



# **Programme of Mental Health Prevention in Primary Care**

***PAPPS Mental Health Working Group***

*Sociedad Española de Medicina Familiar Y Comunitaria*

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**PAPPS**

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(\*) **PAPPS: “Programa de Actividades Preventivas y de Promoción de la Salud” (Health Promotion and Prevention Activities Programme).**

(\*\*) **SemFYC: Sociedad Española de Medicina Familiar y Comunitaria.**

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## INTRODUCTION

The seriousness and frequency of mental illness has been, and probably still is, underestimated. Mental problems generate a significant burden of suffering.

From the context of care, an efficient response must be given to mental health problems. The deficiencies that impede enjoying real quality care are still too many, especially in the care of mental health problems. The need for an adequate training of professionals, the characteristics of suitability that mental health care units or services must meet, adapted to the reality of primary care and the capacity to evaluate the most appropriate procedures when responding to mental problems, are only some of the questions to be resolved in the coming years. Primary Care plays a central role in prevention of Mental Health problems, historically underestimated. Certain protagonists play a fundamental role in this scenario: patients, professionals (paediatricians, family physicians, nurses, psychologists, social workers, psychiatrists), each one in its ambit, but also persons who consult primary care services for other reasons or in which situations or “maladjustments” are detected that make them vulnerable to mental problems. They can best profit from preventive measures by professionals and, in this spirit, PAPPS proposes concrete measures for prevention and health promotion of mental health.

The objective of this booklet is to make quick consultation easier and thereby favour the implementation of the programme, created in 1991 and that actually covers an average population of 8 million users of Public Primary Care in Spain.

Also, with the idea of drawing up a simple list of recommendations to “preserve mental health” which could be given to a majority of the consulting population, a sheet has been created that includes various recommendations aimed at “hygienizing” the attitudes and activities of daily life. We hope it will be useful for those persons receptive to messages from professionals.

As the 1999 WHO World Health Report wrote: “Mental health care, unlike many other areas of health, does not require, in general, costly technology. What it requires is the sensitive work of personnel duly trained in the use of relatively inexpensive drugs and the skills of psychological support outside the hospital ambit.”

We hope this booklet will be useful for all professionals interested in mental health prevention.

*PAPPS Prevention in Mental  
Health working group*

## **Part I**

# **PAPPS Mental Health Programme Recommendations**

**(Compiled summary)**

## Programme of Mental Health Prevention in Primary Care

### 1. CHILDHOOD-ADOLESCENCE

- 1.1. History of psychiatric pathology in the parents.
- 1.2. Care of woman and child during pregnancy and puerperium
- 1.3. Children of single-parent families.
- 1.4. Prevention of mental health problems of pregnancy in adolescence
- 1.5. Backwardness in school and in language development
- 1.6. Prevention of child maltreatment.
- 1.7. Early detection of eating disorders.

### 2. ADULTS-THE ELDERLY

- 2.1. Loss of psycho-physical functions. Care of patient and family
- 2.2. Care of terminal patient and family
- 2.3. Loss of a family member or close relation
- 2.4. Retirement (Preparing social network following retirement)
- 2.5. Elderly patient who frequently changes home
- 2.6. Prevention of the domestic violence. Intimate partner violence.
- 2.7. Prevention of elderly maltreatment.

### 3. COMMON TO BOTH GROUPS

- 3.1. Early detection of anxiety and depression disorders.
- 3.2. Suicide prevention.

#### **IMPLEMENTATION PRIORITY:**

(based on: frequency and severity, feasibility of implementation and availability of support resources)

#### **Childhood-Adolescence**

- History of psychiatric pathology in the parents.

#### **Adult-Elderly**

Attention to grieving in:

- Loss of psycho-physical functions. Care of patient and family
- Care of terminal patient and family
- Loss of a family member or close relation

## 1.1. HISTORY OF PSYCHIATRIC PATHOLOGY IN PARENTS

### Definition

#### **Children younger than age 22 of parents who present:**

Psychiatric pathology diagnosed in the parents:

- Delirium.
- Major depression.
- Mania.
- Attempted suicide.
- Serious personality disorders.
- Schizophrenia.
- Alcoholism and drug abuse.

Suspicion of serious mental pathology, with child or parents presenting any of the following signs of alert:

- Aggressiveness within family.
- Reiterated episodes of sadness and inhibition.
- Prolonged psychiatric institutionalisation.
- Suspicion of drug abuse.
- Important biological, psychological or hygienic needs in children or elements that appear to indicate lack of proper care.
- Mistreatment or abuse of children.
- Episodes of anxiety or depression in mother in child's first year.
- Social isolation of the family.

### General recommendations

- Clearly indicate existence of psychiatric precedents in parents in clinical history of child and in a specific register elsewhere.
- Perform especially close and cautious monitoring of the healthy child's programme (vaccinations, check-ups, periodical visits, etc.), clearly noting appointments.
- Perform in the course of or make an appointment for at least one interview with family members. Pay close, though if possible not explicit or direct, attention to day-to-day care received by child and attention parents pay to child.
- In case of signs of alarm in the child, contact, if necessary, with the physician of adults, the centre's social worker, psycho-pedagogical or mental health services and, additionally, contact paediatrician when psychiatric disorders are detected in the parents.
- Take advantage of an unplanned consultation to take these steps since these types of families tend to miss appointments or interrupt monitoring.

### Signs of alert

#### **Newborn, nursing or child of pre-school age (0-4 years).**

- Deviation from 'healthy child' programme.
- Eating disorders: persistent inappetence, late in eating solid foods, reiterated vomiting or regurgitation, pica, child regularly forced to eat.
- Persistent insomnia or hypersomnia.
- Communication or relationship disorders. Does not laugh, look, speak. Does not respond to social stimuli. Hard to calm down, low tolerance to frustration.
- Evidence of mistreatment.
- Late in psychomotor or language development.
- Anomalies in play and/or in schooling.
- Inappropriate conduct of parents with respect to eating, sleeping and control of sphincter.

School-age child (5-11 years)

- Hyperkinesia: alterations in attention, excessive movement, impulsiveness.
- Signs of depression: sadness, apathy, loss of interest, irritability.
- Communication or relationship disorders.
- Anxiety disorders: phobia, obsessive rituals, sleep disorders.
- Somatic manifestations. Headaches, abdominalgia, vomiting and nausea, alterations in control of sphincter.
- Inappropriate conduct of parents with respect to age of child.
- School failure with evolutive disharmonies.

#### Puberty and adolescence (12-22 years)

- Legal problems.
- Behavioural disorders. Aggressiveness in group or alone, anti-social behaviour, repeated running away from home or in poor conditions.
- Eating disorders. Anorexia, bulimia, obsession with thinness.
- Anxiety.
- Somatic manifestations. Headaches, abdominalgia, vomiting and nausea, alterations in control of sphincter.
- Depression: ideas of suicide, drug addiction, hallucinations or delirium.
- Parents with serious tolerance problems of adolescence crises.
- School or job failure.
- Frequent health services: adolescent visits repeatedly.

#### **Monitoring recommendations**

- Periodicity: Can be included in 'healthy child' programmes.
  - Visit every six months up to the age six.
  - Subsequently, yearly. Up to age 14, by paediatrician and up to age 22 by family doctor.
- These children and families often frequent the visiting-room suddenly. That is why it is essential to take advantage of consultations on demand.
- Systematically investigate no-shows at programmed consultations.

## 1.2.-CARE OF WOMAN AND CHILD DURING PREGNANCY AND PUERPERIUM

### Definition

Pregnancy: period included between conception and childbirth. Puerperium: period that follows childbirth, during which anatomical, metabolic and hormonal transformations take place that re-establish gravid modifications, thanks to an involutonal process. The duration of this period is approximately six weeks and the psychological and adaptive repercussions of this stage present pronounced inter-individual variations.

### Recommendations during pregnancy

- Location: at prenatal care visits, by family doctors or gynaecologists or paediatricians if the centre does not have a specific pregnant-woman care programme.
- Encourage participation of paediatric team in pregnancy and puerperium programmes.
- Facilitate expression and aid in the 'normalization' of maternal fears.
- Encourage satisfactory nursing (in the context of prenatal care).
- Most relevant aspects to be valued by Primary Care Teams (PCTs) during pregnancy:
  - Attitude of acceptance or rejection of pregnancy.
  - Capacity to express feelings about pregnancy.
  - Earlier pregnancies.
  - Experiences in earlier pregnancies: miscarriages, difficult childbirth, psychopathology.
  - Age of woman (greater risk of depression in those younger than 20).
  - Stability of couple.
  - Single parenthood.
  - Treatment and care received by already existing children.
  - Precedents of child mistreatment.
  - Family composition (other members besides couple).
  - Available support (human, affective, material resources).
  - Employment situation and type of activity.
  - Adequate and periodical monitoring of medical controls.
  - Personal pathological precedents, in case of a high-risk pregnancy.
  - Parents with intellectual limitations (oligophrenia, borderline intellectual coefficient)
  - History in the progenitors of: delirium, major depression, mania, attempted suicide, serious personality disorders, schizophrenia or alcoholism and drug abuse.
- Psychological disorders associated with pregnancy: in general accompanied by minor and temporary psychological and behavioural modifications. The most frequent are restlessness, emotional lability, dysphoria, apathy, difficulty sleeping and eating-behaviour disorders. In general, anxiety is more frequent during the first trimester, presenting a tendency to mitigate in the second and frankly improving in the third, to reappear in the weeks following childbirth. Frank depression is between 11 and 17%. In general, these are depressions associated to anxiety symptoms, appearing most frequently in women with pre-existing psychopathological disorders.

### Recommendations in puerperium

- Encourage physical contact of mother with child in first three hours of child's life.
- Interview aimed at observing adaptation to new situation of the woman and the family environment, evaluate emotional state and eventual existence of postpartum depression or postpartum psychosis and exploration of mother-child relationship.
- Encourage creation of groups with psycho-prophylactic objective. When a health centre has professionals motivated to organise them, psychological-help groups are especially useful, so that mothers can share with other women in their same situation the anxieties, fantasies and fears generated during this period.
- For nursing babies, children and mothers at risk, consider the possibility of shelters, day centres, day-care centres and other possibilities of the social network.
- If psycho-social precedents exist: consider house call.
- Preferential care in visits of emotional alterations or manifest incapacities for taking care of child by the mother.

- Most relevant aspects to be considered by the PCTs in relation to puerperium:
  - Conditions of childbirth.
  - State of health of the newborn baby: prematurity, admission to I.C.U.
  - Attitude of acceptance or rejection of newborn baby.
  - Capacity for offering care and love to newborn baby.
  - Attitude towards maternal nursing and prior precedents with other children.
  - Evaluate mood (talking happily about her child).
  - Presence of other children in family.
  - Attention received by other children (periodical control of 'healthy child').
  - Stability of couple.
  - Single parenthood.
  - Family composition (other members in addition to couple).
  - Available support (human, affective, material resources).
  - Employment situation and type of activity performed.
  - Parents with intellectual limitations (oligophrenia, borderline intellectual coefficient)
  - Deviation from 'healthy child' programme and its protocols.
  - Precedents of any kind in the progenitors of: delirium, major depression, mania, attempted suicide, serious personality disorders, schizophrenia or alcoholism and drug abuse.
  
- Psychological disorders associated with puerperium: mood disorders are especially frequent in puerperium. Three fundamental types of postpartum psycho-pathological reactions have been described: puerperal 'blues' (or 'puerperium emotional instability'), puerperal psychosis and puerperal depression. Normally, emotional disequilibrium begins in the hospital appearing in the form of postpartum blues that prolongs itself. On going home the mother feels overwhelmed by the new situation showing symptoms of sadness, irritability and incapacity for taking care of her baby, which frequently generates consultations to the paediatrician. It frequently takes the form of somatizations and shows a tendency to become chronic as a somatic-morphological disorder. In many of these cases the depression is self-limited in a few weeks or a few months but occasionally persists for more than a year after childbirth.
- Risk factors of atypical postpartum depression:
  - Age of mother: More frequent before the age of 20 and after the age of 30.
  - Serious family problems in mother's infancy.
  - Precedents of early separation of her parents (in the mother).
  - Psychiatric problems before pregnancy.
  - Psychiatric or psychological problems during pregnancy.
  - Negative attitude towards pregnancy: Undesired pregnancy, doubts about voluntary interruption of pregnancy (VIP) in the beginning.
  - Tensions in the couple during pregnancy.
  - Severity of postpartum 'blues.'
  - Unfavourable events that generate anxiety experienced during pregnancy.
- Pragmatic criteria to determine emotional state of the mother during puerperium:
  - Do criteria of a diagnosed major depression exist?
  - Are there good moments during the day?
  - Can the woman take care of her child in a good mood at some moment in the day?
  - Do these mood disorders (puerperium 'blues') last more than 4-6 weeks?
  - Does the mother take care of the baby or has she ceded it to other persons because she feels unable to care for it?

Periodicity: at least, at 10 days and between 30-50 days after childbirth.

### **3.1. CHILDREN OF SINGLE-PARENT FAMILIES**

#### **Definition**

Single-parent families are those that are composed by a single member of the progenitor couple (man or woman) and in which, over lengthy period of time, the loss of affective and playful contact of the non-emancipated children with one of the parents occurs. A large number of situations are included in this definition:

- Divorce or conjugal separation.
- Single mothers.
- Death of one of the progenitors.
- Adoption by single persons.
- Permanent or prolonged absence of one of the progenitors: illness, hospitalisations, employment reasons, emigration, abandonment or desertion of the home, imprisonment, exile and wars.

#### **General recommendations**

- Clearly note the situation of single-parenthood in the clinical histories of the child and of the progenitor and in a specific register elsewhere.
- Detect the existence of family dysfunction risk factors.
  - Continuous and intense legal disputes for the custody of the children.
  - Situations of verbal or physical violence towards the child.
  - Isolation and loss of social supports of the progenitors.
  - Difficulties in elaborating mourning by the one that remains alive.
  - Maintenance of concealment of death of the father.
  - Adolescent single mother with little family support.
  - Very unfavourable socio-economic situation.
  - Low level of psychological well-being of mother.
  - Conflictive family dynamics.
  - Presence of small children.
  - Drug abuse by head of family or absent progenitor.

#### **Recommendations to the patient and family**

- Family interview to explain the importance of the masculine and feminine role in the development of the child, as well as to facilitate or recommend the search for a support figure for the progenitor and/or identification figure for the child. The first interview should be as near as possible to the event that set off the single-parenthood. The periodicity of the interviews should be adjusted to the controls of the infantile sub-programme and the existence of risk factors.
- Insist on the importance of the presence of a man and a woman (be they the biological parents or not) near the child in the various stages of his or her evolution.
- During infancy all children benefit from contact with a respectable, rational and benevolent paternal model, although it does not necessarily have to be the biological father.
- For the boy or girl the first signs of approval, recognition and affection communicated by the father are vital (sometimes actively and other times merely with his presence), because it constitutes the most important source of security, self-esteem and sexual identification.
- Monitoring the pregnancy of an adolescent who could end up in a single-parent family deserves special attention, and in the case of a father not living with the mother a continued relationship of the child with men throughout development is recommended.
- In case of divorce or separation controversy exists about whether to include the parent who does not have custody in family interviews or in treatment. There are even doubts about whether the current tendency, which alternates custody of the child with each of the parents, is an appropriate measure in most cases, as it would not respect the dynamics of continuity necessary for the child, rewarding certain aspects of guilt-avoidance of the parents. Recommendations for divorced parents:
  - Assure children that both parents love them.
  - Make sure children understand that they are not the cause of the divorce.
  - Make it clear that the divorce is final.
  - Keep unchanged the most number of aspects of the life of your child.

- Let your child know that he or she can visit the progenitor that does not have custody.
  - If the father who does not have custody does not concern himself, look for an at least symbolic substitute.
  - Protect the positive feelings of child toward both parents.
  - Maintain normal discipline in both homes.
  - Do not discuss children with ex-spouse in their presence.
  - Try to avoid disputes over custody. Child needs to feel stable.
- Women, more so than men, tend to configure single-parent families after a divorce or after widowhood. A second satisfactory couple can improve the quality of life of adults and children.

### **Recommendations to the primary care team**

- Primary care team professionals must know that given the very nature of primary care services, the population tends to seek in them the support it lacks in other social ambits.
- The physician should have psycho-social knowledge and sensitivity, clinical interview and care relationship skills, improving the ability to offer psychological help from the primary care visiting-rooms.
- Primary care professionals, to detect single-parent situations, can perform a genogram on the families they attend, as an exploration instrument that evaluates family structure.
- The physician must maintain a position of listening and understanding, that will enable perceiving the experience and suffering of the child (and often of its parents) in the face of the situation of single-parenthood created and the painful events that accompany it.

## **1.4.-PREVENTION OF MENTAL HEALTH PROBLEMS OF PREGNANCY IN ADOLESCENCE**

The elements of pregnancy in adolescence could be grouped in five sections or sets of problems that PCTs must attend.

### **Prevention of pregnancy in adolescence**

#### **1. Before pregnancy**

- Instructions on family planning to all adolescents.
- Treat ethnic minorities with special care.

#### **2. In case of pregnancy in an adolescent**

- Consider it a pregnancy with a biological, psychological and social risks.
- Especially recommend pregnancy and puerperium help programmes.
- Family interview in order to explore the situation and assure family and social support.
- Collaborate in the search of a support figure for the mother.
- Review and apply the recommendations of its 'children of single-parent families' preventive programme.
- Special attention of the 'healthy child' to parents-child relations. More frequent reviews: in visits of healthy child up to age two, every six months up to age six, and annually subsequently, up to adolescence.

### **Maternalization of future mother**

- Explore acceptance of her pregnancy and help her explore desires, fears, doubt of the voluntary interruption of pregnancy and favour support of the family in the family interview.
- Favour social support: if there are important deficiencies, put the family in touch with social services through the social worker of the centre.
- If the baby is given up, collaborate in clearly defining this, both from the affective as well as legal standpoint.
- Help in definition of dyad: support that, if the mother does not take care of the baby, but it remains in family, that there exist a sufficiently stable and affectively close linking figure for the child.
- Except in this case, the PCT should, in clinical interviews, address fundamentally the mother.
- If the support of the mother is not sufficient, put her into contact with 'informal' and semi-professional organisations in this ambit.

### **Constitution of an originary triangulation**

- Collaborate in the search for a support figure for the mother.
- Recommend the routine relationship or almost routine relationship with individuals of a gender different from the regular carer, if she does it alone.
- Attend the rest of recommendations of the 'children of single-parent' families sub-programme.

### **Assure family and social support**

- Periodical family interviews to explore and facilitate this.
- Review at these not only family, but also social situation.
- If necessary, place family in contact with the social worker of the centre and/or with the social services.

### **Attention to the child as an individual with bio-psychosocial risk**

- Special attention to the 'healthy child' programme carried out with 'children of single-parent families' criteria.
- Review during check-ups of the healthy child up to age two, every six months up to age six and annually subsequently up to adolescence.

- Special attention during these visits to mental health section of this programme.
- Special attention to affective state and relations with mother.
- Special attention to parents-child relations throughout child's infancy and adolescence

## 1.5. BACKWARDNESS IN SCHOOL AND IN LANGUAGE DEVELOPMENT

### 1. Backwardness in school and school failure

#### Definition

- Backwardness in school: when child has fallen back two or more courses compared with chronological cohort.
- School failure: constitutes a sign of alert defined by the following elements:
  - Child is two or more courses behind compared with chronological cohort.
  - Shows disinterest in school and important difficulties in several specific areas.
  - Shows behavioural disorders or clinical symptoms of anxiety and/or depression.

#### Classification

- **Non-specific psychological factors:**

- **Attention-deficit disorder:** they can have, however, a normal or even higher intellectual level. These are children who, in more than one environment (in school and at home, at home and in the street, in the street and at school) manifest difficulties in concentrating attention on any kind of task, especially those that involve planning, complexity or time span. 78% of hyperactive children show learning disorders due to lack of attention, although there are hyperactive children without learning disorders. However, these are children who act impulsively, which often generates conflicts within the environment.

- **Other psychopathological disorders:** infantile depression, disorders linked with childhood, anxiety disorders.

- **Specific psychological factors:**

- **Dyslexia:** consists in the difficulty in obtaining functional reading. They confuse similar letters (b-d, p-q, m-n), invert graphics of certain letters, permute syllables or add letters when reading or writing. As a result, they have difficulties in understanding the meaning of what they read.
- **Dysorthography:** often this is the residual testimony of dyslexia in its improvement phase, when the first serious stumbling blocks to reading have already been overcome. Dysorthography not linked to dyslexia is related to spatial organisation disorders, with poor visual memorisation and often with personality disorders.
- **Dyscalculia:** this is the specific difficulty to handle numbers and figures with ease. It tends to be associated with corporal schema disorders and with a deficient notion of right-left. It is a type of disorder that, like all functional disorders of the various languages (verbal, musical, logico-mathematical, etc.), is often influenced by emotional difficulties of the child.
- **Dysgraphia:** it is a disorder in which the child is subject to important difficulties to write intelligibly. This problem tends to have an anxiety basis although occasionally it can be a real dyspraxia: in these cases the motor difficulties would not be simply 'tensional,' that is, due to a psychomotor blockage of an emotional origin, but the expression of an ideopraxic blockage with a neurological basis.

- **Biological factors:**

- Cognitive alterations with a neurological, metabolic, endocrine basis, etc.
- Sensorial alterations.
- Early psychomotor alterations.

- **Social and psychosocial factors:**

- Family dysfunctions.
- Social network dysfunctions.
- Schooling dysfunctions.

#### General recommendations

- Clearly note the existence of school backwardness or failure in the clinical history of the child and in a specific register elsewhere.
- Evaluation of risk factors or signs of alert: see in 'precedents of psychiatric pathology in parents.'

- Periodical evaluation according to healthy child programme.
  - Somatic examination: screening of psychomotricity, sight and hearing.
  - Mental health and affectivity: 'bifocal' observation in visiting-room (of the child and of its relationship with parents) and also explore key aspects such as play, group integration, capacity for comprehension.
  - Laterality: predominant in eye, hand and foot from age 3-4, age after which it tends to stabilise. The simple observation of a crossed or poorly defined laterality, in absence of other dysfunctions, lacks pathological significance.
- In order to confirm and evaluate the problem, use school recording-book and school reports.
- If the impression obtained in one of several aspects of the previous exploration is that the child is below what would be expected for its age, first of all 'non-professionalised' stimulation of the less developed functions of the child should be recommended to its family, if these are instrumental aspects. If the professional is not sufficiently capacitated in these areas of development or if the problem appears to be important or very evolved, it is more appropriate to hold a cross-consultation with the psycho-pedagogical, infantile mental health or early care team.

## 2. Language development disorders

### DEFINITION

- **Speech disorders:** problems in verbal communication limited to the mechanics of verbal pronunciation, which do not affect the logical or syntactic structuring of language.
- **Language disorders:** if they affect the logical or syntactic structuring of language.

### Classification

- **Speech disorders**

- **Simple late speaking.** This is a transitory problem, not linked to mental deficiency, nor to hearing deficit, nor to personality disorder, with little or no repercussions on the evolution of the child. It is characterised by the late appearance of speech, between 15 and 24-36 months, but subsequently attaining a sufficient linguistic level. In bilingual environments this disorder should be treated with special care, as these types of delays are frequent both at the initiation of language as well as at the initiation of schooling although, if no other chronifying factors exist, 'spontaneous' evolution is favourable.

- **Phonological disorders.** These are mechanical disorders in the emission of certain sounds: dysphonia, dysglossia, dyslalia, etc. Dysphonia is related to functional or pathological alterations of the phonic/sound-producing organs and calls for otorhinolaryngological exploration and treatment. Dysglossia is usually attributable to malformations of the phonic/sound-producing organs. In any case, phonological disorders need to be treated, as they can interfere with learning to read and write. More frequent dyslalia tends to consist in deformations in the pronunciation of certain consonants (lispings, where the 's' is pronounced like a 'th'; rhotacism, in which the 'r' is pronounced in an altered way, etc.), substitution of one sound for another, omission of sounds (such as, for example, final consonants, etc.). They are frequent and harmless until age five, many times accompanied by 'baby-talk.' If they last longer cross-consultation with infantile mental health teams is recommended.

- **Dysphemia or stammering:** This is the alteration in the normal fluidity and temporal structure of speech characterised by repetitions and prolongations of sounds or syllables, interjections, fragmenting of words, audible or silent blockage, circumlocution to avoid these symptoms, words produced with excessive anxiety, etc. Excess anxiety or environmental tension exacerbate stammering. Towards ages 2-3 the transitory appearance of a discrete stammering ('physiological dysphemia') is very normal and calls for anticipatory information to parents to avoid its 'correction,' given that such an attitude could worsen or prolong this 'physiological' dysphemia. Most cases of dysphemia are transitory (its prevalence is 5% in school-children and only 1% in adults), but if it still persists at ages 5-6 recourse to a multi-disciplinary psycho-pedagogical or infantile mental health team for an evaluation should be made.

- **Language disorders (of linguistic or syntactic structuring)**

- **Expressive language disorders.** These are deficiencies in the development of expressive language, but they can only be qualified as such when they can be demonstrated by means of screening instruments, monitoring or by evaluation with tests. It is considered a disorder when the difficulties interfere with academic or relational performance or with social communication,
- **Mixed receptive-expressive language disorders.** These are alterations both in the development of receptive as well as expressive language, but can only be qualified as such when they can be demonstrated by means of screening instruments, monitoring or by evaluation with tests.

### **General recommendations**

- Clearly note the existence of the speech or language disorder in the clinical history of the child and in a specific register elsewhere.

#### **- Specific signs of alert:**

- Absence of modulated sounds or of response to external sounds at 3-5 months.
- Absence or monotony of babbling in second semester.
- Does not say meaningful words and/or does not understand simple signs at two years.
- Does not use more than loose or unintelligible words at age three years (no sentences).
- Persistent alterations in pronunciation (dyslalia) or in verbal fluidity (dysphasia, dysphemias) at four years of age.
- Spontaneous languages: speaking in incomprehensible or nearly incomprehensible slang, with neologisms, paralogisms, etc.
- An evaluation of the psychomotor and language development in all healthy-child check-ups up to the age of six should be systematically carried out.
- Elementary strategies for these types of problems:
  - Discard hypoacusia and other sensorial or neurological disorders.
  - Discard autism and serious development disorders: evaluate connection and expressivity.
  - Evaluate to what extent child understands language of adults.
  - Evaluate child's capacity of expression and communication (non-verbal).
  - Evaluate verbal language: sounds, words, sentences, pronunciation of words and tongue-twisters, grammatical structure.
  - Explore and evaluate family relationships.
- When in doubt, cross-consult, joint consultation and/or referral for exploration to infantile-juvenile mental health team.

### **Recommendations to family**

- Avoid 'anxious persecution of language' or 'excessive preoccupation with language': do not constantly correct the child; do not respond at any age to all the child's desires without it having fully expressed them, that is, favour the child verbally expressing according to its capacity for autonomy.
- 'Language immersion': Recommend to family and relations frequent use of games with the child such as 'I Spy', open-ending stories, talk about daily activities and during these, include children's songs, infrequent language corrections and more like a game than repeating over and over (for example, repeat what was incorrectly said with intentionally incorrect intonation, use in games and with a sense of humour, etc.), modern audiovisual games, etc.
- Systemised family steps to stimulate verbalisation and learning: games with elemental technical support such as games with cassette-recorder (half hour daily of mutual play with the father and/or mother of the child, recording on cassette and listening together after to what was recorded); 'bedtime stories' and 'stories by the fire-light' (10-15 minutes/day of reading short stories by one or other progenitors, alternately); various inventories of fun activities to increase interest in language and in learning, etc.

In case of mild language disorders, only when other systems have failed or are not applicable, or when child is five years-old, the Primary Care Health (PHC) professional can (and should) hold a cross-consultation (if this has not been done yet) and, where pertinent, refer to specialised teams.

## 1.6. PREVENTION OF CHILD MALTREATMENT

· The term maltreatment includes different forms of abuse or aggression: physical violence, emotional maltreatment, sexual abuse, physical and/or emotional negligence, prenatal mistreatment and institutional mistreatment. Child who have been victims or witnesses of maltreatment often experience alterations in their physical, social and emotional development.

· The incidence and prevalence of maltreatment in general is higher in the boys than in the girls, but these ones are victims of sexual abuses more frequently than males. Physical negligence supposes 80 % of the cases.

· Primary Care professionals play an important role in primary prevention, identifying risk factors and situations of major vulnerability:

### **RISK FACTORS AND VULNERABILITY FACTORS**

#### **Personal:**

- *Physical or psychic Deficiencies*
- *Biological or social Dependence*
- *Separation of the mother in the neonatal period*
- *Hyperactive Child*
- *Premature babies*
- *Disabled persons*

#### **Familiar:**

- *Single-parent Families*
- *Unintended Pregnancy*
- *Adolescent parents*
- *Non biological father or mother*
- *Drugs or alcohol abuse*
- *History of violence or sexual abuse in the family*
- *Low impulses control*
- *Psychiatric disorder in the parents*
- *Mental deficiency*
- *Prostitution*
- *Separation in the early neonatal period*
- *Neglect after one of the parents death*
- *History of family maltreatment*
- *Conjugal troubled Relations*
- *Irrational Expectations with regard to the development*
- *Parents not natives*
- *Generational limits not clearly established*
- *Passive mother, dominant father*

#### **Social**

- *Low social support, social isolation*
- *Low socioeconomic level*
- *Overcrowding, immigration, unemployment*

In secondary prevention, alarm signs or symptoms for the different types of violence, like these, must be explored:

### **ALARM SIGNS**

#### **Unspecific:**

- *Non compliance with child medical visits*
- *Frequent attendance for banal motives*
- *Frequent changes of doctor*
- *Denial of reports of hospital stays*

- *Lack of school education*
- *Physical or verbal aggressiveness when correct to the child*
- *Physical or psychological coercions*
- *Conspiracy of silence with regard to the life and the familiar(family) relations*
- *Personal reports of the proper children*

**Less than 5-year-old children:**

- *Psychomotor delay, apathy, isolation, fear, insecurity, frequent hospitalization, enuresis, encopresis, conducts of dependence, sleep disorders, nightmares, appetite changes, anxiety during the medical check-up, bruises (haematomas), burns, contradictory explanations with regard to injuries.*

**Preadolescents:**

- *School failure, conduct disorders, aggressiveness, submission, hyperactivity or inhibition, low self-esteem, language and learning disorders, anxiety or depression, insomnia, school absenteeism, escape from home, sudden loss or gain of weight, sexual knowledge inappropriate for their age*

**Teenagers:**

- *Psychosomatic disorders, appetite changes, depression, suicide ideation, social isolation, escape from home, sexual promiscuity, anxiety, drugs use or alcohol abuse.*

When a case of maltreatment has been diagnosed (tertiary prevention) the doctor has to realize an integral and multidisciplinary intervention:

- Interview and exploration of the child victim of maltreatment
- Risk assessment (physical, psychological and social) to determine the urgency of the intervention:
  - If there is vital immediate risk (physical or psychic) the child must be referred to the hospital.
  - If there is life-threatening social risk it is necessary to communicate it to the Court and to the Service of Attention to children. In case of sexual aggression the child must always be sent to the hospital for gynaecological and forensic assessment.
  - In the rest of the cases one will proceed according to the previous assessment
- Assessment and treatment of the physical injuries and immunizations and prevention of the sexually transmitted diseases and pregnancy if it is the case.
- To communicate injuries to the judicial services.
- To contact with the social worker and to elaborate the social report.
- To report to the Protection service to the Infancy.
- To establish a special plan of follow-up of the child and of the family.
- The interview with the aggressors must be performed in a calm place, in serene and neutral attitude, without judgments or commentaries.. To listen to the aggressor, allows him(her) to recognize and to express his(her) feelings, To inform to the aggressor about the need of hospital assessment of the child, if that is the case.
- Health record of all cases of child maltreatment is mandatory.

## 1.7. EARLY DETECTION OF EATING DISORDERS

- Eating Disorders (ED) constitute at present an important problem of health. In addition, the mass media have created in the general population an alarmist concern, sometimes excessive.

- The ICD-10 and DSM-IV classifications include two specific disorders: the anorexia nervosa and the bulimia nervosa and in addition the category "non specified eating disorders", that includes the majority of the cases.

### RECOMMENDATIONS

- To transmit messages to the family and to the teenager that indirectly protect them from the ED: healthy nourishment, to take at least some meal at home with the family, to facilitate the communication and to improve the self-esteem, to avoid compulsive familiar conversations about nourishment and the image, ...

- To identify to the people with risk factors:

#### **RISK FACTORS**

- *Preadolescents and adolescents*
- *Female sex*
- *Family history of obesity and ED*
- *Some sports or activities (ballet, athletes, models, dancers, gymnasts...)*
- *Homosexuality in men*
- *Excessive dependency, immaturity and isolation*
- *Chronic medical problems affecting self-image (diabetes, obesity...)*
- *Familiar conflict (disorganized families, with low tolerance towards the familiar suffering, critics...)*
- *Stressful vital events in the last years*

In the patients with symptoms or alarm signs, the primary care professional must be able to diagnose the first stages of the disorder and to make an early intervention:

#### **ALARM SIGNS**

##### **FOR ANOREXIA**

- *Slimming*
- *Amenorrhoea*
- *Lanugo*
- *Demand of diuretics or laxatives*
- *Obsessive-compulsive disorder*
- *Activities to become thin*
- *Vomits and indirect signs (facial oedemas, erosion of the dental enamel)*

##### **FOR BULIMIA**

- *Failed attempts to slim*
- *Familiar history of depression*
- *Vomits and indirect signs (facial oedemas, erosion of the dental enamel)*
- *Parotid enlargement*
- *Gastroesophageal reflux*
- *Obsessive and excessive exercise*
- *Dysphoria*

- To interview the patient alone, in a climate of confidence and respect. Useful questions are: Do you think your weight is adequate? Do you eat all sorts of foods? Do you practice exercise? How frequently? Do you like yourself physically? Do you have regular menses? How do you feel at home? How is your mood?

- To make a physical examination and request complementary tests (blood count, iron, proteins, thyroid hormones, electrolytes, electrocardiogram) to make a differential diagnosis and to discard other organic

causes of under nourishment (neoplasm, diabetes, hyperthyroidism, inflammatory bowel disease, celiac sprue) or psychiatric (depression, anxiety, psychosis, drug abuse).

- To contact with a specialist in Mental Health and to refer to the Mental Health Unit when a ED is detected. Also it will be necessary to make an urgent referral to the hospital when severity criteria exist.
- Health record of all cases of ED is mandatory.

## **2.1. LOSS OF PSYCHO-PHYSICAL FUNCTIONS CARE OF PATIENT AND FAMILY**

### **Definition**

Appearance of serious psychophysical disease that entails prolonged or irreversible loss of autonomy. For example: serious neurological or sensorial diseases, serious cardio-respiratory insufficiencies, cardiovascular accidents, invalidating diseases of the locomotor apparatus, mutilations, serious psychiatric illnesses.

### **General recommendations**

- Prioritise recent cases.
- Clearly note disease that originates psychophysical loss in clinical history and in specific register elsewhere.
- Identify or designate family care-person (takes direct care of patient) and liaison (intermediary with physician).  
The same person can fill both roles.

### **Recommendations to family**

- Involve patient in global care plan, participating and committing patient in self-care in order to encourage autonomy and raise self-esteem.
- Offer information on situation, repercussions of loss and grieving process, explaining what can be achieved. Evaluate foreseeable changes in job situation (temporary leave or invalidity), family (change in role, transitory or permanent modifications in lifestyle, dependency on other members, etc.) and level of dependence loss will entail.
- Support changes patient must undergo in value scale, valuing more the relational over physical, the internal over the external, what is conserved over what is lost.
- Encourage expression of feelings, thoughts and fantasies of patient, as well as (in private) special care-person, attempting to accept and explain these manifestations and their most appropriate form of expression and channelling.
- Programme attainable and well-defined objectives in order to subsequently supervise or evaluate them: for example, walk x metres or blocks, see one friend/week, dress completely or partially, etc.
- Encourage contact with mutual support networks and contact with 'informal' — non-professionalised — care network (for example, sports, recreational, cultural groups).
- Encourage contact with specialised associations: multiple sclerosis, Parkinson's disease, alcoholics and their families, family member of cerebral palsy victims, Alzheimer's disease family members, autistics patients family members, etc.
- Information fields to be evaluated in interviews:
  - Somatic aspects of health: how patient eats, sleeps, pain or fatigue, other concurrent health problems.
  - Significance of loss: changes and readjustments it entails, religious beliefs, possible alternatives to substitute loss.
  - Ways of confronting crisis situation: experience and expression of feelings (guilt, impotence, anger, ambivalence, fear, denial, depression).
  - Experience of loss and help expected:
    - How patient thinks he or she will evolve
    - In what aspects he or she is limited
    - If patient agrees with type of help received
    - What does patient expect from our help
    - Who else helps or can help
- Monitoring: evaluate what patient does on a normal day.
  - Growing or diminishing evolution of autonomy or dependence.
  - Evolution of substitutive activities.
  - Evolution of attitudes of family group to loss attending, especially possible increased isolation or deterioration in care.

**Recommendations to family**

Family interview or with family members who will have to bear the fundamental weight of the situation, evaluating repercussions of loss and mourning process and explaining what can be achieved.

Encourage existence of suitable rest and enjoyment period for family member.

Explain psychological repercussions of chronic diseases, advising in day-to-day care of patient.

Integrate centre's social worker, to be included in all decision-making.

## 2.2. CARE OF TERMINAL PATIENT AND FAMILY

### Definition

Patient suffers a clearly documented disease about which an agreement exists not to apply curative treatment and whose life expectancy is not greater than six months.

### General recommendations

- Clearly note terminal situation in clinical history and in specific register elsewhere.
- Identify or designate a main care-person (takes direct care of patient) and liaison (intermediary with physician). The same person can fill both roles.

### Recommendations to patient

- Maintain direct contact with patient (at health centre or at home)
- Interviews should be based on negotiation, caution and respect.
- Do not leave visiting patient until last moment. Continuity in care favours psychological value of relationship.
- Promote maximum well-being and quality of life. Take care of aspects such as effective analgesia, proper hygiene, mobilisation; contain unease and depression of patient and family.
- Carefully explore what patient knows about nature of disease.
- Bring to the fore fears of patient such as fear of pain, loneliness and meaning of life.
- 'To tell or not to tell.':
  - . Avoid ideological apriorisms.
  - . Attend wishes of patient: what patient knows, wants to know, how and when patient wants to know.
  - . Seek co-responsibility of family.
  - . Based on negotiation and not on forced communication.
  - . Include patient in decision-making.
- Circumstances in which patient should be told: if three of the following criteria are met:
  - . Patient repeatedly asks to be told with consistent and reasoned arguments.
  - . Patients who are not very psychologically vulnerable.
  - . Real need to 'arrange' concrete matters: inheritances, legal matters, interrupted relationships, transfers.
    - . When physician knows patient's prior wishes.
- Identify psychological stage of terminal patient (Kübbler-Ross model):
- Denial: this is a form of self-protection. Isolation can also occur.
  - Attitude of professional: self-containment and be attentive to suicide.
- Anger: I'm still alive. Manifest irritability and are demanding.
  - Attitude of professional: do not favour projection or paranoia.
- Negotiation: acceptance or self-delusion.
  - Attitude of professional: tolerate negotiation and denial.
- Depression: for unelaborated past losses and for the future (death).
  - Attitude of professional: accompany psycho-therapeutically including pharmaceutical products.
- Acceptance: integrity that offers peace and tranquillity.
  - Attitude of professional: accompany psycho-therapeutically

### Recommendations to family

- Perform at least one family interview.
- Evaluate level of information family has about diagnosis and feelings associated with loss of loved one.
- Consider level of functioning of family and impact on patient.
- Observe relationship family establishes with primary care team and its demands.

### Recommendations to primary care team

- Professionals should reflect on care given to terminal patients, evaluating feelings that death and its process generate, both in the professional as well as all the team.
- This is a good subject to discuss in 'Balint-type' groups or PCT clinical sessions.

## 2.3. LOSS OF A FAMILY MEMBER OR CLOSE RELATION

### Definition

Recent death or foreseeable final loss of family member or close relation.

### First news of loss

- Initial evaluation: discard:
  - Existence of complex prior mourning.
  - Presence of diagnosed prior psychopathology.
  - Presence of pathological mourning risk factors.
    - Pre-adolescent children.
    - Widows older than age 75.
    - Living alone or socially isolated or with a deficient social network.
    - Sudden death, especially suicide.
    - Difficult relationship with dead person.
    - Precedents of psychiatric disorder, especially depression.
    - Precedents of psychotropic substances abuse.
    - Family dysfunction.
    - Surviving wife, especially in the first year.
    - Low self-esteem and confidence.
  - Risk situation: make appointment within first two months.
  - Absence of risk factors: respect necessary intimacy of first weeks following loss and do not intervene if not expressly requested. Offer possibility of seeing person in three months to evaluate 'how things are going.'
- Establish on which person or persons within the family and close-relations circle the loss could play a psychologically, biologically or socially unbalancing role.
- Clearly note existence of loss in clinical history and in a specific register elsewhere.

### During first year

- Facilitate expression of feelings, memories or significant aspects of persons current situation respecting and not insisting on the need of this expression.
- If there are no clear risk factors or psychopathological factors, act as an accompaniment.
- If intense feelings of guilt or disorders in the elaboration of mourning appear, take special care with guidance and advice.
- Information fields to evaluate in interviews:
  - Somatic aspects of health: how patient eats, sleeps, pain or fatigue, other concurrent health problems.
  - Significance of loss: changes and readjustments it entails, religious beliefs, possible alternatives to substitute loss.
  - Ways of confronting crisis situation: experience and expression of feelings (guilt, impotence, anger, ambivalence, fear, denial, depression).
  - Experience of loss and help expected:
    - How patient thinks he or she will evolve
    - In what aspects he or she is limited
    - If patient agrees with type of help received
    - What does patient expect from our help
    - Who else helps or can help

### After first year

- Help in elaboration touching on subjects such as photographs, clothes, rituals with respect to deceased, visits to cemetery and their periodicity, duration of mourning.
- Encourage expression of what patient 'would have wanted to say to deceased' but was unable to.

- Aspects to monitor in mourning process:
  - Acceptance of loss.
  - Experience of sorrow and suffering.
  - Adapting to environment (counting on absence of deceased).
  - Expression of doubts, guilt, protest, criticism of deceased and of relationship with that person.
  - Reorientation of communication and emotional interests towards new relationships.
- Take into account value of anniversary of death where the signs of remembrance are consciously and unconsciously reactivated.
- Differences between normal and pathological mourning.
  - Normal mourning: passes through phases of denial, anger, negotiation, depression and acceptance.
  - Pathological mourning: irreversible despair or symptoms of detachment from life, social relationships or enjoyment.

## 2.4. RETIREMENT (PREPARING SOCIAL NETWORK FOLLOWING RETIREMENT)

### Definition

The individual's working stage of life ceases, for reasons of age or physical and/or mental incapacity.

Retirement age is set at 65, although it can be early or postponed.

In early or premature retirements we should distinguish:

- Voluntary: the worker freely decides to retire as of the age of 60.
- Imposed or forced: for reasons of job regulation companies retire workers age 55 or younger.

### General recommendations

- Clearly note retirement situation in clinical history and in specific register elsewhere. It would be convenient to specify if a risk of breakdown exists and specify type of retirement; for age, voluntary early or forced early.
- Identify informal or family social network: this is constituted by own family (couple, children, grandchildren and others) and also by others.
- Identify formal or extra-family social network: this constituted by professionals from different fields that carry out support work through various programmes or as a liberal profession.

### Recommendations to patient

**1. Prior care:** if possible in the year prior to retirement.

- Advise of importance of maintaining an active mental, physical and social life.
- Guidance towards reinforcing activities of social, cultural and leisure, amusement and even physical and sports relations.
- Detect foreseeable psychosocial risks on retirement: social isolation, feelings of loneliness, increased passivity and dependence, depression.
- Detect risk factors of decomposition: there is greater risk in:
  - Forced (or imposed) early retirement.
  - Men.
  - Deteriorated prior state of health.
  - Loss of different capacities (expression of feelings, degree of self-confidence and learning skills).
  - Presence of dependent children and absence of spouse (widowed).
  - High degree of prior job satisfaction.
  - Little motivation or interests in other activities.
  - Little or inadequate social support network.
  - Insufficient income (for regular needs).
  - Absence of prior preparation for retirement.

**2. Care during first year:**

- Low risk of breakdown: monitoring in some regular visits for other reasons during two years subsequent to retirement.
- High risk of breakdown: offer, at least, two appointments at two and 6-12 months after effective retirement and subsequently as situation evolves. If at these interviews the existence of an adaptive or psychopathological disorder is detected, the multi-professional capacity for resolution of the primary care team should be evaluated, consulting also with the social worker of the health centre. If necessary the patient should be referred to the mental health unit.

### Recommendations to family

- Explain retirement as a natural process of psychosocial transition, which has relevant repercussions on most aspects of life and can originate personal maladjustments in the retiree and within the family.
- Request family support retiree needs based on corresponding risk-group evaluation (high or low).
- Psychologically reinforce family network, asking directly about fears and concerns raised by approaching retirement, offering information about the situation, its possible repercussions and the adaptation process in this phase of life.

- Prevent possible maladjustments within the family, identifying, with the prior knowledge of the family and that acquired in the interview, those individuals most prone to these breakdowns.
- Involve all members of the family in the resolution of conflicts and adaptive disorders of retirement.
- If the person who is to retire has decided to attend retirement-preparation courses, in the company or outside it, that person should be encouraged to attend accompanied by the person's spouse in order to actively participate in it.
- During the two years subsequent to retirement, in the context of visits for other reasons, we should inquire, at least occasionally, on the general state and mood of the retiree and about the family situation.

### **Recommendations to primary care team**

- The complexity of multi-causal factors and bio-psychosocial breakdowns linked to the retirement process require a multi-professional preventive approach from the primary care team (physicians, social workers and certified nurses).
- Facilitate and enhance, through the team's social worker, the development of knowledge of retiree and retiree-family self-help groups.

## 2.5. ELDERLY PATIENT WHO FREQUENTLY CHANGES HOME

### Definition

Periodical and frequent changes of home of an elderly patient with stays of less than three months.

### Complete evaluation of the elderly patient

**1. Evaluate state of health:** in visiting-room or at home.

- Individual clinical interview: family history, health biography, hygienic-dietetic habits, sleep patterns, social conduct, personality traits and social relationships should be collected.
- Family clinical interview: ideally, this should be done with all those who will be the patient's care-persons in the various homes in order to establish the affective relationship and mutual respect between elderly patient and family. At least, the physician responsible should be informed of the family dynamic directly by the family.
- Physical exploration: for different organs and systems.

**2. Functional evaluation:** can be done in an individual interview or using the following evaluations:

- Basic activities of daily life: Katz, Barthel index, or others.
- Instrumental activities of daily life: Lawton scale, or others.

**3. Mental evaluation:** can be done in an individual interview or using the following evaluations:

- Cognitive sphere: cognitive mini-examination or Pfeiffer test.
- Depression: Yesavage or Goldberg anxiety-depression scale.

**4. Evaluation of socio-family situation:**

- Identify main care-person in family, responsible for care of elderly patient.
- Evaluate characteristics of home (number of rooms and persons living there, available bathrooms, space) and architectural barriers (no lifts and/or different levels).

### Recommendations to elderly patient

- It is important for elderly patient to bring personal belongings with each change of home, especially those with sentimental value (photographs, alarm clock, mementos, etc.).
- Maintain social relationships. Relationships with friends should not be interrupted and mutual visits should be encouraged. Encourage elderly patient to begin leisure activities in and outside home (day centres, retiree clubs, voluntary activities).
- Maintain physical and mental activity (walk, read, travel).
- Respect habits of family members (try to accept that children play and shout, that young people go out, etc).
- Keep chronic and acute medication separate to avoid accidents. Insist on importance of treatment and proper compliance.
- Remind elderly patient that it is important to communicate to care team physical (loss of appetite and/or weight loss) and mental (memory loss or mood changes) changes.

### Recommendations to family

- It is important for the elderly person to have a physical space of his or her own, where personal objects with a sentimental value can be kept. If this is not possible and he or she must share space with other family members, where personal objects can be kept.
- Insist to family to encourage social relations of elderly person and facilitate visits by friends.
- With elderly person's approval, he or she should be assigned tasks to favour family integration.
- Communicate physical as well as mental changes of elderly patient to PCT.
- Separate chronic and acute medication to avoid accidents.
- Habits and attitudes of elderly patient should be respected, as well as schedule and rest periods.
- As much as possible try to extend stays more than three months as long as this does not entail significant difficulties for family.

- Specific recommendations for main care-person:
  - Seek own space for leisure and amusement activities.
  - Count on help groups and other care-persons.
  - Inform elderly patient of disease, foreseeable evolution and complications.
  - Educate about posture and correct mobilisation of the elderly.
  - Inform about available health and non-health resources.

### **Recommendations to primary care team**

It would be convenient at the health centre where elderly patient goes that the same nurse and physician attend elderly patient and that preferably this be the same physician that treat family residing in area.

### **Elaboration of mobile clinical report for elderly patient**

The person responsible for drawing it up will be the regular care team (the physician on the health card).

This team (physician and/or nurse) should establish with the rest of the centre's teams, a verbal and/or written information circuit through this report (Annex). They should be clearly identified to this effect with name, telephone number and preferable calling time for this.

The following information should be included in this clinical report:

- Summary of complete evaluation of elderly person.
- Problems detected and treatment prescribed for each of them.
- Need for some specific check-up and complementary test and approximate date to carry it out.

Subsequent physicians who may attend elderly patient will be invited to note any intervention carried out on clinical course sheet which will be attached to clinical report.

## **2.6. PREVENTION OF THE DOMESTIC VIOLENCE. INTIMATE PARTNER VIOLENCE**

The term domestic violence or intimate partner violence defines those aggressions that take place at home and when the aggressor, generally a man, maintains or has had a partner relationship with the victim.

Domestic violence is an important health problem with intense social repercussion because of the severity of their physical and psychological consequences, as much for the victim as for the family.

The domestic violence takes place in couples of any social class, all the cultures and any group of age.

Primary Care professionals play an important role in primary prevention of domestic violence, identifying risk factors and vulnerability factors to suffer or to cause maltreatment:

### **RISK FACTORS AND VULNERABILITY FACTORS**

#### **Women with risk profile of suffering maltreatment:**

- *Dependency*
- *Experience of conjugal violence in the origin family*
- *Low cultural level*
- *Low socioeconomic level*
- *Psychological and social isolation*
- *Low self-esteem*
- *Disability*
- *Women very identified with the feminine stereotypes (submission)*
- *Pregnancy*
- *Imbalance of power in the couple*
- *Alcohol abuse or drugs consumption*

#### **Men with profile of risk of suffering maltreatment:**

- *Experience of conjugal violence in the origin family*
- *Alcoholism*
- *Unemployment or intermittent jobs*
- *Poverty or economic restraints*
- *Violent man, controller, possessive, low impulse control, man who resolve their difficulties with violence*
- *Low self-esteem*
- *Rigid and stereotyped conception of men's and women's roles*
- *Social isolation*
- *Life centred exclusively in the family*
- *Pregnancy of the couple*

In secondary prevention, alarm signs and signals or symptoms for the different types of violence must be explored:

### **ALARM SIGNS**

#### **Physical:**

- *Injuries*
- *Blow marks*
- *Haematomas*
- *Discrepancies between characteristics and description of the accident*
- *Delay in help request*

#### **Psychic:**

- *Confusion, agitation, anxiety, depression, posttraumatic stress syndrome, suicide attempts*
- *Attitudes of the victim: fear, nervousness, absence of visual contact, restlessness, fright to the smaller noise, anxious glances to the door, passivity, tendency to blame herself and to exculpate to the couple, reluctance to respond questions, incapacity to make decisions..*
- *Emotional state: Sadness, fear to die, suicidal ideas, extreme anxiety.*

**Other symptoms:**

- *Chronic complaints of bad health, insomnia, headache, abdominal pain, sexual dysfunctions, abusive drugs consumption, frequent attendance to the doctor, work absenteeism, caused or spontaneous abortions.*

When a situation of maltreatment exist (tertiary prevention) the doctor should make an integral and multidisciplinary intervention.

- Interview and exploration of the woman victim of mistreatment
- Assessment of vital risk (physical, psychological and social) to determine the urgency of the intervention:
  - If there is immediate vital risk (physical or psychic) is necessary to refer to the woman to the hospital. If there is social risk (life threatening, absence of social support) is necessary to communicate it to the Court. In case of sexual aggression, the woman must always be sent to the hospital, for gynaecological and forensic assessment.
  - In other cases the professional should act according to the previous assessment. – Assessment and treatment of the physical injuries. Immunizations and prevention of sexual transmission diseases and pregnancy (in sexual aggressions) are mandatory.
  - To communicate injuries characteristics to the judicial services.
  - To contact with the social worker and to elaborate the social report.
  - To start up protection strategies and a plan to move away the victim from the aggressor, when physical risk for the victim and her children exist.
  - The interview with the woman with suspicion or being victim of mistreatment must be private, assuring confidentiality. Attitudes and emotional state of the victim must be observed. Professionals must facilitate her expression of feelings.
  - Health record of all cases of intimate partner violence is mandatory.

## 2.7. PREVENTION OF ELDERLY MALTREATMENT

The term elderly maltreatment includes any act or omission that produces damage, deliberate or no, practiced on people from 65 years old, that happens at home, that harms or puts in physical danger, psychic integrity, as well as the principle of autonomy or the rest of the fundamental rights of the individual. The most frequent forms of maltreatment are: physical and/or emotional negligence, physical violence, psychological maltreatment, sexual abuse and economic abuse.

Elderly maltreatment is not privative of low social classes. It is an under diagnosed health problem. Relatives and caretakers are the main perpetrators of violence. All professional working with old people must be alert with respect to signs and symptoms of maltreatment.

Primary Care professionals have an important function in the performances of primary prevention, identifying and modifying, when it is possible, the risk factors of suffering or of causing maltreatment and the situations of greater vulnerability:

### **RISK FACTORS AND VULNERABILITY FACTORS**

#### **For the old one:**

- Very old people
- Deficient state of health
- Incontinence
- Cognitive impairment and conduct disorders
- Physical and emotional dependency from the caretaker
- Social isolation
- History of maltreatment

#### **For the aggressor (when he/she is the caretaker):**

- Physical or emotional overload (vital situations of stress, crises)
- Psychopathology
- Alcohol abuse or other drug addictions
- Familiar experience of maltreatment to elderly or previous familiar violence
- Incapacity of the caretaker to perform cares emotionally

#### **Situations of special vulnerability:**

- Shared house
- Bad relations between the victim and the aggressor
- Lack of familiar, social and financial support
- Economic or housing dependency from the old one.

In secondary prevention, alarm signs and signals or symptoms for the different types of violence must be explored:

### **ALARM SIGNS**

- *Incoherent explanations with regard to the mechanism of production of the injuries.*
- *Delay in help request.*
- *Repeated visits to emergency services or to the hospital by different reasons.*
- *Involuntary drug administration.*
- *Inadequate or lack of effects to suitable treatments.*
- *Bad evolution of the injuries (ulcers) after application of the suitable measures*
- *Under nourishment without apparent reason*
- *Dehydration*
- *Repeated falls*
- *Discordant reports between patient and the aggressor.*
- *Attitude of fear, restlessness or passivity*
- *Emotional state: mood disorder, depression, anxiety or confusion*
- *Refusal of the caretaker to leave alone the old one in the medical interview.*

When a case of maltreatment has been diagnosed (tertiary prevention) the doctor has to carry out an integral and multidisciplinary intervention.

- Interview and exploration of the old victim.
  - Assessment of the vital risk (physical, psychological and social) to determine the urgency of the intervention
  - If there is immediate vital risk (physical or psychic) is necessary to refer to the old one to the hospital. If there is social risk (life threatening, situation of dependency, absence of social support) is necessary to communicate it to the Court. In case of sexual aggression the old must always be sent to the hospital, for gynaecological and forensic assessment.
  - In the rest of the cases one will proceed according to previous assessment.
  - To communicate injuries characteristics to the judicial services
  - To contact with the social worker and to elaborate the social report
  - To inform to the patient about the consequences of maltreatment and to look for a strategy of protection and a security plan to move away the victim from the aggressor.
  - To explain to the patient the possible alternatives and to listen to their desires.
  - If the cause of maltreatment can be the overload of the caretaker or an accessible psychological disorder (depression, anxiety...), primary care professionals must provide him/her help and advise. The prudence, the knowledge of the context and the desires of the patient (when it conserves his faculties) are important factors in the decision making.
- The interview with the old with suspicion of being victim of maltreatment must be private, assuring confidentiality. Observe its attitudes and emotional state in order to facilitate the expression of feelings.
- Health record of all cases of elderly maltreatment is mandatory.

### 3.1. EARLY DETECTION OF ANXIETY AND DEPRESSION DISORDERS

#### Target population

##### - Symptoms and behaviour suggestive of psychopathology:

- Patients with psychopathological manifestations.
- Patients with non-specific somatic symptoms (dizziness, headaches, paresthesia, pain).
- Patients who regularly consume psycho-pharmaceutical or psycho-active substances.
- Multi-consulting and/or overly frequent patients.

##### - Psychosocial transitions with factors that make elaboration difficult.

- Infancy: loss of or separation from parents; loss of contact with home.
- Adolescence: separation from parents, home or school.
- Young adults: broken marriage, pregnancy, birth of handicapped child, job loss; loss of progenitor; unassisted psychosocial emigration.
- Adults and the elderly: retirement; loss of physical functions, mourning; loss of family member; family illness.

#### Interview or anxiety-depression scale

The use of the interview as a fundamental diagnostic tool is recommended using the Goldberg anxiety-depression scale (GADS) as a guide.

Goldberg anxiety-depression scale (can only score symptoms that last more than two weeks).

##### - Scale "A" (anxiety).

- *Have you felt excited, nervous or tense?*
- *Have you been preoccupied with something?*
- *Have you felt very irritable?*
- *Have you had difficulty relaxing? (continue if two or more answers are affirmative).*
- *Have you been sleeping badly, have you had difficulty sleeping?*
- *Have you had headaches or pain in the neck?*
- *Have you had any of the following symptoms: tremors, prickling feeling, dizziness, sweating, diarrhoea?*
- *Have you been preoccupied with your health?*
- *Have you had difficulty falling asleep, staying asleep?*

##### - Scale "D" (depression)

- *Have you felt that your energy is low?*
- *Have you lost interest in things?*
- *Have you lost self-confidence?*
- *Have you felt desperate, hopeless? (continue if any of the above questions are answered affirmatively).*
- *Have you had difficulty concentrating?*
- *Have you lost weight? (due to lack of appetite).*
- *Have you been waking up very early?*
- *Have you felt yourself slowing down?*
- *Do you think you have a tendency to feel worse in the mornings?*

The cut-off point for "probable anxiety" is  $\geq 4$ . For "probable depression,"  $\geq 2$ .

#### Diagnostic interview. Diagnostic guidelines

In patients in which the GADS is positive, a more complete diagnostic interview is recommended taking into account the biological component, social problems and support and emotional aspects. Diagnosis should be confirmed based on diagnostic criteria ICD-10 or DSM-IV.

**Depression**

- Low mood or sadness.
- Loss of interest or capacity to enjoy.
- Other associated symptoms: sleep disorders, guilt or low self-esteem, asthenia or energy loss, lack of concentration, change in appetite, suicidal thoughts or acts.

**Generalised anxiety disorder**

- Mental tension: preoccupation, tense or nervous feelings, difficulty concentrating.
- Physical tension: restlessness, tense headaches, tremors, difficulty relaxing.
- Physical excitement: dizziness, sweating, tachycardia, dry mouth, epigastric discomfort.

These can last for months and often reappear. Frequently they are triggered by stressful incidents.

**Panic attacks**

Sudden and unexplainable attacks of anxiety or fear.

- They present themselves with physical symptoms such as palpitations, chest pain, choking feelings, dizziness, feelings of unreality or fear of some disaster (loss of control or going crazy, heart attack, sudden death).
- They begin suddenly, develop quickly and can last for only a few minutes.
- Patients often fear a new attack and avoid places where these attacks occurred.

**Guidelines for acting (ICD-10 Primary Care WHO, 1996).****Depression****Essential information for patients and family members**

- Depression is frequent and effective treatment exists.
- Depression is not a symptom of abandon or laziness; patients make great efforts.

**Specific recommendations to patients and family members**

- Ask about possible risks of suicide. Can you be sure that the patient does not have suicidal ideas? Close observation by family and friends may be required.
- Plan activities in the short-term for amusement and to build self-confidence.
- Resist pessimism and self-criticism. Do not act under pessimistic ideas (e.g., break up marriage, quit job). Do not concentrate on negative or guilty thoughts.
- If organic symptoms exist, try to find out existing relationship between these symptoms and mood.
- Following improvement, look for possible signs of relapse and plan with patient possible ways of acting if new symptoms reappear.

**Medication**

- Study possibility of administrating anti-depression medication if a significant low mood or lack of interest exists, at least for two to four weeks, or longer if any of the following symptoms are present : asthenia or energy loss, sleep disorders, guilt or self-reproach, lack of concentration, suicidal ideas or of death, lack of appetite, agitation or sluggish movements or speech.
- If there has been a good response to medication in the past, use it again. If patients are elderly or have another organic disease, use other treatments with fewer side-effects. If they are anxious or cannot sleep, prescribe sedatives.

- Explain how medication should be used: medication must be taken daily; improvement will be apparent after 2-3 weeks; minor side effects may appear, which normally disappear after 7-10 days. Consult physician before ending medication.
- Continue anti-depression medication until, at least, three months after symptoms have improved.

#### ***Consultation with specialists.***

- If risk of suicide exists, consider consultation with psychiatrist or hospitalisation.
- If depression persists significantly, consider consulting about other therapies.
- More intensive psychotherapies can be beneficial for chronic treatment and to prevent relapse (e.g., cognitive therapy, interpersonal therapy).

### **Generalised anxiety disorder**

#### **Essential information for patients and family members**

- Stress and preoccupations have physical and mental effects.
- The most effective remedy to reduce the effects of stress is to learn specific techniques (not sedative medication).

#### **Specific recommendations to patients and family members**

- Practice relaxation methods to reduce physical symptoms.
- Plan relaxing and leisure activities in the short term. Recall beneficial activities in the past.
- Identify pessimistic thoughts or exaggerated thoughts (e.g., if daughter is five minutes late leaving school, if patient thinks she has had an accident).
- Try to find solutions to attempt to face these negative thoughts when they come. When patient begins to be concerned about daughter, must say to himself or herself: "I'm beginning to sink into my preoccupations again. She's only five minutes late and she'll be home soon."
- Structured problem-solving methods can help patient face stress situations which contribute to creating preoccupations. Patient should be asked to concentrate on a specific problem and go step by step, seeking solutions.
- The regular practice of physical exercise is beneficial.

#### **Medication**

- If there are several symptoms of anxiety that produce significant anxiousness, anxiolytic medication can be used for no more than two weeks (e.g., diazepam, 5 to 10 mg., at night). Prolonged use can cause dependence and a return to initial symptoms when treatment is terminated.

#### ***Consultation with specialists.***

- Referral to specialist or cross-consultation may be necessary if strong anxiety persists for more than three months.

### **Panic attacks**

#### **Essential information for patients and family members**

- Panic is frequent and effective treatment exists.

- Anxiety often produces alarming physical symptoms. Chest pains, dizziness or difficulty breathing are not necessarily signs of another disease.
- Mental and physical anxiety complement and mutually reinforce each other, concentrating on physical problems will increase fear.
- One should not retire or avoid situations where these attacks have occurred; this reinforces anxiety.

### **Specific recommendations to patients and family members**

- Concentrate on control of anxiety, not on medical problems.
- Practice slow and relaxed breathing. Controlled breathing will reduce physical symptoms.
- Identify exaggerated fears that occur during these panic attacks (e.g., patient is afraid of having a heart attack).
- Plan ways of dealing with fears during panic attack (patient must say: "I'm not having a heart attack. This is a panic attack and will pass in a few minutes").

### **Medication**

- Many patients who suffer panic attacks do not require medication.
- Anxiolytic medication may be of use for patients who suffer mild and infrequent panic attacks (e.g., benzodiazepines , up to three times a day). Continued use may cause dependence and ending medication may cause symptoms to reappear.
- If attacks are frequent and intense, or if significant depression exists, anti-depressives may be of use.
- Avoid clinical tests or unnecessary treatment.

### ***Consultation with specialists***

If attacks persist despite treatment indicated, consider referral to specialist.

## 3.2. SUICIDE PREVENTION

### Risk factors

Psychiatric disorder is the principal risk factor.

- Mood disorders: Depression is the psychic disorder with the highest risk of suicide. Forty-five to 77% of suicides are associated with it. The feeling of despair is even more important than the depression itself. The greatest risk is associated with bipolar disorders.
- Among anxiety disorders, anxiety and panic attacks are the major risks of attempted suicide.
- Alcohol and drug abuse: Drug addiction has been considered in itself a form of indirect self-destruction or chronic suicide.
- Schizophrenia: It is calculated that 10% of schizophrenic patients commit suicide. It tends to occur in the early years of the illness and in many cases a few weeks after receiving hospital release. In these circumstances the risk of suicide is very high. It can be determined by delirious ideas or auditive hallucinations that impel the subject to commit it.
- Personality disorders.
- Physical illness: Special attention should be paid to patients with chronic processes that cause pain, invalidity or have a poor prognosis.
- Other factors or circumstances that influence:
  - Sex: Male.
  - Single men, separated, widowers.
  - Living alone.
  - Lack of social support.
  - Job situation: unemployed.
  - Personal precedents: suicide attempts.
  - Family precedents: family history of suicide.
  - Impulsive adolescents or with anti-social behaviour.

There is no risk factor or combination of risk factors sufficiently sensitive or specific to select patients with suicide ideation who will attempt suicide. However, these factors should be known and taken into consideration.

### Recommendations to professional

- Clearly note existence of suicide risk factors in clinical history and in a specific register elsewhere.
- Many persons who have attempted suicide or have committed suicide had previously in touch with the family physician, who can play a key role in suicide prevention. The main primary care preventive measure appears to be the skills of professionals in the diagnostic and psychotherapeutic approach to the clinical interview.
- Special attention should be paid to the possibility of suicide in patients who have been positively diagnosed with depression and certain cases of anxiety and when other risk factors exist.
- Quiet and open interviews should be maintained, attempting to establish an empathetic relationship with the patient. If potential suicide is suspected do not leave subject unclear. For example, "Have you ever felt so bad that you thought it wasn't worth continuing?" (If necessary, if this is not understood, continue: "It's not worth living").
- Attending to the ideation of suicide or asking questions about it does not put these ideas into the mind of such patients; they already had them. On the contrary, often the patient feels comforted by the courage of the professional who is able to discuss what the patient fears most.
- Threats of suicide should not be underestimated nor disdained.
- Do not trust sudden and unexpected improvements. An unexplainable improvement can be produced by the relief a patient feels upon deciding to commit suicide.
- Feelings of DESPAIR should be evaluated.
- Ask patient who admits ideation about suicide on intent and planning.
- When a serious and sufficiently elaborated idea of suicide is detected, the patient should be referred to the mental health services for treatment and eventual hospitalisation. With patient's permission and if possible a joint interview, informing the family of the seriousness of the situation is recommended, in addition to the need for observation. Family members should be

warned of the precautions to be taken to avoid access to lethal weapons or to hazardous situations or drugs.

- If the ideation of suicide has not been detected, monitoring of the patient can indicate the need to question about this aspect depending on the evolution of the process.
- In case of serious risk direct referral to the psychiatric hospital unit is called for.

## **Part II**

# **Recommendations for promotion of mental health of patients**

## RECOMMENDATIONS FOR PROMOTING PATIENTS'S MENTAL HEALTH

### What is mental health?

Mental health can be defined as the capacity to love, take pleasure, work and tolerate -tolerate self and others -

Caring for mental health and preventing its deterioration requires attending certain aspects of our daily life. Special attention should be paid to two fundamental aspects:

- ***Caring for self.***
- ***Caring for relationships with others.***

### Care of self

#### General recommendations

- **Learn to identify situations that generate mental distress** and confront them.
- **Learn to be at peace with one's self**, knowing what we can change and what we cannot change about ourselves, including our body. This means accepting our capabilities and our limitations.
- **Resist consumerist environment.** Spending more on desires than on needs can generate disappointment and anxiety.
- **Enjoy leisure time** when you have it, employing it on satisfactory leisure activities.
- **Take care of aspects of our daily life** such as **diet, physical exercise** and **sleep**.

Norms to organise activities related to diet, physical exercise and sleep

#### • Diet

- Diet should be varied, healthy, pleasant with enough calories to keep right weight.
- Animal fats, refined sugars and sweets should be reduced, while avoiding beverages with caffeine and excess alcohol consumption.
- Eating times should be respected while taking the necessary time to enjoy the food.
- Enjoying and caring for relations every time one eats with the family is recommended.

#### • Physical exercise

- Regular physical exercise increases life expectancy and helps keep physical and mental health.
- Exercise integrating physical activity in our daily life is recommended: walking, climbing stairs, strolling, etc. Physical exercise does not imply "competitive effort." Reasonable levels of physical exercise are beneficial.
- Physical exercise "all at once" is not necessary; all desirable exercise can be practiced interspersed throughout the day.
- Thirty minutes of moderate physical activity, most days of the week, is enough to obtain a healthy effect of physical exercise.
- Elderly persons, with some degree of handicap, who remain sedentary at home, can improve aspects such as balance, strength and capacity, if they do physical exercise adapted to their personal situation.

#### • Sleep

Proper rest benefits our mental health. The following recommendations can be useful:

- Keep a regular sleep pattern every day, going to bed and getting up at the same time. Do not get up more than two hours later on weekends (assuming you get enough rest during the week).
- If sleep is restful (without sudden or startling interruptions), 7-8 hours a night is enough for an adult, although the hours needed by each person to feel rested varies with individuals.

- Light and relaxing activity before going to bed is good (reading, listening to music, taking a shower, etc.).
- Consumption of beverages with caffeine and alcohol should be avoided; this can fragment sleep. On the other hand, having something light like a glass of milk before going to bed can help falling asleep.
- A proper bedroom environment is recommended. The room should be dark, quiet, ventilated and with the proper temperature.
- If you take a nap, it should not last more than 30 minutes.

## Caring for relationships with others

### General recommendations

- **Sharing things every day** with one or more trustworthy persons protects against mental disorders. Pets can help.
- **Sharing problems** with other persons who have gone through circumstances similar to ours. This helps find a solution to our conflict and helps one feel less alone.
- **Dedicate time to family and friends**, nourishing these relationships by constantly seeking the necessary time to dedicate to them. Friends help to feel greater self-confidence. Friendship means exchange: give support to others and, in turn, receive your support.
- **Relativise the preoccupations your job creates**. Try to “disconnect” after a day’s work.

**Occasionally, however, even while trying to care for mental balance, persons feel their health suffer and are affected by various circumstances:** work, financial difficulties, conflicts in relationships with others, health problems (own or close relations) or for any unidentified reason. In these cases it is good to make a decision that can be crucial to not prolonging the suffering, avoidable in the great majority of cases. Below we note several norms that can be useful to help decide about the need to ask for professional help.

### When to ask for professional help

- . When the feelings of distress are overwhelming, making one feel that life is not being enjoyed sufficiently.
- . When we realise that our state of health is not appropriate and symptoms appear (dizziness, headaches, vertigo, etc.) which we cannot explain and had never suffered before.
- . When work is increasingly experienced as a burden.
- . When there are conflicts in the home that endanger family stability.
- . When, following the death or loss of a loved one, there are difficulties in “moving on.”
- . When there is excess alcohol consumption or consumption of other drugs that interfere with our life.
- . When there is a permanent deterioration in the quantity and quality of nightly rest.

If you would like to have printed copies (in spanish) of these recommendations to give to patients, you can download them at the PAPPS website: [www.papps.org](http://www.papps.org)