Australian psychiatry: coming of age?

Alan Rosen

Director of Clinical Services and Senior Psychiatrist, Royal North Shore Hospital and Community Mental Health Services, Sydney; Associate Professor, School of Public Health, University of Wollongong; Clinical Associate Professor, Department of Psychological Medicine, University of Sydney, New South Wales, Australia, email: arosen@nsccahs.health.nsw.gov.au

Australia, a vast continent of 7 700 000 km^2 (including the island state of Tasmania), is roughly the size of Western Europe or mainland USA, but with a population of only 20.2 million (2004 estimate), mainly concentrated in coastal areas.

Australia's official language is English and its largest religion is Christianity (76.4%). Of the current population 92% are Caucasian, 7% Asian and 1% 'other' in origin, including 350 000 who claim Aboriginal descent. Australia's population growth once relied largely on migration from Britain, and to a lesser extent Ireland, but after the Second World War it was broadened by refugees and others from many other parts of Europe. Since the 1970s there has been more substantial migration from Asia. While refugees continue to be taken in and supported, Australia takes a tough stance on unauthorised arrivals, including prolonged detention, which is beginning to be softened due to growing public concern.

The Commonwealth (national) government is responsible for general policy directions in health, disability, education, employment and so on. The state governments retain responsibility for organising all their own health services and facilities, including mental health services. Consequently, such provision is diverse. Further, Australia has developed a substantial private medical sector, now funded nationally by taxpayers through the Health Insurance Commission, as well as via private health insurance schemes.

Epidemiology

A national cross-sectional community survey of mental health and well-being (Andrews *et al*, 1999; Jablensky *et al*, 1999) was conducted via lay surveyors from the Australian Bureau of Statistics. It revealed that 17.7% of adult Australians met criteria for the common anxiety, affective and/or substance use disorders. More than 20% were likely to have a diagnosable and treatable mental disorder when psychotic, cognitive and personality disorders were included. Only 38% of individuals with a mental disorder (more women than men) sought professional help, which is concerning, and in most cases this was from a general practitioner rather than from a specialist mental health professional. Half as many Australians have a long-term mental disorder as have a long-term physical disorder, with physical disability being more common in the elderly and mental disability being more prevalent in young adults.

Psychotic disorder was found to be associated with a higher prevalence of severe physical illnesses and a much lower access to appropriate medical and surgical interventions (Lawrence *et al*, 2001).

The funding for a new national community survey, which may well have a longitudinal component, was announced by the federal government in July 2005.

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Policy developments and shift in service provision

A National Mental Health Policy was first endorsed by all Australian health ministers and published in 1992. It has been elaborated upon in two further National Mental Plans. These will be the subject of a forthcoming paper in *International Psychiatry*. Together they have sought to promote mental health, increase the quality and responsiveness of services, and to forge a consistent approach to mental health service system reform among Australian states and territories. They also represent a shift over more than a decade to community reprovision from former reliance on psychiatric hospitals. This has occurred with a slight growth in the number of acute beds, mainly in general hospitals, and a 63% decrease in long-stay hospital beds, and partial compensation in the growth of supervised community residential placements, crisis and assertive community treatment teams.

Mental health legislation

Although each state and territory has its own Mental Health Act, a template model Mental Health Act upholding the rights and responsibilities of people with mental illness was developed centrally in the early 1990s (as part of the First National Mental Health Strategy). A Rights Analysis Instrument was subsequently developed by the Federal Attorney-General's Department, which is now used to calibrate all state and territory mental health legislation with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991; Whiteford & Buckingham, 2005).

Workforce and training

There were an average of 87.5/100 000 full-time equivalent professional staff employed in specialist mental health services by 2001–02, including 9.7/100 000 medical, 57.1/100 000 nursing and 20.7/100 000 allied health workers (Department of Health and Family Services, 2004). This represents a 100% growth in professional staffing over the previous decade.

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Australian public mental health services are largely staffed by interdisciplinary teams of at least five fully professional disciplines: psychiatry; psychiatric nursing; psychology (particularly clinical psychology); occupational therapy; and social work. Variably, depending on location, teams may also include rehabilitation or vocational counsellors or instructors, and indigenous and transcultural mental health workers. Increasingly, paid consumer and carer advocates, consultants or teams are being employed in such services. Case management is generally shared between nursing and allied health professions, as Australian standards and guidelines do not support the development of a generic case manager role, either by merging professions or on a non-professional basis (Rosen *et al*, 1995; Gianfrancesco *et al*, 1996; Rosen & Teesson, 2001; National Mental Health Strategy, 2003; Rosen, 2005).

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Following a medical course of 4 years (graduate) to 5 or 6 years (undergraduate) and 2–3 years of rotating hospital resident posts, trainee psychiatrists undergo a 5-year (or more) training period that combines apprenticeship and coursework. This now includes advanced training in a sub-specialty over the last 2 years, which may be child and adolescent psychiatry, adult psychiatry, aged-care psychiatry, consultation–liaison psychiatry, psychotherapy and so on, and which results in the trainee becoming a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP – on which see Boyce & Crossland in this issue).

Nurses are trained on university general nursing courses for 3 years and then may attain postgraduate certificates while working in their chosen specialty (e.g. mental health nursing).

Allied professionals usually have a bachelor degree in their chosen profession, often taking 4 years, but they are being increasingly encouraged to proceed to masters or doctorate level, particularly in psychology.

There are over 2000 psychiatrists; although only around 20% were in public practice (Henderson, 2000), this proportion is growing (it grew by 37% over the decade to 2002) and the number of psychiatrists in private practice has been shrinking by 2–3% per year since 1997 (Whiteford & Buckingham, 2005). Boyce & Crossland in this issue indicate that 40% of Australian psychiatrists now work in the public sector and 60% in the private sector. The apparent difference is explained by the probable increasing proportion of Australian psychiatrists now doing a combination of public and private practice. The RANZCP Workforce Study 2005 revealed that 23% of Australian psychiatrists work solely in public practice, 41% solely in private practice and 36% in both. Comparison with an earlier survey (Australian Medical Workforce Advisory Committee, 1999) indicates a slow decrease in the number of psychiatrists working predominantly in private practice and a slow increase in the numbers of psychiatrists working predominantly in public practice.

In 1999 more than 20% of the health burden in Australia was attributable to mental disorders, yet only 5% of the national health budget was spent on mental health.

The clinical staffing levels in public mental health services (Department of Health and Family Services, 2004) totalled nearly 18 000 by 2002, having grown by 15% since 1992–93, and consisted of 62% nursing, 22% allied health, 10% medical professionals and 6% others. There is currently a shortage in psychiatry of registrars and nurses, as in other Australian health disciplines.

Resourcing

In 1999 more than 20% of the health burden in Australia was attributable to mental disorders, yet only 5% of the national health budget was spent on mental health (Andrews *et al*, 1999). This proportion of expenditure grew only marginally, to 6.5%, in 2001–02 as derived from *World Health Reports* (Rosen *et al*, 2004). Total expenditure on mental health services in 2001–02 was A$3.09 billion, of which 58.2% was spent by the states on the public mental health system, 37.1% was spent by the commonwealth government mainly on pharmaceutical subsidies, general practitioner and private psychiatrist rebates, and 4.7% by private health funds, mainly for private hospital services (Department of Health and Family Services, 2004).

Research

Particular, sometimes outstanding contributions have been and are being made by Australians to psychiatric research in many areas, as listed by Henderson (2000): the phenomenology and treatment of both the depressive and the anxiety disorders; abnormal illness behaviour and somatisation disorder; illness prevention and health promotion; the epidemiology of mental disorders and the social environment; the epidemiology of mental disorders in late life; the neurobiology of schizophrenia; early intervention in the psychoses; mental health service system research; the mental health of indigenous peoples; alcohol and drug misuse; post-traumatic stress disorder; and psychiatry and ethics. To these I would add research in: mental health literacy, stigma and mental health first aid; telepsychiatry and related strategies for rural/remote areas; classification, phenomenology and treatment of depression; consultation–liaison psychiatry; the psychological health of asylum seekers in detention, of refugees and of traumatised populations; medico-legal provision; psychosocial (including family) interventions; crisis and assertive community case management and residential alternatives to in-patient care; interdisciplinary roles, teams and leadership; outcome measurement; and consumer and carer participation in services.

Conferences and forums

Each mental health professional grouping runs its own annual congress or conference, and there are many national and international special interest meetings.

There is a strong independent movement, the Mental Health Services Conference of Australia and New Zealand (www.themhs.org) (Andrews, 2005), which is co-owned by all mental health professions, managers and consumer/carer networks, which promotes joint conferences, binational debates and forums, and mental health service achievement awards for local integrated services, early intervention, comorbidities,

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rural and remote services, indigenous and transcultural mental health services, consumer and carer service initiatives, mass media representations of mental illness and services (print and electronic). The MHS conference begins with separate indigenous, consumer, carer leadership and provider training forums, with all these constituencies coming together for the last 3 days.

Conclusion

Mental health reforms in Australia have resulted in considerable achievements (see forthcoming paper in *International Psychiatry*). However, after 5 years of real growth of integrated community and local hospital mental health services from 1992 to 1997, many community-based psychiatric services are now being increasingly starved of resources, and others were never adequately developed. This plus increasing presentations involving severe comorbidity with substance misuse, particularly in males, has put severe pressure on emergency departments, acute in-patient units and consultation–liaison teams. Private sector resources are not rationally distributed and public health administrations siphon mental health budgets continually. Australia still compares poorly with other Western countries in terms of the proportion of its gross domestic product and health budgets spent on mental health (Rosen *et al*, 2004). So although on paper the Australian National Mental Health Policy has been world class, its implementation has proven patchy and fragile. We now need to lift our game, and call for a consistent independent umpire, a National Mental Health Commission or equivalent.

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SPECIAL PAPER

Fifteen-year follow-up of conversion disorder

H. R. Chaudhry, N. Arshad, S. Niaz, F. A. Cheema, M. M. Iqbal and K. A. Mufti

Fatima Jinnah Medical College, Sir Ganga Ram Hospital, Lahore, Pakistan, email: pprc@wol.net.pk

The terms ‘conversion’, ‘hysteria’ and ‘conversion hysteria’ were used interchangeably to describe a condition characterised by a single somatised symptom, often pseudo-neurological in nature. DSM–III (American Psychiatric Association, 1980) expanded the concept of conversion to generalised symptoms involving loss or alteration of physical functioning suggestive of a physical disorder, along with a clinical indication that the conversion was an expression of psychological conflict or need. The type of symptom or deficit should be specified as: with motor symptom or deficit, with sensory symptom or deficit, with seizure or convulsions, or with mixed presentation (Kaplan & Sadock, 2004).

Lifetime prevalence in the general population has been estimated at between 11 and 300 cases per 100 000. The prevalence is 5–14% of general hospital patients, 1–3% of out-patient psychiatric referrals and

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