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!

JOHN SNOWDON

*The Prince Henry Hospital*
*Little Bay, NSW 2036*
*Australia*

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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!

JOHN P. WATTIS

*St James's University Hospital*
*Leeds LS9 7TF*

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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

nursing home accommodation is less expensive than good mental hospital accommodation.

GAVIN ANDREWS

*University of New South Wales*
*Clinical Research Unit for Anxiety Disorders*
*299 Forbes Street*
*Darlinghurst, NSW 2010*
*Australia*

## *Research opportunities in the USA*

DEAR SIRS

The benefit of a full-time research post is being increasingly recognised as an essential part in the training of a consultant psychiatrist. The possibility of pursuing such research abroad adds to its value. The United States leads the field in many areas and abounds with special research centres, many of which are attached to major universities, attracting the very best of academic professionals. While entry to and working in the US may be fraught with difficulties, acquiring a position as a Post Doctoral Research Fellow is not as difficult as it first seems.

In June 1989 I decided to begin my quest in searching for a research opportunity in Stanford University, California. The Centre for Sleep Disorders, the Eating Disorder Unit attached to the Behavioural Science Department and the Child Psychiatry Department were the main areas in which I was interested. I wrote to all of them, along with letters to many other units, requesting information about the possibility of working there. I received no replies.

Not discouraged by the lack of response, I arrived in the US in September and made appointments to see each of the heads of departments. My first meeting with Dr Gullimineault in the Sleep Centre resulted in an offer of a non-funded fellowship with the promise of a grant application the following year. I could contribute to ongoing research or set up my own project, along with attending various seminars, lectures, tutorials etc. I decided to start working voluntarily while continuing to look for a more organised programme. There was also a possibility of working in the genetics unit of the Child Psychiatry Department, again initially on a voluntary basis. Departmental heads are only too pleased to recruit foreign doctors to help in their ongoing research if it can begin on a voluntary basis. Once you become established and valued in the unit it is unlikely that you will not receive a stipend at some stage.

In November I was successful in obtaining a three year fellowship programme with Professor Agras in the Eating Disorder Unit. This was a full-time salaried research position co-ordinating and managing a research project for which they had received funding. It entailed a multi-million dollar budget (as many American federally funded projects do) and therefore required a lot of administrative as well as clinical and research skills. My first task in preparing for this was to complete a three month computer course and later a statistical course. These were readily made available to me by the Department. I was also able to include some of my own research interests in the protocol.

Being a fellow on an official programme allows you to avail yourself of other academic facilities offered by the university, including lectures, courses and conferences. Salaries are low, ranging from $15,000–$25,000. The holiday entitlement for a Fellow is at the discretion of your sponsor but is usually three weeks per year. Paid maternity leave is also possible –six weeks being the norm. Being a student entitles you to free library facilities and medical insurance coverage which is otherwise expensive. It also allows you the use of all university facilities along with the option of attending any university courses which may be of interest. While you are officially entitled to campus housing, due to the vast number of students, both undergraduate and postgraduate, it is not always possible to obtain. Accommodation is, however, readily available at commercial rates in the nearby area. At the end of the programme you graduate with the other students and receive a certificate of completion.

Passing the ECFMG (formerly called the FLEX exam) is not essential for a research position, but is required if you are considering any clinical work which requires treatment of patients. Specific courses are organised in the States for candidates taking the exam and are especially useful.

Entry into the US requires a visa; if you have not arranged your fellowship in advance, you may enter on a tourist visa and wait for the University to sponsor you for a J-1 visa. If your spouse has a J-1 visa you are entitled to a J-2 which may be exchanged for a J-1 at a later date.

Up to one year's senior registrar accreditation may be given by the Joint Committee on Higher Psychiatric Training if the position is as a full-time researcher. The research project may also be written up for either an MD or PhD.

My advice to colleagues wishing to avail themselves of research opportunities in the US is to persevere, appear in person, and be willing to start on a voluntary basis. Your application should be successful and you will thoroughly enjoy and gain from your experience there.

FIONA MCNICHOLAS

*Department of Behavioural Science*
*Stanford Medical Centre*
*Stanford University*
*CA 94305-5490, USA*