Prevention in Geriatric Psychiatry: The Time for Common Sense

On last September 5th the Fourteenth International Congress of the *International Psychogeriatric Association* (IPA) ended in Montreal (Canada). Its motto "Paths to Prevention" illustrates quite well the subjects that at this time are a matter of concern for the professionals dedicated to the care of elderly people with mental diseases.

Coinciding with the renewed interest in preventive strategies, this Congress also stressed the present crisis of the pharmaceutical industry as to the leadership of therapeutic interventions in psychogeriatry. The perspectives of new treatments, that would entail a significant improvement over those already available to us in clinical areas as important as depression or dementias in older adults, are really not very promising. The decrease in new molecules is not as serious as the fact that the last contributions, although always welcome, are not based on any breakthrough in the understanding of the neurobiological substrate of mental diseases in older adults. These new molecules are generally "copies" of other substances, with improvements in very important aspects, such as tolerance and convenient administration, but they usually do not contribute with any important advances as regards efficacy or improvement of the overall prognosis for the illness. When faced with these facts, the pharmaceutical industry arguments that there are all kinds of difficulties before a drug can be marketed, but it seems evident that this industry has sacrificed innovation for profitability: the repetition of already proved concepts are much more profitable when there are strong and well-trained marketing structures available. From another point of view, it appears that the ethical problem that seems to be the basis of the present economic crisis —putting profitability before the mission belonging to the companies and institutions— has not left the pharmaceutical industry unscathed.

But let us consider some of the conclusion arrived at during the Congress:

- The prevention of Alzheimer's disease should start at school by improving the needy children's nutrition and life conditions.
- In certain countries the diversion of the resources assigned to old

people to other sectors of the population has increased, to the detriment of the elderly.

- Little attention is being paid to the assessment of the adverse effects caused by drug accumulation in older adults. Many cases of delirium, as well as the worsening of the thought impairment associated with dementias, are due to the anticholinergic effects of commonly used substances, many of which are available without prescription, and it is recommended to increase the role of the drugs in the control of these problems.
- Depression in older adults is closely related to social isolation and, as such, a closer contact with their children or grandchildren may contribute to reduce it to a large extent, thus preventing the negative consequences of depression, e.g. suicide.
- The already known strategies for preventing the risks of cerebro-vascular disease – such as increasing social, physical and intellectual activities or adopting the so-called mediterranian diet – are also useful in the prevention of such risks.

As we have seen, this is all about recommendations full of common sense and which entirely coincide with the clinical observations of any psychiatrist treating elderly patients. When hearing these recommendations, we cannot but regret that during decades the scientific interest as to therapies in geriatric psychiatry has been focused almost exclusively on pharmacological treatment of the different nosological entities, giving marginal attention to the preventive aspects and forgetting that the true cure for a disease is that it does not occur. Evidently, this is not a problem observed only in geriatric psychiatry, and several years ago WHO already warned about the difficulties prevention entails in the mental health area (1).

As regards affective disorders, there is an ever-increasing awareness of the fact that depression in the elderly constitutes an enormous public health problem. Between 5-15% of 60 year-old or older adults suffer from depression (2), associated with functional impairment, increased health costs and, possibly, with an increased mortality due to suicides and cardio-vascular deaths. There are recent data showing that the appropriate treatment not only improves the depressive symptoms, but also some of the associated negative consequences, such as deterioration of the health-related quality of life (3)

On the other hand, given that depression is a clinical entity with a high response rate to therapy, and that it is still misdiagnosed today and

scarcely treated among the community-dwelling elderly population, it is a perfect objective for the application of preventive programs. This fact has been detected by several health promoting organisms and entities. For example, a strategic objective of *Healthy People 2010* is reducing the proportion of disabled older adults who inform depressive symptoms, and who present with negative functional repercussion due to said symptoms (4). Another project of great interest (5;6), the *Defining the Public Health Role in Older Adults Project*, has recommended starting multidiscipline approach-structured programs in health centers or other social community structures, as the best way to prevent the consequences of depression in the elderly. This means an important change to the traditional approach of relying only on a correct medical diagnosis and drug therapies, although these naturally form an essential part of the integral approach.

For example, the so-called "DCM model" (*Depression care Management*) is based on the concepts developed for treating chronic diseases (7), and includes elements such as depression diagnosis in older adults through validated instruments, multidiscipline assessment, including analysis of the socio-familial environment, and the administration of psychotherapy and/or drug therapy in accordance with the best available evidence. Treatment results are evaluated periodically by means of validated instruments to check the efficacy and to make timely adjustments. A social worker, nurse or another paramedic professional educates the patient and his family, and assess the impact of the treatment on the patient's functioning in his own home. This professional works in contact with the primary care physician, who prescribes the drug treatment, and with a psychiatrist, who most of the times does not care directly for the patient. Recently similar models have been proposed for approaching Alzheimer's disease and other dementias, although in these cases the model should be based on the concurrence of various reference specialists: psychiatrist, neurologist and geriatrist (8).

In short, these models propose considering the main psychiatric disorders as a public health problem, and approaching them from a chronic illness perspective, with multiple strategies that should always include the intervention in the patient's environment by a multidiscipline team. Common sense is knocking on the door of geriatric psychiatry.

References

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