

RELATIONSHIPS BETWEEN OLD AGE PSYCHIATRY AND GERIATRIC MEDICINE

A joint statement of the Faculty of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists, the Australian Society for Geriatric Medicine and the New Zealand Geriatric Society.



THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS



PREAMBLE

The Faculty of Psychiatry of Old Age, the Australian Society of Geriatric Medicine and the New Zealand Geriatric Society recognise the need for old age psychiatry and geriatric medical services to work closely together to ensure the best treatment and care of older patients, many of whom suffer from complex combinations of mental and physical ill-health. The following is a statement of agreement between the three bodies regarding best policy and practice in this regard.

The statement is a revision of one prepared in October 1990. Old age psychiatry services were being established at that time in many parts of Australia and New Zealand and referral arrangements and service responsibilities varied from place to place. In general, geriatric medicine accepted responsibility for the treatment and care according to the type and complexity of medical problems. In contrast, most old age psychiatry services use aged-based criteria, thereby creating barriers to cross-referral of some patients. There was also uncertainty about whether old age psychiatry or geriatric medicine should take prime responsibility for the assessment and management of the cognitive and behavioural problems associated with dementia.

The aim of the 1990 position statement was not to prescribe identical

services in all parts of Australia and New Zealand. Rather, it established a set of principles to help the two sub-specialties work better together, adapting to local circumstances. These principles still apply. This revised statement reflects the current move, which is endorsed by all three professional bodies, to promote easy access by elderly patients and their carers to high quality, well-integrated community, residential and hospital aged services of which old age psychiatry and geriatric medicine are key components.

RELATIONSHIP BETWEEN SERVICES

1. Both old age psychiatry and geriatric medical services should be available in health care areas with more than 50,000 inhabitants. Where old age psychiatrists are not readily available, arrangements should be made for visits by specialists and/or telephone or video conferences. Where no such arrangements are possible, it is expected that geriatric medical services, adult mental health services, private psychiatrists and general practitioners will liaise to provide a substitute service.
2. Where old age psychiatry and geriatric medical services have defined catchments, their boundaries should correspond.
3. Wherever possible, old age psy-

- chiatry and geriatric medical services should be co-located to promote ease of access and continuity of care for patients, carers and referring agencies. It is imperative, however, that old age psychiatrists maintain close professional and educational links with their colleagues in general psychiatry.
4. Where co-location is not practicable or desirable, it is important that old age psychiatry and geriatric medical services be integrated functionally to ensure the clinical outcomes described below.
 5. Where the two services are co-located, referring persons or agencies should have the option of referring explicitly to either old age psychiatry or geriatric medicine.
 6. Irrespective of service structure, cross-referral between services should be freely available to optimise care and prevent indiscriminate transfer of patients from one service to another.
 7. Criteria for the division of responsibility between the two services must be known and accepted both internally and externally.
 8. Responsibility for patient care must be based on assessed needs. When a patient is referred from one service to another, clinical accountability rests with the original service until the other accepts primary responsibility.
 9. In general, delirium is best managed by physicians. Old age psychiatry services, when resourced adequately, are usually best placed to provide assessment and treatment to patients whose dementia is complicated by behavioural and psychological symptoms.
 10. It is important that services be adequately funded. Resources (staff, physical facilities etc.) should be allocated on the basis of local need in line with the RANZCP's Statement on Psychiatric Services for the Elderly (Position Statement #22).
 11. Reciprocal arrangements for rotations by advanced trainees in each other's disciplines are highly desirable and training committees should provide clear guidance about standards of training and supervision.
 12. Wherever possible, representatives of both disciplines should contribute to medical appointment committees and to planning processes where the outcome impacts on the other subspecialty.