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EDITORIAL

Caring for older adults with disabilities

Aging has two faces, a happy one and a sad one. The happy face typically reflects on subjective or mental well-being. Countless studies have shown increase in self-reported wellness in old age (Thomas *et al.*, 2016). The sad face, as expected, reflects on physical well-being. Physical health is at its best in the 20s and begins to worsen perceptibly in the 50s. It is noteworthy that while the older adults themselves feel happier, along with greater self-reflection, emotional regulation, compassion, and acceptance of diversity of perspectives, all of which are components of wisdom, much of the society focuses on the sad face of aging. By giving far more weight to physical health than to mental prowess, older people are considered disabled. This is pure and simple ageism, which is both broad and deep, and leads to socially promoted trampling of the basic human rights of older adults and deprivation of their liberty, especially in persons with mental illnesses including neurocognitive disorders like Alzheimer's disease, who face an additional stigma against mental illnesses (mentalism). The most vulnerable groups are marginalized communities such as racial/ethnic minorities, migrants, refugees, indigenous people, and lesbian, gay, transexual, and bisexual persons, who have to cope with a third stigma that leads to social exclusion. The result of these various stigmas and prejudices is poor healthcare, resulting in worse physical, cognitive, and mental health, and reduced longevity.

This issue of the International Psychogeriatrics features two Position Statements from the International Psychogeriatric Association (IPA) and the World Psychiatric Association's Section on Old Age Psychiatry (WPA-SOAP), as well as a review paper and two data-based papers along with respective Commentaries.

The first paper by Peisah *et al.* (this issue) focuses on the rights of older adults with mental health conditions and psychosocial disabilities. These rights include quality of life, dignity, respect, access to healthcare and healthy environment, confidentiality, and freedom. The Position Statement lists recommendations not only for policymakers but also for psychogeriatric clinical practitioners. As clinicians and care providers, we must practice what we preach – for example, fighting ageism, promoting not only successful aging but also high-quality end-of-life and palliative care for our patients, promoting rational autonomy, and advocating for better healthcare. I believe that it is also critical to discard apparent indications of generational conflicts in terms of socio-economic policies. Providing resources to one generation does not mean taking resources away from another generation. There is solid empirical evidence demonstrating large benefits of inter-generational activities for the youth and for older adults simultaneously, and indeed, for the society as a whole, and we must promote such initiatives (Parisi *et al.*, 2009).

The IPA-WPA-SOAP Position Statement by de Mendonca Lima *et al.* (this issue) focuses on human rights of liberty that are commonly denied to older adults with mental illnesses. Our patients must be protected against stigma and discrimination that leads to neglect, abuse, violence, and various forms of traumas and adversities. It is essential to ensure liberty for appropriate decision-making by older mentally ill persons, especially for those in institutional settings including hospitals, nursing homes, and prisons. In the US, more people with serious mental illnesses are in prisons and jails than in hospitals, reflecting on a legal system that tends to criminalize psychotic behavior instead of considering it a sign of brain disorders and offering needed therapies (Prins, 2014). Furthermore, people incarcerated when younger and serving long sentences are aging inside the jails. Their healthcare needs change with age and must be attended to accordingly.

The systematic review and meta-analysis by Chinnappa-Quinn *et al.* (this issue) reports increased risk of cognitive decline following hospitalization for acute physical illnesses in older persons without pre-existing clinical evidence of a major neurocognitive disorder like dementia. Notably, this higher incidence of post-hospitalization cognitive deterioration is not related to known risk factors like type of physical illness that precipitated hospital admission or presence of delirium or use of intensive care or surgeries requiring general anesthesia. Lee and Chiu (this issue) make excellent recommendations for reducing the risk of post-hospitalization decline in cognitive function. These include multilevel non-pharmacological strategies for prevention at different stages: primary (physical and mental health promotion), secondary (early diagnosis and treatment of physical illness), and tertiary (early discharge planning and rehabilitation) prevention.

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Aprahamian *et al.* (this issue) present data from a retrospective cohort study of physical frailty in geriatric psychiatry inpatients. A majority (53%) of the study participants met physical frailty criteria while a shocking 84% were frail according to the Frailty Index. An important reason for the elevated prevalence of frailty in this group is high comorbidity, especially metabolic and cardiovascular diseases associated with obesity, as well as alcoholism and smoking. Critical but commonly neglected contributors to the ill health are social determinants of physical and mental health including socioeconomic adversities, social isolation, above mentioned stigmas of aging and mental illness, discrimination against marginalized communities, and poor access to healthcare and healthy environment (Reynolds *et al.*, 2022). Frailty serves to further worsen health and healthcare, thus continuing a vicious circle. This is concerning because frailty is not an inevitable part of aging or of mental illnesses including dementia. Therefore, there is a clear need for assessing, preventing, and managing frailty appropriately in older adults suffering from neuropsychiatric disorders.

Zheng *et al.* (this issue) studied semantic intrusion errors as a function of age, amyloid, and brain volumetric loss in a diverse sample of older adults. The investigators employed the Lowenstein-Acevedo Scales of Semantic Interference and Learning (LASSI-L), which is a reliable and practical cognitive stress test. They found that increased semantic errors were significantly associated with early pathological markers of Alzheimer's disease – *viz.*, amyloid positivity and lower volumes of the brain regions prominently involved in Alzheimer's disease, but not directly with age or APOE genotype. However, age and the APOE genotype had an indirect effect on semantic intrusion errors while age also had an indirect effect via amyloid positivity. A majority of the study participants (53%) were Spanish speakers, indicating broader and pragmatic applicability of the easy-to-administer LASSI-L. Thus, this study has both biological and intervention implications for neurocognitive disorders.

In sum, as psychogeriatric clinicians, educators, researchers, administrators, and public advocates, we need to make conscious efforts to enhance the care and well-being of older adults with mental illnesses. If not us, who will do this critical job?

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