CORRESPONDENCE

Supporting the front line: the development of a consultation liaison psychiatry model in primary health care

DEAR SIR,

In light of the introduction of the *Better Access to Psychiatrists, Psychologists and General Practitioners Through the Medicare Benefits Schedule* by the Australian Government in late 2006, information obtained by the Inner South East Primary Mental Health and Early Intervention Team (PMHT) in Victoria regarding the types of mental illness commonly seen by the service, may be of interest to mental health workers. PMHTs were established in Victoria in 2002 to develop a more inclusive mental health service and to strengthen the partnership between specialist services and primary care providers (for a recent review of collaborative models see Craven and Bland[1]).

The PMHT provides detailed assessments for patients referred by GPs who require clarification on diagnosis or treatment. Data were collected for the first 100 patients referred to and assessed by the service. The data pertains to patient demographics and clinical issues identified on assessment.

The first 100 referrals seen comprised 46 males and 54 females. The average age was 36.9 years (SD 14.1) with a range of 17 to 82 years. About 70% of the patients seen resided in the local area mental health service catchment area.

The breakdown of the 145 diagnoses resulting from the assessment of the 100 patients indicates that depressive disorders made up the bulk of the diagnoses, with a total of 47% consisting of major depression (41%) and dysthymia (6%). Anxiety disorders were the second most common diagnosis with a total of 19%, consisting of panic disorder (8%), generalized anxiety disorder (GAD) (4%), obsessive compulsive disorder (OCD) (3.5%), social anxiety disorder (1.5%), posttraumatic stress disorder (1.5%) and agoraphobia (0.5%).

The predominance of the referral of patients with depression is interesting given that the National Survey of Mental Health and Wellbeing (NMHWB)[2] suggests that anxiety disorders are more common than depressive disorders (9.7% with anxiety disorders compared with 5.8% with major depressive disorder and/or dysthymia). However, the same data show that while anxiety disorders are more common, those with affective disorders are more likely to present to a GP for help (40% with a depressive disorder compared with approximately 20% with an anxiety disorder). The Bettering the Evaluation and Care of Health survey (BEACH)[3] supports this, demonstrating that depression made up 3.5% of all GP consultations while anxiety made up 1.6%.

The referral of more patients to our service with depression rather than anxiety may also reflect the success of the recent advertising campaigns in raising GP and patient awareness about depression, a lower awareness and concern about anxiety disorders, greater GP concern around risk and/or GPs' greater confidence in managing anxiety disorders. The data from our and the above studies do raise the question of a campaign to increase awareness of anxiety problems and the success of currently available treatments.

Among the anxiety disorders, panic disorder was most often diagnosed (8%), compared with approximately 4% each for GAD and OCD. Although one needs to be very cautious with such small numbers, they do not appear to match the breakdown of anxiety disorders found in the community by the NMHWB survey (PTSD 3.3%, GAD 3.1%, social phobia 2.7%, panic disorder 1.3%, agoraphobia 1.1% and OCD 0.4%). The difference between the rates of the disorders found in the community and those assessed by the PMHT may be due a number of factors. Panic disorder can present with a very dramatic history. Perhaps, then, GPs and patients may be keen to seek help very early on in the course of the illness or GPs may feel less comfortable managing panic disorder because of the extreme nature of the symptoms. The lag time between first symptoms of PTSD and the request for help may be longer than that for panic disorder. Using the same line of argument, panic disorder is often very obvious (once an organic cause is excluded), and symptoms of PTSD can be more difficult to uncover and perhaps may be accompanied by more embarrassment or stigma. Those with PTSD symptoms are also catered for by other services such as Transport Accident Commission, WorkCover, etc.

We noted the small number of diagnoses of bipolar affective disorder. We believe that this may be affected by the lower level of public awareness of the disorder at that time compared with now, and that those with clear manic/hypomanic symptoms would likely have been triaged to another part of the service.

While the NMHWB[2] gives important information on the numbers and breakdown of mental health problems in Australian society, this investigation has shown that the percentages of those who were referred to the PMHT for diagnostic clarification and treatment recommendation were somewhat different. This information is important for both determining which areas of mental health promotion and education require additional attention, and also the composition of patient referrals expected for private psychologists and psychiatrists under the new Medicare Better Access program.

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Combination antidepressants: Safe practice, internationally aware clinicians and 'alarmed' academics

DEAR SIR,

Olver *et al.* acknowledge that the 'practice of combination antidepressants may be less dangerous than it used to be'.[1] Meanwhile, the personal and family suffering, economic

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damage, deliberate self-harm and suicide rates in Australia all point to the failure of our current approaches, and emphasize the pivotal role of clinical judgment while awaiting possible/never occurring definitive trials. The absence of appropriate academic research forces clinicians and patients to jointly assess the significant possibility of benefit from combination antidepressants, keeping in mind the confirmation by Olver *et al.* of the safety of such a technique.

Olver *et al.* describe themselves as 'alarmed'. They now realize that they are in a small minority of Australian psychiatrists who have not used combination antidepressants, based on the recent finding reported in this Journal, showing that 79% of Australian psychiatrists have indeed used this technique.[2] It is disappointing to have their attempt to divert the discussion to evidence-based medicine tarnished by their conclusion that the vast majority of their errant colleagues must have been 'seduced' by what they describe as 'fashion' in psychiatry. This is an unfortunate way for academics to dismiss the accumulated knowledge and experience of the vast majority of their colleagues, who use combination antidepressants as needed, usually after clear discussion with intelligent but suffering patients. Highly trained psychiatry specialists do not lose their ability to carefully evaluate potential therapies just because they have decided to practise clinical psychiatry rather than work in academia. Many such psychiatrists would bitterly resent the suggestion to colleagues, and to referring general practitioners (GPs), that they were so unthinking. Many prominent academics in Australian psychiatry have confirmed that they have used combination antidepressants.

Australian psychiatrists (and GPs) must be careful not to be seen as insular and out of touch with the realities of worldwide practice. Information on the use of combination antidepressants is taught by the preeminent Maudsley Hospital in London, by prestigious textbooks such as Kaplan and Saddock, and even in journals written for GPs in Canada.[3] An Australian psychiatrist (or GP) hoping to work overseas would be well advised to know what their international colleagues know about this form of therapy, and avoid pouring scorn (especially at an interview!) on those who practise this particular skill. A prominent US psychiatrist visiting Melbourne some years ago stated, in a personal communication to the author, that '90% of private practice treatment of depression in the United States is combination antidepressants'. Combining mirtazepine with venlafaxine is a standard US protocol, approved by no less a body than the prestigious National Institute of Mental Health.[4]

No one disputes the benefits of the standard monotherapy and supplement techniques available for the treatment of depression. However, psychiatrists and GPs are only too well aware of the large percentage of patients in whom these techniques have partially or totally failed, leaving disabled and suffering patients, some with life-threatening illnesses. Such patients and their families are dependent on intelligent and highly trained specialists who can balance conflicting academic evidence with the clinical wisdom and experience of themselves and their colleagues. Similarly, intelligent and educated patients emphasize their clinical (and indeed legal) right to be informed about combination antidepressants, which have prestigious published academic support, and which have worked for very many other sufferers around the world.

No one disputes the ideal that we would have years of evidence-based medicine supporting our treatments in psychiatry. But while we wait for academic colleagues to produce and replicate these findings, it is not academic good practice to blandly dismiss as misguided the clinical findings of the vast majority of Australian psychiatrists, who have conferred together, have seen hundreds of thousands of patients between them, and voted with their prescription pads.

Do Australian GPs, and therefore their patients, have a right to be educated by psychiatrists about combination antidepressants? Or do they get left with the recent published advice to use electroconvulsive therapy and tricyclics instead?[5] Would any Australian doctor advocate such techniques as preferable to combinations at an interview for an overseas position? What would our patients prefer to try?

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Great title, wrong book

DEAR SIR,

Medical language is a double-edged sword that can illuminate or befuddle depending on its use.[1] In this regard, I note that Robert Kaplan's informative piece about doctors who kill includes a rather distracting abuse of English.[2] In coining the term 'clinicide' for the title of this article, and for his forthcoming book, Kaplan runs the risk of confusing his audience, who quite reasonably may think it refers to the killing of, rather than by, a clinician. The dictionary defines *-cide* as a Latin-derived combining form, indicating a person, thing or process that kills that which precedes the suffix. Just as fungicide kills fungi, any pedant will tell you that matricide, fratricide and filicide refer to the killing of, respectively, one's mother, brother, and child. It follows that clinicide should denote killing of, rather than by, one's clinician. Clinicide thus describes an interesting and important phenomenon, and will be an apt title for a book – but not this one.

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