Chapter 1

What Is the Psychiatry of Old Age and Why Do We Need It?

The psychiatry of old age (POA) is concerned with the identification, assessment, treatment and care of older adults with mental disorders, and of those who care for them. Mental illness in late life is as old as humanity, and there is a long history of social and medical interventions with affected individuals, some more enlightened than others. Traditionally, the care of older people has been centred in the family, and it is only when this source of support is absent or insufficient that the local community or the State has intervened. In mediaeval Europe, the legislation developed for this purpose had as much to do with the management of property as the welfare of the individual, but the records show that in the context of small and relatively cohesive communities, it could deliver sophisticated and effective care for insane and incompetent individuals, both rich and poor. The modern history of old age psychiatry in developed societies has its origins in the changing social demography of the nineteenth century, with the rapid urbanisation of populations and growth in the numbers of old people. With local community support no longer sustainable, the poor and the disabled (older people were often both) were particularly vulnerable. The responses to this welfare challenge were many and various, and included poor laws, pensions and institutional solutions such as workhouses, infirmaries and lunatic asylums. Within these institutions, often later re-labelled as 'hospitals', the frailties of old age were medicalised, and became the professional responsibility of physicians and psychiatrists. So far as mental illness was concerned, however, this was not a responsibility that was especially welcomed by anyone. Mental illnesses in older adults were believed to be degenerative or 'senile' and thus not amenable to treatment. There was particular therapeutic nihilism regarding people with dementia; they could not be discharged from acute medical beds, psychiatrists were not equipped to deal with the problem and no one had anything to offer beyond institutional warehousing in nursing homes or the chronic wards of the old asylums.

This professional pessimism and lack of interest began to be challenged in the second half of the twentieth century by small groups of innovators, particularly in the United Kingdom. The creation of 'geriatric medicine' within the National Health Service (NHS, established 1948), with its avowed interest in all of the physical and mental problems of older people, and its multi-professional approach to solving them, was an important model for the later development of old age psychiatry by pioneers such as Tom Arie and Tony Whitehead. An important factor influencing this change of attitude in service providers was research. In 1944, Martin (later Sir Martin) Roth in the United Kingdom established the modern nosology of what was originally thought to be a single degenerative illness, demonstrating that not all mental illness in old age has the same bad prognosis, and that mortality in individuals with affective and psychotic disorders was much less than in those with dementia. This optimism was encouraged by the successful application of both physical

and social treatments to older patients. A number of large epidemiological studies of mental disorders in community populations aged over 60 or 65 were carried out at this time in the United States, Scandinavia and the United Kingdom, which characterised the full range of these conditions (especially dementia, depression and schizophrenia-like disorders), and the extent to which those affected by them were out of touch with any services. These surveys showed that only a minority of the elderly population was mentally ill; an important message from the emerging science of gerontology was that physical and mental frailty was by no means the inevitable consequence of ageing, and that the compression of morbidity was a realistic and achievable goal.

Another important factor driving change in service provision for older people in high-income countries has been government health policy, developed in response to demographic ageing, the cost-effectiveness of treatment and care and rising expectations of people regarding the quality of that care. By the 1960s, it was widely accepted that the traditional custodial approach to the care of the mentally ill was no longer acceptable, and that the focus of services should move to the home and the community. However, the rate and extent of the development of community-based old age psychiatry services have differed substantially between countries: those with universal health and social care funding and centralised health policy and planning, such as the United Kingdom and Canada, have created much more comprehensive services than those without universal coverage. Active and vocal voluntary and other non-government organisations, such as the Alzheimer's Association (United States), Alzheimer's Society and Alzheimer's Scotland (United Kingdom), Dementia Australia and Alzheimer's Disease International (ADI), have been a valuable stimulus to service development, particularly for the support of carers. The development of services for older adults with mental illness, and the international consensus model of their organisation published by the World Psychiatric Association in 1997, are discussed in detail in Chapter 11.

The Future

Developed societies were the first to experience demographic ageing and the growth in the number of older people with mental illness, but the rest of the world is catching up fast. The World Health Organisation (WHO) estimated that in 2020 there were about 50 million people with dementia in the world, with 10 million new cases annually. The number of those affected by dementia is projected to increase to 152 million by 2050. Most people with dementia live in low- and middle-income countries.

Dementia is not the only disorder that will increase in prevalence with demographic ageing. Other conditions, such as vascular disease, arthritis and sensory impairments, will contribute to an increasing burden of chronic physical and mental disability in old age, as will emerging problems such as the global epidemic of obesity. Other factors will have an impact upon the future welfare and care of older people too. For example, in developed societies, the shifting dependency ratio of the population will require individuals to continue working beyond traditional retirement age, as they always have done in poorer countries. Increased geographic mobility, with children moving away from home and parents relocating on retirement, will reduce the availability of informal care, as will the continued growth in the number of single-person households. Changing cultural ideals, such as Confuscianism or collectivism with migration and increased 'Westernisation', also may contribute to the care of older and frail adults being left to the State, rather than the family. In the developing world, there will be the challenge of competing demands of young and old for healthcare, particularly

for conditions, such as Acquired Immune Deficiency Syndrome (AIDS), that disproportionately affect younger, economically active age groups. For some countries, rapid economic growth may help to some extent with the challenges of demographic ageing, but this will bring complications as well, such as the economic migration of younger people into cities and to more affluent countries. In many places, the stigma associated with mental disorder at all ages is a major obstacle to care provision. There are other, less predictable, eventualities that could have a major impact upon the capacity of all societies to respond to demographic ageing in the years to come, for example the COVID-19 pandemic, which has led to disproportionate mortality among the very old and frail and has caused major social and economic disruption, or climate change bringing about damage to infrastructure, large-scale population movements and potential resource wars. On a more positive note, there would be considerable economic and social benefits globally were we to achieve effective control of widespread endemic diseases such as malaria at last.

These projections and predictions have profound social and economic implications for both developed and developing societies around the world. Even the richest nations may struggle to maintain levels of health and social care at their current levels, and for much of the developing world the models of service infrastructure pioneered in the United Kingdom and other developed countries simply are not suitable or practical. In the likely absence of cheap and simple cures for disorders, such as dementia, other approaches will have to be found. This has led to a greater public health focus on primary prevention, particularly the prevention of cerebrovascular disease through effective control of vascular risk factors such as hypertension, diabetes and smoking. The quest to develop 'disease-modifying therapies' that may prevent or delay the progression of Alzheimer's disease (AD) continues, but such treatments may only be effective if used in the preclinical stages of the disease, before neuropathological damage has reached a critical point. There is also a body of evidence to indicate that the onset of clinical dementia may be delayed in individuals with a greater 'cognitive reserve', suggesting that improved nutrition and education in childhood and young adulthood may have a positive effect on the incidence of dementia in late life. Research continues on strategies to boost cognitive reserve; the 'use it or lose it' hypothesis is attractive, but the evidence is still evolving and the evidence from studies assessing the impact of exercise, social engagement and cognitive stimulation in late life report, at best, only small effect sizes for the benefit to cognition. So far as secondary prevention is concerned, there will be a need to develop new service models for societies that can afford only basic levels of healthcare. Inevitably, these will need to build upon what already exists, for example by developing and extending the role of those professionals, such as nurses, who currently visit families at home. The focus of their new role would be upon improved detection and increasing carer support, through information, training and development of local community solutions where possible. Public education will be critical to increase understanding of mental illness in late life, and to combat the associated stigma.

Further Reading

Articles

Livingston, G. *et al.* (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *Lancet*, 396, 413–446. doi: 10.1016/S0140-6736(20)30367-6.

Comprehensive review and summary of the literature, including evidence for prevention of dementia, compiled and revised in 2018–2019.

Wertheimer, J. (1997). Psychiatry of the elderly: a consensus statement. *International Journal of Geriatric Psychiatry*, 12, 432–435. doi: 10.1002/(sici)1099-1166(199704)12:4<432::aid-gps1576>3.0.co;2-s.

The principles outlined in this editorial remain highly relevant today.

Website

www.who.int/news-room/fact-sheets/detail/dementia Access 31st January 2021.

A source for up-to-date facts about the global prevalence, incidence and impact of dementia.

Book

Dening, T. and Thomas, A. (eds.). (2020). *Oxford Textbook of Old Age Psychiatry*, 3rd ed., Oxford: Oxford University Press.

Easily the best comprehensive multi-author textbook on the subspecialty.