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Training in Australia

Sir – Two excellent articles in 1997 give a very useful perspective on training in the UK and USA.[1,2] As an Irish graduate who has recently returned from a year working as a psychiatrist in Melbourne, Australia, I can recommend the experience to be gained there. Traditionally, the belief has been that doctors go to Australia after their internship to enjoy a year of relaxation (and some work) in the Australian sun. They then return to the UK or Ireland to pursue their intended career. This need not be the case. Psychiatric training in Australia can be incorporated easily into one's career.

There is a shortage of psychiatrists and psychiatric trainees in Australia. This situation is unlikely to change in the near future which augurs well for the Irish doctor wishing to work there. Most of the Australian population live in the urban centres of the coastal regions. This is where most opportunities for training lie. The practice of psychiatry in Australia is similar to Ireland. Melbourne, in the State of Victoria, is a multi-cultural city with a population of three million. In some areas of the city up to 50% of the population do not speak English as their first language. This gives the trainee experience in transcultural psychiatry not to be found in Ireland. It has an advanced and well-funded system of community psychiatry which includes crisis assessment and treatment teams (CAT teams). Their remit is to assess people in psychiatric crisis and treat them at home wherever possible. Working in a CAT team offers novel and extremely worthwhile experience in acute psychiatry.

For the doctor wishing to arrange a period of training in Australia the first thing to do is to arrange a suitable post. Exchange of trainees between some training schemes in Britain and Australia exist. These schemes prove to be extremely popular. To my knowledge, no equivalent exchange exists between Ireland and Australia. For the Irish trainee, simply writing to consultants or clinical directors in the major centres may pay dividends. However, more effective by far are the contacts made by word of mouth and personal recommendation.

When a post has been offered by a hospital, that hospital will provide sponsorship for an immigration visa, usually an occupational training visa. Limited and specific registration with the relevant Medical Practitioners Board in Australia will be granted upon arrival in the country.

The pre-membership trainee will work in a post which is recognised for training by the Royal College of Australia and New Zealand. A letter from that College to this effect can be presented to the Royal College in London.

The post-membership trainee can arrange one year of overseas training which will count toward the Certificate in Specialist Training. It is better to arrange this when already in a senior registrar/specialist registrar rotation. It is usually possible to arrange a year's absence from a scheme knowing there is a place available upon return.

Salaries between the public system in Australia and Ireland are similar. The cost of living is lower in Australia and the much envied superb quality of life is well known. When leaving Australia I was asked by my clinical director to recommend that my Irish colleagues consider going to Australia. I can do this without hesitation from both a professional and a personal perspective. I am aware that many are attracted by the idea of working in Australia but put off by the perceived difficulties in organisation. There have been a number of articles in the last couple of years which have given detailed information to the prospective trainee.[3,4] Having completed a year in Australia and returned to work in Britain I can assure anyone who is interested that the difficulties involved in organisation are not great and forgotten by the time of the first barbecue.

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Re: Suicidal behaviour in children

Sir – Fifty consecutive children attending a Child and Family clinic were asked to complete a questionnaire on suicidal behaviour.[1] The children's mothers were assessed for anxiety and depression[2] as well as neighbourliness.[3] Eight per cent of the children had made a suicidal attempt, 15% had thought of killing themselves but had not made an attempt.

No correlation was found between child suicidal behaviour and mother's anxiety, depression or neighbourliness. Children were aged from nine years to 16 years and the suicidal behaviour increased with age. When asked if they knew somebody who had attempted suicide, all the children who had attempted suicide said they did while 60% of those who had thought about killing themselves said they did and finally 14% of those with no suicidal behaviour said they knew somebody who had attempted suicide.

A previous Irish study[4] showed that 6.9% of female adolescents had suicidal thoughts often. Another Irish study[5] of nine to 11 year olds showed that 15% thought that life was not worth living most of the time while 18.8% thought that their life was not worth living some of the time.

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