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EDITORIAL

Training in old age psychiatry

Old age psychiatry is still a young subspecialty. Although there have been a number of published curricula and training guidelines since 1979 (Blumenthal *et al.*, 1979; Marin *et al.*, 1988; Thorpe *et al.*, 1993), formal criteria for old age psychiatry training were only adopted in the United Kingdom in 1989 (Joint Committee in Higher Psychiatric Training, 1989), the United States in 1993 (American Board of Psychiatry and Neurology, 1992), Canada in 1994 (Le Clair and Sadavoy, 1998), and in Australia and New Zealand in 1999 (Draper and Snowdon, 1999). In this issue, the developmental process continues with the publication of the first European consensus core curriculum on skill-based objectives that define the subspecialty of old age psychiatry. Developed jointly by the European Association of Geriatric Psychiatry, the World Health Organization, and the World Psychiatric Association (WPA) Section of Psychiatry of Old Age, the curriculum is intended to stimulate and facilitate the training of old age psychiatrists in Europe (Gustafson *et al.*, 2003).

The current state of development in Europe is revealed in a WPA survey of teaching and training in old age psychiatry that also appears in this issue. It reports that old age psychiatry is a subspecialty in only 18% of European region countries that responded (Camus *et al.*, 2003), even though Europe is one of the main regions of the world that recognises old age psychiatry. Clearly there is much room for improvement, both in Europe and in other regions, as only 27% of responding countries worldwide recognized old age psychiatry as a subspecialty.

How important is it to have a curriculum and formal training guidelines for training in old age psychiatry? I would suggest that it is essential. Although many current old age psychiatrists around the world have received adequate informal training, it is not possible to assure licensing authorities, our medical peers, the general public and others that we have particular expertise unless we can demonstrate that we have received adequate training. And this means that there has to be a curriculum that outlines the attitudes, knowledge and skills that are fundamental to old age psychiatry and training guidelines that describe how this training should be delivered by training programs.

The European skill-based objectives cover both the curriculum and training guidelines. One important feature of the objectives is that they are designed to be relevant to a broad range of specialists, as old age psychiatrists, general psychiatrists, neuropsychiatrists, neurologists and other physicians provide specialist mental health services to older people in various European countries. In addition, service delivery systems also vary considerably across Europe. This inclusive approach will foster uniformity of standards between countries and training programs and will bring together disciplines across Europe. It is also a model that can be more widely applied in other parts of the world.

This does mean that some sections of the curriculum, e.g. on history taking and mental state examination, are pitched at a more basic level than might be expected but this is required when non-psychiatrists are being trained. It also means that the recommended minimum duration of training of one-year whole time equivalent is certainly less than the two years training required in countries that have established old age psychiatry subspecialty programs. Again this is understandable, as it is likely to be the maximum duration that is currently feasible in some countries.

So, what are the core skills required in practicing old age psychiatry? Unfortunately, the absence of a list of training goals in the European curriculum means that the core skills are not clearly specified. However, I would suggest that they involve the competent ability to assess, diagnose, treat, and manage psychiatric problems in old age in a comprehensive manner and in partnership with older people and their carers. This should occur in a range of clinical settings that include general and psychiatric hospitals, ambulatory clinics, domiciles, and long term residential care. To successfully achieve this also implies the acquisition of skills of consultation, collaboration and liaison with other professionals, e.g. general

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practitioners, geriatricians, and community groups through leadership of and participation in multidisciplinary teams. There are also important skills in the organization, planning and administration of services that includes service delivery evaluation through research-based skills and a willingness to teach others. Underpinning these skills is an appropriate breadth of knowledge that is rooted in evidence-based practice, positive attitudes towards older people and an appreciation of ethical issues in old age.

The European objectives emphasize the importance of appropriate assessment of trainees and accreditation of training programs. The challenge is to develop adequate systems to achieve this without an onerous administrative burden. This will be a particularly important issue in developing countries. In Australia and New Zealand, where a central committee administers subspecialty training in 15 training programs, we have sought to minimize costs. We use email communication, the Internet and teleconferences rather than face-to-face meetings that would require travel and accommodation expenses. We also schedule site visits of training programs to occur before or after meetings and conferences in the same city so that we can arrange for some of the participants to do the accreditation visit. The costs are not just financial. Assessment procedures take time to complete for both trainees and trainers and need to be relevant to the training. But it is just like all forms of education, unless an adequate investment is made in the first place, outcomes are likely to be compromised.

What is the future of training in old age psychiatry? According to the WPA survey, the recognition of old age psychiatry as a subspecialty is neither related to economic development nor the proportion of older people in the population but may be more closely related to the acceptance of old age psychiatry as a distinct academic discipline (Camus *et al.*, 2003). Of interest, the establishment of subspecialty status in Australia and New Zealand required evidence that old age psychiatry represented an internationally recognized body of knowledge in psychiatry. But of course successful presentation of this evidence was aided by the strong local academic standing of old age psychiatry.

The setting up of academic posts in old age psychiatry is likely to be critical at all levels of training, from medical students through to subspecialty trainees. Adequate coverage of psychiatry of old age issues in medical student curricula is unlikely to occur without old age psychiatry academics. Postgraduate training, seen as the most pressing need in the WPA survey, includes the needs of general practitioners, physicians and general psychiatry in addition to non-medical health professionals. Although many topics can be taught by other academics, the broad overview and understanding of the full gamut of issues important in old age psychiatry are likely to be best taught by academic old age psychiatrists. In addition, academic old age psychiatrists will invariably have clinical responsibilities with junior medical staff working along side them. Evidence from Canada suggests that the educational experience in old age psychiatry during psychiatry residency is very influential in psychiatrists' decisions to practice old age psychiatry (Lieff and Clarke, 2000, 2002).

The WPA survey implies that academic posts in geriatric medicine are a forerunner to those in old age psychiatry—certainly that is the case in many countries. The reasons for this are unclear though one may suspect that it reflects whether a health system accepts that the health care of older people is a distinct academic pursuit. If not, the approach in other health systems is to take a more traditional organ system basis, though within this there are clearly neuropsychiatrists, general psychiatrists and neurologists who specialize in treating age-related disorders in their field. This latter approach does raise the concern that there may potentially be gaps in their training experiences—hence the importance of the European style curriculum.

Another extremely important factor in the spread of old age psychiatry training around the world has been the impact of influential old age psychiatrists such as Tom Arie. His 'Nottingham course' was for many now prominent old age psychiatrists their major postgraduate old age psychiatry training. The course proved to be the breeding ground of the now thriving International Psychogeriatric Association (IPA) that prides itself in sponsoring educational initiatives in developing countries. And these initiatives reflect the recognition that the provision of 'on site' training by international experts is likely to have a broader impact in countries where the rapid increase in the ageing population is challenging existing resources. This training may be directed to several levels, upgrading the skills of psychiatrist who are functioning as subspecialty old age psychiatrists but may never have received specific training, as well as to psychiatry trainees, geriatricians, neurologists, physicians, medical students and others.

The Internet also provides opportunities to reach isolated practitioners in the rural areas of developed countries in addition to developing countries. For example, IPA has a free Internet-based educational package on the behavioural and psychological symptoms of

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dementia. Various universities run distance education courses that also utilize the Internet and other technologies such as video conferencing. Since 1998 through the University of New South Wales in Sydney I have co-ordinated a 14 module psychiatry of old age module of a Masters of Geriatric Medicine course that can be used by psychiatry trainees, geriatricians and general practitioners. Most students have either been in rural Australia or from neighbouring South East Asian countries. Some old age psychiatry subspecialty trainees have also used it as part of their training.

Subspecialty training in old age psychiatry clearly should not be viewed in isolation from the old age psychiatry training required at all levels of medical and other health professional training around the world. The new European consensus core curriculum and its predecessors from North America, Australia and New Zealand, however, provide benchmarks that influence old age psychiatry training in each of these spheres. The challenges of providing adequate training in old age psychiatry in an ageing world are immense.

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