Foreign Report

Psychiatry in Australia

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After some 13 years of pale-faced exile in England I returned with some excitement to Australia, eager to share in its psychiatric development and perhaps to benefit a little from the fruits of what appears as the international rapacity of Murdoch, Holmes a Court, Elders IXL et al. The second more furtive wish suffered early set-backs as I discovered that the Australian economy was dipping alarmingly and that the Australian dollar, once to my mind as solid as Ayer's Rock, was sinking rather than floating against other currencies. This has meant cut-backs in government expenditure, health included, threatening my first wish as well.

Entrepreneurship, cultural 'cringe' and the cutting down of 'tall poppies' have been favourite pastimes in Australia but seem less evident now than they were in the past. We in Australia are dependent on foreign ideas in psychiatry as in most other fields but we do not wish to make it easy for their proponents. Visiting professors and other authorities do constitute 'events' here but we like to scrutinise their ideas carefully and argue with them, preferably after wearing down their reserves by imposing hectic schedules of speaking engagements and interstate air travel and through constant temptation by outstanding wines.

Political factors seem always very near the surface in Australia and the practice of psychiatry is much influenced by them. Australia is a federation with a Commonwealth government based in Canberra and individual State governments. Both have responsibilities for health. However, the Commonwealth government has always avoided direct responsibility for mental health services, these remaining primarily state concerns. The states are responsible for psychiatric hospitals and community mental health clinics and they receive grants from the Commonwealth for the public general hospitals some of which have psychiatric units. In Victoria terms and conditions of employment are quite different in the state psychiatric hospital sector and the public general hospital sector, with the former betraying residual signs of an original kinship with the prison system. The Commonwealth government subsidises the private sector through rebates (85%) on the recommended fees for seeing a psychiatrist privately. There is inevitably scope within such a system for attempts to push as much health care as is possible, yet decent, into another system to save money in one's own. Mental health expenditure in most states is said to be about 10–20% of total health expenditure. In Victoria recently mental handicap services have been transferred out of health into community services. Such manoevres help to make some budgets look healthier. Predictions concerning funding of health services over the next few years indicate that consumers will be expected to pay relatively more; for example, recently the Government stopped day-bed subsidies to private hospitals.

Since the states in Australia represent fairly small worlds, Ministers of Health (and their political 'minders') seem to be very aware of what is happening at local levels. This has a number of implications. New programmes may get an enormous push from the top if they appeal and do not contradict party policy. However, political considerations may intrude rudely into affairs which at first sight seem parochial in their compass. 'Industrial implications' (that is, which unions need to be placated) are vital to the consideration of any new initiative and the ledger of recent wins and losses needs to be kept in mind to determine how much obstruction is likely to be encountered and from which quarters. Among other industrial groups, nurses have shown a willingness to go out (and stay out) on strike. Further, a lesser regard for convention, together with a political platform which needs to be seen to be upheld, may result in stunningly 'radical' proposals. For example, a recent first draft of a new Mental Health Act in Victoria provided for a statutory review by a tribunal following the admission of *voluntary* patients to psychiatric hospitals, presumably to ensure that they were in their right minds when they accepted hospitalisation. Happily this was omitted from the final version.

Official documents charting the future course for mental health services tend nowadays to emphasise 'social justice', 'equal access' and 'accountability' while the words 'patient' and 'treatment' make only occasional appearances. 'Client' and 'psychosocial support' are the favoured terms. In many community mental health clinics the concept of the multidisciplinary team is one of an 'equi-disciplinary' team so that new referrals may be assessed by a worker from any discipline who happens to be rostered for intake on that day. There almost seems to be developing a concept of a 'generic' mental health worker. The Australian tradition of egalitarianism, combined with a more widely noted trend towards anti-professionalism, has resulted in much insecurity among the medical profession. One develops the expectation that what was formerly imagined unthinkable may emerge as the major thrust of the next master plan. However, this need not necessarily spell disaster since there always lurks the opportunity for the implementation of new initiatives which will improve rather than damage services.

Most State governments propose that the best direction for mental health services is towards community based care and rehabilitation of the seriously mentally ill. In New

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South Wales, for example, influenced to a large degree by the Hoult experiment in Sydney, the highest priority has been given to the development of community based assessment, crisis care and treatment services. Mental hospital beds are still being significantly reduced amid fears that inadequate funds will be deployed to make the community services truly viable. Restrictive mental health legislation might also interfere with professionals' capabilities to manage patients in the community.

About half of Australian psychiatrists were predominantly in private practice in 1980 and this proportion is increasing. In Victoria, recent figures suggest that about two-thirds are now predominantly in private practice. Only about 20% of College Fellows are in full-time state employment in that state. Commonwealth records indicate a 27% increase in private consultations since 1980 and an 18% increase in private hospital psychiatric bed capacity. Although the standard of care may as a result be high for those not ill enough to require in-patient care or those who can afford private health insurance, patients in the public sector often fare poorly. These include, in particular, those suffering from chronic illnesses. The structural fragmentation of services hampers the establishment of continuity of care and comprehensive community services. In many districts morale amongst mental health professionals is very low. Unfilled job vacancies at consultant psychiatrist level are common; private practice is much more lucrative and the frustrations of dealing with highly centralised administrations which seem to embody all that is most unsavoury about public service bureaucracies can be avoided. Within a few months of starting in private the neophyte can usually be assured of a healthy list of patients. Meanwhile there are major rural psychiatric hospitals which cannot boast a superintendent. This state of affairs is evident in a well-populated state like Victoria but other states such as Queensland and Western Australia are even more inequitably staffed. At the same time there are accusations by government of 'over-servicing' in the private sector; renumeration is on a 'fee-for-service' basis and the doctor decides which service is warranted.

The prominence of private practice has other repercussions. There is less scope for peer review and a greater responsibility for self-motivated continuing education. Less competition for consultant posts means that registrars are less likely to embark on activities that might provide evidence of their excellence and distinguish them from the rest of the field during the deliberations of an appointments committee. Research in particular is affected; higher degrees and publications are not required for a successful private practice. It is a requisite for becoming a Fellow of the College that a dissertation be completed but, of necessity, the standard judged as adequate is considerably below that demanded for a publication. Overall, psychiatry as a discipline suffers.

A major manpower survey in 1980 suggested that there was a shortfall of 294–394 psychiatrists in Australia and that by 1991 there may be a need for an additional 621–692 over and above this. Some states are very poorly endowed. Queensland has approximately one psychiatrist per 50,000 population, falling well outside WHO guidelines. (Many would regard that state as falling within the Third World in any case.) Child and adolescent psychiatry is just getting going while forensic psychiatry and psychogeriatrics are woefully deficient.

To me it appears that there is a healthy blend of British and North American influences in Australian psychiatry, together with some distinctive local flavours. A recent survey has indicated that DSMIII is twice as popular as ICD9 and that over 50% of psychiatrists use it in their general practice. An important and often under-appreciated fact about Australia is its multi-culturalism. The 1981 Census showed that in Victoria 25% of the population was born outside Australia and that 45% had at least one parent born outside Australia. Being a psychiatrist here is like being in a laboratory for comparative psychopathology with a huge array of cultural groups displaying their mental productions. Patients from approximately 100 countries were treated in state psychiatric facilities last year; the ability to interview through an interpreter is an important skill to acquire.

The Royal Australian and New Zealand College of Psychiatrists has about 1500 Fellows (all members are now Fellows) and it is potentially a most important body. Up till now it has not really flexed its muscles. Its most conspicuous activity is the conferring of a professional specialist qualification. The College examination is a rigorous one covering written cases, papers, and two days of clinicals and vivas. Failure at any of these steps means that the next cannot be taken. Characteristic changes come over registrars in the year of their examination. They experience a kind of moratorium from living; their preoccupation is always in the background and often intrusive. Despite the efforts of a sympathetic examinations board, the terror persists. To some extent it is unavoidable since the Australian exam is an 'exit' exam; the successful candidate may retreat into private practice never to be seen again and there must be some way of insuring his competence. I fear that the pain inflicted on psychiatrists in the form of the examination negatively colours their attitude to the College. The problem of continuing education is being tackled by the College but solutions are elusive.

The College could potentially play a large role in influencing services through its power to accredit training. Until now, the curriculum of the individual candidate has been the subject of approval rather than the training programme and facilities of an institution. The latter could result in important incentives to upgrade services to provide adequate training opportunities; a failure to achieve these standards would result in poorer quality junior medical staff. There has been a reluctance to adopt this course so far, presumably since it has been judged unrealistic to expect service changes to occur fast enough. It is likely this policy will change soon with some important consequences. In the meantime the College has taken initiatives to improve the care of the mentally ill, such as the useful Quality Assurance Project. Incidentally, the College headquarters is

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a beautiful Victorian house called Maudsley House, not named after the famous Henry but after his Australian great-nephew (also Henry) who was an important figure in bringing psychiatry out of the asylum and into respectable medicine in the 1920s.

Research in Australia is handicapped by some of the factors mentioned earlier. Sometimes it has proved difficult to fill chairs in the less populous states. It is difficult to generate a 'critical mass' of researchers in one place and it may be that endeavours have been too thinly spread across too many areas. Grants are hard to get; in 1980–1983 only 0.8% of National Health and Medical Research Council funding went to psychiatric projects. However, the quality of research in most university departments is very high. There are many people with imagination, intellect, flair and energy. Even though the distances between capital cities are great, there is a warm camaraderie and much mutual assistance across the Australian research community seen to advantage, for example, at annual meetings of the Australian Society for Psychiatric Research.

I seem to have dwelt to a large degree on negative aspects of psychiatry in Australia, probably because these occupy much of one's thoughts in one's attempts continually to make improvements. There are many positive aspects as well. In a comparatively flexible system as exists here, there is an enormous potential for innovation and growth, whilst avoiding, one hopes, the mistakes made previously elsewhere. The calibre of recruits to psychiatry is very high nowadays and the population of the College is getting proportionally younger and probably more energetic. Salaries, even in the state sector, are high. Warring factions in psychiatry are less evident here than in many other places and there is a sense of pulling together, perhaps somewhat fancifully construed as a remnant of the pioneering spirit of the past. There are enormous spaces to be filled and room for the marks of many to be impressed upon the psychiatric landscape. And Australian 'mateship' is not a myth; I was on first name terms with my bank manager on our first meeting and at the first conference I attended here, name tags did not display surnames.

Owner Occupied Accommodation for Psychiatric Patients

The charity Good Practices in Mental Health (GPMH), 380–384 Harrow Road, London W9 is asking MPs and Senior Civil Servants to consider the establishment of a small group of projects where discharged psychiatric patients are given the opportunity to become owner occupiers instead of going into sub standard housing or to large hostel accommodation. GPMH argues that owner occupation is desirable because if community care is to open up choices for normal living, it does not make sense to restrict choices in tenure at a time when a majority of people either own or are buying their own homes. GPMH suggests that: mortgage financing be experimented with in a number of areas, particularly areas with relatively low cost housing; key health authorities and local authorities be encouraged to negotiate with building societies for the provision of mortgage finance; two or three experimental schemes be established in different areas of the country, using different systems of mortgage financing, with perhaps five to six people being rehoused in each area, and the results of these experimental schemes be evaluated, written up and disseminated to a wider audience.

St Andrew's Hospital and the Broadcasting Complaints Commission

The Broadcasting Complaints Commission adjudicated in February 1987 on a complaint from Dr Gavin Tennent, Medical Director, and the Governors of St Andrew's Hospital, Northampton, about a programme in the Checkpoint series broadcast on BBC1 on 18 October 1984. The programme, entitled 'The Mind Benders', was about a form of treatment known as 'behaviour modification' as practised at St Andrew's and at Spyways Hospital in Dorset.

The Commission considered that the issue of the human rights of patients at St Andrew's was a legitimate subject for the programme to consider. In the Commission's view, however, the main impression left by the programme was that St Andrew's, because of the form of treatment practised in some of the units, was a terrible and fearful place. The evidence before the Commission did not substantiate this. The Commission concluded that in its presentation of St Andrew's and the treatment carried out there the programme was generally unfair to the complainants, although they considered that Dr Tennent was given sufficient opportunity in the programme to answer criticisms. Except on this point the Commission upheld the complaint.

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