EMERITUS PROFESSOR GC SMITH
MBBS,MD,DPM,FRANZCP,FAPM

MONASH UNIVERSITY
DEPARTMENT OF PSYCHOLOGICAL MEDICINE
MONASH MEDICAL CENTRE
246 CLAYTON RD
CLAYTON VIC 3168
TEL (03) 9594 1477
FAX (03) 9594 6499
EMAIL graeme.smith@med.monash.edu.au

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The Committee Secretary
Senate Select Committee on Mental Heath
Department of the Senate
Parliament House
Canberra ACT 2600
Email mental.health@aph.gov.au

Dear Secretary

Re: Terms of Reference Item f, "Special needs of ...people with complex and comorbid conditions.

I welcome the opportunity to make a submission to this important enquiry. Much has been achieved under the National Mental Health Policy, but there remain some major deficits. My particular concern relates to Terms of Reference Item f, "Special needs of ...people with complex and comorbid conditions.

I refer in particular to people with concurrent mental and physical conditions. As you will see from my attached paper "The future of consultation-liaison psychiatry", the magnitude of such comorbidity and its health care costs is enormous, yet it was largely neglected in the National Mental Health Plans, a fact that was acknowledged in the Third Plan but is yet to be redressed in practice.

The Victorian Government has gone some way to redress the problem of comorbidity with its Multiple and Complex Needs Initiative. I serve on the Panel which assesses applications for access to the programs that it provides. Further information could be obtained from its Chair, Professor Margaret Hamilton, email margaret.hamilton@dhs.vic.gov.au

Yours faithfully

Graeme Smith
Professor Emeritus of Psychological Medicine

THE FUTURE OF CONSULTATION-LIAISON PSYCHIATRY

Graeme C Smith, Professor

Monash University Department of Psychological Medicine
Monash Medical Centre
246 Clayton Rd
Clayton VIC 3168, Australia
Email: graeme.smith@med.monash.edu.au

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ADDRESS FOR CORRESPONDENCE
Professor G C Smith
Monash University Department of Psychological Medicine
246 Clayton Rd
Clayton VIC 3168
AUSTRALIA
Tel 61 3 9594 1479
FAX 61 3 9594 6499
Email: graeme.smith@med.monash.edu.au

ABSTRACT

Objective: To review the status of consultation-liaison psychiatry and the factors shaping it, and suggest strategies for its future development.
Method: In addition to searches of the main computerised psychiatric databases and review of relevant Commonwealth of Australia publications, the author drew on discussions with national and international colleagues in his role as convenor of the International Organization for Consultation-Liaison Psychiatry.
Results: Physical/psychiatric comorbidity and somatisation, the conditions in which consultation-liaison psychiatry specialises, are the commonest forms of psychiatric presentation in the community. They are as disabling as psychotic disorders, and comorbid depression in particular is a predictor of increased morbidity and mortality. Acknowledging this, the Second Australian National Mental Health Plan called for consultation-liaison psychiatry to be allowed to participate fully in the mental health care system. It stated that failure to define the term "severe mental health problems and mental disorders" in the First Plan had led to some public mental health systems erroneously equating severity with diagnosis rather than level of need and disability. The call has been largely unheeded. The implication for patient care is both direct and indirect; the context created for psychiatry training by such a restricted focus is helping to perpetuate the neglect of such patients. This is a worldwide problem.
Conclusions: Proactive involvement with consumers is required if the problem is to be redressed. At a service level, development of a seamless web of pre-admission/admission/post discharge functions is required if patients with physical/psychiatric comorbidity and somatoform disorders are to receive effective care, and consultation-liaison psychiatry services are to be able to demonstrate efficacy. Focus on comorbidity in the Australian Third National Mental Health Plan may force resolution of the current problems.

Key words: Consultation-liaison psychiatry, physical/psychiatric comorbidity, somatisation, mortality, morbidity

INTRODUCTION

A highlight of human rights achievements in the last decades of the 20th century was the priority given to mental health service reform in the Western world [1]. The considerable achievements of the Australian National Mental Health Strategy and its Policy and Plan [2] are documented in the National Mental Health Report 2000 [3]. National spending on mental health increased by 30% in real terms, there was a shift to a community-based system of care, and greatly increased consumer participation. However, the shape of mental health services changed in another, less desirable way [4]. Public psychiatry became focussed on psychosis, ending a century-long broader perspective. Particularly disadvantaged were those whom consultation-liaison (C-L) psychiatry had cared for; patients with both physical and psychiatric disorder and those with physical symptoms without sufficient organic explanation, the so-called somatisers. "Mainstreaming" of psychosis-focussed services into general hospitals and the community displaced C-L psychiatry in a confrontation of two somewhat conflicting cultures, centred on the issue of which diagnostic categories should have priority. C-L psychiatry services in public hospitals were cut, and their future jeopardised further by the destabilising effects of ambivalent funding [4]. The inadequate funding for a psychiatric contribution compromised the multidisciplinary outpatient management of complex illnesses such as renal failure, cancer and diabetes, and of problems such as pain and somatisation. C-L services had to devote more of their resources to accident and emergency department work. In the United Kingdom, the fledgling C-L psychiatry services struggled against similar forces [5]. In the USA, the combination of similar public policies and the way in which Managed Care was implemented decimated C-L psychiatry activity [6]. The implications extend beyond the needs of current patients, to those of the future. Since funding policy also determines the context of psychiatric training, this has narrowed in focus, an issue of concern emphasised by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in their review of training [7].

It seems that in Australia, as in other Western countries, the problem arose because of ideological forces redolent of "The Italian Experience" [8]. The concept of "serious mental illness" emerged, with a narrow definition of disorders meeting that criterion [9-10]. It became the basis for determining access to public services and the type of staff employed [11]. C-L psychiatry found itself unable to provide outcome data that would challenge the validity of the definition. As a largely inpatient service, its patients did not stay long enough to permit evaluation of the effects of intervention, and the lack of provision for contact with patients after they were discharged inhibited long-term auditing.

Lobbying by the C-L psychiatry community, including the Section of Consultation-Liaison Psychiatry of the RANZCP, led to acknowledgement in the Second National Health Plan 1998 [12] that some public mental health systems had erroneously equated severity with diagnosis rather than level of need and disability (p 10). It sated that there must be no financial disincentives to C-L psychiatry services participating fully in the mental health care system (p 18). The Plan announced a focus on definitional issues at a national level to encourage national consistency in policy and interpretation across all jurisdictions. Yet none of the subsequent publications, including the mid-term review, have addressed the issue of

physical/psychiatric comorbidity and C-L psychiatry services in a way commensurate with this goal [13-15]. This is in contrast with the response of the RANZCP [7]. Its new curriculum retains a compulsory 6-month rotation in C-L psychiatry, lengthy by world standards, and one of the few programs that makes it compulsory. It also has a program for certification of advanced training in C-L psychiatry. With the aim of promoting the needs of the patient group that it serves, and training and research in the area, the Section of C-L Psychiatry has joined with other regional groups to form an international body, the International Organization for Consultation Liaison Psychiatry [16].

The lack of implementation of the Second National Mental Health Plan's recommendations for correcting the acknowledged deficits in this area is puzzling given that the evidence base concerning the prevalence and seriousness of physical/psychiatric comorbidity and somatisation is now much stronger.

THE SCOPE OF CONSULTATION-LIAISON PSYCHIATRY AND PREVALENCE OF PHYSICAL/PSYCHIATRIC COMORBIDITY AND SOMATISATION

C-L psychiatry specialises in physical/psychiatric comorbidity, somatisation, and the complex systems issues involved in management of these disorders and their associated illness behaviours [4]. These are complex terms, referring to phenomena that have other labels in other discourses. Many patients with physical/psychiatric comorbidity constitute a group with "complex medical illness" [17]. Somatisation is a broader concept than that of DSM-IV or ICD-10 somatoform and somatisation disorder. It embraces those disorders and their sub-groups of conversion, dissociative, pain and hypochondriacal disorders, but also includes the well-defined "abridged" or subthreshold presentations, which have been shown to have significant associations with disability [18]. The term includes those who fulfil Lipowski's definition of somatisation; "the tendency to experience and communicate somatic distress and somatic symptoms unaccounted for by relevant pathological findings, to attribute them to physical illness, and to seek medical help for them" [19]. Many such patients belong to groups that have been well researched; the "distressed high utilizers of medical care" [20] or those with "medically unexplained symptoms" [21-22]. But increasingly, and with good empirically-based reasons, the term "somatiser" is being used to describe also those patients whose presentation of depressive and anxiety symptoms is accompanied by high levels of somatic distress [18,23-24].

The disorders and syndromes in which C-L psychiatry specialises are far more common than has been appreciated in the past. The Australian mental health census [25] found that 43% of those with an affective, anxiety or substance use disorder reported a comorbid chronic physical disorder, reflecting similar findings from the US Epidemiological Catchment Area study [26]. Conversely, those with physical disorder had a prevalence of psychiatric disorder of 25% [25, 27]. These prevalence figures are higher in patients presenting to doctors. For instance, the World Health Organization (WHO) Collaborative Study of Psychological Disorders in General Health Care Settings (PPGHC) [28] reported that over one half of patients with moderate to severe physical illness were psychiatric cases. Similar comorbidity was reported form the Medical Outcomes Study in the USA [29-30]. Within the general

hospital a prevalence of 20-50% psychiatric comorbidity has been noted in the numerous studies on this population [4]. In the primary care setting somatisation disorder, as measured at the WHO PPGHC abridged level, has a prevalence of 20% [18]. Prominent physical symptoms were strongly associated with the reporting of psychological distress in primary care patients in that study [24]. Taken together, these data permit the conclusion that presentation with physical symptoms is the commonest form of psychiatric presentation in the community. This is not transient association; the majority of hospital and primary care patients with physical/psychiatric comorbidity and somatisation still experience significant psychiatric symptomatology over the following 12 months [31-35]. To what extent does this comorbidity matter? Answering that question, and those that follow, has been made easier by the emergence of a wealth of data from epidemiological studies, and by the fact that in some areas there have been sufficient studies to permit valid meta-analysis. The interpretation of such data is not without controversy, and in the sections that follow the conclusions reached must be seen as those that the author feels could be reasonably regarded as valid support for the argument being put, and that other interpretations of the data are possible. We await fuller reviews of each topic.

DOES PHYSICAL/PSYCHIATRIC COMORBIDITY AND SOMATISATION MATTER?

Having both a physical and a psychiatric disorder matters far beyond the personal suffering that each causes. There is now good evidence that depression in the physically ill is associated with a doubling in mortality, from a range of causes, and greatly increases morbidity and health care costs, compared with patients without such comorbidity [20, 36, 37]. Suicide explains only a small proportion of the association between depression and increased mortality; medical causes are by far the commonest, with cardiovascular death the main factor [36]. Conversely, the presence of physical illness is a predictor of poor outcome for depression [31]. The somatoform disorders are associated with disability as great as that for the psychotic disorders [38], and somatisers incur considerable cost [39]. Discussion of some specific physical disorders will illustrate the extent of our current understanding about the importance of physical/psychiatric comorbidity and somatisation.

Depression and cardiovascular disease

The association of depression with cardiovascular death is illustrated by two recent, well-controlled studies [40-41]. Depression at baseline in patients with myocardial infarction was independently associated with 1, 2, 5 and 10-year cardiac mortality, after controlling for measures of cardiac disease severity [41, 40]. The impact is at least as great as that of measures of left ventricular ejection fraction and severity of diabetes [41]. The effect of comorbidity on morbidity, quality of life and resource utilisation is illustrated by the Oxford Myocardial Incidence Study, where psychiatric caseness (mainly depression) at baseline in

patients who suffered myocardial infarction was sustained over 1 year, and predicted poor outcome on measures of quality of life, daily activity, reports of chest pain, use of secondary prevention lifestyle changes and use of resources [42]. In another study, depression at baseline was found to be the best independent predictor of quality of life at 1 year after myocardial infarction, better than severity of infarction [43]. Depression has been reported as an independent risk factor for cardiac events after coronary artery bypass surgery [44]. The data discussed above complement those that have established that depression and anxiety are independent predictors of coronary heart disease in community populations [45-47].

Depression and stroke

A similar story is emerging for stroke. A recent study reported that depressive symptoms 1 month after stroke are independently associated with increased mortality at 12 and 24 months [48]. Depressive symptoms at baseline also appear to be an independent predictor of mortality from stroke in community populations studied over many years, with relative risks of 1.5 to 2.6 [49-50]. This complements findings more extensively replicated that show that depression is an independent predictor of the occurrence of ischaemic stroke [51]. For example, Larson et al. [52] found a 2.6 times greater likelihood of stroke in patients with a history of depressive disorder followed for 13 years in the Baltimore Epidemiological Catchment Area (ECA) study.

Depression and diabetes

A recent meta-analysis of studies on complications in diabetics concluded that there was a consistent and significant association between depression and the occurrence of retinopathy, nephropathy, neuropathy, macrovascular complications and sexual dysfunction, with effect sizes in the small to moderate range [53]. In a USA study, depressed diabetics were found to have total health care expenditures 4.5 times higher than for those not depressed [54]. In the Baltimore ECA study, major depressive disorder at baseline was found to be a risk factor for onset of type II diabetes over the subsequent 13 years [55].

Do subthreshold symptoms of depression matter?

The association between depression and increased mortality and morbidity is not confined to psychiatric caseness. Subthreshold symptoms also matter when there is physical comorbidity. Their high prevalence in such populations makes this an extremely important public health issue [56]. An example of the many studies which have addressed this issue with respect to mortality is the British Health and Lifestyle Survey [57], which showed that the probability of dying over a period of 7 years increases linearly with scores on the General Health Questionnaire at baseline, beginning below the usual cut-off score for caseness. This was not explained by death due to unnatural cause. A more recent example is the cardiac mortality study of Lesperance et al.[41], where there was a dose response relationship between severity of depression and cardiac mortality following myocardial infarction; a significant association was seen at scores below the usual cut-off on the Beck Depression Inventory. The authors concluded that "depression symptoms within the normal range for a healthy population may

constitute a risk factor in patients with coronary artery disease". With respect to morbidity, the Medical Outcomes Study [30] clearly established the effects of sub-threshold depressive symptoms on function in the physically ill. It found that depression and chronic medical conditions had unique and additive effects on patient functioning, even when the depressive symptoms did not meet criteria for depressive disorder. This has been confirmed in later studies [58].

Somatisation

Somatoform disorders matter too, and here the association with subthreshold symptoms is striking. A 1-year follow-up of people with multiple idiopathic symptoms at base-line in the ECA study showed an increased mortality [59]. The WHO PPGHC study showed that the social and psychiatric morbidity is significantly greater in those with 5 or more medically unexplained symptoms, compared to those whose medical symptoms had a physical explanation [60]. Hiller et al. [38] have demonstrated substantial disabilities in all somatoform subgroups and somatisers, at levels comparable to those with other psychiatric disorders. Crimlisk et al.[61], in a paper titled "Slater revisited", have shown, as have others, that conversion disorder breeds true, and is chronically disabling. The rate of new neurological disorder 5 years later was only 4%, while up to 70% were still physically impaired. Seventy five percent were found to have had psychiatric disorders. Multiple physical symptoms are strong predictors of the development of psychiatric illness, as the longitudinal UK National Survey of Health and Development has shown [62]. Conversely, this study also showed that the presence of psychiatric disorder or of subthreshold symptoms increases the odds of reporting physical symptoms 3-7 fold, complementing the findings from the World Health Organization collaborative study of psychological problems in primary care [24].

What mechanisms underlie the increased morbidity and mortality?

The clear association of physical/psychiatric comorbidity and somatisation with increased mortality and morbidity invites consideration of the mechanisms involved. Reduced recognition of depression in the presence of physical disorder may be a factor. Some other factors are easily deduced; behavioural effects such as non-compliance, poor diet, and substance abuse. However, pre-existing mood disturbance remains a significant predictor of coronary heart disease after these factors are controlled for, so other explanations are required [46]. Depression and the physical morbidity may be products of a common underlying factor. This is known for disorders such as hypothyroidism, and strongly suspected in the case of some carcinomas, but it may be that there is a more general association. There is evidence emerging for direct pathophysiological effects of depression and anxiety. Tennant and McLean [46] have reviewed this, highlighting evidence concerning stress-induced vasospasm and other cardiovascular changes, stress-induced platelet changes, heart rate variability in depressed patients, and depression-related cytokine changes which in turn affect platelet activity. Some complex paths leading to cardiac pathology have been elucidated. In the case of hostility, a known predictor of cardiovascular mortality, the mechanism is via the effects on body mass index, which in turn exerts effects on lipids and blood pressure through insulin

[63]. But even in the absence of definitive answers to the questions about mechanisms, effective treatments for physical/psychiatric comorbidity and somatisation are available.

DOES TREATMENT HELP?

The evidence for the efficacy of treatment of physical/psychiatric comorbidity and somatisation is now strong, particularly for psychosocial and psychoeducational interventions. The practice of excluding patients with physical/psychiatric comorbidity from trials of antidepressants limited the data available about their efficacy in such patients in the past [64], but useful data are now emerging [65]. The general conclusion can be made that effective treatment of depression is associated with reduced somatic distress and improved overall health [66]. Discussion of specific disorders clarifies this further.

Cardiovascular disease

A meta-analysis of 37 controlled studies on patients who had experienced a cardiac event within the previous 6 months indicated that psychoeducational programs (health education and stress management) are remarkably effective; "a 34% reduction in cardiac mortality; a 29% reduction in recurrence of myocardial infarction; and significant ($p < .025$) positive effects on blood pressure, cholesterol, body weight, smoking behaviour, physical exercise, and eating habits" [67]. The programs that successfully targeted presumed mediating variables, such as emotional distress, smoking behaviour and physical exercise, were more effective than those that did not.

Exposure to Selective Serotonin Reuptake Inhibitor (SSRI) antidepressant drugs appears to confer protection against myocardial infarction [68]. A recent double-blind placebo-controlled trial of fluoxetine in patients with major depressive disorder, identified up to 12 months after admission for acute myocardial infarction, indicated that the drug was as well tolerated as the placebo, and was associated with no clinically relevant adverse effects [69]. This is consistent with reports from a systematic review of the efficacy and tolerance of antidepressants in a range of physical disorders [65], and should encourage more studies on efficacy in these populations, as well as their use in clinical situations where warranted.

Stroke

Improvement in depression correlates with improvement in activities of daily living function [70]. Although the safety of the use of SSRI's with respect to stroke had been questioned, a population-based case-control study showed that exposure to SSRI's did not seem to be associated with increased risk of stroke [71]. A recent double-blind, placebo controlled study showed that the SSRI antidepressant fluoxetine is well tolerated and effective in early post-stroke depression, confirming the results of early studies [72]. These data should encourage the use of SSRI's in stroke patients who are depressed, and stimulate studies that can show whether early effective treatment of depression can have a positive effect on the rehabilitation outcome and the mortality of stroke patients.

Diabetes

Educational and psychosocial interventions are very effective in improving compliance, functioning and quality of life in adolescent and adult diabetics [73]. Glycaemic control is improved when depression is successfully treated by either cognitive behavioural therapy [74] or antidepressant therapy with nortriptyline or fluoxetine [75-76].

Somatoform disorders

The large amount of research into the treatment of somatoform disorders and somatisation provides good evidence for the efficacy of cognitive behavioural therapy in producing relief of physical symptoms, with benefits sustained for up to 12 months [77]. This includes patients with "medically unexplained symptoms" such as chronic fatigue [78]. A recent 5-year follow-up study on patients with chronic fatigue syndrome treated with cognitive behavioural therapy showed sustained improvement in symptoms for the majority [79]. Brief psychodynamic-interpersonal therapy has also been used successfully in patients who are high users of psychiatric services, including those with somatoform disorders [80].

DO THE OTHER ROLES THAT C-L PSYCHIATRISTS PLAY MATTER?

The "liaison" component of the term "consultation-liaison psychiatry" implies the long-held notion that its practice involves such close association with referring units that education, systemic therapy and emotional support of staff are both possible and desirable. The wisdom of persisting with these components of C-L activity has been much debated [81], but there is renewed support for them. They are seen as being counters to the reductionism of the prevailing economic rationalist approach [82]. There is evidence of cost-offset benefits of C-L psychiatry activity [83], but it is time to study this more broadly, including an examination of the cost benefits to the institution and community of having better functioning patients, doctors and other health professionals [6].

STRATEGIES FOR THE FUTURE

The data presented provide strong evidence for the contention that the needs of those patients who present physical symptoms in association with or in place of psychiatric symptoms should be taken more seriously, by the discipline of Psychiatry and by the State and other

providers [22]. Physical/psychiatric comorbidity and somatisation are serious and treatable disorders, with a high prevalence in the community. Effective treatment of them will reduce overall morbidity and perhaps mortality, with significant implications for health care costs. It is contended that the discipline of Psychiatry has intellectual responsibility for the whole spectrum of psychiatric disorder, not just for psychosis. If it abandons that position, patients with physical/psychiatric comorbidity and somatisation may be deprived of the benefits of the perspective that psychiatry can bring, even if that has to be delivered indirectly. What can be done to help maintain this position?

The draft RANZCP Policy Options Discussion Paper [84] points the way. It emphasizes the need to form new partnerships with organisations that share psychiatrists' concerns about health systems developments, including key consumer and carer groups. Meeting this challenge may pose major difficulties for C-L psychiatrists [85]. However, colleagues in the USA have shown how effective an organised strategy can be [86]. Largely excluded from Managed Care Plans, they organised themselves through the Academy of Psychosomatic Medicine, and building on the Surgeon General's Report [87] established a position statement and successfully lobbied for the setting of standards which would help ensure that patients with physical/psychiatric comorbidity receive adequate, integrated care. In the United Kingdom, the Section of Liaison Psychiatry of the Royal College of Psychiatrists has liaised with the Royal College of Physicians to produce a Joint Report; "The psychological care of medical patients: recognition of need and service provision" [88]. It sets standards for clinical practice and provision of C-L psychiatry services similar to those proposed by the Section of Consultation-Liaison Psychiatry of the RANZCP [4].

Liaison with educators

The Australian Medical Council (AMC), which accredits Medical Schools, also supports the importance of the concepts of C-L psychiatry. It has enshrined the principles of physical/psychiatric comorbidity in its objectives for basic medical education [89]. "Patient-centered medicine" is the expression it uses to describe the concept. C-L psychiatrists need to be involved with the AMC, and to make submissions when their own medical schools are being accredited.

Advocacy in Primary Care

Advocacy in Primary Care is required. The RANZCP is already engaged in this. The joint report of the Royal Australian and New Zealand College of Psychiatrists and Royal Australian College of General Practitioners on Primary Care Psychiatry [90] makes extensive recommendations, the implementation of which would make general psychiatrists out of general practitioners. The Australian Government has altered the National Health Scheme rebate arrangements in a way that makes it more financially viable for general practitioners to

engage in psychiatric assessment and counselling sessions. Psychologists and allied health professionals are now funded, albeit minimally, as will be psychiatrists, when they liaise with general practitioners. At both a Federal and State level, extra funding has been provided for general practitioner education in psychiatry. Psychiatry must maintain intellectual leadership here.

Liaison with policy makers and consumer and support groups

Those working in the area of psychosis have shown how productive liaison with consumer and support groups can be in influencing policy and research funding. Since it was formed in 1994, the RANZCP Section of Consultation-Liaison Psychiatry has contributed to policy documents of the National Health and Medical Research Council and other bodies on issues such as guidelines for psychological care in cancer. But C-L psychiatrists needs to be proactive in seeking out groups who advocate for people with physical illness and unexplained medical symptoms, and encouraging them to press for health policy changes. The American Heart Foundation has provided a model for this [91].

Integration with other conceptual models

C-L psychiatrists must become aware of challenges to the utility of the biopsychosocial model on which much of their work has been based [92], and the fact that the issues addressed by it are now being taken up in other conceptual models, and by groups outside psychiatry. Complexity is one such paradigm. It is now accepted as a challenging theoretical problem, requiring useful solutions in the health care area as much as in other areas of human endeavour [93]. Model development [94], and empirical studies on the measurement of doctor-patient interaction [95] and on the interaction of biological, psychological and social interventions [96] are some of the responses to this challenge. The World Health Organization Quality of Life Project epitomises the surge of interest in the concept of patient-centredness, and in production of instruments to identify and measure what matters to the patient [97]. C-L psychiatrists need to find the common ground with these paradigms, and work with those who use them.

Maintaining clinical leadership and the C-L model

Maintaining clinical leadership and the C-L model within the C-L psychiatry services of general hospitals is another challenge. A multltidisciplinary service is required and is established robustly in some places. But there is a strong case for the overall clinical leadership being provided by a psychiatrist. It is the psychiatrist who possesses the complete set of skills for assessing and managing the complex biopsychosocial issues involved. The patients have medical conditions, and are medically referred, with the expectation that the assessment and intervention processes will have a major medical input, even if, and

appropriately so, other mental health professionals have major involvement as well. For public inpatients of a general hospital, the only access that they and their doctors have to psychiatrists is through the staff provided by the hospital. There are implications here for the level of medical staffing. Standards have been set by the Section and by other national bodies [4].

Outcome measures: the need for reorganisation of services

In his review entitled "Implementing depression treatment guidelines", Gregory Simon [98] concludes that efforts to implement depression treatment guidelines using educational approaches have yielded inconsistent and disappointing results. He states that the key ingredients for improving depression treatment are similar to those for improving the care of most other chronic medical conditions. Evidence from some key studies indicates that if we want all people with physical-psychiatric comorbidity warranting treatment to receive effective treatment and complete the course of such treatment, we will need to implement a process totally different to that which exists in C-L psychiatry services today. There must be systematic follow-up of patients' treatment adherence and clinical outcomes [99], achieved at modest cost [100]. However, this would require considerable reorganisation of resources. The Report of the Federal Minister for Health's Expert Group on Outpatient Services [101] advocated the retention of outpatient services, delivered in multidisciplinary mode, as part of a seamless web of pre-admission/admission/post discharge functions, delivered in a flexible structure and location, with integration with primary care. When such structures are in place it will be possible to report outcome routinely and in a way that will help determine the effectiveness of C-L psychiatry services. Such studies will need to include measures of the contribution that patients treated by C-L psychiatry and health-care professionals supported by such activity make to the efficiency and well being of the hospital, and to the economy in general.

Risk factor screening would be an important part of the reorganised process. The European Consultation Liaison Psychiatry Workgroup has developed a risk factor screening instrument for complexity of care [17]. It uses data obtained from the chart, the patient, the doctor and the nurse at admission. Complexity is operationalised in terms of length of stay, medical uncertainty (diagnostic and laboratory tests, medical and paramedical consultations), multiple treatment (number of types of medications and number of nursing interventions), co-ordination of care, and mental health problems. It has strong predictive power. A second stage instrument would be needed to identify the care needs of those patients identified as being at high risk [102]. Empirically-based intervention programs could be implemented, monitored and their efficacy measured in routine audit using appropriate instruments such as the Medical Outcomes Study SF-36 [30]. The C-L psychiatrist's role in this model would be to take clinical responsibility for the process, but its implementation and quality assurance are delegated to those appropriately qualified in the C-L psychiatry team, and to the primary care doctors.

The need for a sustainable system

George Engel reminded us that when we ask a medical student to integrate the biological, the psychological and the social aspects and management of a patient, we are setting a task which most practicing doctors find impossible to perform. This seems to be true of health-care systems also. Compromise is needed. Ideological-driven policy must be tempered by evidence, and a way found to meet the needs of all whose psychosocial status is impacting on their physical health and vice-versa. A major focus on comorbidity in the Third Australian National Health Plan would provide a forum for a wider discussion of the issues raised in this paper, and force a decision about the way ahead.

CONCLUSIONS

1. Patients with physical/psychiatric comorbidity and somatisation continue to have their needs met poorly in the public sector, despite the acknowledgement of this in the Australian Second National Mental Health Plan.

2. The implication for patients is both direct and indirect; the context in which psychiatrists are training is helping to perpetuate the problem.

3. Other disciplines are becoming involved in the theory and practice of the field, and C-L psychiatry must work with them, whilst maintaining leadership in what is primarily a medical field.

4. Proactive involvement with other stakeholders is required if the problem is to be redressed.

5. A major focus on comorbidity in the Australian Third National Mental Health Plan would force a resolution of the current divided approach to mind and bodily health.

6. Resolution is likely to involve a radical change in health-care delivery, including development of a seamless web of pre-admission/admission/post discharge functions integrating public and private spheres.

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