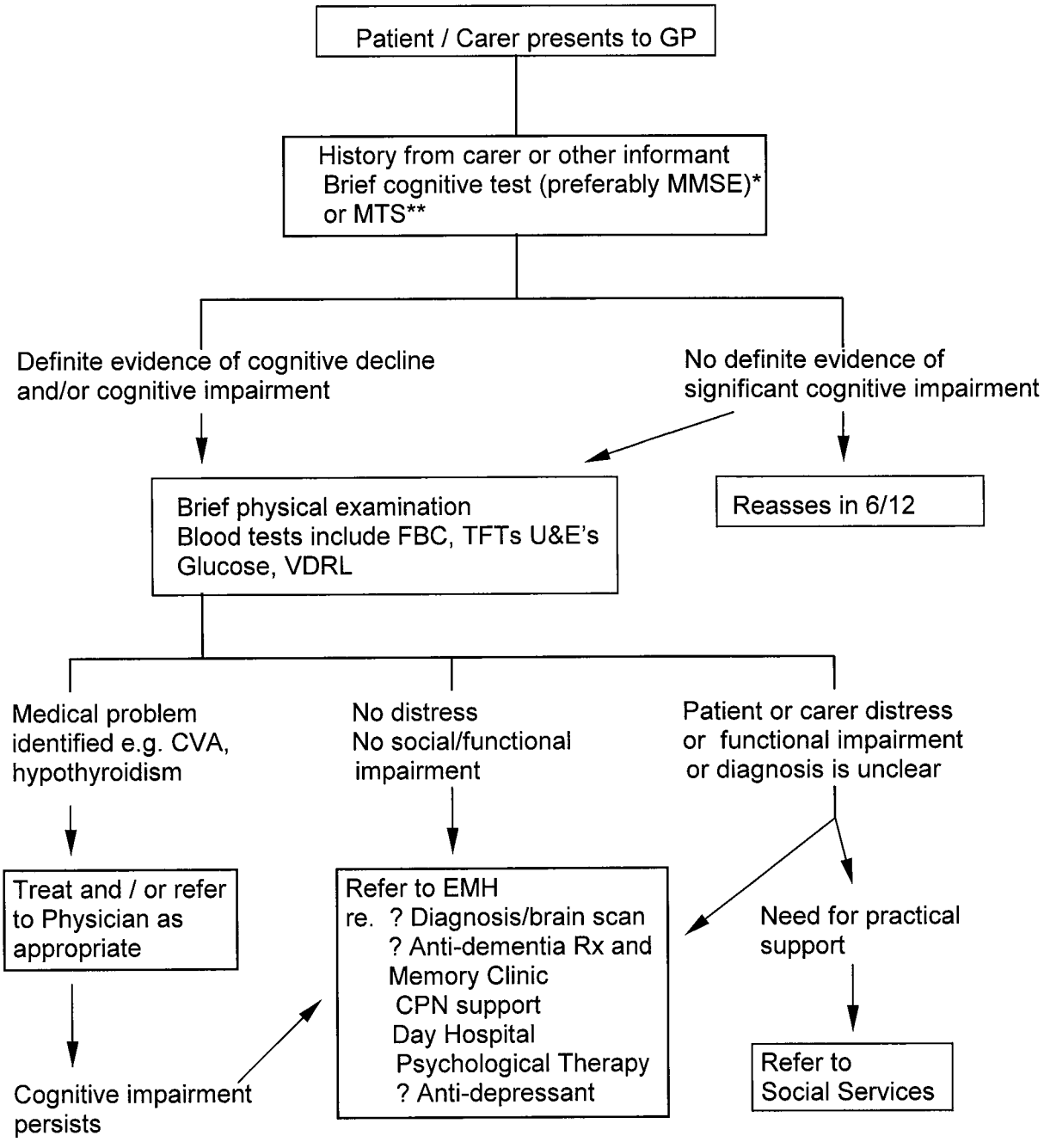
NSF for OLDER PEOPLE
MENTAL HEALTH

Referral and Care Protocol for Dementia

1. Referral and Diagnosis



* MMSE:

- Score of ‹ 24 indicates definite cognitive impairment
- However, MMSE score is only a guide

Anybody with clear cognitive decline should be investigated further, even if MMSE score › 24.
Patients with MMSE score > 24 should be referred to EMH if dementia is suspected by patient, carer or GP

** MTS:

- If MTS is performed this should include a test of short-term memory, i.e. name and address.

MINI MENTAL STATE EXAMINATION (MMSE)

Patient's name	Date of birth	Date of test

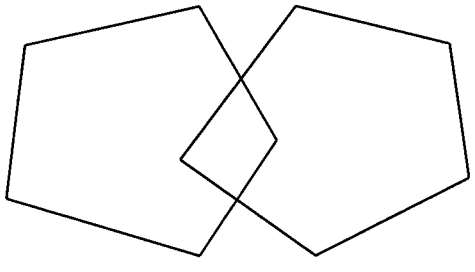
	Score	Max. points
ORIENTATION		
• What is the (year) (season) (date) (day) (month)	( )	5
• Where are we (country) (county) (town/city) (floor)?	( )	5
REGISTRATION		
• Name 3 common objects (e.g. "apple", "chair", "penny") Take 1 second to say each. Then ask the patient to repeat all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials ( )	( )	3
ATTENTION		
• Spell "world" backwards. The score is the number of letters in the correct order (D__L__R__O__W__)	( )	5
RECALL		
• Ask for the 3 objects repeated above. Give 1 point for each correct answer. NB Recall cannot be tested if all 3 objects were not remembered during registration.	( )	3
LANGUAGE		
• Name a "pen" and a "watch". Give 1 point for each correct answer.	( )	2
• Repeat the following: No ifs, ands, or buts. Give 1 point for correct answer.	( )	1
• Follow a three stage command: "Take a piece of paper in your right hand, fold it in half and put it on the floor". Give 1 point for each stage followed correctly.	( )	3
• Read and obey the following: "Close your eyes" (see below)	( )	1
• Write a sentence. (See below)	( )	1
• Copy the following design. (See below)	( )	1
TOTAL	( )	**30**

Reading

Writing

CLOSE YOUR EYES

Construction



2. Treatment and Management

2.1 Anti-Dementia Drugs (for Alzheimer's Disease)

- Donepezil (Aricept) - start dose 5 mg o.d.
- Galantamine (Reminyl) - start dose 4 mg b.d.
- Rivastigmine (Exelon)- start dose 1.5 mg b.d.
- All 3 drugs are anti-cholinesterase inhibitors and are most effective in mild to moderate dementia.
- Treatment should be initiated and supervised by specialist service.
- Main side-effects: Nausea, vomiting, diarrhoea, stomach cramps, headaches, dizziness, fatigue, insomnia and nightmares, anorexia, bradycardia
- Benefits:
  - Slow down cognitive decline
  - Improvement in non-cognitive symptoms including mood, anxiety, general alertness.
  - Generally apparent within 1-2 months of Rx
  - Benefits can last for several years, therefore discontinuation needs to be closely monitored and Rx reinstated if signs of deterioration occur after stopping.
- Anti-cholinesterase inhibitors can also be of benefit in patients with Lewy Body Disorder and those suffering with hallucinations.

2.2 Antidepressants

- Patients presenting with symptoms of dementia frequently have concurrent depression.
- Depression in dementia patients warrants Rx which can sometimes lead to improved cognitive function.
- Drugs commonly used (see also Referral Protocol for Depression).

  - SSRI's (e.g. Citalopram, Sertraline) - if sedation not wanted; concurrent physical problems.
  - Trazodone) if sedation needed
  - NaSSA (Mirtazepine))
  - SNRI (Venlafaxine)
  - Start with low dose and build up slowly

2.3 Neuroleptics

- Indicated for psychotic symptoms, agitation, aggression in some patients (generally over-prescribed!)
- Atypicals better tolerated by the elderly.
  NB: All neuroleptics carry the risk of side effects and should be used with caution. The choice of drug (including Risperidone and Olanzapine) should be informed by the side effect profile of the drug and the individual circumstances of the case.
- Use short-term only and monitor response.

2.4 **Others**

- Carbamazepine / Sodium Valproate / Lithium - for mood stabilisation or frontal lobe symptoms.
- Hypnotics for insomnia e.g. Zopiclone, Temazepam, but use with care in view of addictive risk and side-effects e.g. confusion, ataxia.

3. Care

3.1. General guidelines

- Wherever possible the patient should be assessed and managed within his/her own environment.

- Sudden changes in circumstances out of hours should be managed as follows:
  a) Assessment by GP on duty
  b) If EMH Service required
     → phone St James' Hospital for duty doctor on call
  c) If social crisis
     → phone A.S.W.

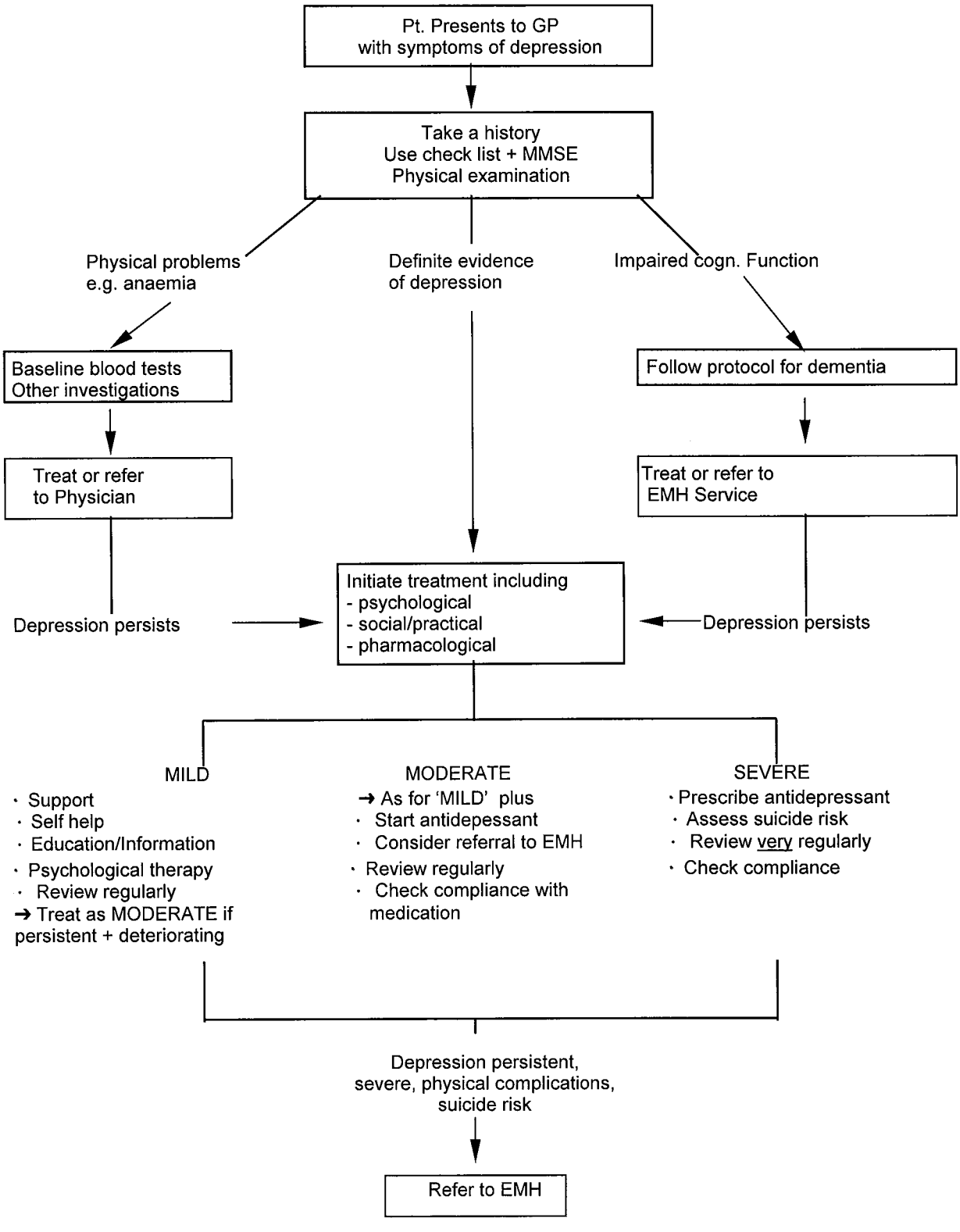
3.2. Urgent contact names and addresses

- EMH Consultant led teams - please see Appendix A
- Social Services - please see Appendix A
- Other organizations - please see Appendix A

NSF For Older People

Joint Protocol for Depression

1 **Referral and Treatment Pathway**



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Joint Protocol for Depression

2. **Depression Screening Checklist**

PART 1

a) How have you been feeling recently?

b) Do you feel sad or tired?

c) Do you just have no interest in anything ?

If YES to either b) or c) continue with Part 2 below.

PART 2

Tick all that apply.

1. ☐ Sleep disturbance (if YES indicate type of disturbance)
   - ☐ *Difficulty falling asleep*
   - ☐ *Early morning wakening*

2. ☐ Appetite disturbance (if YES indicate type of disturbance)
   - ☐ *Appetite loss*
   - ☐ *Appetite increase*

3. ☐ Concentration difficulty

4. ☐ Psychomotor retardation or agitation

5. ☐ Decreased libido

6. ☐ Loss of self-confidence or self-esteem

7. ☐ Feelings of guilt

8. ☐ Thoughts of death/suicide/deliberate self harm or reported concern by others

   (YES indicates risk assessment)
   - ☐ *Do you feel that life is not worth living any more?*
   - ☐ *Have you felt like acting on this?*
   - ☐ *Have you made any plans?*
   - ☐ *Have there been any previous attempts?*

SUMMING UP

4 positive responses from Part 2 for two weeks or more indicates mild depression.

4 - 7 positive responses indicates moderate depression

Any positive responses plus **a positive response to Question 8** indicates severe depression and the risk assessment should be carried out.

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Joint Protocol for Depression

3. General Guidelines

- Depression is common in the elderly
- Active antidepressant treatment is effective, even in the frail elderly or in patients with dementia
- Potential problems / limitations:

  - poor tolerability and higher risk of side-effects
  - concurrent physical illness
  - concurrent mental illness, e.g. dementia (but important to treat depression in patients with dementia)
  - polypharmacy and risk of drug interactions

- Psychological therapies are also effective in the elderly (e.g. cognitive or interpersonal therapy)

- Social or practical support is often required

3.1. General Guidelines for Drug Treatments

- Antidepressants are all equally effective
- The choice of antidepressant will depend on the treating clinician's experience but it is crucial to consider in each case the risk / benefit ratio based on:

  - efficacy
  - tolerability
  - safety
  - potential drug interactions

- Start at low dosage but build up as quickly as possible
- A trial of 6 weeks at max tolerable dosage is needed before a drug can be considered to have failed
- A 2nd line drug should be from a different class of antidepressant
- Recurrent depression requires long-term treatment.
- Once improved, continuation at the same dosage for at least 6 months is recommended though some patients (especially with recurrent depression) may need to continue same dosage for 2 years.
- Long-term treatment after 6/12, possibly at reduced dosage may be required (approx. 2 years)
- Withdrawal should be gradual to avoid discontinuation syndrome

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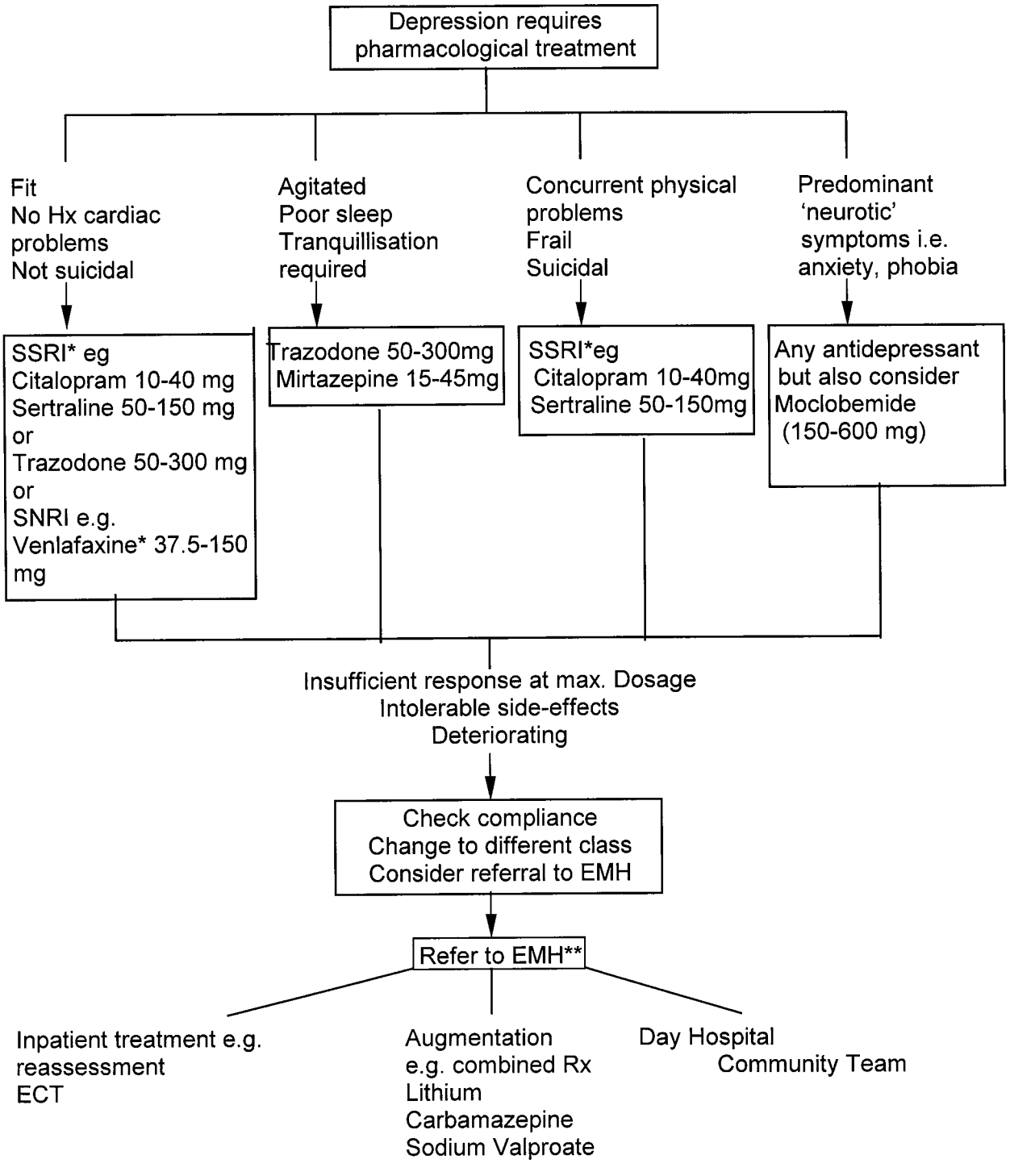
Joint Protocol for Depression

4. Prescribing Guidelines



* Please note recent advice by CSM on safe use of SSRI's and Venlafaxine:

SSRI's: 1 Do not exceed recommended dose
2 Phase out gradually to avoid withdrawal reactions
3 Monitor closely for suicidal risk

Venlafaxine: Should not be used in patients with heart disease, electrolyte imbalance or hypertension but do not stop suddenly in patients doing well and not experiencing side-effects.
Should only be initiated in Secondary Care (or by GP with Mental Health Special Interest).
Once started on antidepressants patients should be reviewed regularly to monitor for side-effects.

** See list of contacts on Appendix A

Appendix A

NSF For Older People

List of Contacts

1. EMH Services

- Portsmouth City (Dr C Trotter / Consultant Locum)
  Referrals by letter or phone to:
  St James Hospital - 023 92894463 (Consultant Locum)
  St James Hospital - 023 92894498 (Dr Trotter)

- Havant / Petersfield (Dr M Brown / Dr S Hogg)
  Referrals by letter or phone to:
  50 Leigh Road, Havant - 023 92471551(Dr Brown)
  Petersfield (redirected to Havant) - 023 92454698 (Dr Hogg)

- Fareham and Meon Valley (Dr J Daoud / Consultant Locum / Dr R Lusznat)
  Referrals by letter or phone to:
  St Christopher's Hospital - 01329 286321

- Gosport (Consultant Locum)
  Referrals by letter or phone to:
  Gosport War Memorial Hospital
  023 9252611 (switchboard) or
  023 92603267

- Multidisciplinary team provides comprehensive diagnostic and management service. Advice on and input from other agencies, day care, benefits, etc., will be provided and co-ordinated by initial assessor.

- The EMH Services do not cover patients with Learning Disabilities and Dementia. These should be referred to the Learning Disabilities Service.

- The EMH Services do, however, accept and encourage all new referrals of patients > 65 years, as well as patients < 65 years who present with cognitive impairment and a likely diagnosis of dementia.

2. Social Services

3. Other agencies

3.1 Dementia

3.2 Depression

NATIONAL SERVICE FRAMEWORK

FOR OLDER PEOPLE

JOINT PRIMARY AND SECONDARY CARE PROTOCOLS FOR

DEMENTIA AND DEPRESSION

Elderly Mental Health Service
Portsmouth City Primary Care Trust
East Hampshire Primary Care Trust
Fareham & Gosport Primary Care Trust

Comments please to:
Dr Rosie Lusznat
St Christopher's Hospital
Fareham

February 2005