

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.

Steve Iliffe,

Professor of Primary Care for Older People, University College London, Primary Care & Population Health, Royal Free University College Medical School, London.
E-mail: s.iliffe@ucl.ac.uk

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.

Arshya Vahabzadeh,

The Evington Centre, Gwendolen Road, Leicester, Leicestershire, LE5 4QF.
E-mail: Arshya@drarshya.com

Mizrab Abbas,

CT2 Psychiatry Trainee, The Evington Centre, Leicester.

Ann Boyle,

Head of School of Psychiatry, East Midlands (South) Deanery, The Evington Centre, Leicester.

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Greaves and Jolley¹ challenge the architects of the National Dementia Strategy and the army of builders trying to turn plans into a reality. Provocatively (to continue the building analogy) they query whether the 'right' buildings are under construction. Constructing a memory service for early recognition of dementia, repairing care homes, and re-fashioning hospital care to make it 'dementia friendly' all require equal attention and careful surveying; not least because the former may overshadow the latter. The possible creation of a National Care Service makes predictions of need at population level essential.

However, although the pay levels of care home staff are low and their skills are often taken for granted, it is also a matter of planning (or lack of it) that has erected fences — or sometimes dug moats — between this provision and other health and care services. While high turnover of frontline workers, and especially managers in care homes may cause problems in many areas, the greater problem is the isolation of the care home sector from primary care, voluntary, and community provision. What role does it play in the training of GPs, for instance, and why is 'institutionalisation' (a terrible word) so often seen as simply a negative option?

Greaves and Jolley are some of the few doctors working in the community to

engage with this subject. Social care interest groups welcome their contribution to a debate that is about the building of a National Care Service, not just the strategy for people with dementia. Social care, like general practice, knows that most people with dementia have multiple disabilities. Strategies can be blueprints but they should not build higher walls around clinical conditions and imprison specialists in ivory towers.

Jill Manthorpe,

Professor of Social Work, Social Care Workforce Research Unit, King's College, London. Email: jill.manthorpe@kcl.ac.uk

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More randomised controlled trials on frequent attendance

We appreciate the comments that Smits¹ *et al* made on our article.² From this reading we deduce that they would agree with its main findings: the way in which frequent attendance is defined has an impact on the factors associated with it and their discriminative power, and the use of the top decile cut-off seems to be more recommended than the top quartile.

They introduce an interesting idea that is clearly relevant to this discussion. We should focus on those frequent attenders that persist over time, as there is a significant proportion of those who left their status after 2 or 3 years. No doubt this is a reasonable and pragmatic approach. Unfortunately, no randomised control trials that show there is some kind of GP intervention to reduce these visits of persistent frequent attenders have been published. However, a randomised control trial of a successful GP intervention with

frequent attenders in primary care was published in the *BJGP*.³ Although further randomised controlled trials are necessary, this comprehensive GP intervention with frequent attenders resulted in a significant and relevant reduction in their consultations. In fact total visits of frequent attenders of the intervention group were reduced by nearly 40%, while in the control group there was virtually no change. Moreover, this effect was found for frequent attenders of only 1 year ('short frequent attenders').

Therefore, given the evidence available so far, we cannot conclude persistent frequent attending is of more importance and clinical usefulness than short-term frequent attending, but rather the opposite.

We believe it would be more interesting to concentrate scientific efforts to determine whether that or other interventions are effective in reducing frequent attendance and if it is achieved by cost-effectiveness and cost-utility.

Juan Bellón on behalf of the authors, Universidad de Malaga, Departamento de Medicina Preventiva y Salud Publica, Campus de Teatinos s/n, Malaga 29071, Spain. E-mail: JABELLON@terra.es

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Non-verbal behaviour

We are grateful for Dr Hay's interest¹ in our editorial² and agree that the physical positioning of the computer screen is an important influence on non-verbal communication in the consultation. We