Psychiatric Bulletin (1992), **16**, 552–554

Letter from . . .

Australia (Melbourne)

DAVID AMES, Senior Lecturer in Psychiatry of Old Age, University of Melbourne, Academic Unit for Psychiatry of Old Age, Royal Park Hospital, Private Bag No. 3, Parkville, Victoria, 3052, Australia

Australia is a unique, geologically ancient island continent. Its flora and fauna are unlike those found anywhere else and the same may be said of its people, politics and health services. The population of 17.3 millions represents a multicultural mix, with an anglo-celtic core conflated by sustained post-war immigration from southern Europe, Turkey, south-east Asia and south America. One in five current Australians was born elsewhere, one in ten comes from a non-English speaking background, and a quarter of those born here have a parent who was born overseas. Aboriginals and Torres Strait Islanders form 1.4% of the total population. They have third world mortality figures but die of first world diseases, their life expectancy being 20 years less than that of other Australians. Two hundred and four years after what they see as the British invasion, their standard of living lags far behind all other socio-cultural groups in the country. Most members of the Aboriginal community do not live long enough to develop Alzheimer's disease, but it and other age-related diseases are emerging as the major determinants of health costs as Australia moves towards the 21st century.

Although only 11.4% of Australians are aged above 65, the rate of growth in our elderly population is exceeded among developed countries only by Japan, Canada and the remnants of Yugoslavia (Jorm, 1990). Because the prevalence of dementia is directly related to age (Jorm *et al*, 1987), between 1986 and 2006 the number of dementia sufferers here will grow by between 69% and 77% with the peak rate of increase occurring right now. Australia spends above £500 million on institutional care for the aged each year in providing 59 nursing home beds and 36 hostel places for every thousand people aged 70 and over. Over two thirds of those in such institutions suffer from dementia. In order to respond to this epidemic it has been necessary for our governments (both federal and state) first to take note of demographic change and second to develop appropriate and affordable models of care for our aged population.

Australia has unique fauna and unique aged care services. (Copyright Nucolorvue Productions Pty Ltd.)

For a country with a three year electoral cycle Australia was surprisingly quick to achieve governmental recognition of the implications inherent in an ageing society (McLeay, 1982). The work of Anna Howe and her colleagues at Melbourne's National Research Institute of Gerontology and Geriatric Medicine had a significant impact on the development of government policies in this area. By highlighting Australia's high rate of institutional care for its elderly, by demonstrating the *ad hoc* nature of much nursing home placement and by publicising the grossly low expenditure on home support services in comparison to the funding for institutional care, these researchers facilitated three important developments in national aged care policy.

First and most important was the creation in 1984 of regional geriatric assessment teams (GATs) which now cover the whole country. These teams have a core of geriatrician, social worker, nurse and occupational therapist and usually are based at a geriatric facility with some acute beds. The GATs represent a unique Australian response to the need of old people for a multidisciplinary assessment prior to entry to long-term care. Because they have ministerial

The Australian Alps from the summit of Mt Stirling. Although Australia is geologically old, its ageing population is catching up fast.

delegation to approve funding for individual patients in nursing homes and hostels the GATs are the effective gatekeepers to these institutions and provide assessment for many patients with dementia. The second initiative of note has been the redirection of an increasing proportion of the nursing home budget to the provision of home and community care. Last has been a planned reorientation of institutional care away from heavily staffed nursing homes with an emphasis on the physically dependent toward cheaper hostel care for the ambulant elderly, particulary those with dementia.

One interesting aspect of recent developments in aged care is the degree to which they have been driven by research. Australian researchers continue to produce high quality research on ageing and related areas, despite relatively low levels of government support. In the broad areas relevant to the psychiatry of old age Australia has three research groups of world class. The National Health and Medical Research Council's Social Psychiatry Research Unit in Canberra has been led by Scott Henderson since its inception in the 1970s and now directs its main efforts to studying the epidemiology of dementia. In Melbourne a team directed by Colin Masters, based at the Pathology Department of the University of Melbourne and the Mental Health Research Institute of Victoria, continues to make a significant contribution to understanding the role of amyloid protein in the causation of Alzheimer's disease, building on the central role which Masters played in the sequencing of the amyloid found in plaques. Last, worldwide attention has been directed at the innovative carer education programme developed by Henry Brodaty and Meredith Gresham at Prince Henry Hospital in Sydney.

Because Australian psychiatrists tended to neglect the area of dementia prior to the 1980s, geriatricians have played a more important role in the assessment and care of dementia sufferers than they have in Britain. Thus many uncomplicated cases of dementia are assessed by GATs, whereas the psychiatric services tend to be consulted when disturbed behaviour or non-cognitive manifestations of dementia predominate. Academic appointments in the psychiatry of old age are a recent innovation, the first having been made at the University of Melbourne in 1989. There has been steady growth since then, with two Professors of Psychogeriatrics taking up chairs in late 1990. For the foreseeable future there will be enormous opportunities throughout the country for psychiatrists willing to commit themselves to the

https://doi.org/10.1192/pb.16.9.552 Published online by Cambridge University Press

development of services, training and research in the psychiatry of old age. Public psychiatry in Australia is understaffed both at trainee and consultant level due both to a planned decline in the number of undifferentiated medical graduates and the continued drift of qualified psychiatrists from salaried positions to so-called private practice, largely paid for by government funded insurance rebates. A considerable proportion of the income of the average psychiatrist in private practice is derived from open-ended dynamic psychotherapy with relatively well patients and the extraordinary tolerance of the government in failing to limit the number of such sessions which will be rebated (Andrews, 1991) reinforces the continued movement of psychiatrists out of full-time salaried public practice, to the likely detriment of patients with dementia and functional psychoses among whom the elderly are prominent.

For the British psychiatrist or trainee there are a number of ways to work in Australia. Formal registrar exchanges between London and Sydney are established and there are plans to extend these swaps to include Melbourne. At an informal level trainees willing to expend a few pounds in postage will find a six month job opening at a reputable hospital without much difficulty. For those with the MRCPsych there is a welcome both for those seeking a year or two at senior registrar or junior consultant level and for those who desire to make a permanent home here. Air fares to Australia have never been lower in real terms than they are at present so there is every opportunity for those contemplating a job here to come and inspect us on a brief advance visit.

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Psychiatric Bulletin (1992), **16**, 554–555

Computers in psychiatry

An introductory course

D. J. WILLIAMSON, Research Registrar, Department of Clinical Research, Crichton Royal Hospital, Dumfries DG1 4TG

4. Spreadsheets

Imagine an "intelligent" sheet of paper, on which you could record data in an organised fashion, and format its appearance for publishing purposes, but which could also do it's own calculations, (with the answer appearing automatically), *and* draw graphs of the results. This is essentially what a spreadsheet does.

A spreadsheet is ruled up into a grid of rows (numbered 1, 2, 3 etc) and columns (labelled A, B, C etc). The place where a column and a row intersect is called a cell and is named after the column and row (A1, B2, C3 etc).

	A	B	C	D	E
1		Column			
2		Column			
3	Row	Cell B3	Row	Row	Row
4		Column			
5		Column			

Typically, a modern spreadsheet will encompass several hundred columns and around ten thousand rows. This is much too large to fit on one screen and