Position Statement 31 ‘Relationships between old age psychiatry and geriatric medicine’ (PS31) is a joint statement of the Faculty of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian and New Zealand Society for Geriatric Medicine (ANZSGM).

Background

The Royal Australian and New Zealand College of Psychiatrists’ (RANZCP) Faculty of Psychiatry of Old Age and the Australian and New Zealand Society for Geriatric Medicine (ANZSGM) recognise the need for old age psychiatry and geriatric medical services to work closely together to ensure the best treatment and care of older people, many of whom suffer from complex combinations of mental and physical ill health. The following is a statement of agreement between the two bodies regarding best policy and practice in this regard. The statement represents an ongoing revision of one prepared in October 1990. 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 subspecialties work better together, adapting to local circumstances. These principles still apply, with their longevity reinforcing their sound basis. This revised statement aims to promote easy access by elderly people and their carers to high quality, well-integrated community, residential and hospital aged services of which aged psychiatry and geriatric medicine are key components.

Relationships between services

1. Both old age psychiatry and geriatric medical services should be available in all health care areas and preferably with face-to-face services in areas with more than 50,000 inhabitants. Where old age psychiatrists or geriatricians are not readily available, arrangements should be made for visits by specialists and/or telephone or video conferences. The use of e-health services is to be encouraged. 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. Where old age psychiatry and geriatric medical services have defined catchments, their boundaries should correspond.

2. Wherever possible, old age psychiatry and geriatric medical services should be co-located to promote ease of access and continuity of care for people, carers and referring agencies. It is imperative, however, that old age psychiatrists, and old age psychiatry services maintain close professional and educational links with their colleagues in general psychiatry.

3. 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. This may be achieved through governance structures or agreed working relationships.

4. 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.

5. Irrespective of service structure, cross-referral between services should be freely available to optimise care and prevent indiscriminate transfer of people from one service to another.
6. Criteria for the division of responsibility between the two services must be known and accepted both internally and externally.

7. 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.

8. 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 people whose dementia is complicated by very severe behavioural and psychological symptoms.

9. Government funded support services should be supported and integrated within the client’s overall clinical care plan. This includes Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRT) in Australia. In New Zealand, due to the different models of care and funding in each of the 20 district health boards, old age psychiatric services and geriatric services should work collaboratively in the development of dementia services at the district health board level. Services which specialise in managing dementia-related behaviour, for example DBMAS and SBRT in Australia, are complementary, but not a replacement for, comprehensive geriatric or psychogeriatric assessments.

10. It is important that services be adequately funded. Resources, such as staff and physical facilities, should be allocated on the basis of local need in line with the RANZCP’s Statement on Psychiatric Services for the Elderly (RANZCP, 2015; McKay et al., 2015) and ANZSGM Position Statement Number 8: Comprehensive Geriatric Assessment and Community Practice (ANZSGM, 2011).

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 sub-specialty.

References


Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.
### REVISION RECORD

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