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Guest Editorial

Can Geriatric Psychiatry Services Make a Difference?

During the past 30 years, the growth of geriatric psychiatry services has been dramatic. Indeed, in this issue of *International Psychogeriatrics*, Reifler and Cohen report that most developed countries can boast of an impressive range of clinical services that include a variety of hospital-based, community-based, and long-term-care programs.

Much of this growth has been fueled by beliefs and rhetoric. Geriatric psychiatrists have rallied to advocate positive attitudes toward the aged, publicize healthcare inequities, and trumpet the development of mental health services for the elderly. Innumerable descriptions of one service or another are testaments to their zeal.

Unfortunately, despite the recommendations of a WHO Scientific Group (World Health Organization, 1972), there is little proof that most of these services make any difference. For the moment, the enthusiasm, intuition, and practice styles of geriatric psychiatrists are accepted substitutes for evidence of effectiveness.

The best evidence of effectiveness comes from well-designed controlled trials. To date, only 11 trials of geriatric psychiatry diagnostic and treatment services (7 randomized, 4 nonrandomized) have been published in the English or French language literature. Ten have involved systematic detection of depression (n = 6), delirium (n = 1), or any mental disorder (n = 3) in hip fracture inpatients (n = 2), medical-surgical inpatients (n = 1), medical inpatients (n = 1), or aged individuals in residential care (n = 1), home care (n = 2), primary care (n = 2), or the community (n = 1). Systematic detection was followed by consultation alone in three studies, consultation-liaison in three, consultation-nurse intervention in two, or psychogeriatric team intervention in two. The results of these studies were positive in six and negative in four.

What can we learn from these studies? On one hand, effective services seem to involve systematic detection followed by consultation-liaison, consultation-nurse intervention, or team intervention for depression in home care patients or community subjects; consultation-nurse intervention for delirium in medical inpatients may be effective. On the other hand, ineffective services seem to involve systematic detection followed by consultation alone, particularly in primary care patients.

Obviously, relatively few services have been studied. In the future, those services that best manage specific mental disorders in specific types of elderly patients in certain situations and at least cost must be identified by a series of clinical trials. These trials should focus on five issues. First, the need for special geriatric services should

be defined by comparing the outcomes of elderly patients with specific mental disorders treated in geriatric or adult programs. Second, the effectiveness of specific services should be established by comparing the outcomes of those receiving or not receiving the service (e.g., consultation vs. no consultation). Third, the effectiveness of different types of geriatric psychiatry services (e.g., outpatient assessment vs. inpatient assessment) in managing specific mental disorders should be compared. Fourth, the staffing of these services should be investigated by examining the outcomes of those receiving care from different types of healthcare professionals and different groups of healthcare professionals. Finally, the location of these services (e.g., institution-based vs. community-based programs) should be assessed. All of these studies should include adequate measures of physical and mental illnesses, cognitive impairment, functional disability, social and economic circumstances, and quality of life. Measures of costs should include monetary costs, burden on healthcare personnel, and burden on family and/or caretakers.

Alternatively, systematic literature reviews may assess the potential effectiveness of services in managing specific disorders. A methodology for such reviews has been described (Cole, 1993). The five steps in the review process are as follows: (a) identification of the target illness, (b) development of a service model for the target illness, (c) establishment of criteria that must be satisfied for service procedures to be considered effective, (d) review of the evidence from published clinical research to determine whether service procedures meet the criteria, and (e) classification of recommendations based on the strength of the evidence.

Treatments and services based only on beliefs and rhetoric are all too frequent in health care. The legacy of most is wasted resources. Gamma globulin to stop the spread of poliomyelitis in the 1950s is a case in point. This program was initiated on the basis of intuitive feelings or "reasonableness" and selective recollection of favorable rather than unfavorable outcomes. Serious questions were eventually raised about the effectiveness of this program but only after much futile suffering. In the case of geriatric psychiatry services, beliefs and rhetoric have played an important role in changing attitudes and mustering resources for new systems of care. At this point, geriatric psychiatrists must promote health services research in order to provide the elderly with mental health services of proven effectiveness.

Can geriatric psychiatry services make a difference? If we believe the results of the aforementioned trials, the answer can be affirmative. However, geriatric psychiatrists must have the wisdom and courage to use the results of evaluative studies and modify their service delivery accordingly.

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