Psychiatry of old age (POA) is a psychiatric subspecialty focusing on the mental health of older people. This subspecialty has been developing in the UK since the 1940s; and in Australia and New Zealand, since the 1970s and 1980s. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) section in POA was established in 1987. POA gained faculty status in 1999 and there are now more than 270 faculty members. Training in POA is mandatory in the RANZCP fellowship programme. For example, in their first three years of training, all psychiatry trainees are expected to have in-depth knowledge of specific POA disorders, including: dementia, very-late-onset schizophrenia-like psychoses, and the effects of ageing in people with early-onset and late-onset psychotic disorders. In addition, trainees can specialise in POA by completing a certificate of advanced training.

Like in other developed countries, the population of older people, in particular the oldest old group (85 years and over), is increasing rapidly in Australia and New Zealand. Mental health disorders in older people are associated with age-related biological, psychological, social and developmental factors. These factors include physical illnesses, cognitive decline, grief and loss, resilience, vulnerability, role changes, aged residential care and end-of-life care. Old age psychiatrists, who usually work in the setting of a multidisciplinary team that provides home-based treatment, skillfully take these factors into consideration in their assessment, formulation and management of mental health disorders in older people.

Draper reviewed the effectiveness of POA services and concluded that there is a level II evidence for community POA services, in terms of acute treatment outcomes, particularly with depression.2

One of the challenges facing the subspecialty of POA is consolidating where our specialist skills can best be deployed. This need has come about as a result of increasing awareness and recognition of late-life mental health disorders, the ageing population of people with adult-onset mental health disorders (which is often complicated by physical comorbidity), a change in the provision of aged residential care, increasing barriers to care for people with mental health disorders and resource constraints. Some of these factors have driven a change in service structure and provision in the UK. Despite the clear evidence that older people derive better outcomes from specialised services, ‘ageless’ mental health services have recently been created by some UK health providers.3 The threat of the development of ageless mental health services and potential disintegration of POA services has prompted our UK colleagues to clarify their criteria of POA services.4 Recently, the RANZCP Faculty of POA also decided to revise the core entry criteria for a POA service:

1. People with serious mental disorder, aged 65 or over, newly presenting to local mental health services or have not been under the care of other local mental health services for a regionally-specified amount of years.

2. People with serious mental disorder and significant aged-related physical illness or frailty that compounds or complicates the management of the mental disorder.

3. People with serious mental disorder and significant psychological or social difficulties related to the ageing process, where their needs may best be met by a service for older people.

4. People, of any age, with a primary dementia and serious behavioural and/or psychological symptoms and signs.

These criteria are intended to define our role in treating mental health disorders in older people and guide POA service development in Australia and New Zealand. They are not exclusive of some of the other specialist skills and knowledge that POA may have, such as the assessment...
and management of mild cognitive impairment and mild dementia in memory clinics, capacity assessments, elder abuse, etc.

Dementia is a neurodegenerative disorder and our geriatric medicine, neurology and increasingly palliative-care colleagues also have a share in the management of this disorder; however, old-age psychiatrists have a unique role in the assessment and management of dementia. General psychiatry training has equipped us with a broad working knowledge of the psychosocial and cultural aspects of mental health disorders. These skills and knowledge are particularly valuable for understanding the psychological suffering and family dynamics in people with dementia, and for providing person-centred treatment beyond the medical diagnosis. In this edition of *Australasian Psychiatry*, Looi, one of our faculty members, has provided an updated review of fronto-temporal dementia. In addition, there are several papers addressing the psychosocial aspects (e.g. driving and gambling) of dementia.

There have been concerns that POA services risk turning into a dementia-only service. For example, in New Zealand there is a government mandate establishing a dementia care pathway in each of the 20 district health boards. A significant amount of effort and resources have been devoted to establishing these pathways, which will streamline dementia service provision; however, it is important to remind ourselves that one of the reasons for establishing the subspecialty of POA was to better serve older people with mental health disorders within psychiatry and adult services. The two case reports on bipolar disorder and treatment-resistant depression in this edition of *Australasian Psychiatry* have prompted us not to lose sight of the core mental health disorders (i.e. schizophrenia, bipolar disorder and depression) in older people. Research and service development on these core mental health disorders in older people is lagging behind. For example, a quick glance at Scopus found that in 2014, there were 434 and 30 dementia publications in Australia and New Zealand, respectively; compared to 29 in Australia and 3 in New Zealand late-life schizophrenia publications, in the same period.

I believe it is time for POA to refocus on the core mental health disorders and improve the care and quality of life of older people with these disorders. For example, late-life suicide is a growing public health concern worldwide. A recent study found that globally, suicide rates (both men and women) increase with increasing age in 5-year age-bands, between the ages of 60–64 years and 90–94 years. Old-age psychiatrists have a crucial role in suicide prevention, by contributing our understanding of late-life mental health disorders and their interaction with physical illnesses, cognitive decline and other psychosocial issues associated with ageing. We also have a role in translating evidence-based psychological treatment of late-life depression. With the arrival of the baby boomers, there will be an increasing demand for psychological treatment for depression, e.g. cognitive behavioural therapy and interpersonal psychotherapy. POA services will require a well-coordinated plan to prepare a workforce that can meet the needs of our coming cohort of older people, in both primary and specialist care settings.

In conclusion, POA has a specialised role within psychiatry, in meeting the mental health needs of older people. The new RANZCP POA service criteria will assist in promoting our identity in psychiatry. Dementia currently forms a significant part of the work of POA, but the core mental health disorders in older people should deserve similar attention.

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**References**


**Podcast**

Talking about frontotemporal dementia with Prof Jeff Looi

**Andrew Amos**  
Psychiatric Registrar, Acute Care Team, Gold Coast Mental Health and Integrated Care, QLD, Australia

Email: Andrew.Amos@health.qld.gov.au

Improvements in economic, social and medical organisation across developed and developing nations have led to increasingly rapid demographic changes, including longer life expectancy and the associated ageing of populations. While more people living longer, healthier, happier lives is an undoubted good, there is a growing recognition that current medical structures may not be optimally designed to manage the diverse physical, mental and behavioural issues that grow more prevalent with age.

In the October 2015 issue of the *Australasian Psychiatry* podcast, I interview Associate Professor Jeffrey Looi,