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Commissioning dementia services

Iliffe[1] makes important points about complex conditions but offers a very limited view of the possibilities for commissioning dementia services.

Any qualified provider broadens the options and there is no reason why the whole system needs to be commissioned from a single provider. In acute hospitals, services may be provided by liaison psychiatry or physicians or both. Liaison psychiatry could extend into the community[2] or intermediate care services. In care homes, where frailty is common, there might be an alliance of community geriatrics and old age psychiatry with the independent sector. Home treatment may include joint health and social care, memory services, and care advisors.

What is crucial is that the whole system has to be commissioned and commissioners see the whole system and bind the component parts together. This point is made in the National Institute for Health and Care Excellence dementia commissioning guide with reference to dementia clinical networks.[3] Networks define a whole system where local providers are clearly identified to meet local need and operate a unified, interactive dialogue, not a care pathway that patients do not follow.

The new commissioning environment creates an exciting opportunity to think more imaginatively and this will be needed to meet the dementia challenge. This has to be more than the 'is it the GP or the specialist?' question.

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2 Parsonage M, Fossey M, Tutty C. *Liaison Psychiatry in the Modern NHS*. Centre for Mental Health, 2002.

3 National Institute for Health and Care Excellence. *Support for Commissioning Dementia Care*. NICE, 2013.

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Dementia commissioning – a missed opportunity

Professor Iliffe finishes his editorial with a question,[1] but does not address a much more important issue in dementia care in this country – that although dementia is considered a public health priority by the World Health Organization,[2] the Department of Health's dementia commissioning pack does not prioritise dementia.

According to the Alzheimer's Society, more than half of cases of dementia continue to remain undiagnosed in the UK (www.alzheimers.org.uk). Significant resource allocation is needed to address poor diagnosis rates in the population via public mental health campaigns. This should also address the still prevailing stigma about dementia and highlight the potential prevention strategies.

The Royal College of Psychiatrists and the Royal College of General Practitioners have tried to address this by producing the Joint Commissioning Panel for Public Mental Health (JCPMH); however, most health and well-being boards responsible for delivering the public health agenda do not have statutory representations from mental health trusts.

The Commissioning for Quality Innovation and Prevention (CQUIN) schemes for 2013–2014 have allocated resources for integrated/collaborative care in dementia but the funding is non-recurrent. The chronic underfunding of old age services to the tune of over approximately £2 billion needs to be addressed. Most consultants working in an older people's mental health service have a catchment population twice the upper limit suggested by the Royal College of Psychiatrists.[3]

General practitioners need to remain the focal point of coordinating dementia care and need further training in complex care rather than financial incentivisation under the Quality and Outcomes Framework.

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3 Mynors-Wallis L. *Safe Patients and High-Quality Services: A Guide to Job Descriptions and Job Plans for Consultant Psychiatrists* (College Report CR174). Royal College of Psychiatrists, 2012.

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Author's response

In the 'quick and dirty' poll I carried out among psychiatrists in the South West, the least popular option for reconfigured services for people with dementia was the Gnosall model, described in greater detail by Susan Benbow and colleagues. This model inverts the natural world, putting the general practitioners (GPs) in charge while fostering 'interactive dialogue', and is surely an example of the more imaginative thinking that David Anderson hopes commissioners will display. Its attractiveness remains to be seen, as it is now at the point where its methods must be picked up from the 'innovator' group which created it, and used by less determined but perhaps more typical 'early adopters'. We shall see whether this happens. Since 90% of care homes are outside the public sector (even if they receive enough public funds to be inside the public domain), the second most popular option also fits David Anderson's suggestion about an 'alliance of community geriatrics and old age psychiatry with the independent sector'. This is a difficult option, because it could bring the specialist alliance into conflict with generalists over who is the clinical lead for people with dementia, with an uncertain outcome when clinical commissioning groups are heavily influenced by GPs, and are very aware of the need to reduce costs. Even more imaginative ideas about multiple providers seem to many to simply replicate the current fragmented system; curing fragmentation of provision by further fragmentation sounds counterintuitive to many, unless the whole process is to be led by consumers under a 'personalisation' agenda.

The most popular option was a redrawing of the traditional boundary between specialist and generalist services, with GPs taking more clinical responsibility for continuing support. This is a comfortably low-risk gamble, for specialists at least, because their likely funding scenario is limited growth at best, with budget shrinkage more likely. The question is how to do it. There are many assumptions that could impede change even in this less challenging option. One is identifying 'knowledge deficit' as the core problem in general practice, as Sudip Sikdar does. This does not fit with the findings of the EVIDEM-ED trial that tailored, workplace-based educational interventions do not change practice, even when policy pressure, consumer demand and incentivisation combine to create a theoretically ideal climate for such change. Low diagnosis rates (based on Quality and Outcomes Framework returns) are exaggerated as a problem by a health service that functions as a target-driven industrial machine, distracting practitioners from the need for timely diagnosis and continuing support for their patients. Any stigma can be 'addressed' as a public health problem (although public health medicine has not been prominent in dementia policy and practice debates) but that does not necessarily change it, whereas dementia prevention strategies are based on supposition, not evidence of effectiveness. Commissioners are in the difficult (but commonplace) position of having to make investment decisions with poor evidence against a background of competing professional and commercial agendas, while not being able to change the one thing that might be critical – the GP contract. Getting commissioning right for people with dementia will be difficult, so I look forward to carrying out more polls and listening to the debate they provoke.

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Review

The 10 Best-Ever Anxiety Management Techniques Workbook

Margaret Wehrenberg
WW Norton, 2012, £13.99, pb, 224 pp.
ISBN: 9780393707434

Margaret Wehrenberg developed this self-help workbook following the publication of *The 10 Best-Ever Anxiety Management Techniques* in 2008. She takes the ten techniques and aims to show readers how to put them into practice. She attempts to do this by including new worksheets, exercises and self-assessment tools. Also included is an audio CD, developed to be used alongside the workbook.

The workbook is divided into four parts. Part one, 'Assess yourself', systematically discusses the key features of anxiety disorders and common comorbid conditions. Part two, 'Managing the anxious body', describes diaphragmatic breathing, progressive muscle relaxation and the use of imagery for relaxation. Part three, 'Managing the anxious mind', helps the reader to identify catastrophic thinking and cognitive distortions. The author discusses several cognitive techniques including thought-stopping and thought replacement. Part four, 'Managing anxious behaviour', introduces the concept of desensitisation and recommends the use of hierarchies and gradual exposure.

The workbook can be used independently of the original book. Wehrenberg refers readers to her original text at several points in this book, but these references add little. Consequently, I would not recommend that owners of the workbook purchase the original text.

The selling points of the workbook include the self-assessment tools and checklists. Checklists are used throughout and readers are encouraged to tick off symptoms they have experienced. The workbook then gives an indication of when the reader might be suffering from a disorder according to the number of symptoms experienced. The author admits that these are not validated tests but they are presented in a way that encourages self-diagnosis. The majority of the checklists are composed of questions that one would take in a standard psychiatric history. A minority seem wholly inappropriate, a notable example being the suggestion that adolescents feeling overwhelmed by the choices of where to apply to college should seek attention-deficit disorder screening.

We must not lose sight of the fact that this is a self-help book for people with anxiety disorders. The workbook's strength lies in describing behavioural techniques such as diaphragmatic breathing and progressive muscle relaxation. The accompanying CD helps readers practise these techniques – I challenge anyone to listen to this and not find themselves more relaxed. The workbook is a good introduction to cognitive techniques. Several different techniques are briefly discussed and it is left to the reader to identify and implement those that would be useful to them. However, I doubt that one would be able to usefully apply them without additional support.

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