The massive impact of the dementia lobby is evident worldwide and most certainly in the UK. Dementia is seen to be everywhere. It contributes to the difficulties of people living in the community, in care homes and in hospitals. Its characteristics of variability, 24 h presence, and combinations of dependency and hazardous behaviour, make it the number one threat to the peace of mind of patients, their families, clinicians and managers; people experience adversity and money can be misspent. A huge amount is being done to improve dementia care across the spectrum of lay and professional education and action [1].

Dementia is not the only mental disorder encountered in late life: the three most common mental disorders affecting older people when they are in hospital are dementia, depression and delirium. These may occur separately or concurrently and each of them is associated with poorer outcome in terms of survival, continuing disability and return to the community. Among older people admitted to a general hospital, out of 330 people, 220 will have a mental disorder: 102 will have dementia, 96 depression and 66 delirium [2]. This means that appropriate care of at least two-thirds of older patients requires that general hospital professionals of all disciplines are competent in the recognition and management of these conditions. Geriatricians should feel equipped to play their part in this by their educational, clinical and training experiences.

In this issue of the journal Mayne et al. [3] report findings from a survey of geriatricians who are identified as ‘Dementia Champions’. They are a mixed bunch. Their range of clinical activity varies and their experiences of dementia, which have prepared them for their role, span reading, self-study, involvement in research, clinical attachments and structured training. They ask that trainees in future have more and better dementia training, with more structure and less variability between centres. Their comments indicate that there is experience, education and encouragement to be found, but that trainees have to make an effort to make up the best programme to suit their ambitions. Some may feel there is nothing wrong in that, others may prefer a more coordinated approach.

In the past

The need to improve education and training about mental illnesses for geriatricians and physical illnesses for psychiatrists has been noted for many years. It was recommended in a report by a group of geriatricians and psychiatrists, The Organisation of Psychogeriatrics, in 1971 [4]. That group was advised by Lord Amulree [5], a geriatrician and first president of the British Geriatrics Society.

Prof. Arie improved undergraduate and postgraduate training at the University of Nottingham by establishing a joint geriatric-psychiatric Department of Health Care of the Elderly in 1977 [6]. Benefits of Nottingham’s old age teaching strategy were apparent: good teaching in geriatric medicine was not only associated with better attitudes to older people, but could affect career choices [7]. If enthusiastically delivered, it might be one way to influence positive interest in older people and their illnesses at all stages of their careers. This joint model of clinical service, teaching and research on older people’s health would be useful for almost all doctors.

Geriatric medicine has preferred a return to integration within general medicine [8]. Health service structural changes have distanced geriatric medicine from old age psychiatry, partly by their segregation into separate and competing NHS Trusts [9]. These managerial changes, rather than consideration of potential clinical benefits, have almost certainly contributed to the rarity of joint departments in the UK [10].

The present

The Royal College of Physicians curriculum for geriatric medicine training recommends: ‘A minimum of a full-time attachment of 4 weeks or equivalent’ and ‘It is envisaged that each region will set up an appropriate programme in collaboration with their Psychiatric colleagues’ [11]. In our experience, this intensity or reciprocity of training is rare.

The Royal College of Psychiatrists curriculum for postgraduate old age psychiatry training suggests that trainees should: ‘Contribute to the management of interfaces between old age psychiatry, geriatric medicine, social services, independent sector providers and primary care’ and work in joint psychiatric-geriatric wards. The latter is somewhat surprising, given their extreme rarity [12]. Nowhere does it suggest placements within geriatric medicine departments [13]. There is clearly scope for improving and sharing learning at the trainee level.

The British Geriatrics Society has a ‘Dementia and Similar Disorders’ Special Interest Group (DSD-SIG), affiliated to the
Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. The DSD-SIG website states that relevant education of clinicians is an objective. Undergraduate training is not mentioned [14]. Unfortunately, the joint group appears to be dormant.

The future?

Re-establishment of better cross-disciplinary links between geriatric medicine and old age psychiatry is urgently required, both at the professional organisational level and in clinical practice. These links have to surmount barriers and organisational boundaries.

A combined approach will have greater and more relevant influence on training of undergraduates and postgraduates in medicine and in other caring professions. As old age psychiatrists, we and our specialist old age trainees, would welcome longer periods of reciprocal attachments during training, providing levels of hands-on work and clinical supervision appropriate to the trainee’s needs. Education and training has the potential to improve services for older people with dementia and other mental disorders much wider than just within the two specialties; it must influence the thinking and competence of healthcare professionals of all disciplines in primary as well as secondary care.

Mayne et al’s survey is well timed and its messages should be used to trigger appropriate improvements which are shamefully overdue. These changes should apply to the education and training of all the professions and should encompass all aspects of mental health among older people. Perhaps we can ride with the success and impact of the dementia lobby to achieve an even greater good.

Key points

• Reciprocal training, of geriatricians about psychiatry and psychiatrists about geriatric medicine should, and can, be improved.

Conflicts of interest

None declared.

References


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