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Integrated multidisciplinary approach for dementia care

To read the study on dementia care by Wolfs *et al*[1] was a delight. They deserve a round of applause for not only conducting a trial in a very complex but essential service but also for demonstrating that an integrated multidisciplinary approach has a positive impact on dementia care. As a consultant old age psychiatrist in the English National Health Service, would I repeat this study?

In the 1970s, we experimented joint working with our colleagues in elderly medical care. At some district general hospitals, joint assessment wards were set up for older patients with complex medical and psychiatric problems. Although the idea looked attractive, the key issue for professionals was who provides and who is responsible for general care practitioners, geriatricians or old age psychiatrists. Unfortunately, the arranged marriage between the medical and psychiatric services ended in an amicable separation, if not divorce, at most places. This separation has not been helped by the fact that these services are delivered by separate hospital trusts. The situation is getting worse as many more hospitals are being managed by ever-growing-mega trusts.

Psychiatry services for older people are now well established across the UK, based on the principle of multidisciplinary working especially in the community. Dementia care has improved significantly with the introduction of memory assessment services across the UK. To bring physicians and psychiatrists together at the research-oriented teaching hospitals may be attractive, but to bring them together for integrated multidisciplinary assessment and diagnostic work does not hold any realistic future.

There are drawbacks in the Dutch study. Only 65% of patients agreed to participate. Health-related quality of life was the primary outcome. A difference of 10% or more between the intervention group and the control group had been determined as a clinically relevant difference, but the study resulted in only 9.6% group difference after 12 months. Moreover, the proportion of patients who improved more than 10% was only 39% compared with over 22% in the control group. Does this modest result justify integration of medical and psychiatric services for dementia care in the UK? The answer, I am afraid, is negative at the moment. The important lesson to learn, however, is to provide a dementia diagnostic service in terms of comprehensive assessment, reaching a diagnosis and communicating that to patients and their carers with a comprehensive care plan. I would be more interested in conducting a randomised controlled trial to evaluate the clinical effect of a diagnostic approach rather than the traditional assessment approach by the existing community mental health teams for older people.

1 Wolfs CAG, Kessels A, Dirksen CD, Severns JL, Verhey FRJ. Integrated multidisciplinary diagnostic approach for dementia care: randomised controlled trial. *Br J Psychiatry* 2008; **192**: 300–5.

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Authors' reply: Dr Jha feels that our study is flawed by an inclusion of only 65% of patients willing to participate. A participation rate of 65% is common in this type of study. We anticipated before the start of the study that the rate of non-participants might amount to 40%, and therefore the actual inclusion rate was higher than expected. More importantly, the two groups did not differ regarding relevant characteristics affecting the prognosis, such as age, diagnosis, gender and baseline cognition. Moreover, Dr Jha found the results of our study quite modest. We do not entirely agree with this: a difference of 9.6% between groups regarding health-related quality of life is higher than found in any pharmacological study in dementia so far. We furthermore emphasise that usual care in our region is provided by an active university medical centre and a community mental health service that have collaborated in the past on several projects. We therefore expect that the effects of our study may be underestimated, and would be higher in other regions. Indeed, a marriage between different disciplines involved in the care of people with dementia sometimes involves conflict and is dependent on the willingness to invest in the relationship. So far, a lot of work has already been performed and although the marriage still isn't perfect, we think that it does have a realistic and happy future.

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Anxiety disorders in mothers and their children

Schreier *et al*[1] have found that the risk of anxiety disorders in children is increased when mothers have specific anxiety disorders such as social phobia and generalised anxiety disorder. They also claim that their findings confirm and extend the findings of Bijl *et al*.[2] However, Bijl *et al* did not demonstrate that parental anxiety symptoms were significantly related to psychiatric disorders in the children, including anxiety disorders. In addition, anxiety disorders in the children were not related to most parental psychiatric symptoms. Moreover, their patients were older (adult children) than those in Schreier *et al*'s study and we are not certain whether it is possible to compare these two different populations.

1 Schreier A, Wittchen H-U, Höfler M, Lieb R. Anxiety disorders in mothers and their children: prospective longitudinal community study. *Br J Psychiatry* 2008; **192**: 308–9.

2 Bijl RV, Cuijpers P, Smit F. Psychiatric disorders in adult children of parents with a history of psychopathology. *Soc Psychiatry Psychiatr Epidemiol* 2002; **37**: 7–12.

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