

**KINGDOM OF BAHRAIN
MINISTRY OF HEALTH
PSYCHIATRIC HOSPITAL**

**FAMILY PHYSICIAN AND THE ELDERLY
MENTALLY ILL IN PRIMARY CARE**
BOOKLET GUIDE

Prepared by
Dr Adel Al-Offi
Consultant Old Age Psychiatry
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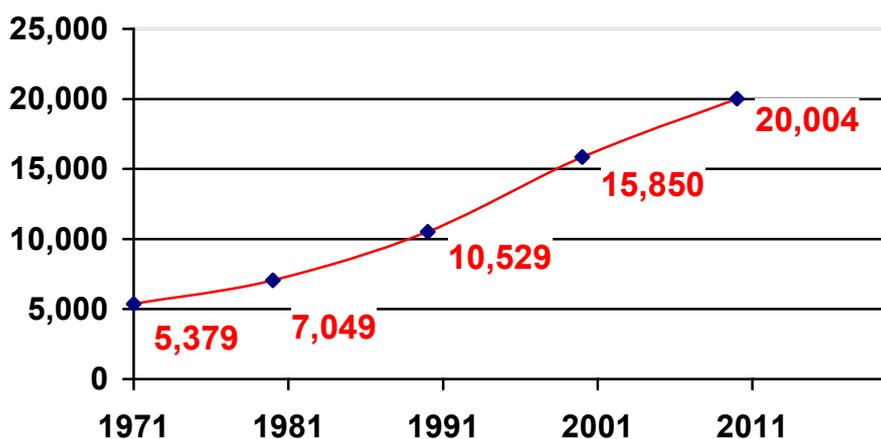
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1. Introduction

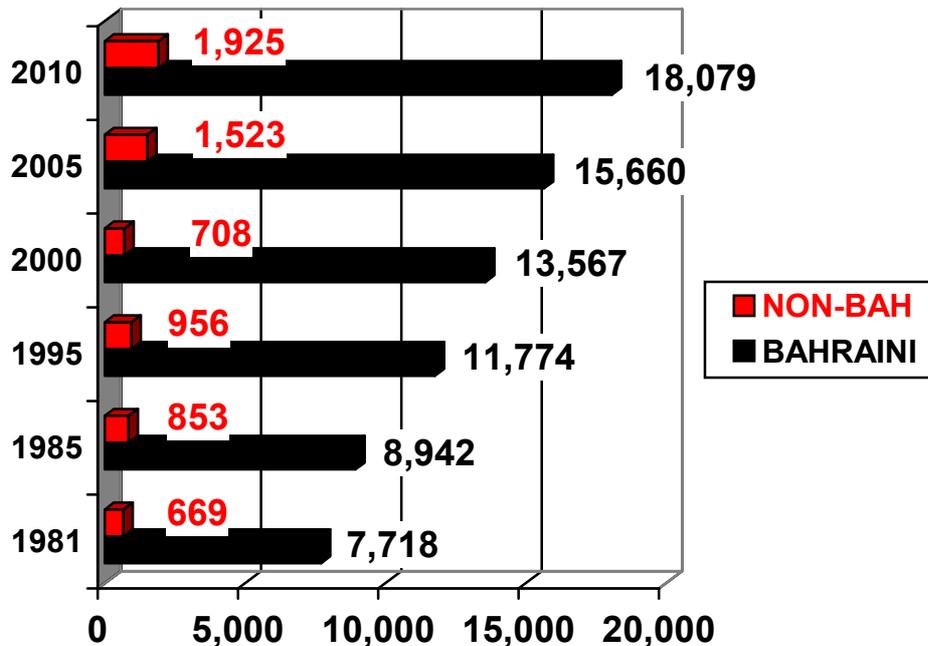
One of the main features of the world population in the 20th century has been a considerable increase in the absolute and relative numbers of older people in both developed and developing countries. This phenomenon is referred to as "population ageing". Over the last fifty years mortality rates in developing countries have declined dramatically raising the average life expectancy at birth from around 41 years in the early 1950s to almost 62 years in 1990. By 2020, it is projected to reach 70 years. By 2020 the number of elderly people worldwide will reach more than 1 000 million with over 700 million of them in developing countries. Over the next quarter-century, Europe is projected to retain its title of "oldest" region in the world. Currently, elderly people represent around 20% of the total population now and will represent 25% by 2020. Population ageing has also been projected to aggravate the magnitude of mental health problems. This will happen because of the increasing life expectancy of those with mental disorders and an ever-growing number of people reaching the age at which the risk of such disorders is high. Estimated at 29 million today, the number of people affected by senile dementia in Africa, Asia and Latin America may exceed 55 million in 2020. Total population in Bahrain will reach 993,828 in 2010, and 33,885 will be above 60 years.

2. Elderly population 65 years and above in Bahrain 1971-2010



Central Statistics Organization-Kingdom of Bahrain

3. Elderly Bahraini and non-Bahraini population 65 years and above 1981-2010



Central Statistics Organization-Kingdom of Bahrain

4. Role of the Family Physician

- The Family Physician gives personal and continuing care to individuals, families, and practice population, irrespective of age, sex, and illness.
- His aim is to make early diagnosis; include and integrate physical, psychological and social factors in consideration about health and illness; and will undertake the continuing management of patients with chronic, recurrent, or terminal illnesses; will know how and when to intervene, through treatment, prevention, and education.
- The Family Physician is unique in that offers the physician the privilege of managing patients throughout their life cycle. These physicians see patients and their families in both good times and bad. Such longitudinal relationships highlight the importance of emotional factors in the patient's life.

5. Relationship between primary care and mental health in elderly

- When faced with mental health problems, older persons frequently turn first to their primary care physicians. Over half of older persons who receive mental health care are treated by their primary care physician (Lebowitz et al, 1997).
- Going to a primary care physician does not carry the same stigma that specialty mental health services do; while many older people prefer to receive mental health treatment in primary care settings (Unutzer et al, 1997).
- A significant number of older adults with depression are underdiagnosed and undertreated by their primary care physicians.
- 70% of older adults had seen their physicians within one month of their committing suicide (Cooper-Patrick et al, 1994; Courage et al, 1993; NIMH, 2000).
- Total prevalence of psychiatric morbidity is 21.9%.
- General practitioners referred only those who were very ill, and the proportion of known cases was very low.

There are several models aimed at improving mental health services in primary care have been developed. Gask et al (1997) describe these models as follows:

- a) Attached mental health professional – Many primary care practices have affiliations with a mental health professional, who may be a psychiatrist, nurse, clinical psychologist, social worker, or other mental health professional. The professional can screen for mental health problems, conduct therapy sessions, and monitor medication compliance. Coordination with the primary care staff does not tend to be as intensive or as integrated as in the consultation-liaison model described below.
- b) Consultation-liaison – This model emphasizes teamwork and regular collaboration between a mental health specialist and the primary care team. The goals are to treat milder mental disorders, selectively encourage referral of serious mental illness, and enhance the primary care physicians' skills in the detection and management of mental illness.
- c) Community mental health teams – These teams operate within the community but are often based in psychiatric hospital services. They serve as a single point of referral for multi-disciplinary care with pooling and discussion of referrals. They provide assessments, education, and consultation in varying patterns of integration with primary care and community agencies.

6. Evaluation of the elderly patient with mental illness in primary care

- Assess each patient carefully – mental decline is NOT normal for the aged.
- Always carefully evaluate physical condition. An impaired physical state can markedly alter the psychiatric evaluation. Make sure the patient can hear and see. Check for deficiency states (iron, folate, vitamin B12 and D, calcium, serum proteins).
- Interview technique – be respectful, use name, sit near, speak slowly and clearly, allow time for answers, be friendly and personal, be supportive and issue oriented, keep interview short.
- Collect history, do mental status- perhaps in more than one interview.
- Use diagnostic tools for depression, dementia, etc.
- Assess the major risk factors: Loss of spouse, friends, physical health, job, status, independence, poverty, social isolation- impaired mobility, sensory deprivation, chronic pain, fears- of being dependent, of being alone, of being helpless.
- See family- assess their strengths, dynamics, and support for the patients, hidden agendas.

7. General treatment principles for elderly mentally ill in primary care

- Be supportive, respectful, sympathetic, and a “good listener”.
- Encourage patients to express themselves (about guilt, loneliness, helplessness).
- Be directive and reality oriented. Help in a concrete way with problems (calling elderly social service, arrangement other service like day care centers...).
- Strengthen defenses rather than restructure them.
- Encourage self-esteem. Reminiscence is adaptive coping behavior and promote self-esteem.
- Encourage continued interests, friendships, socialization, activates, and self-support and keep the patient doing them.
- Be an ongoing presence. Be available-frequent, regular, short sessions. Be reachable by telephone.
- Involve and work with the family. Teach them appropriate skills and expectations.
- Know and use community resources.
- Start “low” and go “slow” with medication.

8. Common psychiatric illness of the elderly in primary care

8.1 Depression

Depression in old age are characterized by greater abnormalities, less frequently positive family history, poor treatment response, and greater risk of both progression to dementia, and earlier mortality than those with a past history of depression earlier in life (Alexopoulos1989). Around 10-15% of elderly people in the community have some degree of depressive symptomatology. Significant depression were found in third of elderly patients attending their GP (McDonald 1986).

Depression and neurodegenerative disorder

Disorder	Prevalence of Depression %
Dementia (hospitalised)	25-52
Dementia (community care)	5-38
Stroke	30-60
Parkinson's disease	5-70

The American Association for Geriatric Psychiatry reports about 25 percent of people experience depression coexisting with a chronic illness. The illnesses that particularly affect mental health in the elderly include:

- Ischemic heart disease
- Stroke
- Cancer
- Chronic lung disease
- Arthritis
- Alzheimer's disease
- Parkinson's disease

Clinical presentation of depression in elderly

- More severity
- Somatic complaints (De Alarcon1964)
- Excessive Hypochondriasis (Gurland1964)
- Greater agitation (Winokur1973)
- More frequent delusions (Hordern1963)
- More endogenous picture (Blazer 1986)
- Confusion
- More thought about death wishes
- Lower prevalence of family history of affective disorder than young
- Loss of enjoyment (anhedonia)
- Slowly progressive especially in very old
- Deteriorating self-care, a change in eating habit and loss of weight – earliest indication of depression or dementia.
- Depression can occur with cognitive impairment.

- Delusions of guilt, poverty, nihilistic are common with severe depression.
- Depression superimposed upon dementia
- Alcohol abuse and dependence

When to refer depressed elderly patients to old age psychiatry?

Diagnostic Uncertainty

- Symptoms of known medical illness mimic, overlap, mask, or distort symptoms of depression.
- The differential diagnosis of depression and neurological disorders such as dementia, delirium, Parkinson's disease or stroke is unclear.
- When depressive symptoms occur in the context of late-life losses, declining health, or disability, a geriatric psychiatrist can determine whether psychotherapy is indicated as the treatment of choice or an adjunct to antidepressant medication.

Severe or Urgent/Emergent Situations

- The patient is suicidal or homicidal.
- The patient has delusions or hallucinations.
- The patient is disabled by severe depression, and may be refusing to eat or drink.
- The patient needs evaluations for Electro-Convulsive Therapy (ECT).

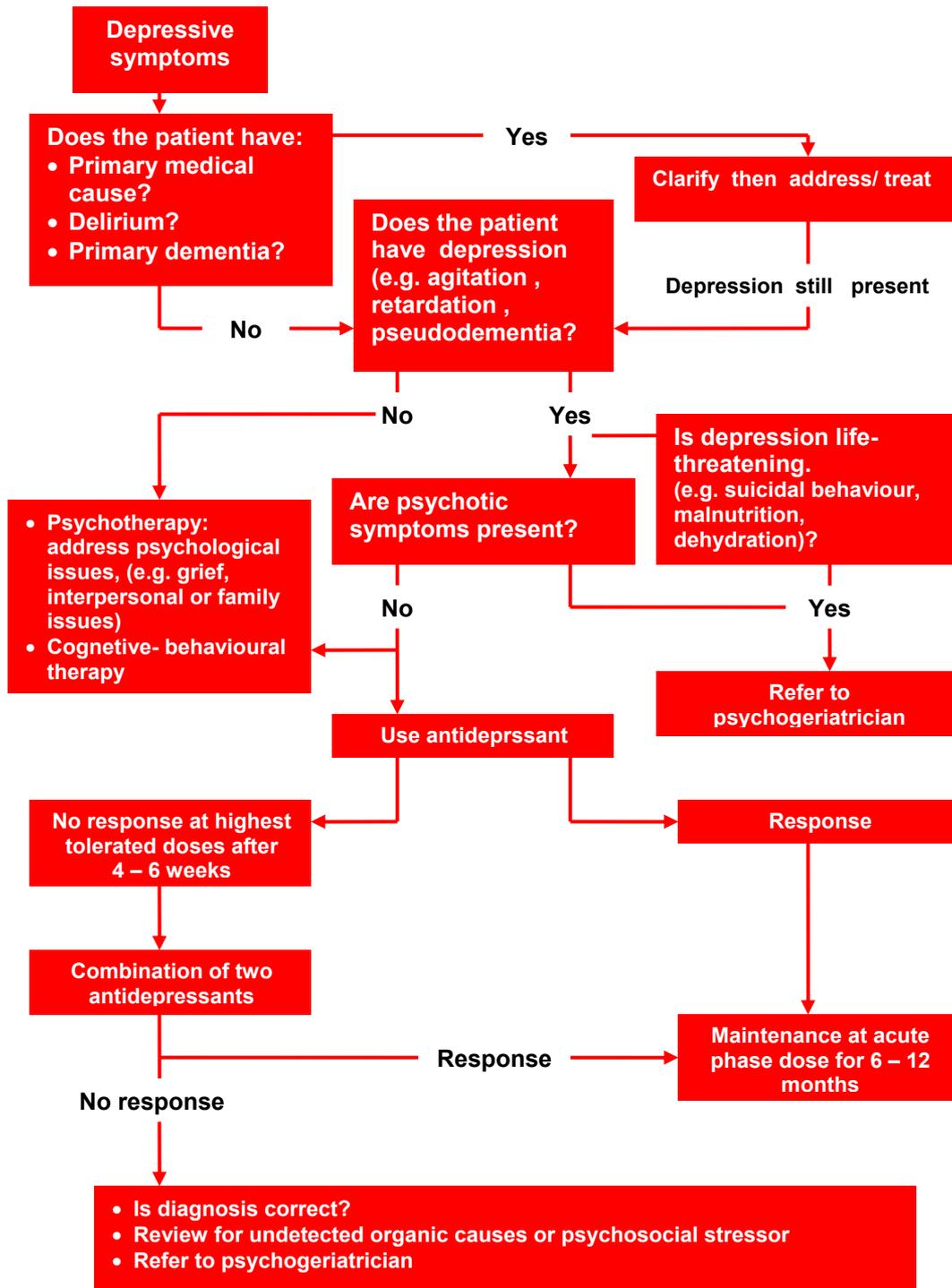
Complicated treatment

- The family physician is uncertain about antidepressant selection.
- The patient has failed to respond to one or two adequate trials (8 to 12 weeks at a therapeutic dose) of antidepressants with which the PCP is comfortable, or gets worse during treatment.
- Antidepressant side effects or drug interactions limit effective therapy.
- The patient and/or caregivers are noncompliant with treatment.
- Difficult, demanding or unreasonable behavior of the patient or caregiver undermines treatment.
- When staff in a geriatric care facility seems to have difficulty working effectively with depressed patients, a geriatric psychiatrist may be able to provide formal or informal staff consultation and education.

Maintenance management

- When the risks and benefits of continuing maintenance antidepressants are uncertain.
- A patient on a maintenance regimen experiences an exacerbation of depression or other worsening of mental status.

Depression management flowchart



8.2 Bereavement

An acute grief reaction is a normal, understandable reaction to loss. It may precipitate or exacerbate other psychiatric conditions, and may be complicated, delayed or incomplete, leading to seemingly unrelated problems years after the loss.

Bereavement is a process. A helpful model is to think of four tasks to be completed by the bereaved person:

- Accepting the reality of loss
- Experiencing the pain of grief
- Adapting to the world without the deceased
- “letting go” of the deceased and moving on

The patient:

- Feels overwhelmed by loss
- Preoccupied with the loved one
- May present with somatic symptoms following loss

The Family Physician is in unique position to:

- Help the bereaved to express their feelings and come to terms with their loss.
- Encourage the bereaved to begin life again after an appropriate time.
- Detect and treat pathological grief.

Diagnostic features

- Low sad mood
- Disturbed sleep
- Loss of interest
- Guilt or self-criticism
- Restlessness
- Guilt feeling
- Seeing the deceased person or hearing their voice
- Thoughts of joining the deceased

Consider depression if:

- The person become stuck of any point in the process.
- A full picture of depression is still present two months after the loss.
- Signs that the grief is becoming abnormal (severe depression, social isolation, guilt feelings, hopelessness and suicidal ideation).

Advice and support to the patient and family

- Enable the bereaved person to talk about the deceased and the circumstances of the death.
- Encourage free expression of feelings about the loss.
- Offer reassurance that recovery will take time.
- Take into the account the cultural context of the loss.

Medication

- Avoid medication if possible.
- Consider antidepressant for complicated grief with depression.

Referral

- If the patient is severely depressed or showing psychotic features.
- If the patient is suicidal.
- If the symptoms have not resolved by one year.

8.3 Suicide

- There is strong link between depression and suicide, with 70% of suicide following depressive illness.
- The highest rates being reported in men aged 65 or more.
- Increasing age is also an important risk factor for suicide.
- More than half of the elderly men who commit suicide or who kill themselves after murdering their wives have clear evidence of psychopathology, but their primary physicians apparently fail to detect or properly treat it.
- Two thirds of those who attempt suicide have consulted their GP in the previous month.

What are the warning signs?

- Loss of interest in things or activities that are usually found enjoyable
- Cutting back social interaction, self-care, and grooming.
- Breaking medical regimens (e.g., going off diets, prescriptions)
- Experiencing or expecting a significant personal loss (e.g., spouse)
- Feeling hopeless and/or worthless ("Who needs me?").
- Putting affairs in order, giving things away, or making changes in wills.
- Stock-piling medication or obtaining other lethal means.
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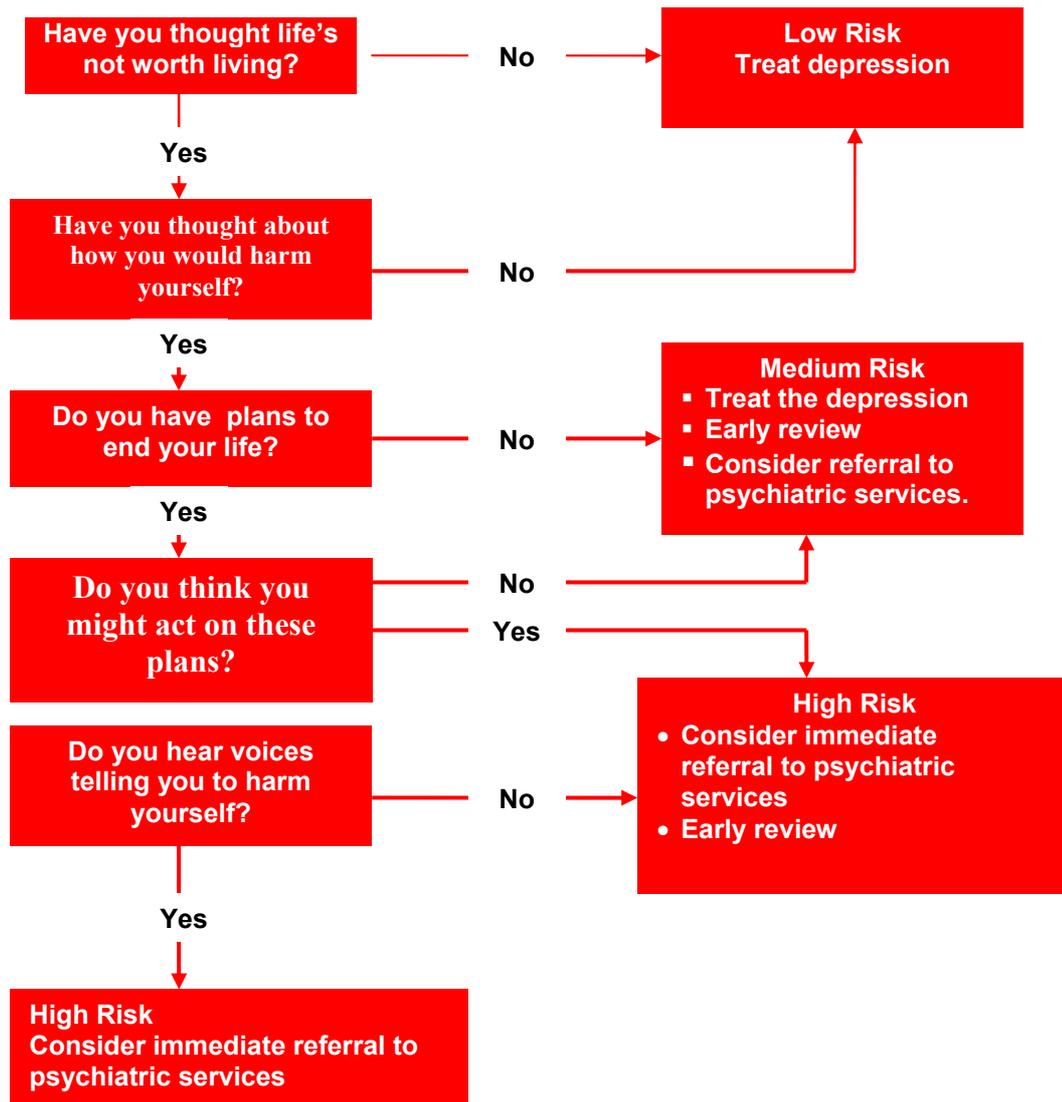
Risk factors

Elder suicide is associated with depression and factors causing depression, e.g., chronic illness, physical impairment, unrelieved pain, financial stress, loss and grief, social isolation, previous attempts, and alcoholism. Depression is tied to low serotonin levels. Serotonin, which decreases with aging, is a neurotransmitter which limits self-destructive behavior.

Assessment

- Physicians need not fear that broaching the subject of suicide will spur or encourage a patient to take such action. Indeed, systematic assessment and implementation of a treatment plan can save the patient's life.

- An important question to ask patients who report psychological distress is, "Have things gotten so bad you have considered taking your own life?" Most patients who have had suicidal feelings are ambivalent about those feelings and will readily discuss them.
- A question that must follow is, "Do you have a plan to harm yourself?" Follow-up questions should explore the patient's access to firearms, harmful medications, and other means of suicide.



Conclusion

- It is essential for primary care physicians to ask each new patient about mood and to assess any psychiatric disorders and accompanying suicidal ideation.
- Most patients with suicidal feelings are ambivalent about these feelings and are relieved when a physician recognizes their despair.
- An open attitude and careful questioning can help physicians obtain a thorough history and assess the patient's risk of suicide.
- Physicians then can decide whether patients should be treated on an outpatient basis, hospitalized, or referred to a psychiatrist.

8.4 Late onset schizophrenia (Paraphrenia)

Paraphrenia is a psychotic disorder characterized by bizarre delusions without personality deterioration that is commonly seen in early onset schizophrenia. It occurs predominantly in women and is associated with auditory and visual sensory deficits, a history of personality disorder, social isolation, lower social class, and no children.

Advice and support of patient and family

- Insure the safety of the patient.
- Minimize stress and stimulation.
- Do not argue with psychotic thinking.
- Avoid confrontation or criticism.
- Assess ability to drive safely.

Medication

Antipsychotic medication (see the table of commonly prescribed psychotropic medication and their side effect).

Referral

- As an emergency, if the risk of suicide, violence or neglect is considered significant.
- Urgently for all first episodes, to confirm the diagnosis and arrange care planning.
- For all relapses, to review the management plan.
- If there is non-compliance with treatment

8.5 Dementia

Dementia in the elderly has been recognized since Esquirol described "démence senile" in his textbook *Des Maladies Mentales* in 1838. The essential feature of dementia is impairment in short- and long-term memory, associated with impairment in abstract thinking, impaired judgment, other disturbances of higher cortical function, or personality change. The disturbance is severe enough to interfere significantly with work or usual social activities or relationships with others. The diagnosis of dementia is not made if these symptoms occur only in the presence of reduced ability to maintain or shift attention to external stimuli, as in delirium; however delirium and dementia may coexist.

Primary degenerative dementia of the Alzheimer type appears to be the most common dementia. Other causes include: vascular disease (Multi-infarct dementia); Dementia with Lewy Bodies; central nervous system infections; brain trauma; toxic-metabolic disturbances; normal-pressure hydrocephalus; neurological diseases such as Huntington's chorea, multiple sclerosis, Pick's disease, cerebellar degeneration, progressive supra-nuclear palsy and Parkinson's disease; post-anoxic or post hypoglycemic states.

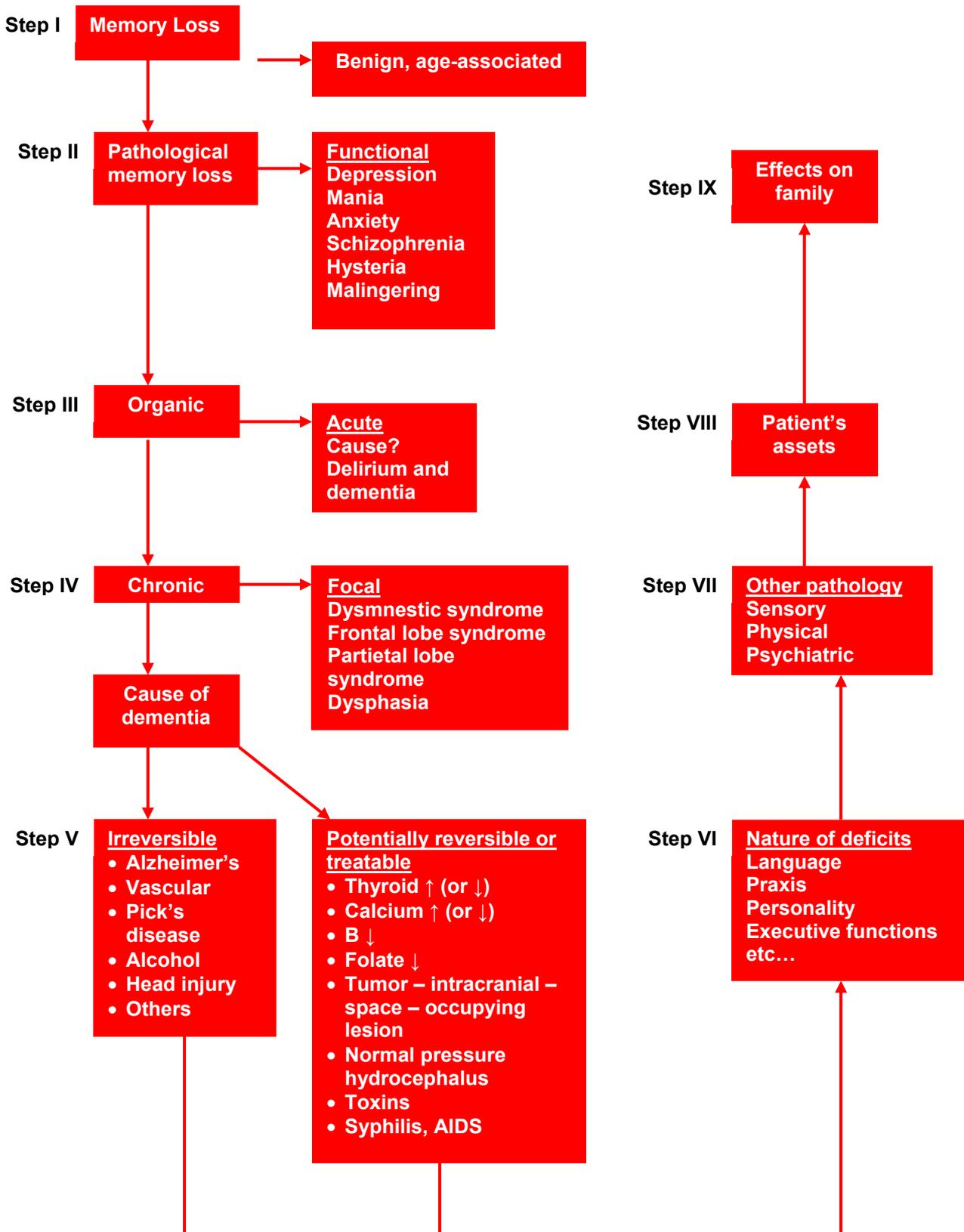
Prevalence

The prevalence of dementia increases with age and is estimated to be about 20% at 80 years of age. The annual incidence of senile dementia of the Alzheimer type is 34.3/100 person years at risk in the 90 year age group. The incidence is higher in women than in men. In one third of cases, dementia is associated with other psychiatric symptomatology (depressive disorder, adjustment disorder, generalized anxiety disorder, alcohol related problems).

Exclude

- Depression
- Poor hearing or vision
- Hypothyroidism
- Alcohol brain disease
- Cerebral tumor
- B12 deficiency
- Neurosyphilis
- Chronic subdural haematoma
- Normal pressure hydrocephalus

Assessment elderly patient with memory loss





A person with dementia can reasonably expect from the service:

- An accurate diagnosis
- Appropriate care and support within the primary care setting
- A focus on domiciliary support
- Access to specialized assessment where necessary
- Access to specialized support where necessary
- Co-coordinated and culturally appropriate care
- Education and information
- Support for their caregiver

Recommendations

- People with dementia and their carers need continuity of well co-ordinate care throughout the span of the illness.
- As General Practitioners are often the first point of contact for services, it is vital that there is consistency of diagnostic criteria and prompt access to specialist advice available for those cases which require it.
- General Practitioners should be conversant with appropriate referral and information services.
- Every patient should have access, when necessary, to expert specialist advice on dementia from a publicly funded service.
- There should be nationwide uniformity of Elder Abuse Services in the country.
- Carers must have specific information and counseling for emotional problems throughout the illness.
- Carers need services that are timely, appropriate and individually planned.
- Implementation of standardized, mandatory training in dementia for all medical students in both the pre-clinical and clinical years.
- Mandatory training in dementia for all medical students in both the pre-clinical and clinical years, should be implemented.
- National standards for dementia - specific training included in service contracts with residential care facilities, in particular those providing specialized dementia care.
- Training programmes for family carers should be available throughout the country.
- Protection of personal property and rights should be freely available to health professionals and carers.

Referral

- There is doubt about the diagnosis. The patient is under 65 years old.
- Memory loss is not the main features.
- There are focal neurological signs.
- Abnormal gait precedes the cognitive impairment and especially if incontinence develops early; normal pressure is a possibility.
- History of fall.
- The patient is suffering from behavioral or psychotic disturbance
- Consider referral to social service for practical help like day center and mobile unit.

- For confirmation of the diagnosis, further assessment and initiation of anticholinesterase drug.

8.6 Acute confusional state

Delirium is the term used to describe a state of fluctuating organic mental confusion usually of abrupt onset (over few hours) and of relatively short duration (days) – WHO1987- American P A 1994.

Acute confusional state is distinguished from acute psychosis by the fact that the patient is disoriented with memory loss; and from dementia by its recent onset, by drowsiness, which is often intermittent, and indeed by the fluctuating nature of the symptoms altogether.

Degrees in delirium

Mild

- Failure to maintain attention, worse in the evening or at night.
- Gaps in memory.
- Subjective feeling of uncertainty or apprehension.

Moderate

- Patient easily distractible
- Disruption in sleep/wake cycle, sleep in appropriate times.

Severe

- Patient lapses into periods of coma, which often rapidly alternate with periods of increased arousal.
- Attention very difficult to keep.

Coma

- Unresponsive to all except noxious stimuli

Causes of delirium

Hypoxic

(Poor cardiac output, pneumonia, stroke, cerebral swelling, anaemia)

Infective

(UTI, cerebral infection, syphilis, chest)

Toxic

(Drugs like psychotropic, antidepressant, anti Parkinson, cardiac, alcohol, anticonvulsants, lead intoxication)

Metabolic

(Thyroid, electrolyte, low magnesium, high calcium, vitamin deficiency thiamine, uraemia)

Sensory deprivation

Visual, auditory, pain, constipation, urinary retention

CNS disorder

Trauma, ischaemia, dementia)

Risk factors

- Pre-existing cognitive impairment
- Advanced age
- Evidence of infection or other severe illness
- Dehydration, hypotension and elevated blood urea Abnormal electrolytes
- Use of neuroleptic and narcotics
- Presence of fracture or advanced cancer

Referral

Referral to a medical is nearly always indicated because it is a medical emergency and if there is:

- Unclear cause
- Poor family support
- History of drug or alcohol

8.7 Alcohol problem

Recent literature demonstrates that substance abuse in the elderly is far from rare, and that, in heavy drinking societies, alcohol and drug dependence in fact constitute a public health problem of moderate proportion in the elderly. Difficulties in diagnosis of alcoholism in the elderly

The general practitioner is undoubtedly the person with most opportunity to identify alcoholism in an elderly patient, whose social and family isolation is relatively common. However, the doctor is often confronted with denial of the problem, by the patient and especially by the family.

- Almost 10 % of those over 65 years have an alcohol abuse problem.
- Alcohol consumption and alcohol abuse decreases with age; alcoholism in elderly people remains a significant public health problem.
- Two forms of alcoholism in elderly subjects can be distinguished: alcoholism beginning before the age of 65 years and continuing, and alcoholism beginning after the age of 65 years.
- Elderly alcoholic subjects have either a history of excessive consumption over 40 or 50 years, or a moderate consumption, which increases at times of strain.
- Late alcoholism in the elderly is often related to loneliness, loss of the spouse, disabling illness and isolation.
- Elderly with alcohol problem, often taking multiple medications, present an increased risk of medication / alcohol interactions, especially with tranquillizers and sedatives.
- Elderly patients have memory deficits and have difficulty evaluating their average consumption.

- The principal assessment questionnaires such as MAST, SMAST and CAGE have been validated in adults with an average age well below 65 years, still working and likely to be driving.
- Elderly subjects often have lower tolerance to alcohol, due to a reduction in their body fluid, cardiac output, metabolism and liver enzyme activity. It appears that elderly alcoholics consume less alcohol than the average for young drinkers.
- Many symptoms of alcohol abuse, such as muscular pain, insomnia, loss of libido, depression, anxiety, memory loss and cognitive changes, may be attributed to the age of the patient when in a younger patient they will be linked to chronic alcoholism.

There are five different categories of alcohol use:

- 1) **Abstainers or light drinkers.**
- 2) **Moderate drinkers.** Men who drink two or fewer drinks a day, and women and seniors who drink one or fewer drinks a day are considered moderate drinkers.
- 3) **At-risk drinkers.** Men, who drink more than 14 drinks a week, or more than four per occasion, are considered at-risk. So are women who drink more than seven drinks a week, or three per occasion. (Drinking four or more drinks per occasion is defined as binge drinking.)
- 4) **Alcohol abusers.** Abusers meet at least one of these criteria:
 - failure to meet obligations at work, home or school;
 - recurrent use in hazardous situations, like while driving;
 - legal problems related to alcohol use;
 - continued use despite alcohol-related social problems.
- 5) **Alcohol dependent.** Dependent patients meet at least one of these criteria:
 - withdrawal symptoms;
 - use of larger amounts of alcohol than intended;
 - unsuccessful attempts to control use;
 - excessive time spent recovering from alcohol use;
 - continued use despite alcohol-related physical or psychological problems.

Alcohol use and psychological problem

- Anxiety disorder
- Depression
- Sleep disorder
- Suicide and suicidal attempts

- Sexual dysfunction
- Severe memory impairment
- Cognitive deficits
- Morbid jealousy
- Rage states
- Paranoia
- Delirium

Tools for effective brief interventions

The six critical principles are summarized by acronym FRAMES (Millar & Sanchez 1993):

- **F**eedback of personal information; current health status and blood tests)
- **R**esponsibility; emphasizing the patients personal responsibility for the change.
- **A**dvice; giving clear advice may involve prompting total abstinence, and to reduce drinking to safe levels.
- **M**enu; offering patients a menu of alternative strategies emphasises perceived control and personal choice which may lead to greater commitment to change.
- **E**mpathy is potent determinant of patient motivation and change.
- **S**elf-Efficacy; the practitioner's belief in the patients ability to change can also influence recovery.

There is strong evidence that brief intervention in the primary care setting is a powerful and effective tool in influencing the behavior of heavy drinkers.

Referral

- Severe depression
- History of failed primary care treatment
- Comorbid psychiatric disorder
- Risk of harm to self or others
- Danger of withdrawal symptoms
- Poly-substance abuse
- Lack of social support structure

8.8 Smoking

The GP is the person best placed to help patients give up smoking. Five per cent of patients will stop smoking following simple advice from their GP and still be non-smokers after 1 year.

A plan for stopping smoking

- 1) Don't tell a patient to stop smoking: ask if he or she would like to stop. Find out what went wrong with previous attempts.
- 2) Give educational procures.
- 3) Obtain, if possible, a commitment from the patient to stop smoking.
- 4) Encourage the patient to keep a diary for 1 week before stopping, detailing every cigarette smoked, the setting and why it was needed.
- 5) Suggest to patients that:
 - They appoint on which to give up;
 - Prior to this date, they should remove all ashtrays, etc., from their immediate environment;
 - They must be firm about refusing cigarettes from others and the early days avoid situations that are conducive to smoking;
 - They should invent methods of distracting themselves from the short-term cravings that can occur;
 - They transfer the money saved daily to a suitably labeled jar.
- 6) Prescribe "Nicorette"; start with 4mg for anyone smoking over 20 cigarettes/day.
- 7) Follow up at 1 week then monthly

8.9 Insomnia

Although insomnia can be a problem at any stage of life, it is particularly common after the age of 65 years. A number of changes in sleep physiology are associated with age, such as loss of total sleep time, reduction in slow-wave sleep, increased number of arousals and in sleep latency, and changes in circadian distribution (increased daytime sleep propensity, with loss of circadian amplitude. Furthermore, insomnia is facilitated by the concomitant presence of psychosocial influences with an increased risk for psychiatric disorder, medical illness and the use of medications and alcohol. Evaluation of insomnia in the older patient requires a careful history and physical examination, supplemented by a sleep diary.

A patient complaining of insomnia may describe one or more of the following symptoms:

- Difficulty falling asleep.
- Frequent waking during the night.
- Early-morning wakening.
- Daytime sleepiness.
- A general loss of well-being through the individual's perception of bad night's sleep

Before treating insomnia with drugs, consider:

Is the underlying cause being treated (e.g. depression, mania, breathing difficulties, urinary frequency, chronic pain, alcohol problem, etc.)?

Is substance misuse or diet problem?

Are other drugs being given at appropriate times (i.e. stimulating drugs in the morning, sedating drugs at night)?

Have all sleep hygiene approaches been tried?

Sleep hygiene approaches

- Increase daily exercise (not in the evening)
- Reduce daytime napping
- Reduce caffeine or alcohol intake, especially before bedtime
- Only use the bed for sleeping
- Use anxiety management or relaxation techniques
- Develop a regular routine of rising and retiring at the same time each day

Guidelines for prescribing hypnotics

- Use the lowest effective dose.
- Use intermittent dosing (alternate nights or less) where possible.
- Prescribe for short-term use (no more than 4 weeks) in the majority of cases.
- Discontinue slowly.
- Be alert for rebound insomnia/withdrawal symptoms.
- Advise patients of the interaction with alcohol and other sedating drugs.
- Avoid the use of hypnotics in patients with respiratory disease or severe hepatic impairment and in addiction-prone individuals.

Referral

Where symptoms are severe and long- lasting and the above measures are unsuccessful, consider referral to mental health service.

8.10 Abuse of the elderly

Elder abuse is a repeated act against or failure to act for an elderly person which causes distress or damage and so prevent them living a full life.

Presenting circumstances

- Delay in seeking treatment
- Multiple missed appointments
- Explanation is not consistent with findings.
- Frequent change in address and doctors.

History

- Previous unexplained injuries.
- Previous report of similar injuries.

Mental state examination

- Patient appear anxious, withdrawn and cowed.
- Patient reports feeling low, miserable, and suicidal, but without other evidence of depressive syndrome.
- Patient appear fearful of carer and reluctant to speak in their presence
- Patient cognitively impaired.

Physical examination

- Signs of injury, fracture, laceration, abrasions, burns, and bruises.
- Poor personal hygiene.
- Evidence of misuse of medication.
- Sexually transmitted disease.
- Pain, itching or bleeding from genital area.

Investigation

- Evidence of malnutrition.
- Evidence of blood loss.
- Evidence Sexually transmitted disease.
- X-ray evidence of current or previous fractures.

The possible abuser

- History of alcohol and drug abuse.
- History of abuse as a child.
- History of incapacity of to cope with responsibility.
- Poor relation with parents.

Types of abuse

Needs for	Freedom from	Abuse/Neglect
Food Warmth Physical intimacy	Hunger Cold Pain	Physical abuse
Sexual intimacy	Personal intrusion	Sexual neglect Sexual abuse
Caring relationships	hatred	Psychological neglect Psychological abuse
Financial security	poverty	Financial neglect Financial abuse
Choices about life	regulation	Neglect by society Abuse by society

The elderly cases with abuse must be referred to

- Secondary care for further treatment.
- Psychiatry of old age.
- Local service authority.

9. Instrumental tools commonly used in primary care setting

9.1 Geriatric Depression Scale 30

The Geriatric Depression Scale can be used to evaluate the elderly individual for depressive symptoms. It is a self-rating instrument that is easy to answer and geared towards the geriatric patient.

Choose the best answer (YES OR NO) for how you felt over the past week.		Points for Response	
1	Are you basically satisfied with your life?	YES	NO
2	Have you dropped many of your activities and interests?	YES	NO
3	Do you feel that your life is empty?	YES	NO
4	Do you often get bored?	YES	NO
5	Are you hopeful about the future?	YES	NO
6	Are you bothered by thoughts you can't get out of your head?	YES	NO
7	Are you in good spirits most of the time?	YES	NO
8	Are you afraid that something bad is going to happen to you?	YES	NO
9	Do you feel happy most of the time?	YES	NO
10	Do you often feel helpless?	YES	NO
11	Do you often get restless and fidgety?	YES	NO
12	Do you prefer to stay at home rather than going out and doing new things?	YES	NO
13	Do you frequently worry about the future?	YES	NO
14	Do you feel you have more problems with memory than most?	YES	NO
15	Do you think it is wonderful to be alive now?	YES	NO
16	Do you often feel downhearted and blue?	YES	NO
17	Do you feel pretty worthless the way you are now?	YES	NO
18	Do you worry a lot about the past?	YES	NO
19	Do you find life very exciting?	YES	NO
20	Is it hard for you to get started on new projects?	YES	NO
21	Do you feel full of energy?	YES	NO
22	Do you feel that your situation is hopeless?	YES	NO
23	Do you think that most people are better off than you are?	YES	NO
24	Do you frequently get upset over little things?	YES	NO
25	Do you frequently feel like crying?	YES	NO
26	Do you have trouble concentrating?	YES	NO
27	Do you enjoy getting up in the morning?	YES	NO
28	Do you prefer to avoid social gatherings?	YES	NO
29	Is it easy for you to make decisions?	YES	NO
30	Is your mind as clear as it used to be?	YES	NO

- Points in **RED** are assigned for depressive responses
- Scores of 0-10 are not increased and are "normal" for the elderly
- Scores of 11 are borderline
- Scores of 14 are increased and associated with depression

9.2 Mini-Mental State Examination (MMSE)

Note: The MMSE is a required part of this dementia assessment.

Maximum score appears before each assessment item. Fill in patient score for each item in the space provided.

(10) Orientation (5 points each)

- () What is the (year) (season) (day) (date) (month)?
- () Where are we: (state) (county) (town) (hospital) (floor)?

(3) Registration

() Name three unrelated objects. Allow one second to say each. Then ask the patient to repeat all three after you have said them. Give one point for each correct answer. Repeat them until he or she learns all three. Count trials and record. Trials: _____

(5) Attention and Calculation

() Ask patient to count backwards from 100 by sevens. Give one point for each correct answer. Stop after five answers. Alternatively, spell world backwards.

(3) Recall

() Ask patient to recall the three objects previously stated. Give one point for each correct answer.

(9) Language

- () • Show patient a wrist watch; ask patient what it is. Repeat for a pencil. **(2 points)**
- () • Ask patient to repeat the following: "No ifs, ands, or buts." **(1 point)**
- () • Ask patient to follow a three-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." **(3 points)**
- () • Ask patient to read and obey the following sentence which you have written on a piece of paper: "Close your eyes." **(1 point)**
- () • Ask patient to write a sentence. **(1 point)**
- () • Ask patient to copy a design. **(1 point)**



Scoring:

24-30 Uncertain Cognitive Impairment

18-23 Mild to Moderate Cognitive Impairment

0-17 Severe Cognitive Impairment

*The score ranges listed here are widely used, but it should be noted that an MMSE score is only an initial indicator of cognitive status, and norms for the MMSE vary greatly depending on a person's age, education level, and race. **Total Score:** -----

Assess level of consciousness along a continuum:
Alert Drowsy Stupor Coma

9.3 Ischemic Score of Hachinski et al

Indication: to Separate Patients with Vascular Dementia from Primary Degenerative Dementia

The Ischemic Score can be used to identify patients with vascular dementia by assessing clinical findings.

Clinical Findings (13)	Points
abrupt onset	2
stepwise deterioration	1
fluctuating course	2
nocturnal confusion	1
relative preservation of personality	1
Depression	1
somatic complaints	1
emotional incontinence	1
history of hypertension	1
history of strokes	2
evidence of associated arteriosclerosis	1
focal neurological symptoms	2
focal neurological signs	2

• Minimum score: 0 • Maximum score: 18

Score	Diagnosis
> 7	vascular dementia
4 – 7	borderline mixed
< 4	primary degenerative dementia (Alzheimer etc.)

9.4 Confusion Rating Scale

The Confusion Rating can be used to quickly and simply assess patients for cognitive impairment. Trends over time may indicate improvement stability or deterioration in response to changes in clinical status or to therapeutic interventions.

Parameter	Finding	Points
Memory	complete	0
	occasionally forgetful	1
	short-term loss	2
	short and long term loss	3
Orientation	complete	0
	oriented in ward identifies people correctly	1
	misidentifies but can find way about	2
	cannot find way to bed or toilet without assistance	3
	completely loss	4
Communication	always clear retains information	0
	can indicate needs understands simple verbal directions can deal with simple information	1
	cannot understand simple verbal information OR cannot indicate needs	2
	cannot understand verbal information AND cannot indicate needs; retains some expressive ability	3
	no effective contact	4

Interpretation:

- Minimum score 0
- Maximum score 11
- Higher scores indicate greater confusion
 - Demented patients had higher scores than other patients (typically 6 or greater); a score ≥ 4 correctly classified 91% of demented patients.
 - Normal elderly and elderly with psychiatric illnesses such as depression or schizophrenia had similar scores; a score ≤ 3 correctly classified nondemented patients.

9.5 CAGE Screening Tool

Indication: for alcohol problem

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring

Item responses on the CAGE are scored 0 or 1, with a higher score and indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

9.6 The Michigan Alcoholism Screening Test-Geriatric Version (MAST-G) The MAST-G has 24 yes/no questions.

1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?
2. When talking with others, do you ever underestimate how much you actually drink?
3. Does alcohol make you sleepy so that you often fall asleep in your chair?
4. After a few drinks, have you sometimes not eaten or been able to skip a meal, because you didn't feel hungry?
5. Does having a few drinks help decrease your shakiness or tremors?
6. Does alcohol sometimes make it hard for you to remember parts of the day or night?
7. Do you have rules for yourself that you won't drink before a certain time of day?
8. Have you lost interest in hobbies or activities you used to enjoy?
9. When you wake up in the morning, do you ever have trouble remembering part of the night before?
10. Does having a drink help you sleep?
11. Do you hide your alcohol bottles from family members?
12. After a social gathering, have you ever felt embarrassed because you drank too much?
13. Have you ever been concerned that drinking might be harmful to your health?
14. Do you like to end an evening with a nightcap?
15. Did you find your drinking increased after someone close to you died?
16. In general, would you prefer to have a few drinks at home rather than go out to social events?
17. Are you drinking more now than in the past?
18. Do you usually take a drink to relax or calm your nerves?
19. Do you drink to take your mind off your problems?
20. Have you ever increased your drinking after experiencing a loss in your life?
21. Do you sometimes drive when you have had too much to drink?
22. Has a doctor or nurse ever said they were worried or concerned about your drinking?
23. Have you ever made rules to manage your drinking?
24. When you feel lonely does having a drink help?

Score greater than **5** indicates possible alcohol problems.

The Michigan Alcoholism Screening Test-Geriatric Version can be found in "Alcoholism in the Elderly: Diagnosis, Treatment, Prevention, Guidelines for Primary Care Physicians." The Guidelines, endorsed by the American Society of Addiction Medicine, are available from the American Medical Association's department of geriatric health. © The Regents of the University of Michigan, 1991.

9.7 Sleep problems questioner

A. Have you had any problems with sleep?	YES/NO
○ Difficulty falling asleep?	
○ Restless or un-refreshing sleep?	
○ Early morning awakening.	
○ Frequent or long periods of being awake?	
If YES to any of the above, continue below	
1) Do you have any medical problems or physical pains?	
2) Are you taking any medication?	
3) Do any of the following apply? Drink alcohol, coffee, tea or eat before you sleep? Take day time naps? Experience changes to your routine e.g. shift work? Disruptive noises during the night?	
4) Do you have problems at least three times a week?	
5) Has anyone told you that your snoring is loud and disruptive?	
6) Do you get sudden uncontrollable sleep attacks during the day?	
7) Low mood or loss of interest or pleasure?	
8) Worried, anxious or tense?	
9) How much alcohol do you drink in a typical week (number of standard drink/week)	
Summing up	
Positive to any of 1, 2 or 3 (consider management of the underlying problem).	
Positive to 4 : indication of sleep problem	
Positive to 5 : consider sleep apnoea	
Positive to 6 : consider narcolepsy	
Positive to 7 : consider depression	
Positive to 8 : consider anxiety	
If weekly drinking is more than 21 standard drinks for men and more than 14for women, consider alcohol use problem	

9.8 Questioner for abuse in the elderly

The American Medical Association recommends that doctors routinely ask geriatric patients about abuse, even if signs are absent. Keeping questions direct and simple and asking in a nonjudgmental or nonthreatening manner increases the likelihood that patients will respond candidly. The patient and the caregiver should be interviewed together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate, objective documentation of the interview is essential. The following questions can be used to elicit information about elder abuse.

1) Physical abuse

- Are you afraid of anyone at home?
- Have you been struck, slapped, or kicked?
- Have you been tied down or locked in a room?
- Have you been force-fed?

2) Psychological abuse

- Do you ever feel alone?
- Have you been threatened with punishment, deprivation, or institutionalization?
- Have you received "the silent treatment"?
- Do you receive routine news or information?
- What happens when you and your caregiver disagree?

3) Sexual abuse:

- Has anyone touched you in a sexual way without permission?

4) Neglect

- Do you lack items such as eyeglasses, hearing aids, or false teeth?
- Have you been left alone for long periods?
- Is your home safe?
- Has anyone failed to help you care for yourself when you needed assistance?

5) Financial abuse

- Is money being stolen from you or used inappropriately?
- Have you been forced to sign a power of attorney, will, or another document against your wishes?
- Have you been forced to make purchases against your wishes?
- Does your caregiver depend on you for financial support?

Follow-up questions (if abuse is identified)

- How long has the abuse been occurring?
- Is it an isolated incident?
- Why do you think this happens?
- When do you think the next episode will occur?
- Is the abuser present now?
- Is it safe for you to return home?
- What would you like to see happen?

Have you ever received help for this problem before?

10 Use of psychotherapeutic medications in elderly

- The elderly generally have more medical problems and often are taking several types of medications, So the possibility of negative drug interactions is higher.
- Elderly tend to be more sensitive to medications.
- The physician will often prescribe a lower or less frequent dosage to an elderly patient to avoid overdose or toxic levels of the medication.
- The elderly may accidentally take too much of a medication because they forget that they have taken a dose and take another dose.
- The use of a seven-day pill box is especially helpful to an elderly person.
- The elderly and those close to them need to pay special attention and watch for adverse physical and psychological responses to medication.

The American Society of Consultant Pharmacists has developed these guidelines for use of psychotherapeutic medications in older adults.

Definitions

Psychotherapeutic medication: Any medication intended to affect mood, mental status or behavior.

Guidelines

- Older adults should be screened for presence of affective, cognitive and other psychiatric disorders.
- Older adults who exhibit symptoms of psychiatric disorders should be thoroughly assessed by a qualified health care professional.
- Behavioral symptoms in older adults should be objectively and quantitatively monitored by caregivers or facility staff and documented on an ongoing basis. When possible, psychiatric symptoms should also be monitored in this fashion.
- If the behaviors do not present an immediate serious threat to the patient or others, the initial approach to management of behavioral symptoms in older adults should focus on environmental modifications, behavioral interventions, psychotherapy or other nonpharmacologic interventions.
- When medications are indicated, select an appropriate psychotherapeutic agent, considering effectiveness of the medication and risk of side effects.
- Begin medication at the lowest appropriate dosage and increase the dose gradually.
- Monitor the patient for therapeutic response from the medication and for adverse drug reactions.
- The psychotherapeutic medication regimen should be routinely re-evaluated for the need for continued use of medication, dosage

(Approved by the ASCP Board of Directors: July 21, 1999).

Antipsychotic Medication					
Name	Sedation	Extra-pyramidal	Anti-cholinergic	Hypotension	Prolactin elevation
Chlorpromazine	+++	++	++	+++	+++
Clozapine	+++	-	+++	+++	-
Flupentixol	+	++	++	+	+++
Haloperidol	+	+++	+	+	+++
Olanzapine	++	+/-	+	+	+
Quetiapine	++	-	+	++	-
Risperidone	+	+	+	++	+++
Sertindole	-	-	-	+++	++
Thioridazine	+++	+	+++	+++	++
Ziprasidone	+	+/-	-	+	+/-
Zotepine	+++	+	+	++	+++
Zuclopenthixol	++	++	++	+	+++
High incidence +++		Moderate ++		Low +	
				Very low -	

Antidepressant Medication			
Name	Indication	Main Side Effect	Major Interaction
Amitriptyline	Depression Nocturnal Enuresis	Sedation; postural hypotension; tachycardia/arrhythmias, dry mouth, blurred vision, constipation, urinary retention	SSRIs (except citalopram), phenothiazine, cimetidine, alcohol, antimuscarinics, antipsychotic(especially thioridazine/pimozide), MAOIs
Clomipramine	Depression Phobia& Obsession	As above	As above
Citalopram	Depression Agoraphobia Panic disorder	Nausea, vomiting, dyspepsia, abdominal pain, diarrhea, rash, sweating, agitation, anxiety, headache, insomnia, tremor, sexual dysfunction, hyponatremia, cutaneous bleeding.	MAOIs -avoid St. Johns Wort-avoid Caution with alcohol, NSAID, warfarin.
Escitalpram	Same as above	Same as above	Same as above
Fluoxetine	Depression Anxiety OCD Bulimia nervosa Premenstrual dysphoric disorder	As for citalopram, but insomnia and agitation more common. Rash May alter insulin requirement.	MAOIs-never Avoid: selegiline/ st.John's wort/terfenadine Caution- alcohol/NSAIDs/tryptophan/warfarin
Fluvoamine	Depression	As for citalopram but nausea more common	MAOIs-never Avoid- astemizole/cisapride/terfenadine Caution- alcohol/NSAIDs/tryptophan/warfarin
Paroxetine	Depression Anxiety OCD Panic disorder Agoraphobia Social phobia PTSD Generalized anxiety disorder	As for citalopram but antimuscarinic effects and sedation more common. Extrapyramidal symptoms rare. Discontinuation symptoms common- withdrawal slowly	MAOIs-never Avoid- astemizole/cisapride/terfenadine Caution- alcohol/NSAIDs/tryptophan/warfarin

Sertraline	Depression +/- anxiety and prevention of relapse of depression OCD (under specialist supervision in children)	As for citalopram	Caution- alcohol/NSAIDs/tryptophan/warfarin
Moclobemide (reversible inhibitor of MAO-A)	Depression Social phobia	Sleep disturbance, nausea, agitation, confusion Hypertension reported – may related to tyramine ingestion	Tyramine interactions possible in high doses >600mg/day CNS excitation/depression with pethidine Avoid Clomipramine/levodopa/selegiline, SRIs Caution with morphine/tricyclics Cimetidine-use half dose of moclobemide
Mirtazapine	depression	Increase appetite, weight gain, drowsiness, edema, dizziness	Caution with alcohol & sedatives
Venlafaxine	Depression +/- anxiety	Nausea, insomnia, dry mouth, dizziness, sweating, nervousness, headache, sexual dysfunction, elevation of BP in higher doses, discontinuation symptoms- withdraw slowly	MAOIs-avoid Caution: alcohol, cimetidine, Clozapine/warfarin

Hypnotics				
Name	Usual therapeutic dose (mg/day)		Time until onset (mints)	Duration of action
	Adult	Elderly		
Diazepam	5-10	Quarter to half the adult dose	30-60	Long
Lormetazepam	0.5-1.5		30-60	Short
Oxazepam	15-30		20-50	Medium
Nitrazepam	5-10		20-50	Long
Temazepam	10-20		30-60	Short
Zaleplon	10		30	Very short
Zopiclone	3.75-7.5		15-30	Short
Zolpidem	5-10		7-27	short

Mood stabilizers			
Name	Precautions	Side effects	Drug interaction
Lithium (Blood level is between 0.6-1.0 mmol/l)	Renal dysfunction Thyroid dysfunction	Thirst, polyuria, GI upset, tremor, diabetes insipidus, acne, muscular weakness, cardiac arrhythmias, weight gain, hypothyroidism	Antipsychotic (rarely observed in practice) Diltiazem/verpamil Diuretics ACE inhibitors NSAIDs Xanthines, Ncl
Carbamazepine	Leucopenia	Drowsiness, ataxia, diplopia, agranulocytosis, rashes	MAOIs-needs 2 weeks washout Lithium Antipsychotic
Valproate	Renal and hepatic functions, FBC, then every 6 months	Moderate weight gain, hair loss, nausea, vomiting, mild sedation	Anticonvulsants Aspirin MAOIs

Anticholinesterase Inhibitors			
Drug	Starting dose	Usual treatment dose	Adverse effect
Donepezil	5mg daily	10mg daily	Nausea Vomiting Insomnia Diarrhea
Rivastmine	1.5mg twice daily	6mg twice daily	Nausea Vomiting Insomnia Diarrhea
Galantamine	4mg twice daily	12mg twice daily	Nausea Vomiting Insomnia Diarrhea
Memantine	5mg daily	20mg daily	Hallucinations Dizziness Confusion

11. United Nations principles for older persons

Independence

Older persons should: have access to adequate food, water, shelter, clothing and community support and self help; have the opportunity to work or to have access to other income- generating opportunities; be able to participate in determining when and at what pace withdrawal from the labour forces take place; have access to appropriate educational and training programmes; be able to live in environments that are safe and adaptable to personal preferences and changing capacities; be able to reside or home for as long as possible.

Participation

Older persons should: remain integrated in society, participate activity in the formulation and implementation of polices that directly affect their well-being, and share their knowledge and skills with younger generation; be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities; be able to form movements or associations of older persons.

Care

Older persons should: benefit from family and community care and protection in accordance with each society's system of cultural values; have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay, the onset of illness; have access to social and legal services to enhance their autonomy, protection and care; be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment; be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfillment

Older persons should: be able to pursue opportunities for the full development of their potential; have access to the educational, cultural, spiritual and recreational recourses of society.

Dignity

Older persons should: be able to live in dignity and security and be free of exploitation and physical or mental abuse; be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

مبادئ الأمم المتحدة لكبار السن

مبدأ الاستقلالية

يحق لكبار السن فرص:

- الحصول على ما يكفي من طعام، ماء، سكن، ملابس ورعاية صحية من خلال الدخل، الدعم الأسري والمجتمعي والمساعدة الذاتية.
- العمل أو الحصول على فرص أخرى لزيادة الدخل.
- المشاركة في تقرير متى وبأي درجة ينسحبون بها من القوى العاملة.
- الحصول على التعليم وبرامج التدريب الملائمة.
- العيش في بيئات آمنة وقابلة للتكيف مع متطلبات الفرد وتغير قدراته.

مبدأ المشاركة

يحق لكبار السن

- الاندماج في المجتمع، والمشاركة بنشاط في صياغة وتطبيق السياسات التي تؤثر مباشرة في معيشتهم، وتبادل المعلومات والمهارات مع الشباب.
- القدرة على السعي إلى تطوير الفرص لتقديم الخدمات الخاصة للمجتمع وأن يعملوا كمتطوعين في مواقع ملائمة لرغبتهم وقدراتهم.
- تشكيل هيئات وجمعيات لكبار السن.

مبدأ الرعاية

يحق لكبار السن

- الاستفادة من خدمات الرعاية والحماية الأسرية والمجتمعية وفقا لنظام القيم الثقافية في كل مجتمع.
- الحصول على الرعاية الصحية والحصول على الخدمات الاجتماعية والقانونية. والاستفادة من مستويات ملائمة من الرعاية المؤسسية.
- التمتع بالحقوق الإنسانية وتوفير الاحتياجات الأساسية عند الإقامة في أي مسكن، والاستفادة من خدمات الرعاية والمعالجة، والاحترام الكامل والحق في إتخاذ قرارات تخص رعايتهم.

مبدأ الإشباع الذاتي

يحق لكبار السن

- إستغلال فرص التطوير الكامل لقدراتهم.
- الاستفادة من الموارد التعليمية، الثقافية، الروحية والترويحوية في المجتمع.

مبدأ الكرامة

يحق لكبار السن

- العيش بكرامة وأمان والمعاملة الحسنة بغض النظر عن السن، الجنس، العرق، الإعاقة أو أي حاله أخرى، وكذلك تقدير إسهامهم الإقتصادي مهما كان.

12. Resource directory

Psychiatric Hospital: <ul style="list-style-type: none">▪ Out-patient clinic▪ Old age consultant▪ Community psychogeriatric▪ Social worker▪ Clinical Psychologist▪ Pharmacy▪ Occupational Therapist▪ Psychogeriatric ward	Contact number 17279311 17279326 17279336 17279359 17279314 17279348 17279351 17279354
National Committee for Elderly	17688520
Mobile Unit For Elderly	17688520
NBB For Geriatric Care	17687093
Administrator of Geriatric Care- Muhharag	17322911
UCO For Elderly	17677717
Al-Manar Parents Care	17683399
Wisdom Society For Elderly	17727575
Muhharag Social Welfare Center	17335450
Help line for Narcotics Anonymous (NA)	17533558
Help line for Alcoholic Anonymous (AA)	17530020
Public Information for Narcotics Anonymous	17531515

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Centre for Health Services Research, and Department of Primary Care, University of Newcastle upon Tyne

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