Living well with dementia: how can GPs help?

This year National Dementia Awareness week will be held between 18th and 24th of May. Throughout the week there will be national and regional press coverage, awareness-raising and fundraising events across England, Wales and Northern Ireland, and a national advertising campaign. However current evidence tells us that we need to do more than just raise public awareness, we as professionals need to stop burying our heads in the sand! In 2008, the National Audit Office report on dementia provided a wakeup call for primary care in the UK. The GP survey they completed revealed that the majority of respondents had a “widely held perception that little could be done” for people with dementia. In addition, only 31% GPs felt they had “sufficient training to diagnose and manage dementia.”

In contrast, the World Alzheimer Report in 2011 adopted a more positive approach. In addition to summarising the evidence on effective interventions, the report also emphasised the importance of primary care, and the role of the GP and set out to dispel the myth that ‘… nothing can be done’ for people with dementia! Two international reviews: (Iliffe et al 2010; Robinson et al 2010) also highlighted the unique potential of the GP in dementia care. Potential roles for the GP include dementia – case finding; assessment of cognitive function; communication of the diagnosis; early intervention (drug/non-drug;) provision of support and information; supporting carers future care planning, management of behavioural problems, and end of life care.

So the question we need to ask is how can primary care provide better quality care to people living with dementia?

Our first crucial task is to start at the very beginning, before the point of diagnosis when a person presents to their GP with symptoms of possible dementia, he/she should explore their concerns (What are you worried this might be?) and discuss possible diagnoses. Evidence has shown that people who are more prepared for a diagnosis of dementia seem to be better adjusted to receiving one (Robinson et al. 2010). The GP should also discuss what will happen to the patient during the assessment process and how long this might take. If the diagnosis of dementia is subsequently confirmed, then the GP should meet with the patient and their family to discuss their understanding and initial feelings around this.

For people diagnosed with Alzheimer’s disease, drugs to reduce the rate of cognitive decline are available but the increasing evidence base for non-drug interventions should make commissioners review what is currently provided as standard care for all people with dementia. This should include: additional psychological support; early interventions; information provision and practical support; and discussing their views on future care.

In terms of non-drug interventions, the World Alzheimer Report (2011) concluded that the evidence for Cognitive Stimulation Therapy (CST) for people with dementia was sufficiently strong enough for it to be offered as part of routine care. CST has also been found to be as cost effective as dementia drugs. CST comprises cognitive and social skills training, delivered in twice weekly sessions usually over 7 weeks. Information about training including course and information manuals can be found at www.cstdementia.com.
Information provision is key to both people and their family living with dementia. A systematic review (Corbett 2011), found that it did lead to an improved quality of life. There are a variety of ways GP’s can help people get more information and also practical support. These include existing voluntary organisations such as Alzheimer’s Society/DSDCs, in addition to local Dementia Services Development Center. The RCGP is currently involved in developing a web-based tool for sharing information and knowledge on dementia the Dementia roadmap.

Information on the range of assistive technologies available and how to purchase them can be found at www.atdementia.org.uk.

Future care planning plays a key role in dementia care as it is inevitable that people with dementia will lose the capacity to make decisions about their future. Such discussions are termed Advance Care planning and a number of written documents can be completed to confirm a patient’s wishes (see Box 1):

**Box 1: Outcomes of ACP discussions: international and national terminology.**

- **Statement of wishes and preferences:** Documents an individual’s wishes for future care and is not a legally binding document. In the UK this is known as an advance statement.
- **An advance directive for refusal of treatment (or ‘living will’):** This is a statement of an individual’s refusal to receive specific medical treatment in a pre-defined future situation. It is legally binding and comes into effect when a person loses mental capacity. In the UK, this is known as an advance decision to refuse treatment (ADRT).
- **A proxy decision maker or Power of Attorney (POA):** This is a legally binding document whereby the person (‘donor’) nominates another (‘attorney’) to make decisions on their behalf should they lose capacity. In England, following the Mental Capacity Act, this is now known as a Lasting Power of Attorney (LPA); there are two separate aspects to LPA, one relating to a person’s health and welfare and a second in relation to property and affairs.

There is evidence to show that ACP in dementia can reduce inappropriate hospital admissions at the end of life but there is still limited implementation of Advanced Care Planning in practice. In the early stages of dementia the GP should inform the patient and the family about the concept of LPA. Patients can complete their own LPAs via the internet but it may be better to signpost them to a solicitor or the Alzheimer Society for legal advice. ACP is particularly useful in the latter advanced stage of dementia, especially for those people in care homes where completion of a DNAR document and /or a Do Not Admit to Hospital document may prevent unnecessary interventions and distress.

It is equally important for the GP to support the family caring for the person with dementia. Guidance has consistently shown that carers of people with dementia have worse physical and mental health outcomes. They also experience symptoms of grief and loss, whilst their relative is still alive, as the person with dementia loses mental capacity and then
communication skills. If the family carer is a patient on the GP’s list, the GP should record them as a carer and assess their physical, psychological and practical needs. Screening for depression is particularly important and offering appropriate interventions, alongside information and practical support, will be helpful.

Finally, another key area for primary care is the promotion of ‘vascular health’ i.e. ‘a healthy heart and a healthy mind’. Recent research has shown that the current prevalence of dementia is not as high as was predicted a decade ago; this is thought to be due to the increasing attempts of primary care to help people modify risky lifestyle behaviours. There is increasing evidence confirming the importance of vascular risk factors in both vascular dementia and Alzheimer’s disease; it is imperative we encourage our patients to keep physically, mentally and socially active to maintain “healthy hearts and healthy minds”!

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References
