The subject was politely requested to answer the questionnaire by a research resident (A.C.) who neutrally remained present during the assessment. Twenty-seven subjects (17 male and 10 female) underwent the computerised screening test and then were interviewed by a senior psychiatrist (M.C. or P.S.). The mean age of the sample enrolled was 35.08 ± 10.25 (SD) years, the educational level was 10.62 ± 3.33 (SD) years.

Problems arose right from the first subject. Performance time was more than ten minutes and all but two subjects (regardless of being a legitimate psychiatric case or not) repeatedly asked for help in spite of the exhaustive computer suggestions. The subjects, when asked to comment on the procedure, showed frustration and anxiety about their performance (23 subjects: "I don't know; I didn't manage"; "I'm afraid of having made mistakes"; "It is embarrassing") or refusal (two subjects: "It's stupid"; "useless") and they couldn't wait to finish the test. The two remaining subjects (one with a high school diploma in computer sciences and one airline pilot) performed without any problems. Examining the data of the questionnaire, the GHQ threshold score of 4/5 offered identification as "cases" of 50% of the patients and 100% of the controls.

Apart from the fact that almost all of our subjects had never seen or utilised a computer, the problem did not seem to be the understanding of the programme instructions, but the response to an interface (the screen) by another interface (the keyboard) and the co-ordination between the two.

Perhaps the subjects of our sample have never known how "interesting and sometimes enjoyable" (Hughes *et al*, 1986), "very easy" or "very acceptable" (Lewis *et al*, 1988) a computerised assessment could be as reported by perhaps a little too optimistic view.

We know about the important utilisations of computerised procedures in patients without any informix knowledge and sometimes severely disabled patients but perhaps more regard for computer-patient interface patterns is needed in settings where an immediate understanding of the procedure without extensive explanations is necessary. Perhaps Italian knowledge about informix, or that of our sample, is not as widespread and high as in some countries, nevertheless it is probably no less so than in others. And yet there is a whiff of problems in the acceptability of computerised assessments in other reports (Lewis *et al*, 1988).

We feel sure that computer usefulness lies in simplifying and facilitating screening procedures in general practice but probably a different kind of interface such as a "touch-screen" system or an extremely simplified keyboard could give more accessibility in such a setting. This is a matter for our present ongoing search.

"... and the computer said: talk to me about your mother ..." perhaps does not belong to the near future of our patients after all.

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Psychiatry in Australia

Dear Sirs

Andrews (*Psychiatric Bulletin,* July 1991, **15,** 446–449) contrasts Australia's 74 specialist psychiatric beds per 100,000 with England's 142 beds per 100,000. He adds together the costs of psychiatrists' and hospital beds, and reckons that the total costs of psychiatric services in Australia and England are, respectively, $5.17 million and $8.23 million per 100,000 population. Andrews attributes the greater costs in England to "continuing reliance on admission to hospital as the primary means of service delivery". He states that Australia appears to have one of the lowest bed ratios of any developed nation.

It is surprising that Professor Andrews does not draw attention to the difference between age distributions of Australian and English in-patients, while comparing costs. In Australia, the number of beds per 100,000 occupied by those under 65 years of age is about 66; in England, the corresponding number estimated for 1991 is about 67 (Wing, 1986). Andrews' figures can be explained by the difference in costs attributable to care of elderly people. The lesser number of elderly people in psychiatric hospitals and units in Australia (when compared to England) is partly because our population is younger (about

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12% aged 65 or more), and partly because a far smaller proportion of dementing persons are in hospitals; more are in nursing homes. The possibility that the lower number of psychogeriatric beds is partly due to the excellence of our community psychogeriatric services can be rejected; such services are presently embryonic, in spite of lobbying and recommendations to our Governments. There is insufficient attention, in Australia, to the psychiatric problems of elderly people in the community and in nursing homes. Many remain untreated or are treated inappropriately (by staff who have not been psychiatrically trained). Professor Andrews (1990) does not help the situation when he suggests that Australia needs only one psychogeriatrician per million population!

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DEAR SIRS

Professor Andrews' fascinating paper on psychiatry in Australia (*Psychiatric Bulletin*, July 1991, **15**, 446–449) makes an interesting comparison of the different costs of British and Australian style services. Unfortunately there are two fallacies in his comparison related to demography, epidemiology and the evolution of different styles of provision.

The first is that only 10% of the Australian population are over the age of 65 years compared with 15% of the British population. Put another way, an Australian population of 100,000 would contain only 10,000 old people whereas a similar British population base would contain 15,000. The *per capita* public health spending on those over 65 in the UK is 4.3 times that on younger people (Centre for Policy on Ageing, 1989). This is reflected to some extent in psychiatric bed use with 33% of all psychiatric admissions and 37% first admissions over the age of 65 and over 56% bed occupancy due to the needs of old people (DHSS, 1986).

The second fallacy derives from the high Australian institutionalisation rate for old people outside the hospital sector. In the early to mid 1980s there were 47 nursing home beds/1000 elderly in Australia compared with around 35 beds/1000 elderly in the UK for the public and private nursing and residential sectors combined (Centre for Policy on Ageing, 1989).

A great deal of the apparent extra bed use (and associated cost) in the UK reflects the extra demands of a proportionately larger elderly population and the greater use of nursing home beds in Australia which was not costed in Professor Andrews' comparison.

Whether these factors balance or even overturn his calculations I would not like to say. They certainly point to the difficulties in making such comparisons without considering the wider demographic and social context. The figures I have used were derived from the early to mid 1980s and it may be that "back door privatisation" of long stay care for old people in the UK (Annis *et al*, 1991) has moved us nearer to the Australian model!

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DEAR SIRS

I agree with Drs Wattis and Snowdon that some of the apparent cost advantages of Australian psychiatry would be lessened if we could adjust for the different systems for handling elderly people with dementia. In Australia services for the elderly – hostel and nursing home accommodation and medical care – are being increasingly organised outside psychiatry. This is reflected in the workload of psychiatrists in that only 5% of their patients are over 65 whereas 10% of the population is over this age.

I think that this trend will continue, partly because of the desire of the States to transfer the cost of aged persons' care to the Commonwealth Government which does not provide psychiatric services, and partly because the elderly themselves are suspicious of mental health services, fearing institutionalisation in a mental hospital. They therefore seek mental health care from general practitioners and geriatricians. I think that psychogeriatricians will have a diminishing role in direct patient care and increasingly become consultants to these other segments of the medical profession. I understand that we are not following the English model, but I would have no means to decide which model is best for the patient, although it would seem that the Australian model is potentially less expensive in the sense that good

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