COUNTRY PROFILE

Australian psychiatry: coming of age?

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A ustralia, a vast continent of 7 700 000 km² (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.

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 re-provision 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

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 professionals.

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.
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.

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. 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, bional debates and forums, and mental health service achievement awards for local integrated services, early intervention, comorbidities,
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

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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...