awareness regarding elderly persons to help them lead productive and independent life.

This policy has resulted in the opening of new schemes such as –

- Promotion of the concept of healthy ageing.
- Setting up of Directorates of Older Persons in the States.
- Training and orientation to medical and paramedical personnel in health care of the elderly.
- Assistance to societies for production and distribution of material on elderly care.
- Strengthening of primary health care system to enable it to meet the health care needs of older persons.
- Provision of separate queues and reservation of beds for elderly patients in hospitals.
- Extended coverage under the Antodaya Schemes especially emphasis for elderly people.

National Council for Older Persons (NCOP)

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A National Council for Older Persons (NCOP) was constituted in 1999 under the chairpersonship of the Ministry of Social Justice and Empowerment to operationalize the National Policy on Older Persons. The NCOP is the highest body to advise the Government in the formulation and implementation of policy and programmes for the elderly.

The basic objectives of this council are to:

o advise the Government on policies and programmes for older persons.

o represent the collective opinion of elderly persons to the government.

o suggest steps to make old age productive and interesting.

o provide feedback to the government on the implementation of the NPOP as well as on specific programme initiatives for elderly.

o suggest measures to enhance the quality of inter-generational relationships.

o provide a nodal point at the national level for redressing the grievances of older persons which are of an individual nature provide lobby for concessions, rebates and discounts for older persons both with the Government as well as with the corporate sector.

o work as a nodal point at the national level for redressing the grievances of elderly people.

o undertake any other work or activity in the best interest of elderly people.

The council was re-constituted in 2005 and met at least once every year. At present there are 50 members in it, comprising representatives of Central and State Governments, NGO's, citizens' group, retired persons' associations, and experts in the fields of law, social welfare and medicine.

Central Sector Scheme of Integrated Programme for Older Persons (IPOP)

An integrated Programme for Older Persons (IPOP) is being implemented since 1992 with the objective of improving the quality of life of senior citizens by providing basic amenities like food, shelter, medical care and entertainment opportunities and by encouraging productive and active ageing. Under this scheme

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financial assistance up to 90 percent of the project cost is provided to Non-Governmental Organizations for running and maintenance of old age homes, day care centers and mobile medicine units. The scheme has been made flexible so as to meet the diverse needs of the older persons including reinforcement and strengthening of the family, awareness generation on issues pertaining to older persons, popularisation of the concept of lifelong preparation for old age etc.

Several innovative projects have also been added which are as follows:

- Maintenance of respite care homes and continuous carre homes.
- Sensitizing programmes for children particularly in schools and colleges.
- Regional resource and training centers for caregivers of elderly persons.
- Volunteer Bureau for elderly persons
- Formation of associations for elderly.
- Helplines and counselling centers for older persons.
- Awareness Generation Programmes for elderly people and caregivers.
- Running of day care centers for patients of Alzheimer's Disease/Dementia, and physiotherapy clinics for elderly people.
- Providing disability and hearing aids for the elderly people. The eligibility criteria for beneficiaries of some important projects

Supported under IPOP Scheme are:

- Old age homes – for destitute elderly persons.
- Respite care homes and continuous care homes – for elderly persons who are seriously ill and require continuous nursing care and respite
- Mobile Medicare units – for older persons living in slums, rural and inaccessible areas where proper health facilities are not available. The scheme has been revised in April, 2008. Besides an increase in amount of financial assistance for existing projects,

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- Governments/Panchayati Raj institutions/local bodies have been made eligible for getting financial assistance.

Inter-Ministerial Committee on Older Persons

An Inter-Ministerial Committee on Older Persons comprising twenty-two Ministries/Departments, and headed by the secretary, Ministry of Social Justice and Empowerment is another coordination mechanism in implementation of the NPOP. Action Plan on ageing issues for implementation by various Ministries/Departments concerned is considered from time to time by the committee.

National Old Age Pension (NOAP) Scheme

Under NOAP Scheme, in 1994 Central Assistance was available. The amount of old age pension varies in the different States as per their share to this scheme. It is implemented in the State and Union Territories through Panchayats and Minicipalities.

The assistance was available on fulfillment of the following criteria:-

- 65 years or more should be the age of the applicant (male or female)
- The applicants who have no regular means of subsistence from their own source of income or through financial support from family members or others. The Ministry is now implementing the Indira Gandhi National Old Age Pension Scheme (IGNOAPS). Under this scheme Central assistance in form of Pension is given to persons, above 65 years @ Rs. 200/- per month, belonging to a below poverty line family. This pension amount is meant to be supplemented by at least same contribution by the States so that each applicant gets at least Rs. 400/- per month as pension. The number of beneficiaries receiving central assistance, in the form of pension, was 171 lakh as on 31st March, 2011.

Further the Ministry has lowered the age limit from the existing 65 years to 60 years and the pension amount for elderly of 80 years and above has also been increased from Rs. 200/- to Rs. 500/- per month with effect from 01.04.2011. This decision of the Government of India has been issued to all States/UTs vide letter no. J- 11015/1/2011-NSAP dated 30th June, 2011.

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National Programme for Health Care of Elderly (NPHCE)

National Programme for Health Care of Elderly (NPHCE) is an articulation of the international and national commitments of the government as envisaged under (UNCRPD), National Policy on older Persons (NPOP) adopted by the Government of India in 1999 and Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisional for medical care of senior citizen. Ministry of Health and Family Welfare (MOHFW) has taken appropriate steps in this regard by launching the National Programme for Health Care of Elderly (NPHCE) as a centrally sponsored scheme under the new initiatives in the XI five years plan. Presently, it is being rolled out in 100 districts.

The vision of the NPHCE is:

- To provide accessible, affordable and high quality long-terms comprehensive and dedicated care services to an Ageing population.
- Creating a new "architecture" for Ageing.
- To build a frame-work to create an enabling environment for "a society for all ages".
- To promote the concept of Active and Healthy Ageing.
- Convergence with National Rural Health Mission, AYUSH and other line departments like Ministry of Social Justice and Empowerment.

Specific Objectives of NPCHE are:

- To identify the health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support.
- To provide an easy access to promotional, preventive, curative and rehabilitative services to the elderly through community based primary health care approach.
- To build capacity of the medical and paramedical professional as well as the care-takers within the family for providing health care to the elderly.

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- To provide referral services to the elderly patients through district hospitals, regional medical institutions. Core Strategies to achieve the objective of the Programme
- Community based Primary Health Care approach including domiciliary visits by trained health care workers.
- Dedicated services at PHC/CHC level including provision of machinery, equipment, training, additional human resources
- (CHC), IEC etc.
- Dedicated facilities at District Hospital with 10 bedded wards, additional human resources, machinery, and equipment,
- consumable and drugs, training and IEC.
- Strengthening of 8 Regional Medical Institutes to provide dedicated tertiary level medical facilities for the elderly, introducing PG courses in Geriatric Medicine, and in-service training of health personnel at all levels.
- Information, Education and Communication (IEC) using mass media, folk media and other communication channels to reach out to the target community.
- Continuous monitoring and independent evaluation of the programme and research in Geriatrics and implementation of NPHCE.
- Promotion of public and private partnerships in Geriatric Health Care.
- Mainstreaming AYUSH – revitalizing local health traditions, and convergence with programmes of Ministry of Social Justice and Empowerment in the field of geriatrics.
- Reorienting medical education to support geriatric issues.

National Policy on Senior Citizens 2011

- The foundation of National Policy for Senior Citizens 2011 is based on several factors – demographic explosion among the elderly, the changing economy and social milieu, advancement in medical research, science and

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technology and high levels of destitution among the elderly rural poor. In principle the policy values an age integrated society.

- It believes in the development of a formal and informal social support system, so that the capacity of the family to take care of senior citizens is strengthened and they continue to live in the family. All those of 60 yearsand above are senior citizens. This policy advocates issues related to senior citizens living in urban and rural areas, special needs of the 'oldest old' and older women.

- It will endeavour to strengthen integration between generations, facilitate interaction between the old and the young as well as strengthen bonds between different age groups.

- It believes in the development of a formal and informal social support system, so that the capacity to the family to take care of senior citizens is strengthened and they continue to live in the family. The policy seeks to reach out in particular to the bulk of senior citizens living in rural areas who are dependent on family bonds and intergenerational understanding and support.

The focus of the new policy:

- Promote the concept of 'Ageing in Place' or ageing in own home, housing, income security and homecare services, old age pension and access to healthcare insurance schemes and other programmes and services to facilitate and sustain dignity in old age. The thrust of the policy would be preventive rather than cure.

- Mainstream senior citizens, especially older women, and bring their concerns into the national development debate with priority to implement mechanisms already set by governments and supported by civil society and senior citizens' associations. Support promotion and establishment of senior citizens' association, especially amongst women.

- The policy will consider institutional care as the last resort. It recognizes that care of senior citizens institutional care as the last resort. It recognises that care of senior citizens has to remain vested in the family which would partner the community, government and the private sector.

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- Long term savings instruments and credit activities will be promoted to reach both rural and urban areas. It will be necessary for the contributors to feel assured that the payments at the end of the stipulated period are attractive enough to take care of the likely erosion in purchasing power.
- Being a signatory to the Madrid Plan of Action and Barrier Free Framework it will work towards an inclusive, barrier-free and age friendly society.
- Recognise the senior citizens are a valuable resource for the country and create an environment that provides them with equal opportunities, protects their rights and enables their full participation in society.
- Towards achievement of this directive, the policy visualizes that the states will extend their support for senior citizens, living below the poverty line in urban and rural areas and ensures their social security, healthcare, shelter and welfare.
- It will protect them from abuse and exploitation so that the quality of their lives improves.
- Employment in income generating activities after superannuation will be encouraged.
- States will be advised to implement the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 and set up Tribunals so that elderly parents unable to maintain themselves are not abandoned and neglected.
- Support and assist organisations that provide counseling, career guidance and training services.
- States will set up homes with assisted living facilities for abandoned senior citizens in every district of the country and there will be adequate budgetary support.

SOME OTHER IMPORTANT ACTIVITIES

International Day of Older Persons

The International Day of Older Persons is celebrated every year on 1st October, 2009. On 01.10.2009, the Hon'ble Minister of Social Justice and

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Empowerment flagged off "Walkathon" at Rajpath, India Gate, to promote inter-generational bonding. More than 3000 senior citizens/elderly people from across Delhi, NGOs working in the field of elderly issues, and school children from different schools participated in this.

Role of Non-Governmental and voluntary organisations:

While the government continues its efforts to introduce programmes for the welfare of the elderly, it is the non-governmental organisations which have played a key role in bringing to the forefront the problems of the older people to the society at large and through its various services it has sown the seeds for a forum whereby the voice and the concerns of the elderly can be addressed. Presently there are many non-governmental organisations working for the cause of the elderly in India. In India most of the non governmental organizations have concentrated their work among the lower income group and the disadvantaged sections of the society.

This is mainly because one- third of these people are defined as "capability poor" which means that they do not have access to minimum levels of health care and education for earning a decent living. However in the first few years of the growth of the NGO's the emphasis was on the abuse of women due to the gender discrimination prevalent in our Indian society.

It is only in the last few years when the demographers provided alarming statistics on the growth of the elderly population that a need was felt to work in this area as it was always assumed that the elderly were well taken care of and were safe in the custody of the well integrated joint family system in India. Initial studies show that the elderly are taken care of by the family but the reality and recent ethnographic cases studies also prove that the so called "joint family system" in India is a myth and the elderly though they live with their sons and their families are neglected and uncared for by them. This scenario led to the emergence and mushrooming of various NGO's working towards the concerns of the elderly.

In recent years several national level and state level voluntary organisations have been set up for promoting the welfare of the elderly, for advocating a general national priority to their problems and needs and for organising services. The Government describes the services they are providing as residential care, day care,

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geriatric care, medical and psychiatric care, recreation, financial assistance and counselling. These services are however primarily urban based. One of the premier voluntary organisation which began work on the cause and care of the older people of our country is Help Age India. It is a secular, a political, non profit, non governmental organisation and is registered under the Societies' Registration Act, 1960, in 1978.

Help Age India was formed in 1978 with the active help from Mr. Cecil Jackson Cole, founder member of help the Aged, United Kingdom. In its newsletters and brochures one can clearly see it has charted out its goals and objectives which are "To create an awareness and understanding of the changing situation and the needs of the elderly in India and to promote the cause of the elderly.

To raise the funds for creation of infrastructure through the medium of voluntary social service organisations for providing a range of facilities especially designed to benefit the elderly and thus to improve the quality of their lives." Help Age India is basically a funding organisation which looks for partner agencies in the field that are able to implement the various projects and programmes of the organisation. The head office of Help Age India is located in New Delhi and it has around twenty-four regional and area offices located all over the country.

Old Age Homes and Day Care Centres:

Help Age India has sponsored the construction and maintenance of old age homes in India. These homes cater to the needs of those elderly who are unable to live by themselves and for those who have been abandoned by the family or are neglected and uncapped for by their children.

These old age homes provide and cater to the various needs of the elderly so that they can spend the "evenings of their lives" with dignity and respect and not feel a burden to the society. There are over 800 old age homes all over India and nearly half of them are being sponsored and funded by Help Age India.

Besides old age homes, Help Age India also supports day care centres where the elderly come for a few hours every day or on certain days of the week and spend some time together. These centres combat the loneliness they face and

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create a sense of "we feeling" among them. In some of the centres being supported by Help Age India in rural areas they are also places where the income generating activities are conducted.

SCHEMES OF OTHER MINISTRIES:

Ministry of Railways

The Ministry of Railways provided the following facilities to senior citizens (elderly).

- Separate ticket counters for the elderly people at various Passenger Reservation System Centres.
- Provision of Lower Berth Quota – provide in AC and Sleeper Classes. Provision of 30 percent discount in all Mails/Express.
- Provision of wheel chairs at stations for the disabled elderly passengers
- Railway grant 75 percent concession to Senior Citizens undergoing major heart/cancer operations from starting station to Hospital station for self and one companion.

Ministry of Health and Family Welfare:

Central Government Health Scheme provides pensioners of central government offices the facility to obtain medicines for chronic ailments up to three months at a stretch. Ministry of Health and Family Welfare provides the following facilities for the elderly people:

- Provision of separate queues for elderly people in governmental hospitals. Set up of two National Institutes on Ageing at Delhi and Chennai.
- Provision of Geriatric clinic in several government hospitals.

Ministry of Finance:

Some of the facilities for senior citizens provided by the Ministry of Finance are:

- Exemption from Income Tax for senior citizens of 60 years and above up to Rs. 2.50 lakh per annum.
- Exemption from Income Tax for senior citizens of 80 years and above up to Rs. 5.00 lakh per annum.

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For an individual who pays medical insurance premium for his/her parents or parents who are elderly or senior citizen, deduction of Rs. 20,000 under section 80D is allowed.

An individual is eligible for a deduction of the amount spent or Rs. 60,000, whichever is less for medical treatment of a dependent elderly or senior citizen.

(i) Department of Pensions has set up a Pension Portal to enable senior citizens or elderly to get information regarding the status of their application, the amount of pension, documents required etc. The Portal also provides for lodging of grievances. The recommendation of the Sixth Pay Commission on provision additional pension to older persons is given below:

Age Group Percentage Pension to be added

80 + 20
85 + 30
90 + 40
95 + 50
100 + 100

Insurance Regulatory Development Authority (IRDA):

Insurance Regulatory Development Authority (IRDA) vide letter dated 25.05.2009 issued some instructions on health insurance f**or elderly or senior citizens to CEOs of all General Health Insurance Companies which inter- alia includes:**

Allowing entry into health insurance scheme till 65 years of age Provision of transparency in the premium charged.

Reasons to be recorded for denial of any proposals on all health insurance products catering to the needs of senior citizens.

Ministry of Civil Aviation:

Under the Ministry of Civil Aviation, the National Carrier, Air India provides concession in air fare up to 50 percent for male passengers aged 65 years and above and female passengers aged 63 years and above on production of proof of age and nationality on the date of commencement of journey.

Ministry of Road Transport:

The Ministry of Road Transport and Highways has provided reservation of two seats for elderly or senior citizens in front row of the buses of the State Road

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Transport Undertakings. Some States Governments are providing fare concession to senior citizens in the State Road Transport Undertaking buses for e.g. in Punjab Elderly women above 60 years enjoy free travel, Free passes are provided to old people who are freedom fighters to travel in fast and express buses in Kerala. Some State Governments also introducing the Bus models according to the convenience of the elderly.

Miscellaneous:

- Mumbai Police (1090), Dignity Foundation and many other organizations have given help lines for senior citizens.
- MTNL gives 25 percent concession in rent of land line telephone.
- Postal Savings Schemes – Senior Citizens Saving Scheme (9 percent interest to elderly, 10,000 to 15 Lakhs), Monthly Income Scheme (Return of 8 percent and a bonus of 10 percent on maturity) Large number of association of senior citizens have come up in all areas, giving opportunities to express and share one's views, get knowledge about various facilities available, get entertainment, group support etc.

Insurance schemes:

Several types of insurance schemes for the benefit of elderly people were introduced time to time by several government and private insurance companies which are – Jeevan Dhara, Jeevan Akshay, Jeevan Suraksha, Bima Nivesh, Senior Citizen Unit Plan and several other medical insurance schemes like Group Medical Insurance Scheme, Jan Arogya etc. The schemes Jeevan Dhara, Jeevan Akshay, Jeevan Suraksha and Bima Nivesh have been discontinued and relaunched in the new version as New Jeevan Dhara, New Jeevan Akshay, New Jeevan Suraksha and New Bima Nivesh respectively.

Senior Citizens Unit Plan (SCUP) –

Senior Citizens Unit Plan is a Scheme under which one has to make a one time investment depending on his/her age and have the benefit of medical treatment for self and spouse at any of the selected hospitals on completion of 58 years of age.

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SCUP have special arrangements with New India Assurance Co. Ltd. (NIAC) under an exclusive medical insurance cover where by the bills from the hospitals in connection with all medical treatment by you will be settled directly by NIAC up to the prescribed limit.

Age group of 18-54 years can join this Scheme. The person may be a resident or a non-resident Indian. The person will be entitled for a medical insurance cover of Rs 2.5 lakh after he/she attains the age of 58 years. This insurance cover is available for both the citizen and his/her spouse. After the age of 61 years both of them are eligible for a cover of Rs 5 lakh after adjusting any claims made earlier.

The citizen can avail medical treatment in any of the hospitals under this Scheme. The Trust will call for all details about recent photograph, signature and address of the member and the spouse as soon as the member attains the age of 54 years so as to prepare an identity card cum log book, for the member and the spouse.

Medical Insurance Scheme –

The Medical Insurance Scheme known as Mediclaim is available to persons between the age of 5 years and 75 years. Earlier, the sum insured varies from Rs 15,000 to Rs 300,000 and premium varies from Rs 175 to Rs 5,770 per person per annum depending upon the different slabsof sum insured and different age groups. However, with effect from 1 November 1999, these limits of benefits and the premium rates have since been revised. The sum insured now varies from Rs 15,000 to Rs 500,000 and premium varies from Rs 201 to Rs 16,185 per person per annum depending upon different slabs of sum insured and different age groups. The policy is now available to persons between the age of 5 years and 80 years. The cover provides for reimbursement of medical expenses incurred by an individual towards hospitalisation/ domiciliary, hospitalisation for any illness, injury or disease contracted or sustained during the period of insurance.

Group Medical Insurance Scheme –

The Group Medi-claim policy is available to any group/ association/ institution/ corporate body of more than 100 persons provided it has a central administration point. The policy covers reimbursement of hospitalisation and/or domicillary hospitalisation expenses only for illness/diseases contracted or injury sustained by the insured person. The basic policy under this scheme is Mediclaim

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only. This policy is also available to persons between the age of 5 years and 80 years. The sum insured varies from Rs 15,000 to Rs 500,000 and premium varies depending upon the different slabs of sum insured and different age groups.

Jan Arogya –

This scheme is primarily meant for the larger segment of the population who cannot afford the high cost of medical treatment. The limit of cover per person is Rs 5,000 per annum. The cover provides for reimbursement of medical expenses incurred by an individual towards hospitalisation/ domiciliary hospitalisation for any illness, injury or disease contracted or sustained during the period of insurance.

National Old Age Pension Scheme Principal Areas of Intervention and Action Strategies

- Old age pension scheme would cover all senior citizens living below the poverty line.
- Rate of monthly pension would be raised to Rs.1000 per month per person and revised at intervals to prevent its deflation due to higher cost of purchasing.
- The "oldest old? would be covered under Indira Gandhi National Old Age Pension Scheme (IGNOAPS). They would be provided additional pension in case of disability, loss of adult children and concomitant responsibility for grandchildren and women. This would be reviewed every five years.

Public Distribution System

The public distribution system would reach out to cover all senior citizens living below the poverty line.

Income Tax

- Taxation policies would reflect sensitivity to the financial problems of senior citizens which accelerate due to very high costs of medical and nursing care, transportation and support services needed at homes.

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Microfinance

- Loans at reasonable rates of Interest would be offered to senior citizens to start small businesses. Microfinance for senior citizens would be supported through suitable guidelines issued by the Reserve Bank of India

Health care

With advancing age, senior citizens have to cope with health and associated problems some of which may be chronic, of a multiple nature, require constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, especially when accompanied by impaired functional capacity require long term management of illness and nursing care.

Healthcare needs of senior citizens will be given high priority. The goal would be good, affordable health service, heavily subsidized for the poor and a graded system of user charges for others. It would have a judicious mix of public health services, health insurance, health services provided by not – for - profit organizations including trusts and charities, and private medical care. While the first of these will need to be promoted by the State, the third category given some assistance, concessions and relief and the fourth encouraged and subjected to some degree of regulation, preferably by an association of providers of private care.

The basic structure of public healthcare would be through primary healthcare. It would be strengthened and oriented to meet the health needs of senior citizens. Preventive, curative, restorative and rehabilitative services will be expanded and strengthened and geriatric care facilities provided at secondary and tertiary levels. This will imply much larger public sector outlays, proper distribution of services in rural and urban areas, and much better health administration and delivery systems. Geriatric services for all age groups above 60 ---preventive, curative, rehabilitative health care will be provided. The policy will strive to create a tiered national level geriatric healthcare with focus on outpatient day care, palliative care, rehabilitation care and respite care.

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Twice in a year the PHC nurse or the ASHA will conduct a special screening of the 80+ population of villages and urban areas and public/ private partnerships will be worked out for geriatric and palliative health care in rural areas recognizing the increase of non – communicable diseases (NCD) in the country.

Efforts would be made to strengthen the family system so that it continues to play the role of primary care giver in old age. This would be done by sensitizing younger generations and by providing tax incentives for those taking care of the older members.

Development of health insurance will be given priority to cater to the needs of different income segments of the population with provision for varying contributions and benefits. Packages catering to the lower income groups will be entitled to state subsidy. Concessions and relief will be given to health insurance to enlarge the coverage base and make it affordable.

Universal application of health insurance – RSBY (Rashtriya Swasthya Bima Yojana) will be promoted in all districts and senior citizens will be included in the coverage. Specific policies will be worked out for healthcare insurance of senior citizens.

1. From an early age citizens will be encouraged to contribute to a government created healthcare fund that will help in meeting the increased expenses on health care after retirement. It will also pay for the health insurance premium in higher socio economic segments.

2. Special programmes will be developed to increase awareness on mental health and for early detection and care of those with Dementia and Alzheimer‟s disease.

3. Restoration of vision and eyesight of senior citizens will be an integral part of the National Programme for Control of Blindness (NPCB).

4. Use of science and technology such as web based services and devices for the wellbeing and safety of Senior citizens will be encouraged and expanded to under - serviced areas.

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5. National and regional institutes of ageing will be set up to promote geriatric health care. Adequate budgetary support will be provided to these institutes and a cadre of geriatric health care specialists created including professionally trained caregivers to provide care to the elderly at affordable prices.

6. The current National Programme for Health Care of the Elderly (NPHCE) being implemented in would be expanded immediately and, in partnership with civil society organizations, scaled up to all districts of the country.

7. Public private partnership models will be developed wherever possible to implement health care of the elderly.

8. Services of mobile health clinics would be made available through PHCs or a subsidy would be granted to NGOs who offer such services.

9. Health Insurance cover would be provided to all senior citizens through public funded schemes, especially those over 80 years who do not pay income tax.

10. Recognize gender based attitudes towards health and develop programmes for regular health checkups especially for older women who tend to neglect their problems.

Safety and Security

Provision would be made for stringent punishment for abuse of the elderly.

- Abuse of the elderly and crimes against senior citizens especially widows and those living alone and disabled would be tackled by community awareness and policing.
- Police would be directed to keep a friendly vigil and monitor programmes which will include a comprehensive plan for security of senior citizens whether living alone or as couples. They would also promote mechanisms for interaction of the elderly with neighborhood associations and enrolment in special programmes in urban and rural areas.
- Protective services would be established and linked to help lines , legal aid and other measures.

Housing

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- Shelter is a basic human need. The stock of housing for different income segments will be increased. Ten percent of housing schemes for urban and rural lower income segments will be earmarked for senior citizens. This will include the Indira Awas Yojana and other schemes of the government.
- Age friendly, barrier - free access will be created in buses and bus stations, railways and railway stations, airports and bus transportation within the airports, banks, hospitals, parks, places of worship, cinema halls, shopping malls and other public places that senior citizens and the disabled frequent.
- Develop housing complexes for single older men and women, and for those with need for specialized care in cities, towns and rural areas.
- Promote age friendly facilities and standards of universal design by Bureau of Indian Standards.
- Since a multi - purpose centre is a necessity for social interaction of senior citizens, housing colonies would reserve sites for establishing such centres. Segregation of senior citizens in housing colonies would be discouraged and their integration into the community supported.
- Senior citizens will be given loans for purchase of houses as well as for major repairs, with easy repayment schedules

Productive Ageing

- The policy will promote measures to create avenues for continuity in employment and/or post retirement opportunities.
- Directorate of Employment would be created to enable seniors find re-employment.
- The age of retirement would be reviewed by the Ministry due to increasing longevity Welfare
- A welfare fund for senior citizens will be set up by the government and revenue generated through asocial security cess. The revenue generated from this would be allocated to the states in proportion to their share of senior citizens. States may also create similar funds.
- Non-institutional services by voluntary organizations will be promoted and assisted to strengthen the capacity of senior citizens and their families to deal with problems of the ageing.

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- All senior citizens, especially widows, single women and the oldest old would be eligible for all schemes of government. They would be provided universal identity under the Aadhar scheme on priority.
- Larger budgetary allocations would be earmarked to pay attention to the special needs of rural and urban senior citizens living below the poverty line.

Establishment of National Council for Senior Citizens

- A National Council for Senior Citizens, headed by the Minister for Social Justice and Empowerment will be constituted by the Ministry. With tenure of five years, the Council will monitor the implementation of the policy and advise the government on concerns of senior citizens. A similar body would be established in every state with the concerned minister heading the State Council for Senior Citizens.
- The Council would include representatives of relevant central ministries, the Planning Commission and ten states by rotation.
- Representatives of senior citizens associations from every state and Union Territory.
- Representatives of NGOs, academia, media and experts on ageing. The council would meet once in six months.

Responsibility for Implementation

- The Ministries of Home Affairs, Health & Family Welfare, Rural Development, Urban Development, Youth Affairs & Sports, Railways, Science & Technology, Statistics & Programme Implementation, Labour, Panchayat Raj and Departments of Elementary Education & Literacy, Secondary & Higher Education, Road Transport & Highways, Public Enterprises, Revenue, Women & Child Development, Information Technology and Personnel & Training will setup necessary mechanism for implementation of the policy. A five - year perspective Plan and annual plans setting targets and financial allocations will be prepared by each Ministry/ Department. The annual report of these Ministries/ Departments will indicate progress achieved during the year. This will enable monitoring by the designated authority.

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International Plan of Action on Ageing: report on implementation Report by the Secretariat

The United Nations Second World Assembly on Ageing (Madrid, 8-12 April 2002) unanimously adopted the Madrid Political Declaration and International Plan of Action on Ageing, 2002. WHO's contributions to the Assembly included the submission of a policy framework, and the formulation of regional action plans for implementing the International Plan, notably by the United Nations Economic Commission for Europe, the United Nations Economic and Social Commission for Asia and the Pacific, and the United Nations Economic Commission for Latin America and the Caribbean. Reports on the content of the policy framework and the outcomes of the Second World Assembly were submitted to the Fifty-fifth World Health Assembly.

- The present report summarizes WHO's contributions to the implementation of the International Plan of Action since 2002 and the results of disseminating the active ageing policy framework.

- WHO defines active ageing as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age". The policy framework takes into account the determinants of health throughout the life course, and has helped to shape ageing policies at national and regional levels and to direct academic research on ageing; it has also influenced the practical application of policies at community level. Policy-makers at various levels have adopted the framework's conceptual approaches. Basic indicators for monitoring the implementation of active ageing policies are now being formulated and should be ready in 2005.

- A series of international conferences on ageing, such as the International Federation on Ageing's Sixth and Seventh Global Conferences (Perth, Australia, 27-30 October 2002 and Singapore, 4-7 September 2004, respectively) and the forthcoming XVIII World Congress of Gerontology.

- (Rio de Janeiro, Brazil, 26-30 June 2005), have adopted the active ageing conceptual approach with its three pillars of health, participation and security in

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their respective agendas. WHO has taken an advisory role in international as well as in national research projects on active ageing, such as those sponsored by the European Commission.

FOCUS ON PRIMARY HEALTH CARE

1. Good health is imperative for older people to remain independent and continue to contribute to their families and communities. The Madrid International Plan of Action prioritizes access to primary health care and, accordingly, that has become WHO's focus in order to provide the regular, continuing contacts and care that older people need to prevent or delay the onset of chronic, often disabling diseases and to enable them to be vital resources to their families, societies and the economy. Consequently, WHO has launched a series of complementary projects focusing on the provision of integrated care that aims to be available, accessible, comprehensive, efficient, and responsive to both gender and age.

2. The objective of WHO's project to formulate an integrated response of health-care systems to rapid population ageing in developing countries is to create a knowledge base to support countries in reorienting policies towards integrated health and social care systems serving older populations. The first two phases (now completed) of the project, conducted in 12 developing countries (Botswana, Chile, China, Ghana, Jamaica, Republic of Korea, Lebanon, Peru, Sri Lanka, Suriname, Syrian Arab Republic and Thailand), consisted of quantitative and qualitative research on the care-seeking behaviours of older people at primary health-care level; the roles, needs and attitudes of their service providers; and the types of services provided. Governments, academic institutions, and nongovernmental organizations contributed to this interdisciplinary research project, which resulted in the sharing of information and models of good practice among the participating countries and a series of specific policy recommendations. The next phase, being implemented in collaboration with the WHO Centre for Health Development, Kobe, Japan, brings in six additional countries (Bolivia, India, Kenya, Malaysia, Pakistan, and Trinidad and Tobago) and focuses on older people who do not use primary health care. The project will lead to comprehensive policy recommendations on developing a continuum of care within the primary health-care sector aiming towards integrated old-age

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care. Thereafter, work will focus on step-wise implementation of the recommendations. The project was conceived as a model to stimulate exchanges of knowledge, experience and models of good practice between developing countries with rapidly ageing populations, and with the aim of building relevant research capabilities in developing countries.

3. In 2002, WHO initiated the related age-friendly primary health care project in order to sensitize and educate primary health-care workers and build capacity in primary health-care centres to provide for the specific needs of their older users. Despite the vital role of such centres in older people's health and well-being, there are many barriers to care that may result in older people not changing behaviours detrimental to health or becoming discouraged from seeking or continuing treatment. The project provides a set of age-friendly principles for primary health- care centres1 and training and information materials for primary health-care workers on how to overcome such barriers. Implementation of the principles will be piloted in at least four developing countries with the aid of a set of training and information materials, including a protocol for evaluating the impact of the project. Once finalized, that package will be made widely available in electronic and other formats to health and social care providers.

4. Recognizing the importance of relevant training for future health workers, WHO has partnered with the International Federation of Medical Students' Associations in a continuing effort to put ageing in the mainstream of medical curricula and to strengthen the teaching of geriatric medicine in 42 countries. The WHO Centre for Health Development, Kobe, is standardizing terminology and definitions for a glossary on community-based health care for older people. The first of several case studies on model practices in delivery of primary health care to ageing populations in mega-cities will focus on Shanghai, China. A research advisory meeting organized by the Centre outlined a proposal for exploring the effects or urbanization, environmental change and technological innovations on ageing populations.

5. In 2003 the World Health Survey collected information in 71 countries on population health status and health services coverage, including data on older age groups. This information should lead to a better understanding of

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the determinants of health and causes of morbidity at older ages. A longitudinal study on health and ageing, which builds on the Survey, is being conducted in six countries.

EMERGING ISSUES

1. The International Plan of Action on Ageing, 2002 identified two emerging areas requiring urgent action: older persons and HIV/AIDS; and abuse of older people. Worldwide, particularly in sub-Saharan Africa, older people (mostly women) absorb enormous additional burdens placed on the family by the HIV/AIDS pandemic. In response, WHO has developed a method to asses the needs of older carers through pilot research in Zimbabwe. The project is intended to be replicated in other countries in order to provide evidence-based data for interventions.

2. In work towards the prevention of abuse of older people, WHO is conducting research in collaboration with the University of Geneva on reliable tools to facilitate detection of such abuse at the primary health-care level. Following a large study in Canada that validated one such tool, WHO will pilot the application in four other countries. The project builds on a qualitative study jointly conducted by WHO, the International Network for the Prevention of Elder Abuse, and HelpAge International. That study's resulting publication on the views of older people on elder abuse has been widely disseminated.1 WHO was one of the parties to the Toronto Declaration on the Global Prevention of Elder Abuse launched at the Ontario Elder Abuse Conference (Ontario, Canada, 18-20 November 2002).

REGIONAL WORK

- Work at regional level is largely focused on how to provide community-based primary health care to growing numbers of older people. In September 2002, the 26th Pan American Sanitary Conference adopted resolution CSP26.R20 urging Member States to implement the International Plan of Action on Ageing, 2002 and to provide adequate support for implementation of priority areas, such as access to health care, essential drugs and vaccinations for older people.

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- The Regional Office for the Americas has developed a training manual for primary health-care providers on old-age care. It collaborated with six Member States (Chile, Costa Rica, El Salvador, Mexico, Panama and Uruguay) to implement training programmes for primary health- care professionals and is monitoring the improvement of quality of care. It collaborates with health system reform projects in Bolivia, Ecuador and El Salvador to ensure provision of health services to older persons. It has established a network of trainers in geriatric care. In the area of research, PAHO conducted a study on health, well-being and ageing in collaboration with ministries of health and universities in 10 countries.

- In 2003, the Regional Committee for the Eastern Mediterranean at its Fiftieth Session adopted resolution EM/RC50/R.10 on health care for the elderly, which emphasizes the need to establish and improve the integration and coordination of health, welfare and other sectors in order to develop comprehensive services and programmes. Eight countries have included healthy ageing in collaborative programmes with the Regional Office for the eastern Mediterranean during the current biennium. An in-depth study on the current state of community-based care for older people has been conducted in Bahrain, Egypt, Islamic Republic of Iran and Lebanon.

- The Regional Office for the Western Pacific works with five Member States in the Region (China, Mongolia, Philippines, Republic of Korea and Viet Nam) to support community-based programmes for older people. Its recent document on a health promotion approach to ageing and health for developing countries provides guidance to countries on how to improve health promotion, disease prevention and health services delivery for older people. Other publications with practical information on old-age care are being prepared.

- In the South-East Asia Region, the focus has been primarily on old-age care at the primary health-care level. The Regional Office prepared both a manual for primary health-care workers and a regional model for comprehensive community and home-based health care, which was pilot-tested in Bhutan, Myanmar, Nepal, Sri Lanka and Thailand. A recent document on health of the elderly in South-East Asia has been widely disseminated.

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- The African Union has adopted a regional implementation plan for the Madrid International Plan of Action on Ageing, 2002. While still assessing the implementation plan, the WHO Regional Office for Africa aims to promote health care for older people in addition to its continuing collaboration with HelpAge International in selected countries on supporting older carers of people living with HIV/AIDS and their children.

- The Regional Office for Europe continues its work on ageing within the Healthy Cities programme, of which healthy ageing is one of the three core themes. The Regional Office recently published two documents on how to provide better palliative care for older persons.

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM

The Madrid International Plan of Action on Ageing, 2002 and subsequent United Nations resolutions asked for a strengthening of the functions of the focal points on ageing throughout the United Nations system in order to put work on ageing at the heart of all United Nations system activities and to improve communications and intersectoral information on the implementation of the International Plan.

WHO designated a focal point on ageing for the Second World Assembly on ageing and its follow-up implementation activities.

UNFPA and WHO recently agreed to conduct a study on the factors that determine the health status of older women and their access to care as a joint contribution to the tenth anniversary of the adoption in 1995 of the Beijing Platform for Action.

The project will emphasize best practices worldwide and policy recommendations. Other collaborative activities within the United Nations system include the production of informational materials for the annual International Day of Older Persons.

Although the Millennium Development Goals do not specifically mention the roles and contributions of older persons to development, rapid population ageing has many far-reaching societal and economic implications.

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WHO consistently draws attention to the importance of a holistic lifecourse approach to ageing, including consideration of determinants of health and emphasis on a continuum of health and social care services that enable older people to remain healthy and productive within their families and communities.

Through the United Nations Focal Point on Ageing and other United Nations agencies, WHO seeks to ensure the integration of ageing issues into policies and programmes for attaining the Millennium Development Goals and to provide continued overall commitment on population ageing issues.

Principal Areas of Intervention and Action Strategies

Strategies to implement the national policy intent are described below.

Financial Security

Old age pension scheme

- It would cover all senior citizens living below the poverty line.
- Rate of monthly pension would be raised to Rs.1000 per month per person and revised at intervals to prevent its deflation due to higher cost of purchasing.
- The "oldest old" would be covered under Indira Gandhi National Old Age Pension Scheme (IGNOAPS). They would be provided additional pension in case of disability, loss of adult children and concomitant responsibility for grand children and women. This would be reviewed every five years.

- Public distribution system (PDS)
- The PDS would reach out to cover all senior citizens living below the poverty line. Income Tax
- Taxation policies would reflect sensitivity to the financial problems of senior ci tizens which accelerate due to very high costs of medical and nursing care, transportation and support services needed at homes.
- Microfinance
- Loans at reasonable rates of Interest would be offered to senior citizens to start small businesses. Microfinance for senior citizens would be supported through suitable guidelines issued by the Reserve Bank of India.
- Settlement of Retirement Benefits

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- Prompt settlement of all retirement benefits like pension, gratuity PF, etc. Widows will be given special consideration in the matter of settlement of benefits accruing to them on the demise of husband.
- Pension Schemes
- To facilitate the establishment of pension schemes in nongovernmental employment, with provision for employers also to contribute. Pension Funds will function under the watchful eye of a strong regulatory authority.

- To consider much higher annual rebate for medical treatment, whether domiciliary or hospital based, in cases where superannuated persons do not get medical coverage from their erstwhile employers.

Health Care and Nutrition

The 2011 national health policy recognizes that with advancing age, senior citizens have to cope with health and associated problems some of which may be chronic, of a multiple nature, require constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, especially when accompanied by impaired functional capacity require long term management of illness and nursing care.

Health care needs of older persons will be given high priority to ensure good affordable health services which will be very heavily subsidised for the poor and a graded system of user charges for others.

The primary health care system will be the basic structure of public health care. It will be strengthened by larger budgetary support to provide geriatric care facilities and curative, restorative and rehabilitative services at secondary and tertiary levels. Twice in a year the PHC nurse or the ASHA will conduct a special screening of the 80+ population of villages

Private organizations and not for profit organizations will be encouraged to provide health services, and health insurance services for the aged by offering grants, tax relief and land at subsidized rates to provide free beds, medicines and treatment to the very poor

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Public hospitals will be directed to ensure that elderly patients are not subjected to long waits and visits to different counters for medical tests and treatment. Geriatric wards will be set up.

Medical and paramedical personnel in primary, secondary and tertiary health care facilities will be given training and orientation in health care of the elderly. Facilities for specialization in geriatric medicine will be provided in the medical colleges. Training in nursing care will include geriatric care.

Difficulties in reaching a public health care facility will be addressed through mobile health services, special camps and ambulance services by charitable institutions and not for profit health care organizations.

Older persons and their families will be given access to educational material on nutritional needs in old age.

Mental health services will be expanded and strengthened. Families will be provided counseling facilities and information on the care and treatment of older persons having mental health problems.

National/State Commission for Senior Citizens

A National Commission for Senior Citizens at the centre and similar commissions at the state level will be constituted. The Commissions would be set up under an Act of the Parliament with powers of Civil Courts to deal with cases pertaining to violations of rights of senior citizens.

Establishment of National Council for Senior Citizens

A National Council for Senior Citizens, headed by the Minister for Social Justice and Empowerment will be constituted by the Ministry. With tenure of five years, the Council will monitor the implementation of the policy and advise the government on concerns of senior citizens. A similar body would be established in every state with the concerned minister heading the State Council for Senior Citizens.

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The Council would include representatives of relevant central ministries, the Planning Commission and ten states by rotation.

Representatives of senior citizens associations from every state and Union Territory.

Representatives of NGOs, academia, media and experts on ageing.

The council would meet once in six months.

National Association of Older Persons

An autonomous registered National Association of Older Persons (NAOPS) was sought to be established in 1999 policy but is absent in 2011 policy. The NAOPS is expected to mobilize senior citizens, articulate their interests, promote and undertake programmes and activities for their well being and to advise the Government on all matters relating to the Older Persons. The Associationwill have National, State and District level offices and will choose its own bearers.

The Government will provide financial support to establish the National and State level offices while the District level offices will be established by the Association from its own resources which may be raised through Membership, subscriptions, donations and other admissible means. The Government will also provide financial assistance to the National and State level offices to cover both recurring as well as nonrecurring administrative costs for a period of 15 years Responsibility for Implementation

The Ministries of Home Affairs, Health & Family Welfare, Rural Development, Urban Development, Youth Affairs & Sports, Railways, Science & Technology, Statistics & Programme Implementation, Labour, Panchayati Raj and Departments of Elementary Education & Literacy, Secondary & Higher Education, Road Transport & Highways, Public Enterprises, Revenue, Women & Child Development, Information Technology and Personnel & Training will setup necessary mechanism for implementation of the policy.

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A five-year perspective Plan and annual plans setting targets and financial allocations will be prepared by each Ministry/ Department. The annual report of these Ministries/ Departments will indicate progress achieved during the year. This will enable monitoring by the designated authority.

Role of Block Development Offices, Panchayat Raj Institutions and Tribal Councils/Gram Sabhas

- Block Development offices would appoint nodal officers to serve as a one point contact forsenior citizens to ease access to pensions and handle documentation and physical presencerequirements, especially by the elderly women.

- Panchayat Raj Institutions would be directed to implement the NPSC 2011 and address local issues and needs of the ageing population.

Gerontological social work practice.:

Gerontological social workers, also known as geriatric social workers, coordinate the care of older patients in a variety of settings, including hospitals, community health clinics, long-term and residential health care facilities, hospice settings, and outpatient/daytime health care centers.

As the need for geriatricians grows, so will the role of social workers in elderly care.

In outpatient settings, geriatric social workers are advocates for the older adults, ensuring they receive the mental, emotional, social and familial support they need, while also connecting them to resources in the community that may provide additional support.

In inpatient and residential care settings, they conduct intake assessments to determine patients' mental, emotional and social needs; collaborate with a team of physicians, nurses, psychologists, case managers and other health care staff to develop and regularly update patient treatment plans; discuss treatment plan options with patients and their families; and manage patient discharges.

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This guide features interviews with gerontological social workers. All interviewees were compensated to participate.

Role of Social Workers in Elderly Care

Those who work in geriatric social work help their clients manage psychological, emotional and social challenges by providing counseling and therapy, advising clients' families about how to best support aging loved ones, serving as the bridge of communication between clients and the rest of the care team, and ensuring that clients receive the services they need if or when they move between inpatient and outpatient treatment programs, in-home care, day treatment programs, and the like.

The role of social workers in elderly care leads to unique opportunities, which include making deep and meaningful connections with clients and their families, changing problematic systems at both the personal and community levels, and the knowledge that their work has a direct positive impact on those in need.

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