Psychosocial Rehabilitation in Older Adults: Old Wine in a New Silver Bottle?

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Psychosocial rehabilitation has traditionally been thought to be important and relevant to adults of working age with chronic mental disorders. This is usually the group of patients with diagnoses of chronic schizophrenia or bipolar disorders with long term disabilities that cause day to day challenges in coping with a normal well-adjusted life involving good social and occupational functioning.

However, with life-expectancy increasing across most of the world and people choosing to retire earlier than before, rehabilitation is as important—if not more—in the older adult demographic. There are many mental disorders such as dementias and affective disorders that are common and prevalent in the older adult population. This burden is only set to increase in the next 30 years [2].

In addition, this group consists of the so-called ‘graduate’ patients who develop mental disorders as

younger adults but continue to be afflicted with symptoms and resultant disability beyond working age. I want to challenge some established notions and invite you to think about psychosocial rehabilitation in this age group from different perspectives.

Like mental disorders during adulthood, those in the elderly tend to be chronic—and although not necessarily life-limiting—cause significant impairment, disability and handicap. The World Health Organisation has defined rehabilitation as ‘a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment’. Put simply, rehabilitation helps a child, adult or older person to be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful life roles such as taking care of family [6]. This opens the door for providing innovative and smart interventions for this patient group with a view to enhancing the quality of their life and ‘making every day count’.

Patients with dementia, the vast majority of whom are over the age of 65, often tend to suffer in silence and do not necessarily have a voice speaking up for them. As we know, dementias do not have a cure at present and their diagnosis often engenders a degree of helplessness and hopelessness, not only in patients and their carers, but also in professionals working in health and social care. Decisions made by professionals tend to be coloured by this rather pessimistic outlook.

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However, the very concept of rehabilitation and recovery is based on making the best of an existing situation and working within the limitations imposed by the illness.

Older Adults and Rehabilitation in the UK

In the last two decades, UK Government policy has been giving increasing importance to mental health. Successive frameworks of care and NHS guidance have emphasised the importance of personalised care, recovery from a social and occupational perspective rather than just symptomatic relief and moving care away from hospitals into the community [1].

These changes have largely been driven by the need to ensure better integration and quality of life for such patients as well as the realisation that hospital-based care, particularly for long-term conditions including mental disorders, is much more expensive than care provided in the community. In the UK, we are lucky to have a well-established, separate speciality of old age psychiatry, with its own training requirements and service provision including consultant posts in old age psychiatry.

Comorbid conditions such as dementia and other functional mental disorders often become barriers to rehabilitation and affect the ‘rehab potential’ for such patients. It is therefore essential that recovery focuses not only on rehabilitation in the traditional sense but also on the treatment of coexisting mental disorders [3].

Over the last 20 years, mental health services in the UK have tended to move away from rehabilitation wards for patients with mental disorders, repurposing this resource to provide services closer to home in collaboration with voluntary organisations, charities, and other pre-existing community assets. Many of these assets are focused on improving health and well-being and hence, prevention of disorders in the first place in addition to providing rehabilitation for patients during their recovery journey.

No amount of healthcare can be a substitute for good quality, affordable and readily available social care. Loneliness, social isolation, and bereavement are part of the natural life-cycle in this group and measures to reduce these risk factors for developing mental illness are vital to combat mental ill health at the population level.

Self-Management in Dementia?

As part of the dementia care pathway in the UK, patients and carers are given a standard package of information, advice and support at the time of diagnosis. This includes Cognitive Stimulation Therapy and strategies to deal with ongoing memory problems. Although there is no cure or recovery in the true sense in dementia, every effort is made to ensure that patients continue to live well with dementia and have a good quality of life.

However, the concept of self-management in dementia is still in its infancy. Understandably, this is because the person with the disease becomes progressively less capable of managing their own illness and its damaging consequences. Such self-management has to involve carers and significant others in the patient’s life. When I tested promoting self-management in dementia based on a template of self-management in diabetes mellitus, the results were mixed. In line with expectations, the group of patients who were in the earlier stages of dementia, were well motivated and had a good family support network, did well with the information, support and advice that was provided as part of a self-management package [5].

The challenge with adapting the concept of rehabilitation to dementia is that the goal post is constantly changing. This makes it difficult for an inflexible package of care and support to work well. The people around the patient should be equipped with the tools to flex the support and the stimulation they provide to the person with dementia depending on the stage of the disease and any day-to-day fluctuations.

This is particularly so in Dementia with Lewy Bodies in which fluctuating cognitive function is a defining feature. These fluctuations can be part of the natural course of the illness or can be brought on by intercurrent infections or other physical disease. They change the person’s ability to cope with activities of daily living, their insight into the condition and their mental capacity to make decisions.

Although we are getting better at using technology in the care of patients with dementia, its full potential has not yet been exploited. Part of psychosocial rehabilitation of patients with dementia could include the use of assisted technology to deal with the behavioural and psychological symptoms of dementia which are often the most challenging aspects of a patient’s condition. Such symptoms frequently result

in carer stress, leading to multiple hospital admissions and ultimately, institutional care for the patient. Assisted technology has helped many patients stay at home for longer.

The needs of older people with functional mental disorders are similar to those of working age adults with similar conditions. However, there are complexities added on by ageing that need to be taken into account when planning care [4].

In conclusion, psychosocial rehabilitation and recovery for older adults should be as much a part of an overall package of care as it is for the younger age group. As more and more of us are living longer and looking forward to greater dignity and independence in our older years, policy and practice should undergo a paradigm shift by thinking about prevention, recovery, and rehabilitation in a way they have not done before. It will provide greater autonomy and choice for patients and their loved ones in planning for, and coming to terms with, some inevitable afflictions of old age.

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