Letters

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National Dementia Strategy

Greaves and Jolley¹ make good points about the National Dementia Strategy, and the need to take a primary care approach to it. While we agree with most of their arguments, they have underestimated the political pressures that shaped the Strategy. Firstly, the care of frail older people is so variable in quality that it is a gift to crusading journalists, with prime time TV programmes and a running campaign in the *Daily Mail* alarming politicians. Secondly, the relatively marginalised discipline of old age psychiatry has sensed an opportunity to raise its profile and increase its resources. Thirdly, the Alzheimer's Society is a formidable lobbying group that also provides supportive services at national level and in some localities. Finally, behind all these stakeholders stands the pharmaceutical industry, with an interest in promoting the use of symptom-modifying treatments to an under-served patient group, while companies compete to create disease-modifying agents.

It is hardly surprising that the Strategy favours a clinic-based medical model of response to the costly clinical problem of dementia, rather than a disability model of support for people with dementia and their families. The medical model is weakly contested, partly because general practice has largely abdicated from the task of clinical care and either gratefully passed responsibility to specialists, or worse, adopted a nihilist position that 'nothing can be done'. The result is that the more zealous specialists can liken dementia to cancer, and argue that

people with dementia syndrome need the same level of expertise as those with malignant disease, overlooking the gulf in the effectiveness of therapies between the two domains.

The National Dementia Strategy was designed for a health service growing in a strong economy, not one in an economic recession. Given the growth in the numbers of the oldest old, specialist services may not be able to cope with rising demand, and the usual demarcation lines between generalists and specialists may have to move. Greaves and Jolley have highlighted one way to do this in the Gnosall service, and there are other examples of primary-care based and jointly-led memory assessment services.² All of them assume that there is little rocket science in recognising and responding to dementia syndrome (although there may be much in differentiating sub-types) and that skill transfer is possible and effective when collaborative ways of working are developed and sustained.

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Competing interests

Steve Iliffe was chair of the working party on early diagnosis in the external reference group for the National Dementia Strategy, 2008–2009.

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The discussion paper on the National Dementia Strategy¹ made for very interesting reading. Both the National Dementia Strategy and 'The Use of Antipsychotic Medication for People with Dementia' report² highlighted the importance of a greater focus being placed on training in dementia for GPs and GP trainees. Disappointingly, research suggests only 31% of GPs believe they have received sufficient basic- and post-qualification training in dementia.²

Seeking to develop an evidence-based approach to addressing these training needs for current and future GPs is vital to ensure the success of the National Dementia Strategy. Promisingly, our own preliminary research in the East Midlands has demonstrated that GP trainees who have completed a training placement in old age psychiatry demonstrated a more evidence-based and considered approach to managing the behavioural and psychological effects of dementia than their peers.

Of topical interest with regards to over prescription of antipsychotics in dementia by primary care, these trainees displayed both greater appreciation of the risks of antipsychotic medication and were less likely to prescribe them as first-line treatment compared to trainees who had not completed an old age psychiatry placement.

We very much welcome this article and look forward to seeing more like it as dementia becomes more prevalent in our society.

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