Guest Editorial

Geriatric Mental Health Care by Family Physicians

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The National Institute of Mental Health and the National Association of State Mental Health Program Directors jointly sponsored an invitational conference in June 1985 on geriatric mental health research at Sonesta Beach, Florida. Researchers, clinicians, and state government policy makers attended to generate collaborative efforts for research, particularly in systems of delivery for geriatric mental health care. Two family physicians were among the 100 participants.

The content of the conference is of special interest to family physicians. As primary caregivers, family physicians provide a large portion of the mental health care in this country, and in rural areas where psychiatric consultation is not readily available, this share is even greater. Elderly patients have a disproportionate need for mental health services. As the percentage of elderly continues to increase, geriatric mental health care will become an increasingly important role required of family physicians.

Most geriatric mental health problems are well

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within the scope of family physicians. Familiarity with the patient's social situation and with community resources enables the family physician to address these problems on an individual basis and in many instances to avoid costly institutionalization or to arrange care in a minimally restrictive environment.

Often the geriatric patient with behavior problems or cognitive deficits presents with a differential diagnosis including psychiatric and medical possibilities. The biopsychosocial training of family physicians should serve them well in dealing with these cases.

Yet, Rovner has found that in an urban community nursing home, about two thirds of mental health problems were unrecognized, and of those mental health problems that were recognized, most were misdiagnosed (Barry W. Rovner, MD, personal communication, June 1985). Similarly, most geriatric mental health professionals would agree that the most common cause of reversible organic brain syndrome in the elderly is iatrogenic through inappropriate use of medication. These concerns suggest an area where quality might be improved with beneficial results for patients and society.

At several times during the conference, attention was focused on the lack of communication between primary caregivers and community mental health centers. Although community mental health centers might serve as a resource for consultation and referral for family physicians, working relationships are not always constructive. Physicians cite lack of feedback as the problem. I recall (from my own rural practice experience) having patients transferred to the state psychiatric hospital who were referred at discharge to the community mental health center, and I recovered them only later when they returned to my office with a physical problem. Other patients went independently to the community mental health center, but I was never informed. Such practices do not foster a good consulting relationship.

Many community mental health centers have little or no capability to offer geriatric mental health consultative services because of lack of staffing expertise and funding deficiencies. Efforts to make the necessary expenditures to improve the quality of these services deserve the support of the medical community.

Some states have developed innovative models for community-based geriatric care. Florida has begun its Geriatrics Residential Treatment System, which offers alternative community-based care to elders with psychiatric problems who might otherwise be institutionalized. This series of group homes provides graduated levels of care to allow these elders to reside in a relatively unrestrictive environment at minimal cost. The program is funded by the State of Florida with additional funding from city and county governments and from private sources.

Rhode Island is experimenting successfully with a program that subsidizes informal caregivers for maintaining elders at home[1] (Thomas D. Romeo, personal communication, June, 1985). Families who earn less than $21,000 per year and whose elder would otherwise qualify for institutionalization are paid $75 per week and given training in basic geriatric care and in stress management.

If family physicians had a good working relationship with community mental health centers, and community mental health centers could deliver consultation and referral services to the elderly at the home or in community nursing homes, the mental and physical suffering of many patients could be reduced, and many unnecessary and costly institutionalizations could be avoided. New systems of geriatric mental health care, such as Florida's Geriatric Residential Treatment System program, Rhode Island's Home Care Subsidy Program, or other models might evolve elsewhere and deserve the interest and participation of family physicians.

Reference

1. Rhode Island Subsidy Program. (RI Gen Law), chapt 40.1-1-10.1, 10.2