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SENILE DEMENTIA IN ISRAEL: A FIRST ASSESSMENT

discussion paper

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SENILE DEMENTIA IN ISRAEL: A FIRST ASSESSMENT

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ABSTRACT

This paper reviews the available information on senile dementia in Israel and identifies the blatant gaps in our knowledge of the extent of the problem. Assuming that the six percent prevalence rate for moderate to severe dementias found abroad is also applicable to Israel, there are over 19,000 elderly Jews in Israel with the symptoms of deteriorating intellect, changes in personality and an inability to perform daily activities, which characterize this progressive cerebral disease. An estimated 78% of the moderately to severely demented elderly live in the community, while only 17% are in long-term care institutions and 5% in mental hospitals.

The paper then turns to an overview of the adequacy of existing provisions for detection, diagnosis and treatment. Demented elderly or their caretakers rarely initiate visits to the primary care physician in response to cognitive or mental symptoms, and primary care physicians rarely refer suspected cases for diagnosis to geriatricians, psychiatrists or neurologists. Public mental health and welfare services are presently inadequate to meet the needs of the demented and their families.

There is urgent need for a short, easily administerable screening instrument for dementia to aid physicians, social workers and public health nurses in identifying suspected cases in need of referral in the early stages of deterioration when intervention is most effective. In addition, existing contacts between demented elderly and health and social service professionals should be better utilized in diagnosis and treatment.

TABLE OF CONTENTS

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1. INTRODUCTION

A progressive cerebral disease characterized by a deterioration in intellect, changes in personality and an inability to perform day-to-day activities, dementias affect 10-15% of the population over age 65 in surveyed countries. The approximately 6% over age 65 who are moderately to severely impaired require constant supervision and care. The probability of becoming demented increases with age, rising from 2% at age 65 to 20% after age 80 for moderate to severe cases. Other than advancing age, no other factors - such as sex, ethnic origin, social class or family history - have been shown to clearly increase the probability of developing senile dementia (Henderson, 1984; Kay and Bergmann, 1980; Small and Jarvik, 1982).

Cognitively impaired elderly are the greatest consumers of health and social services in all developed countries (WHO, 1972). Although no reliable mortality statistics are available for non-hospitalized patients, there is evidence that the life expectancy for hospitalized patients suffering from senile dementia is lower than that of unaffected persons of the same generation (Kay, 1962). While advances in medical management have prolonged the lives of the demented elderly, they have simultaneously prolonged cases of dependence on society and its institutions (Gruenberg, 1978).

The natural history of the early development of senile dementia is unknown. So-called "mild dementia" is a particularly elusive condition. Reports of its prevalence vary enormously among field surveys, from 5% to 50% of those aged 65 or older (Cooper and Bichel, 1984). Longitudinal epidemiological studies are needed to investigate the proportion of mildly demented who proceed to show the

characteristic progressive mental deterioration in the areas of memory, learning, attention, communication and cognition. Only then can criteria be developed to distinguish between the "benign senescent forgetfulness" of normal aging and the early stages of the gross intellectual deterioration associated with dementia (Bergmann, 1979).

Two of the most common forms of dementia are senile dementia of the Alzheimer's type and multi-infarct dementia. The former, accounting for an estimated 50% of all known cases, is characterized by specific histological changes in the brain. Although its cause or causes are unknown, various studies have implicated chromosomal abnormalities, changes in the immune response, neurotransmitter defects and slow viruses as etiologically related (Eisdorfer et al., 1979; Gajdusek, 1977; Nandy, 1981; Roos, 1981; Torack, 1979; Walford, 1982). Multi-infarct dementia, which affects approximately 20-30% of the demented elderly, results from numerous small infarcts in the brain tissue and is often associated with hypertension or diabetes. In about 10-15% of all cases of dementia there is evidence of both of these forms (Blessed et al., 1968). "Cerebral arteriosclerosis," the term once used to describe most cases of mental deterioration in the elderly, is today viewed as a medical misdiagnosis (Hachinski et al., 1974).

Many potentially reversible conditions may cause dementia, including infections (e.g., meningitis, neurosyphilis), drug intoxications, vitamin deficiencies, alcoholism, disorders of thyroid metabolism (e.g., hypo- and hyperthyroidism), and cerebral disease (e.g., cerebral tumors, normal pressure hydrocephalus) (Jolley and Arie, 1980; Roth, 1983; Roth, 1980). In a number of small-scale studies of demented patients referred for psycho-neurological testing,

potentially reversible and treatable causes for dementia were found in 10-40% of the cases (Smith and Kiloh, 1981; Wolff, 1982). However, many of the patients studied were less than 65 years of age and had special problems, such as drug abuse and alcoholism, that prompted their referrals for testing.

In countries such as Israel and the United Kingdom where medical services are subsidized and easily available, improper drug management is a particular danger, possibly leading to adverse drug reactions and symptoms of dementia. In the United Kingdom, for example, three-quarters of those aged 75 and older are on regular medication, and one-fifth suffer from adverse reactions to medication. Another fifth of the elderly in the U.K. who are given prescriptions fail to use them (Livesley, 1983). Some cases of dementia would be prevented or reversed by more careful monitoring of the effects of medication (Henderson, 1984).

Many depressive symptoms are also symptoms of dementia. Apathy, psychomotor retardation, impaired concentration, confusion, and complaints of memory loss, are common to both demented and depressed (or "pseudo-demented") subjects (Duckworth and Ross, 1975). Tragically, depressed elderly who could benefit from psychiatric therapy are often labeled as demented without prior psychiatric consultation (American Journal of Psychiatry, 1982).

The results of several in-depth investigations by neurologists, psychiatrists and internists, indicate that as many as half of the elderly who are told that they suffer from progressive intellectual impairment do not, in fact (Reding et al., 1984). Diagnostic errors appear to be due in part to the limited resources available to

referring physicians and to the limitations of neuropsychiatric diagnoses, usually based on one-time rather than long-term assessments of patients.

For 25-30% of demented patients, thorough diagnostic evaluation reveals disorders that call for specific therapy or treatment; these therapeutic measures, however, may not always reverse the symptoms of dementia or lead to full recovery. The disorders include multi-infarct dementia (therapy - reduction of hypertension or anti-coagulation), malignant brain tumor (therapy - surgery, radiation or chemotherapy), Parkinson's disease (therapy- L-Dopa) and others (Small and Jarvits, 1982). While no medical treatment has so far been proven to stabilize or reverse the progressive deterioration of patients with senile dementia of Alzheimer's type, clinical symptoms, such as disturbed or restless behavior (or associated physical conditions) can be partially controlled.

2. EPIDEMIOLOGICAL DATA FROM ISRAEL

The overall prevalence of senile dementia in Israel is unknown. Some data, however, is available on the number of cases in institutional settings.

Fleishman and Tomer (1985) investigated the proportion of patients with various diagnoses, including organic brain syndrome, residing in independent, nursing, and frail units of six long-term care institutions. When their data are applied to the total elderly population in long-term care by type of bed, as reported by Factor et al. (1982), we find that in 1981 over 3,300 beds in long-term care institutions were occupied by elderly persons with a diagnosis of

organic brain syndrome (including dementia). In other words, 26% of the elderly in long-term care settings were diagonosed as having organic brain syndrome. This percentage may have included patients who were incorrectly diagnosed as demented; in addition, it may have excluded patients who were demented but were not diagnosed as such.

Information concerning the number of demented elderly in mental hospitals is even more sparse. The Ministry of Health has analyzed data on the diagnoses of elderly patients for first admissions only. Of these, an estimated 56% are diagnosed as having organic psychoses, including dementia (Popper and Rahav, 1984). If this percentage is applied to data on bed occupancy by the elderly in August, 1981, a rough calculation reveals that of a total of 1,662 elderly patients in mental hospitals, about 931 suffered from senile dementia.

If the 6% prevalence rate for moderate to severe dementia suggested by other studies is applicable to Israel, there should be over 19,000 moderately to severely demented elderly, or over 38,000 mildly to severely demented elderly, in the country. Subtracting the above estimate of the number of demented residing in institutions, we arrive at an educated guess that about 78% of the moderately to severely demented elderly - over 15,000 individuals - live at home; 17% live in long-term care institutions and a mere 5% in mental hospitals (see Table 1). This pattern resembles that of studies abroad in which about 75% of persons with chronic brain syndrome were estimated to be living at home and the remaining 25% were living in institutions (Kay and Bergmann, 1980).

The old-old (aged 75 and older), who comprise the age group at greatest risk of becoming demented, also form the most rapidly growing population group in Israel. It is projected that between 1980 and

Table 1: Types of Residence of Demented Elderly Jews in Israel, 1981

Types of Residence	Total Number of Elderly	Percentage with Dementia	Number of Cases	Proportion of Total Moderate-Severe	Proportion of Total All Severities
Long-term care institutions	12,573[a]	26 "organic brain syndrome" (including senile dementia)[a,d]	3,335	.17	.09
Mental hospitals	1,662[b]	56 "organic psychoses" --first admissions[e]	931	.05	.02
Community	307,365	5 "moderate and severe dementia"	15,030	.78	—
		11 "mild, moderate and severe dementia"	34,326	—	.89
All Types	321,600[c]	6 "moderate and severe dementia"[f]	19,296	1.00	—
		12 "mild, moderate and severe dementia"[f]	38,592	—	1.00

[a] Factor et al, 1982.

[b] Popper, 1984.

[c] Central Bureau of Statistics, 1982.

[d] Tomer and Fleishman, 1984.

[e] Popper and Rahav, 1984.

[f] Kay and Bergmann, 1980.

1990 the 75+ age group will grow by 60%, while the 65+ age group will grow by only 20%. By the end of the decade, 40% of the elderly in Israel will be over age 75 (Factor et al., 1982). If present trends continue, within five years we may anticipate a population of 25,000 moderate to severe cases of dementia, of which over 18,500 will be cared for at home.

Almost no systematic data has been gathered in Israel on the cognitively impaired elderly who reside at home. Only a small minority of those suffering from dementia are served by public mental health or welfare services or are considered in need of referral by general practitioners. The data that is available is conflicting. During its first year of operation the community-based Psychogeriatric Clinic of North Jerusalem initated extensive community outreach efforts to attract clients, including contacts with Kupat Holim physicians and municipal social workers. Despite its efforts, the clinic succeeded in diagnosing only 41 cases of cognitive impairment in a catchment area of about 8,500 elderly - a mere 0.8 percent of the catchment population (Weihl et al., 1983).

On the active lists of Kupat Holim regional home care teams are about 2,450 elderly patients, of which only 7.4% (or approximately 180 patients) have been diagnosed as suffering from organic mental syndrome (Kupat Holim, 1983).

Extrapolating from the results of a study in progress (Habib et al., 1984), about 150 cases of "mentally infirm" and "mentally infirm and nursing" elderly in Jerusalem were awaiting placement in institutions or receiving services via Kupat Holim Clalit, the Ministry of Health, or the municipal welfare services in June, 1983. These "mentally infirm," who include the demented elderly, represent

only about 19% of the estimated non-institutionalized moderate to severely demented elderly in Jerusalem.

By contrast, the only community surveys of elderly in Israel in which cognitive impairment was screened, carried out in Bnei Brak and Pardes Katz (Silberstein et al., 1981), revealed very high prevalence rates. If the age-specific rates for moderate and severe cognitive impairment reported in those surveys are applied to the Jewish population in Israel over age 65, the prevalence of moderate and severe dementia would be 6% for males and 12% for females (according to Bnei Brak data) or 11% for males and 32% for females (according to Pardes Katz data). [1]

These high rates may indeed reflect a relatively high prevalence of dementia in Israel. The proportion of demented elderly living in the community would, therefore, be even greater than that estimated earlier. However, the high rates may also be due to artifacts.

One factor is the questionable validity of the screening instrument. The screening instrument used in the Silberstein study has not been validated on Israeli elderly. One source of concern is that it may have been biased in favor of those elderly with higher educational attainments and Western cultural background, and the cultural patterns of the scores reinforce this concern. The study found that those born in Asia or Africa were 4.5 times as likely as those born in Europe or America to have moderate to severe cognitive

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[1] Silberstein measured cognitive impairment using a slightly adapted version of a short, portable 10-question screening instrument for cognitive impairment (SPMSQ) developed by Pfeiffer in the United States. The cutoff points for moderate to severe cognitive impairment were those recommended by Pfeiffer (1975).

impairment. Similarly, 40% of the elderly with no education and 13% of those with some primary school education were moderately to severely impaired according to the screening test, while only 3% with secondary school or above education were so impaired (Silberstein, 1981). Alternatively, elderly with these characteristics may actually suffer less from dementing illness, due to more favorable environmental conditions or genetic factors (Gurland, 1981).

Still another factor is differing rates of institutionalization among the cognitively impaired of different sociocultural groups. European- or American-born elderly are institutionalized in long-term care institutions at a rate slightly double that of Asian- or African-born elderly (Habib et al., 1984). Israel Psychiatric Register data indicates that the rates for first admissions to inpatient mental hospitals for those aged 70+ born in Europe-America were almost twice as high as the rates for those born in Asia-Africa, with organic conditions diagnosed in three-quarters of all such admissions (Mendel et al., 1971). Thus the differential community rates may in part be explained by the fact that the demented from Africa and Asia are more likely to reside at home than their European- or American-born counterparts.

3. SENILE DEMENTIA AND THE PRIMARY CARE PHYSICIAN

The paucity of diagnosed cases of senile dementia may be due to a combination of two factors: (1) demented elderly or their relatives rarely initiate visits to primary care physicians in response to cognitive or mental symptoms associated with dementia, and (2) primary care physicians rarely refer suspected cases to geriatricians,

psychiatrists or neurologists for diagnosis.

Forgetfulness, confusion or eccentric behavior are not popularly viewed as medical problems, but rather as signs of normal aging, or, perhaps, premature aging resulting from stress or reduced social and intellectual stimulation. Often, demented persons initially deny that they have cognitive difficulties and succeed for a time to compensate for them by restricting problematic activities. Symptoms may develop gradually and insiduously, and their presence may fluctuate, so that deterioration is often significant before it is acknowledged by the demented individual or those close to him (Bergmann, 1982).

Family members of dementing individuals experience strong, often conflicting emotions which may hinder them from seeking medical help for their relative. Feelings of resignation or hopelessness over signs of "senility" or embarrassment over bizarre or antisocial behavior are common (Krulik et al., 1984). In addition, family members may feel an underlying sense of guilt about possible past neglect or abuse of the elderly person, or they may fear that the physician will misunderstand their feelings of burden, frustration, or resentment (Jerusalem Municipality, 1984). They may feel that the physician will ridicule them for worrying about normal senility and will dismiss the situation as beyond hope, thereby confirming their worst fears that nothing can be done (Cohen, 1981).

There is a striking contrast between attitudes toward seeking medical help for dementing illness and seeking help for other, non-mental chronic diseases of the aged. Even chronic aches and pains, considered signs of normal aging, are viewed as legitimate complaints to bring the general practitioner. While not curable, they are at

least regarded as treatable through administration of drugs and use of mechanical aids to reduce functional impairment. They do not, moreover, carry the stigma of a mental disorder.

Were deterioration in cognitive and mental functioning in dementing elderly accompanied by obvious physical deterioration in their ability to perform activities of daily living, perhaps more cases would reach medical attention. Dementia, however, is not significantly associated with gross difficulties with personal care except at the more advanced stages. A study of mild dementia in elderly community residents found that their abilities to dress and to remain continent did not correlate significantly with the screening test assessment of their degree of cognitive impairment (Hughes et al., 1982). In a large study of elderly community residents in London and New York, researchers developing an indicator scale for detection of dementia and depression discarded items concerning problems with ambulation, toileting, showering and grooming after they were found to lack discriminatory powers (Golden et al., 1983). In Bnei Brak, activities of daily living (ADL) were performed with no help or with only partial help by 99% of the cognitively unimpaired, 91% of the moderately cognitively impaired, and even by 64% of the severely cognitively impaired. In terms of mobility, 95% of the cognitively unimpaired were either totally independent or required help only outdoors, as compared to 89% of the moderately impaired and 64% of the severely impaired (Silberstein, 1981). Thus, most cognitively impaired elderly were no more disabled in daily physical functioning than cognitively unimpaired elderly.

Physically impaired elderly often turn to their primary care physicians for a diagnosis when it is a prerequisite for obtaining

special medical equipment or skilled or semi-skilled nursing care through Kupat Holim. In contrast, demented elderly rarely need such special services until the very advanced stages of the disease. Before that time, their most apparent needs are for household help and the continuous presence of a familiar adult to protect against self-harm. These are needs that families usually fulfill as a matter of course, without the intervention of a physician. To seek professional advice may represent an admission of failure to the families, an acknowledgement that their resources are no longer adequate to cope with the deteriorating situation. Specialized medical attention is often sought when it is too late to reverse the dementia, leaving custodial institutional care as the only viable remaining alternative (Bergmann, 1982).

Routine visits to the primary care physician could provide the occasion for patients or their caretakers to disclose relevant symptoms or for physicians to observe these symptoms themselves. Virtually all elderly are covered by comprehensive health insurance, and the rate of visits to the physician among the elderly in Israel is among the highest in the world. In a national survey, nearly three-quarters of the elderly were found to have visited a physician at least once within the previous three months, and 48% saw a physician at least once every two weeks (Davies et al., 1982). However, routine consultation rates may be lower than the average for the cognitively impaired, who depend on others both to recognize their difficulties and bring them to medical attention.

The discovery of neglected cases of cognitive impairment may be aided by an outreach program in which a public health nurse makes home

visits to high risk elderly persons (the old-old, recently widowed, or living alone) who are registered at the Kupat Holim clinic but have not consulted with their primary care physician in the past half year or so. In addition to promoting contact between patient and physician, the nurse can counsel the caring family or neighbors in such matters as home safety or use of drugs.

Mild and even moderate dementia are often not observable in the brief consultations that typify most Kupat Holim visits. The demented may look "normal" and often preserve their verbal and social skills, including the ability to respond to small talk and confabulate when unsure of the facts, long after other cognitive abilities have deteriorated. While general practitioners may routinely screen for hypertension, heart conditions and other chronic diseases, it is the exceptional physician who screens high-risk elderly patients for dementia. No standardized screening instrument for dementia has been popularized in Israel; nor has one been validated for the multi-ethnic, partially illiterate elderly living in the community.

Even when the presence of dementia is suspected, the primary care physician is unlikely to refer the patient to a specialist if routine laboratory tests prove negative. Physicians may be influenced by the culturally determined perception of senility as a condition unresponsive to therapeutic intervention. Their reluctance to make referrals may also be due to inadequate motivation or training in the area of senile dementia.

4. COMMUNITY-BASED SERVICES FOR DEMENTED ELDERLY

Municipal social workers could play an important role both in referring cognitively impaired elderly for medical diagnosis and treatment, and in providing them with direct services. Unfortunately, this potential contribution is largely untapped.

Where good channels of communication exist between municipal social services and psychogeriatric diagnostic services, social workers prove to be important referral agents for the cognitively impaired. In the follow-up study of the North Jerusalem Psychogeriatric Clinic service, it was found that among clients referred by Kupat Holim general practitioners, those with cognitive impairment were underrepresented relative to their estimated proportion in the community. In contrast, over half the clients referred by social welfare agencies suffered from cognitive impairment (Weihl et al., 1983). The physicians, on the whole, appear to be skeptical that their patients may benefit from psychogeriatric intervention, whereas social agencies, who often bear most of the burden of care, are much more likely to seek professional diagnostic services for their clients. In fact, the provision of some services is contingent on obtaining an appropriate psychogeriatric diagnosis.

In many communities, formidable obstacles prevent the social worker from seeking diagnosis and treatment for a client. While some municipal mental health clinics are staffed by professionals with special expertise and interest in aging clients and close ties to community social workers, physicians, and nurses, many mental health clinics have little regard for the psychiatric problems of the elderly. Although social workers often feel it is outside the realm

of their professional expertise to supervise the lengthy procedure of obtaining necessary referrals for their clients and arrange for laboratory tests, CT scans, EEGs, etc., many feel morally obligated to undertake these responsibilities since no one else does.

Frustrated by their difficulties in obtaining a diagnosis through the district mental health clinic or through referrals from the Sick Fund primary care physician, many social workers resort to informally enlisting the help of individual psychiatrists or geriatricians with whom personal-professional relations have been built. The specialist examines the client as a private patient, often waiving the fee for those who cannot afford the services provided (Jerusalem Municipality, 1984).

In addition to the logistical problems of obtaining a diagnosis, social workers are handicapped in their attempt to identify cases in need of diagnosis; they lack a short, easily administerable screening instrument for measurement. Instead of identifying dementia cases in their early stages, when treatment or management is most effective, social workers often enter the scene only after conditions have severely deteriorated and the caretakers have become demoralized.

Community-based services are presently far from adequate for diagnosed cases of dementia, much less for the estimated 15,000 moderate to severe cases residing in the community (Krulick et al., 1984). While the number of psychogeriatric centers has grown in recent years, few have active outreach programs. Some, such as a new unit within the Psychiatric Department at Shaare Zedek Hospital, may diagnose most elderly with suspected dementia referred to them, but treat only Alzheimer's disease patients. A number of community-based psychogeriatric centers that use an interdisciplinary team approach

for diagnosis and treatment are now being developed. They may serve as excellent models for urgently required additional services.[2]

Physicians, social workers, community health nurses and service planners must balance the main objectives of medical care for demented elderly: to reduce disability and distress, preserve autonomy for as long as possible, and postpone the need for institutional care, against the possible conflicting interests and needs of the patient's family or caretakers. Families also deserve attention by community services, not only because of the financial burden they carry in supporting a cognitively impaired relative, but also because of the emotional stress of care, which can result in serious family strife and contribute to physical disorders (such as hypertension), psychiatric disorders (such as depression), and maladaptive behaviors. According to one Israeli study of families caring for a chronically ill relative, the burden of care was perceived by caretakers to be highest when patients suffered from mental impairment only (i.e., dementia), as opposed to both mental and physical impairment or physical impairment only (Krulick et al., 1984).

Established community services for the chronically ill, such as meals, home visits by public health nurses, laundry and housekeeping services, and volunteer visitors, are also utilized by demented elderly and their families. Additional services, however, should be developed to meet some of their special needs: 24-hour

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2 Examples include centers being developed in Haifa (Fleeman Hospital), Ramat Hen (Kupat Holim), Rishon Lezion (Shmuel Harofe Hospital), Yafo (Tsehelon), Pardes Katz (Pardes Katz Hospital), Tel Aviv (Ichilov Hospital), Safed (Safed Regional Home for the Aged), and Ramat Gan (Tel Hashomer Hospital).

companion services; holiday, weekend, and night respite services in which the elderly are cared for temporarily outside of their homes; and day centers, which provide social activities and stimulus to the elderly, in addition to temporarily releasing a family member from caretaking responsibilities.

Special programs for cognitively impaired elderly in day centers or day hospitals, such as those in Jerusalem (Baich et al., 1985), Pardes Katz, Haifa and Kiriat Hayim, are highly regarded by participating families; however, they currently serve a total population of only 200 elderly at most, and the majority operate only 2 or 3 half-days a week, hardly enough to lighten the burden of the caretakers. A number of these centers are currently organizing support groups for primary caretakers. Their role in educating caretakers, providing emotional support, and reducing feelings of burden should be evaluated.

5. CONCLUSIONS

If the prevalence of senile dementia in Israel is similar to that found abroad, most of the cognitively impaired elderly Israelis live in the community and are cared for by relatives or neighbors without benefit of psychogeriatric diagnosis or treatment; when a crisis point is reached in their care, they are institutionalized. Since some forms of dementia (and most cases of "pseudo-dementia") are reversible and can be treated or managed if identified in the early stages of deterioration, it is imperative that suspected cases be diagnosed early.

Kupat Holim primary care physicians, municipal social workers,

and public health nurses are the most suitable candidates to be trained in methods of early case detection. Training should include learning about the epidemiological, medical, and social aspects of senile dementia, as well as competence in using a short, standardized screening instrument for dementia. The screening instrument should test basic intellectual abilities and assess social functioning and should be reliable enough to detect and quantify deterioration over time, if administered at suitable intervals. Such instruments are in use in the United States and Great Britain, and an adaptation suitable to the ethnic and educational composition of the elderly Israeli population should be validated and put into use.

The problem of case identification, however, cannot be solved until already existing contacts between elderly and professionals in the health and social services are utilized more effectively for diagnosis and treatment. Only the coordinated efforts of primary care physicians, nurses, social workers, health care planners and health care administrators can lead to more satisfactory treatment of a major and growing public health problem.

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ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה בישראל

JOINT (J.D.C.) ISRAEL
BROOKDALE INSTITUTE OF GERONTOLOGY
AND ADULT HUMAN DEVELOPMENT IN ISRAEL

דמנטיה סנילית בישראל: הערכה ראשונית

דפי דיון

נאוה הבר-שיים

ד-113-85

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יה והתפתחות אדם וחברה. הוא נוסד
ע המאוחד של יהודי אמריקה), בעזרתן

ולהציב להן פתרונות חילופיים בשירותי
מיעדיו הוא להגביר שיתוף הפעולה של
ילים בקהילה כדי לגשר בין מחקר לבין

להתייחסותם של אנשי מקצוע ומתמחים
יבור, המשתתפים בעיצובם של המדיניות

בעלות חשיבות לאומית לשם העשרת
השירותים החברתיים.

מחבר או המחברים וללא כוונה ליצג את
שורים למכון.

דמנטיה סנילית בישראל: הערכה ראשונית

נאוה הבר-שיים

ירושלים

יוני, 1985

תקציר

המאמר סוקר את המידע הזמין על דמנטיה סנילית בישראל, ומצביע על הפערים העיקריים בידע המצוי ברשותנו על הבעיה. בהנחה שגם בישראל, כבחו"ל, מגיע שיעור הימצאותה של המחלה בדרגת חריפות בינונית וגבוהה ל-6%, מסתבר כי 19,000 קשישים יהודים בישראל סובלים מן הסימפטומים המאפייניים מחלה מוחית זו: הדרדרות שכלית, שינויים באישיות ואי יכולת לבצע פעולות יומיומיות. לפי הערכות שנעשו, 78% מכלל הסובלים מן המחלה בצורתה הקשה או הבינונית מתגוררים בקהילה, ואילו 17% בלבד מאושפזים במוסדות לטיפול ממושך, ו-5% בבתי חולים לחולי נפש.

בהמשך המאמר מוצגת סקירה כוללת של הלימות האמצעים המופעלים לצורך זיהוי סימפטומים, אבחון וטיפול. קשישים הסובלים מדמנטיה סנילית או תומכיהם אינם פונים, על פי רוב, לרופא המשפחה עם הופעתם של סימפטומים קוגניטיביים או נפשיים, ורופאי המשפחה, מצידם, מפנים רק לעתים רחוקות את המקרים החשודים לרופאים גריאטריים, פסיכיאטרים ונוירולוגים לצורך אבחון. שירותי הרווחה ובריאות הנפש כיום אינם ערוכים לענות על צרכיהם של הסובלים מדמנטיה סנילית ומשפחותיהם.

יש צורך דחוף במכשיר ניפוי שיעזור לרופאים, עובדים סוציאליים ואחיות בריאות הציבור באבחון המקרים שיש חשש להיותם נגועים במחלה, והזקוקים להפניה בשלבי ההדרדרות המוקדמים, שבהם יש להתערבות הרפואית השפעה רבה ביותר. בנוסף, יש לנצל ביתר יעילות את הקשרים הקיימים בין הקשישים הסובלים מן המחלה לבין אנשי מקצוע בשירותי הבריאות והחברה לצורך אבחון וטיפול.

תוכן העניינים