disabled and numerous population of clients and should-be clients resident in the Sector.

At Monash Medical Centre, an interim report has been prepared which is the first major step taken by the Centre towards integration with Heatherton Corporation. A final report with recommendations is expected by the end of 1991 and a provisional date for integration is 1 July 1992.

In this inaugural article, space has permitted just a brief overview of the principal achievements and major integration developments in region 8. The major benefit to date has been significant progress in improving access and equity to specialist services for people with serious mental illness living in region 8.

The regional agenda for 1991/92 can be taken up in more detail in a future report, and will focus on such important issues as the application of service standards, and the implications for the region of the document "Policy and Strategic Directions for Public Psychiatric Services in Victoria" released for consultation by OPS in September 1991.

I wish to take the opportunity of applauding SEPA on their initiative in establishing the Public Psychiatry Bulletin and look forward to contributing to further issues.

Lakeside Hospital: Background to developments and changes

MARGARET TOBIN, Director of Clinical Services, Lakeside Hospital

Health Region 2, known as the Central Highlands/Wimmera Region, covers an area of 45,496 square kilometres, extending from Ballan to the South Australian border and from Patchewollock to Lake Bolac. It has a resident population of 196,000 of whom some 62% reside in the Central Highlands Sector centred around Ballarat. The region covers an area equal to 20% of the State of Victoria, has 9.8% of the state population and currently receives 18.6% of the O.P.S. budget. Hence it is over-resourced relative to the rest of the state. Public sector mental health spending is approximately $147 per capita compared to the state average of $50.

Whilst these data suggest gross maldistribution of resources, it is necessary to set them in an historical context.

Lakeside Hospital, Ballarat, and Aradale Hospital, Ararat were major receiving centres for the treatment resistant patients occupying acute admissions beds in metropolitan hospitals. This trend of transferring treatment resistant patients to the rural centres continued well into the 1980's - although at a much reduced rate in the latter years. Consequently a "chicken and egg" syndrome developed. Whilst resources were locked up in rural beds they were not available to develop alternative forms of care in the major population centres. Consequently there were frequently no alternatives to the patient being sent to occupy one of these beds, hence keeping the bed open and the resources maldistributed.

At the same time as the first vocal lamentations of the inequity and inherent inefficiency of this rural bed based system were occurring, the attractions for professional staff of work in the rural sector were diminishing. As a consequence by 1988 there were 4 psychiatrists, 6.5 junior medical officers, 3 social workers and 0.5 psychologists as the total complement of professional staff caring for two hospitals with a total population of approximately 600. There were no occupational therapists at all.

It is inevitable when professional staff numbers are inadequate that patient care must be nursing based and given the institutional forces operating, that it would be largely custodial. The large numbers of patients discharged from these two institutions in the early 1980's had not been accompanied by significant developments in community nursing numbers nor by advances in technology of community nursing care.

An attempt at a review of Region 2 resourcing was commenced with the appointment of a Task Force in early 1989. This failed to achieve its goals of organizational change due to three factors. Firstly there was inadequate definition of its terms of reference, secondly it was composed largely of Region 2 origin staff and thirdly it commenced and proceeded with inadequate consultation with key figures in the organization - namely the consultant psychiatrists. Its results were largely overlooked apart from the general acceptance of the need for development of Child, Adolescent and Family Services and enhancement of community services.

In summary then there was disquiet at many levels with an inequitable resource base in the region and a largely custodial system of care. This unease was combined with a professional staff group inadequate in numbers to provide the necessary clinical leadership for organizational development, and a Task Force which failed to produce the necessary impetus to change.

As a result of this combination of forces Lakeside Hospital was a target for externally induced change and this occurred via the replacement of the Chief Executive Officer with an Administrator with wide ranging powers and the institution of a Board of Inquiry. A number of the recommendations made by the Board of Inquiry concerned removing some historically based practices in the systems

of care provided in the institution and whilst painful these have been largely welcomed by staff anxious to work in a modern psychiatric setting. However it is unclear to many remaining staff why some individuals were personally targeted by the Inquiry and this has left a legacy of hurt which will take a considerable time to heal. Nonetheless the ultimate results of these two "juggernaut" approaches to change have been positive. There is now a modern organizational structure with clear lines of responsibility. Funded medical staff positions have increased by fifty per cent and there is a potent Allied Health Department of multidisciplinary composition. The institutions have reduced in size to a total of 250 beds across the two hospitals and a community based service is providing equitable access to a broad range of treatment options for the local population. No one believes the task is completed but there is a broad base of confidence in the future and an impetus to growth and development which will be difficult to stifle. The challenges of this future growth and development will be discussed in subsequent editions of the Bulletin.

Community Services Victoria News

PAT HANNA, CSV Representative, SEPA Committee

The C.S.V. executive has had a policy since mid 1990 of ceasing to employ medical staff under the Intellectually disabled Persons Services (I.D.P.S.) Act 1986 by mid 1993.

Currently C.S.V. employs paediatricians and career medical officers under the act. They work in institutional and community settings.

Most of the paediatricians are employed in the community in the early childhood area (0-6 yrs) of I.D.S. (Intellectual Disability Services). Prior to the announcement of the policy this group of salaried doctors were transferred into F.Y.C.S. (Family Youth and Child Services).

The salaries, of doctors who leave, other than those employed in the F.Y.C.S. area, are to be used to fund community medicine departments at Monash and Melbourne Universities to provide medical undergraduates and graduates with training in intellectual disability focussing on adults with a disability.

Medical Services have always been provided by doctors working in the community to those people with a disability living in the community. This client group tends to have fewer problems with their health both mental and physical associated with a caring supportive family.

Those who were admitted to institutions in the past often have numerous health and other problems and have little or no family or other support.

Although some patients/clients have been relocated in the community there are still a sizeable number still living in institutions.

Salaried doctors who have left have not been replaced and there are now only three full time and one half time doctor in the institutions.

Kew Cottages has one full time and one half time doctor and Fairfield has two full time.

General practitioners have been given access to institutions to provide medical services to clients on a fee for service basis by bulk billing MediCare.

There are two general practitioners working in this way at Sunbury, three at Janefield and five at Kew Cottages.

Some salaried doctors have retired on age grounds, those on contracts have had them terminated others have left because their employment was temporary, some younger doctors were encouraged to apply for the E.R.P. (Enhanced Resignation Package) and younger doctors were made offers.

The latest effort of non medical management to rid themselves of salaried doctors is to declare positions redundant. This applies to positions held by "permanent" medical staff.

The F.Y.C.S. paediatricians thought that they were safe but one of their number was threatened with a redundant provision letter but this has not been forthcoming, but the person was pressured to express an interest in the E.R.P. So that they could make an offer which management hoped might be accepted.

Doctors are made "unattached officers" it seems, although technically "exempt" staff have the same rights as public servants in this position to retraining and redeployment and income maintenance.

The institutional doctors have been threatened with doing non medical work but at present are still doing medical or medically related work.

Doctors whose positions have been declared redundant elsewhere have so far been able to continue as before during ordinary hours.

On call allowances have been abolished for medical officers and C.S.V. has talked about it for some paediatricians but as it is built into the senior part of the award this will restrain management.

C.S.V. did not implement the new award in some fashion until September 1991. There are problems with it in translations and medical officers in particular who are well down in salary because of this are also reduced in salary because of the loss of the 120 hr availability for call which counted as salary for superannuation purposes in the old award. This is particularly concerning for career medical officers who are nearing the end of their working lives as it will affect their superannuation unless there is some way of correcting this situation.

C.S.V. doctors have no way of making up the shortfall in their pay.