Old Age Mental Health in Uganda

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Abstract:

Uganda's life expectancy has tremendously improved and many of her citizens can live well past their 60th birthday, with 4.7 per cent of the population aged 60-plus. Despite the policy reforms within the ministry of health, it is obvious that much as the government is trying to do something about the plight of the elderly, at least judging from the setting up of a department of the elderly and the disabled in the Ministry of Gender, a lot still remains to be done. The social security benefits are not only very small, but most elderly people are too weak to perform productive work and are economically dependent on others like their children, grandchildren, relatives and neighbors for survival. Increasing numbers of the elderly even bear the burden of looking after their grandchildren with their meager resources due to death of the parents of the children, mostly from HIV/AIDS.

As people age, their healthcare needs generally increase, but there are inadequate systems in place to keep track of the health trend of older people, and the society is not yet coping with the provision of appropriate services. Failing health and rising expenses are a major source of worry and stress among the elderly. Yet something is amiss in all this. Older people are currently finding huge barriers to accessing healthcare and yet the elderly with mental health disorders have not been given the appropriate attention. Many elderly with mental illnesses may not even report for health care services.

Key words:

OLDER PEOPLE: People who have lived for 60 years and more.

ELDERLY: A group of people who have lived past 60 years of age.

MENTAL HEALTH: Anything related to psychiatric disorder, be it an individual with psychiatric problem, the care that a psychiatric person receives or any medical services offered to such a person.

GERONTOLOGY: The scientific study of aging, its effects and how the physical, social, emotional, and or psychiatric needs of those affected by aging can be squarely addressed.

Background

As per the 2002 Census, only 5% of Uganda's 24.2 million people were aged 60 years and above, while 50% were less than 15 years. This is compared to 4.1% during the 1991 Census. As is the situation worldwide, the elderly population in Uganda is therefore growing fast. At an annual rate of 7.4%, the ageing population in Uganda will double to 3 million in less than 10 years (Uganda Reach the Aged Association, 2009). The Uganda National House Hold Survey Report of 2009/2010 indicated that the population of older persons in Uganda was 1,304,464 of which 703,811 were females. The 2012/13 Uganda National Household Survey on the other hand, indicated a total of 1,580,261 older persons (UBOS 2014). In 2013, the Uganda Bureau of Statistics estimated that the total population of Uganda was at 34.5 million and the proportions of older persons have not changed much (UBOS 2014).

The Government of the Republic of Uganda comprehensively developed the National Policy for Older Persons in 2009 with guidance and support of many stakeholders, coordinated through the Ministry of Gender, Labor and Social Development (MGLSD, 2009). The Policy provides a framework for addressing, programming and legislation to identify opportunities and harness the potential of older persons. Subsequently, the National Minimum Health Care Package exists but pays little attention to the specific needs of the older people (WHO SAGE-Uganda, 2011).

The HIV/AIDS scourge had a major toll on the well being of the elderly in Uganda. Many of these older people have lost family to HIV/AIDS, meaning they can't rely on traditional family support as they get older and will often be required to look after grandchildren following the death of parents. Around half of Ugandan orphans are looked after by grandparents (Katie Chronicles, 2010).

There is scanty information about the mental health of the elderly in Uganda, mainly because the special medical problems of the elderly are not addressed by the health care system, yet most illnesses for the elderly are treated on non-psychiatric wards (Nakasujja Noeline et al, 2007) with possibility of missing or misdiagnosing the psychiatric elderly patients (Ruegg et al, 1988).

Culture and context of older persons

In traditional Ugandan society, older persons were revered and respected for their wisdom and experience (Uganda Reach the Aged Association, 2009). Their counsel was sought in times of crises and formed the final decision that could be made. Older people were also the vehicles through which traditional customs and values were passed from one generation to another. Social gatherings could not be held without the presence of older persons. However, those traditions have been largely discarded today, and there is evidence that Uganda's older persons do not enjoy the privileged position of which they once were assured (Barney Cohen and Jane Menken, 2006). Much as they play an important role in society, they are not acknowledged. The prevailing negative attitude towards the elderly leads to a lot of suffering for this group of people (Kabole, 2003), predisposing them to psychiatric illnesses.

Across the continent, millions of families would not survive without the contribution of older people – from caring for orphaned grandchildren and infected own children to providing much needed household income (HelpAge International, 2009). Older persons in Uganda contribute immensely to the creation of wealth, support and care for children including HIV/AIDS orphans, creation of social cohesion and conflict resolution in their communities and the nation as a whole (MOGLSD, 2009). They make valuable contributions to society as guardians of traditions and cultural values that are passed on from generation to generation (Cummings and Galambous, 2005). Today the African traditional forms of caring for older people are breaking down.

Like in most parts of Africa, Uganda is not exceptional to some forms of violence against older women which is based on cultural practices that specifically target widows who are regarded as insignificant without their husbands. While widows of all ages are subjected to mistreatment, older widows are particularly vulnerable because age lowers their status in the community and makes caring for them more difficult. Older women face double tragedy, in this regard, and are increasingly abused physically, socially, economically and psychologically by their families and/or communities. They are segregated and marginalized leading to loneliness, loss of self-esteem and economic deprivation (Golaz & Rutaremwa, 2011). Some older women are abused sexually and physically, aggravating the vulnerability to mental health concerns.

Socio-economic changes in the country have weakened family structure, denying older persons adequate care and provision. Family bonds have been weakened by the high cost of living, HIV/AIDS, and urbanization, which have led families to live far from villages where many older persons live. Most people have little understanding of mental disorders and do not know that effective treatments and services are available. Like elsewhere in developing countries, most mentally ill patients, including the elderly, seek care from traditional healers (Kapur, 2007), and only end up at the health facilities as a last resort.

The impact of HIV/AIDS

The role of grandparents in the care of children has been emphasized (Cattell Maria, 1990 and Zimmer Zachary, 2005). In Uganda, it is estimated that 50 per cent of double orphans are cared for by older people. Yet older people are often excluded from development programmes and discriminated against by services such as health care. Despite this indispensable contribution, many older people in Africa continue to experience deepening poverty, discrimination, violence and abuse (HelpAge International, 2009), and are unable to access entitlements that are theirs by right.

Globally, older people are sexually active and at risk of HIV infection (Cooperman, 2007). In addition, older persons, especially in Africa have taken over the care of infected adults and orphaned grand children. The care role aggravates their poverty, while putting them at risk of infection from direct contact with sick relatives. AIDS claimed the lives of younger family members who older people would otherwise depend upon for support. With an estimated 1.7 million orphans, Uganda has the highest proportion of AIDS orphans in the whole world, most of whom have been caused by AIDS (Ntozi and Ahimisibwe, 2011).

Older people are also more likely to have co-morbidities, more likely to experience a rapid progression to AIDS and, consequently, to have lower survival rates. There is also increased risk of side effects of ART and elevated risk of psychiatric disorders (Llorente and Malphurs 2006). The Uganda AIDS Indicator Survey 2004 – 05 showed that HIV prevalence among older people is lower than in people under 5, but only slightly so (Uganda Ministry of Health and ORC Macro, 2006).

Socio economic profile

Studies have singled out the older population as prone to poverty. The older people perceive old age to be characterized by ill-health, dependency, low incomes and depreciated asset bases, changed body features and physiological state (Najjumba-Mulindwa, 2003). Najjumba further found that, the single, widowed, disabled, women and the elderly living alone are most prone to chronic poverty resulting from unemployment, chronic ill health, lack of skills, HIV/AIDS, lack of social security systems, low land productivity, political instability, low agricultural returns and functional inability due to old age, which predisposes them to mental stress and depression.

Many older people in Uganda live in rural areas, where there are fewer social services (Population Secretariat, 2013). They experience economic exclusion, and are often denied employment and access to insurance or credit schemes. Pensions are rare and mainly concern former civil servants. A common practice in Uganda, as in many African societies, when older persons living alone need help, is to entrust them to one of their grandchildren (Golaz and Rutaremwa, 2011). The child takes care of his or her grandparent while maintaining the link between the household of origin and that of the elderly person. But, conversely, an elderly person cannot refuse the custody of a child (Williams 2003), to the extent that some older people find themselves with several dependent children in their care. This role is sometimes imposed upon older adults (Seeley et al., 2009) but the presence of a child within the household often also provides a source of help for an elderly person (Ssengonzi, R. (2007). An older adult living with a child is relatively less vulnerable than a person living alone, because, in addition to the help that he or she brings, the child provides access to wider family support. However the child might be a socio-economic burden to the older person in need of care as children themselves require care.

The majority of older persons live in semi-permanent or makeshift structures, usually grass thatched with mud walls; the homeless ones move from place to place, sometimes occupying abandoned structures (Golaz and Rutaremwa, 2011). The dilapidated state of the houses they occupy puts them and their dependants under danger as they threaten to collapse

over them especially during the rains. The walls, floors and roofs are full of cracks, exposing them to cold and harmful animals and insects. Some of the diseases that the elderly suffer from are related to the poor conditions they live in. Lack of personal effects such as bedding and adequate clothing aggravates the health problem, including mental illnesses. Older persons depend on one meal a day; others survive on a meal for two or more days. Usually this is one type of food only (Kikafunda and Lukwago, 2005). Lack of a balanced diet leaves many emaciated and exposed to diseases that could be avoided. Malnutrition remains another health problem among older people, especially those living in rural areas. Research also revealed that lack of clean water is another crucial problem for older persons in Uganda (Uganda Reach the Aged Association, 2009). Older adults are forced to travel long distances to find clean water. Dependence on contaminated water puts their health at risk.

Access to health and related care

Similar to the scarcity of reliable population-based information about disease, disability and health risks in the older population, there is limited data about geriatric service provision and utilization in Uganda. There is not enough evidence but through many media reports, it is clear that transforming health care has not all been positive for poor and older citizens, and, in particular, has resulted in the marginalization of geriatric services in Uganda.

According to the 2013 World Population Ageing Report, the commonest problems among older people include visual impairment, cancer, hypertension, diabetes, osteoporosis, dementia and depression (United Nations, 2013). Older people are usually more susceptible to fatal forms of malaria owing to age-associated loss of immune function (Herrmann and Krause, 2004). Health care is however, inaccessible to older people due to high cost and long distances to medical services. With the country's patchy and complex healthcare system, many elderly people with multiple health needs shun health units, overwhelmed by the long waits and complex procedures. There is no doubt that there is limited information on the health and wellbeing of older persons (WHO SAGE, 2011). In Uganda in particular, older adults have lesser access to health facilities than others, and there are few adapted health facilities (Najjumba 2003). Failure

to tackle the old age vulnerability especially in terms of access to health services is lack of fulfillment of human rights.

Despite the above conditions, it is a distressing reality that the use of gerontology inpatient and outpatient health services in Uganda is far below par. Given such vulnerability to many diseases and health conditions, there are numerous factors accounting for this apparent state of apathy towards the unmet health as well as mental health needs of the elderly. There are some obvious health and social care policy gaps at the macro level. "The government's historical priorities have been maternal and child health and this may not be easy to change quickly or easily in terms of policies targeted at older people. Additionally, there is a mentality that older people are less productive than young people and therefore, less deserving of healthcare. This surely, has exacerbated the effects of ageing in a country that already has a weak and under-developed health system.

Mental health care and the elderly

Poor mental health can engender poor physical health and vice versa (Peters S 2003). The Ugandan government recognizes mental health as a serious public health and development concern, and has, of recent, implemented a number of reforms aimed at strengthening the country's mental health system (Fred Kigozi et al, 2010). Some hope generally exists for better mental health programmes.

The devolution of mental health was stimulated in 1996, when WHO encouraged the Ministry of Health to strengthen mental health services and integrate them into primary health care (Kigozi, 2007). Standards and guidelines were developed for the care of children and adults with epilepsy and other mental disorders from community level to tertiary institutions. Health workers were trained to recognize and manage or refer common mental and neurological disorders. A new referral system was established along with a supervisory support network. Linkages were set up with other programmes such as for those with HIV/AIDS, health education for adolescents.

In order to improve service utilization and uptake, efforts were made to raise awareness of mental health in the general population. A draft Mental Health Policy was developed in 2000

(Kigozi et al 2010). The Mental Health Act was revised and integrated into a Health Services Bill (Chris Kiwawulo, 2010). Since then, mental and neurological drugs have been included in the essential drugs list. At the same time, the ministry also equipped mental health units at 13 regional referral hospitals countrywide to help treat patients, a move that aimed at reducing the capacity of the 900-bed national psychiatric hospital in Butabika by at least half. According to the second Health Sector Strategic Plan, 2005, mental health is now included as one of twelve components of the National Minimum Health Care Package to be provided at all levels of care (MOH, 2005).

Despite the reforms and subsequent improvement of mental health services, Uganda's mental health system still faces a number of shortcomings. Butabika hospital remains the only national referral mental hospital (MOH 2010). There is a general lack of trained human resources and a scarcity of funding, with no special provisions for mental health funding (Flisher AJ et al 2009 and Ndyanabangi 2004). According to the 2006 WHO-AIMS assessment report, only one percent (1%) of health care expenditures by the Uganda government's ministry of health was specifically directed towards mental health in primary care. However, as part of the integrated health service delivery, other aspects of mental health are funded within the general health budget as well. The support from donors, including from African Development Bank (ADB), raised the financial base to approximately 4% (Fred Kigozi et al, 2010).

In 2011, Uganda had only 28 psychiatrists for a population of 33 million people and the upcountry mental health units had very low numbers of medics in the field of psychiatry, making them as good as useless. Most mental health service provision is mainly done by clinical officers and nurses due to the inadequacy of mental health specialists. In addition, most medical students rarely opt for psychiatry because it is less lucrative. Not even scholarships can lure students to pursue psychiatry at post graduate level (Kiwawulo, 2010).

The WHO SAGE report 2011 revealed that many older people are lonely and feel depressed, calling for a need for service providers to add the component of psychosocial support as they deliver services to them but in Uganda, many mentally ill elderly patients end up on non-psychiatric wards owing to somatisation of their illnesses (Noeline Nakasujja et al, 2007) and for some, a psychiatric diagnosis may be missed or misdiagnosed (Ruegg et al., 1988).

Mental health problems are increasing, with depression at 12-68%, anxiety disorders at 20-62% and alcohol dependency at 14% in the general population (MOH, 2007). According to one of the Consultant Psychiatrists at Butabika National referral hospital, depression and dementia are the most commonly diagnosed conditions among the elderly in Uganda. Data from supervision reports shows that about 75% of attendances at Mental Health Clinics have some form of neurological problem commonly epilepsy, with cases of dementia on the increase especially among persons living with HIV/AIDS.

In the attempt to assess prevalence of depression among HIV patients in the WHO SAGE study, 22 people (4.3%) were diagnosed with depression, the majority (28%) of whom were women, compared to only 16% men. In the same vein, 48% of elderly in-patients in the study of psychiatric disorders (Nakasujja et al., 2007) were diagnosed with a psychiatric illness. Some of the predisposing factors to the mental illnesses include; divorce/separation, low education levels, dependants within the household and with no children offering support. Previous studies reflected similar profile of the elderly (Mugisha, 1985; Uganda MOFPED 1995a and 1995b). Post Traumatic Stress Disorder (PTSD) as a result of events that cause horror is the most common mental illness among people in Northern Uganda. This condition emerged in Uganda as a result of the 1987 to 2008 protracted Lord's Resistance Army war in which thousands of people were brutally killed (Kiwawulo 2010).

Fortunately, the Consultant psychiatrist reported that mental illnesses are often treatable, although somewhat expensively. A patient with mental health problems is handled by many experts including doctors, conselors and psychologists, making the cost very high.

The policy environment

The Government of the Republic of Uganda has realized the increasing population of older persons and is committed to addressing their concerns (Kigozi 2010). It recognizes that as people reach old age, they should continue enjoying dignified lives through active participation in economic, social, cultural, and political spheres as stipulated in the National Policy for Older Persons (MOGLSD 2009). The government therefore, is determined to enhance the recognition

of the contributions of older persons and to eliminate all forms of neglect, abuse and violence against older persons.

The 1995 Constitution recognizes the value and rights of the elderly. Article 32 of the constitution stipulates that: "The State shall make reasonable provision for the welfare and maintenance of the aged".

Chapter 4 of Uganda's Constitution stipulates the rights and freedoms every Ugandan should enjoy, including the right to basics of life and a life of dignity. Article XIV of the Uganda's Constitution (1995): states: "All Ugandans enjoy rights and opportunities and access to education, health services, decent shelter, adequate clothing, food security and pension and retirement benefits."

Article 32 of the Constitution regarding affirmative action in favor of marginalized groups states that: "Not withstanding anything in the Constitution, the State shall take affirmative action in favor groups marginalized on the basis of sex, race, color, ethnic origin, tribe, creed, gender, age, or any other reason created by history, tradition or custom for the purpose of redressing imbalances which exist against them.''

The Government is also a signatory to UN Conventions and those of its organs. The ILO Convention 102 of June 2001 sets out the minimum standards of social security benefits for old age, invalidity, survivors, medical care, sickness, unemployment, employment injury, family and maternity benefits (International Labor Office, 2001). The Uganda-Human Rights Commission, a body established under Article 51 of the Constitution of Uganda, 1995 and the Uganda Human Rights Act No 4 1997, promote and protect human rights and investigates at its own initiative a violation of any human rights including the rights of older persons among other age groups (OHCHR, 2013).

The Ministry of Gender, Labour and Social Development, has a full-fledged Department in-charge of Disability and Elderly, with a Minister of State for Disability and Elderly Affairs. The Department is responsible for initiating policies, plans, laws and programs to protect and promote rights of older persons. For instance, there exists the rights-based National Policy for Older Persons (2009), the National Council for Older persons Act (2012) and the National Plan of Action for older persons 2012/2013-2016/2017, which are all in line with the Madrid International Plan of Action on Ageing.

Regarding health care, Uganda developed a National Minimum Health Care Package and promoted Public-Private partnerships to ensure that people receive appropriate health services; but these initiatives haven't paid the necessary attention to the specific health needs of older people (WHO SAGE, 2011). Mental health services in Uganda were decentralized in the 1960s and mental health units were built at regional referral hospitals. According to the World Health Organization (WHO) report on mental health policy and service provision 2010, the mental health units were manned by psychiatric clinical officers, and had low staff morale, chronic shortage of drugs and inadequate funds for community activities. Since the decentralization of mental health services, the government of Uganda improved pre-service and in-service training for mental health workers with rehabilitation and remodeling of the mental health infrastructure in the country (Sheila Ndyanabangi et al., 2004). But the burden of mental disorders in Uganda is high in a country that is poorly resourced.

Caregiving and the social support systems

Traditionally, the Ugandan social structure was organized around the family and community. The African extended family network knitted together a network of blood relations, in-laws and close friends (Mugayehwenkyi Kenneth, 2012). This network acted as insurance against all disabilities of old age and other shortcomings. The young and energetic were insurance for their older folks and took care of their needs. Sadly, several factors have interfered with the treasured network leaving the elderly vulnerable. While the traditional system has diminished, it has not been replaced by any other form of social security system that caters to the elderly. Many old people, especially women, still find great satisfaction in providing care and support within their households, either to fellow adults or to children/grandchildren despite the difficulties of caregiving. Alternatively, older people need to be cared for, but it is often difficult to obtain the care. The few lucky ones receive care from their daughters, sons or siblings in form of financial assistance to pay for health care, medicine, schooling, food and clothing (WHO, SAGE 2011). Grandchildren in some instances provide physical assistance such as fetching water, agricultural work, cooking and buying food. The burden of caregiving is manageable for the older people who receive the support they need from family, community and service

providers, but if the conditions are not met, as may often be the case, caregiving by the elderly, becomes a burden that endangers their wellbeing.

There are some registered organizations that have emerged to assist older persons in many ways because the elderly most times lack a voice and, as already discussed in different sections, are often marginalized. Most of these organizations are usually community-based organizations, which are uncoordinated and poorly funded. Consequently, the impact of their activities and programmes has gone largely unnoticed. Moreover, older persons have just been recently included in National and Local Government structures; thus, their needs and concerns have never been represented.

The Uganda Reach the Aged Association (URAA) was formed in 1991. The Association coordinates the activities of age care organisation in Uganda established to tackle the problems of older people and to lobby for the mainstreaming of their issues into development agenda in order to bring a lasting improvement in their lives. URAA advocates for the improved quality of life and preservation of the dignity of older persons in Uganda (Uganda Reach the Aged Association, 2010).

The Child and Elderly Support Organization (CESO), an initiative that transforms the lives of children and elderly people who live under horrible and hard life conditions, focuses on giving education to vulnerable children and developing their talents, as well as supporting elderly care (CESO, 2013). More support is provided to the elderly in their homes especially if there are some caretakers in the homes. A few older people are under the care of the organization, mainly those who don't have caretakers at home. CESO works to help the elderly socially, emotionally, and financially and many other ways possible so that they don't feel lonely, isolated or neglected.

Joy For Elderly Care – Uganda is a charitable nongovernmental organization that was founded in November 2006 to help the elderly and their children/ grandchildren live a more meaningful and decent life. Currently located on Kira Road, Kamwokya, Kampala District, the organization enables elderly persons to engage in small but productive businesses within their homes, such as markets, craft making, and small gardening to meet their financial needs and enable them to look after their grandchildren and any other vulnerable children within their care.

Uganda Rural Elderly Support (URES) is a non-governmental organization established in 2007 to assist the elderly in rural areas by enabling them to obtain skills and facilities for their livelihood (Uganda Rural Elderly Support). The needy rural elderly vary from those staying alone with no relative to those with orphans and grandchildren. URES assists the elderly in Uganda to seek health care from Health Centres. At the health centres, the sick are treated and given drugs while URES meets the medical costs, since the elderly cannot pay for their medical bills.

HelpAge has worked in Uganda since the early 1990s with its Affiliate the Uganda Reach the Aged Association (URAA) and other partners (HelpAge). The two organizations' focus is on empowering older people to demand their rights and entitlements including benefiting from the existing national poverty reduction programmes in Northern Uganda. HelpAge's projects try to influence more effective health services as well as ensuring older people are included in key national health and HIV and AIDS programmes.

Coping mechanisms for caretakers

Many people with mental illness must rely on family and friends for support and to help them in their daily activities (World Federation for Mental Health 2014). Whereas some patients with mental health problems may become aggressive, caretakers are advised to accept their condition and have a positive attitude towards them (Kiwawulo, 2010). The caretakers of mental health patients need regular counseling, lest they develop psychological problems too as was also revealed by the WFMH that caring for those with neurological disorders requires tireless effort, energy and empathy, and indisputably, greatly impacts the daily lives of caregivers (World Federation for Mental Health 2014). The caregivers must be educated on the fundamental aspects of mental health care, they should strive to make friends with the patients to avoid rejection, and, most importantly, to make it easier for the caregiver to look after them.

Caretaking of the elderly is fast becoming a complex issue, worse still for family members of mentally ill elderly patients. Some caregivers instead of understanding the mental illness feel that the illness of a family member is something of which to be ashamed (Nicholas 2007).

Recommendations for improving the situation

There is scant information on mental health for the elderly in Uganda. Only few mental health patients, including the elderly, seek health care from mental clinics, majority go to the general health care system, despite the increasing support to improve the mental health services in the country. The lack of basic and accurate information on the existing situation of mental health in Uganda reveals the need for epidemiological and other population based intervention studies to inform policy and service planning and development. For clear decisions to be made, basic information on the existing situation is necessary to raise the concerns on how to adequately meet the mental health needs of the country per age group, including the elderly. The situation analysis would also provide the basis on which monitoring and evaluation can be designed. For example, research would be phenomenal in determining the different aspects of human resources and training or medicines procurement and distribution.

In addition to having accurate information, proper use of research to inform policy development requires the development of skills to translate the research into policy directions and objectives. Putting in place information systems that collect accurate and timely data should be coupled with capacity development of programme managers, planners and policy makers to use the information in a way that facilitates the appropriate delivery of mental health information and services, as well as accessibly present sound evidence to inform directions for mental health resourcing. Existing policies and programmes of the government, donor community, civil society and private sector need to be reviewed to incorporate issues of older persons' mental health concerns.

There is need to undertake awareness raising campaigns to sensitise professionals and educate the general public on the needs and rights of older persons, including those with mental health disorders. Organizations working with and for older people need to have their capacity strengthened to create a strong voice for the rights of older people and to call for the implementation of the National Policy on older persons and the Mental Health Act in regard to the older people. The Government should put emphasis on lifelong health promotion and prevention of problems through integration of gerontology in the health delivery and education

structure. Gerontology can effectively address the above challenges by using multi-faceted health promotion strategies while advocating full access to sound healthcare for older persons. “Service integration will require a step-by step approach. First is to demystify the notion that ageing means frailty thus the inclusion of awareness programs about ageing as a process and its impact in later life in the social and healthcare programs. Other efforts gerontology emphasizes to increase uptake of health services by older persons include: Outreach efforts to locate and identify older persons who are depressed and provide care relevant to their needs and mobile programs with staffs that treat consumers in their own homes.

The government should invest and undertake more research on the health situation, opportunities and priorities for the elderly with mental health problems, since this is an area that lacks adequate information to make a strong case for the country.

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