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Galletly, Cherrie Ann; Watson, Darryl Peter
[Substance misuse in patients with acute mental illness](#) Medical Journal of Australia,
2006; 184 (12):645-645

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Substance misuse in patients with acute mental illness

Cherrie Ann Galletly and
Darryl P Watson

TO THE EDITOR: There has been much public discussion recently about comorbidity between substance misuse and psychiatric disorders.^{1,2} Drug and alcohol misuse can precipitate, exacerbate and prolong psychiatric disorders, and is often accompanied by a range of social problems. Here we report on the prevalence of substance misuse in an unselected group of patients admitted to the 20-bed acute psychiatric facility at Lyell McEwin Health Service, situated in an underprivileged region of northern Adelaide. The facility has five closed beds and 15 open beds.

In October 2005, 45 patients (23 men, 22 women; mean age, 39 years) were admitted to the unit, of whom 28 (62%) were detained involuntarily. Semi-structured interviews, clinical history taking and collateral information gathering revealed that 27 patients (60%) had a comorbid substance misuse disorder. The most common substance misused was cannabis (20 patients [44%]), followed by alcohol (16 patients [36%]), amphetamines (15 patients [33%]), opiates (6 patients [13%]) and benzodiazepines (5 patients [11%]). Misuse of more than one substance was common — for example, all 15 patients diagnosed with amphetamine misuse also misused cannabis. Patients who misused cannabis were younger (mean age, 33 years) than those who did not (mean age, 44 years) ($t_{43} = 0.23$; $P = 0.023$) and were more likely to be male (61% of male patients misused cannabis compared with 27% of female patients; $\chi^2 = 5.14$; $P = 0.036$). Of 19 patients with psychotic disorders, 11 misused cannabis.

These results indicate high rates of substance misuse in patients admitted to a psychiatric facility. Cannabis misuse by young men is a particular concern. It is apparent that more than half of inpatients with acute psychiatric conditions could benefit from interventions to address their substance misuse.

The extent of cooperation between drug and alcohol services and mental health services varies between different localities and between the private and public sectors. In states such as South Australia, where there is a historical separation between drug and alcohol services and mental health services, the treatment of these disorders is regarded as outside the role of mental health services. Patients considered to have a primary problem with substance misuse are treated by specialised drug and alcohol services. This

service divide does not reflect clinical reality. Patients with comorbidity can “fall through the cracks”, each service regarding them as someone else’s responsibility.

Postgraduate training in psychiatry includes both academic input and the submission of case logs describing 10 patients with addiction disorders, but this aspect of training may need to be expanded in response to changes in the pattern of disorders in the patient population. Mental health clinicians, along with general practitioners and doctors working in settings such as emergency departments, will increasingly need to be highly skilled in diagnosing and managing comorbid drug and alcohol and psychiatric disorders.

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A call for help. Australia needs a standard emergency phone number in all hospitals

Gerald F Williams

TO THE EDITOR: Much has been written to describe the best clinical protocols to improve patient outcome following a medical emergency in hospital.¹⁻⁴ However, one simple step in the process has not been clearly articulated: what is the hospital internal emergency number to ring to summon the medical emergency or “code blue” team?

Each hospital in Australia sets its own emergency phone number. Examples include 333, 444, 555, 666, 777 and 2333 — there are probably others. For the highly mobile workforce in our hospitals, it is often difficult to recall which number to ring when challenged by the immediacy of a situation.

All hospitals should upgrade their phone systems to have a single standard phone number for internal emergencies. This solution has been successfully applied in the broader community. In the Australian community an emergency call is 000, in the United States it is 911, and in the United

Kingdom it is 999. It ought to be possible for all Australian hospitals to use a standard emergency telephone number to initiate an internal emergency response. I have only been able to find one health service internationally that has attempted this solution — the UK National Health Service advises trusts to use the number 2222.⁵

Technical advice on what number would be most suitable in Australia would be required. Telecommunications experts should advise on the technical aspects, cost and a reasonable time frame for all hospitals. State and federal health services would need to direct all hospitals to move to the new number, either as able or by a date to be determined.

I hope to raise the debate on what appears, at a superficial level, to be a very simple initiative that could save lives, or at least remove one more cause of error and delay in the internal emergency response of each hospital.⁵ I have written to various authorities asking that this concept be explored. Those that have responded agree in principle, but have not taken responsibility for its progression. If this is a good idea, who should or could take control of it? It would be helpful to find an authority to back this proposal. This is a call for help.

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“Positive” family planning: another personal viewpoint

Jane M Andrews

TO THE EDITOR: I am not a regular correspondent, as, with three children and a career, I rarely have the time. But, having read the recent personal perspective on missed conception¹ and the accompanying commentary,² I felt compelled to offer my own personal

perspective on how, in medicine as a profession, we value (or don't value) childbearing.

Chapman and colleagues² discuss the need for workplace reforms as a means of reducing barriers to earlier childbearing. If we, as doctors, are serious about this issue we need to lead by example and address workplace difficulties in promoting childbearing as a positive choice in our own profession. Despite women comprising at least half the medical students, they are still under-represented in most specialties, principally because training and childbearing are realistically seen by many women as "either/or" options.

From my own experience, I can offer some illustrations of very real ways childbearing is devalued or discouraged in medicine. In my interview (around 1990) to gain admission to a physician training scheme, I was asked about my plans for a family, with the clear implication that, if I was considering having children, I should reconsider my options. Once a trainee, at the same hospital, I was advised by a senior (female) physician to delay pregnancy as long as possible, as it would mean death to any career aspirations. In my final year of advanced training, I was offered a job at one hospital, only to be un-offered the job days later when they heard, on the "grapevine", that I was pregnant. When, as a National Health and Medical Research Council Research Scholar, I became pregnant with my second child and wanted to reduce my hours to part-time, I found the scholarship income became taxable — as it was assumed that part-timers were topping up income with private work. This significantly devalued the scholarship and went nowhere near covering childcare costs! After completing my PhD, in the course of applying for research funds while still working part-time, I discovered that granting bodies in Australia have no standard methodology for assessing curricula vitae of part-timers. With mothers comprising a large proportion of the medical part-time workforce, this effectively excludes us from competing for funds unless we wish to outsource our children.

As recently as 2 years ago, when discussing these sources of inbuilt bias against medical mothers with a colleague, I was told my comments were inappropriate and offensive. If we, as a profession, can't even discuss these stories, how can we set an example of positive family planning to the community at large?

In listing the events described, I am not seeking sympathy or redress or claiming my path has been unusually difficult. Nor do I regret having my three lovely children! If one speaks to any working mother, similar stories

emerge. As long as women feel the problems are their individual issues to grapple with in silence and embarrassment, rather than *system* failures, women embarking on any career will continue to be faced with a very real choice between children and a career (as opposed to a "job"). We may not be able to solve these issues on a community-wide basis, but let's at least look in our own backyard.

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Adverse drug events: counting is not enough, action is needed

Graeme C Miller, Helena C Britt, Lisa Valenti and Stephanie Knox

TO THE EDITOR: In an editorial in the 3 April 2006 issue of the Journal,¹ Roughead and Lexchin estimated the annual incidence of adverse drug events (ADEs) in patients presenting to general practitioners, based on our data presented in the same issue.²

Calculating the incidence of ADEs from general practice encounter data is fraught with difficulties. Roughead and Lexchin's calculation depends on all general practice patients having an equal chance of being in the sample. This would only hold true if all patients attended their GP an equal number of times. However, in our study, the age distribution of patients with ADEs shows that they are more likely to belong to older patient groups with a much higher than average general practice attendance rate. They thus represent a smaller proportion of all general practice patients, as their chance of being in the sample is much higher.

Adjusting for the age and sex distribution results in an estimated incidence of about 1.6 million people. Further, these 1.6 million would, if asked, have reported an ADE in the previous 6 months. This cannot be extrapolated to an annual incidence of ADEs. The annual incidence figure could in fact be larger than that suggested by Roughead and Lexchin.

We believe that recurrent monitoring of ADEs in patients attending general practice is a useful way of measuring the impact of the interventions suggested by Roughead and

Lexchin, regardless of the difficulty of extrapolating to population incidence.

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Health services research in Hungary

Imre Boncz and Andor Sebestyén

TO THE EDITOR: We read with great interest the editorial by Gruen and colleagues on the recent developments in health services research and the establishment of an EPOC (Effective Practice and Organisation of Care) satellite at the National Institute of Clinical Studies in Australia.¹

Before the social and political changes in Central and Eastern Europe in the 1990s, policymakers in Hungary (population 10 million) and many other former socialist countries had little interest in the effectiveness of health service interventions.² Important tools of health policy decision making were missing from the health care system. Over the past 16 years, efforts have been made in Hungary to strengthen the institutional background and tools of health policy decision making. We would like to highlight some milestones of this process.

During the 1990s, Hungarian researchers were sent to foreign universities to receive formal training in subjects related to health services research. Later, academic institutions and departments were established (Health Services Management Training Centre at Semmelweis University [Budapest], School of Public Health at the University of Debrecen [eastern Hungary], Unit of Health Economics and Health Technology Assessment at Corvinus University [Budapest], and Department of Health Insurance and Health Policy at the University of Pécs [southern Hungary]).

In 2004, the National Institute for Strategic Health Research was established to guide governmental health policy decision making by undertaking activities in four main areas: health informatics and information policy;

health economics; health services and health system research; and health technology assessment and coverage policy. A key issue of Hungarian health policy was the introduction of the "fourth hurdle" (cost-effectiveness) into the decision-making process.³ In a first step towards achieving this, methodology standards were published by the Ministry of Health, which regulates the guidelines for conducting economic evaluation.^{4,5}

During the development of health services research in Hungary, we carefully studied many aspects of the Australian experience, published in the international literature or presented at scientific meetings, including: coverage policy, drug pricing and reimbursement, health technology assessment, price/volume agreements, diagnosis-related groups, evidence-based guidelines, the National Health and Medical Research Council, the Pharmaceutical Benefits Advisory Committee and the Pharmaceutical Benefits Scheme, and performance measurement. Several of these (coverage policy, drug pricing and reimbursement, and diagnosis-related groups) had a significant effect on Hungarian health policy decision making.

We found the main advantages of the Australian system, compared with other countries, to be the strong scientific and professional background (evidence-based medicine) and the transparency of decision making. Although we did not make any formal ranking of countries, the Australian experiences were evaluated as worthwhile for local application, together with those of the Netherlands, Sweden and the United Kingdom.

Notwithstanding the considerable distance between Australia and Hungary, we look forward to reading about further developments in health services research and the Australian EPOC satellite, and hope that we can also benefit from your experience with the appropriate implementation of research findings throughout health policy decision making and into everyday medical practice.

Imre Boncz, Department Head¹

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⁵ Gulacsi L, David T, Dozsa C. Pricing and reimbursement of drugs and medical devices in Hungary. *Eur J Health Econ* 2002; 3: 271-278. □

The Research Quality Framework

E Malcolm Symonds

TO THE EDITOR: Shewan and Coats¹ are right to draw attention to the shortcomings of the Research Assessment Exercise (RAE) in the United Kingdom in relation to the formulation of the Research Quality Framework in Australia. The impact of the RAE on clinical academic medicine in the UK has been disastrous, and it will take years to recover.

Driven by the imperatives of the RAE, gross distortions of the role of medical schools have occurred. Many major departments, particularly in the surgical disciplines, have been closed, irrespective of the service and teaching implications.

Over the past 6 years, some 20% of clinical lecturer posts have been abolished.² These are training-grade posts that inevitably make only a limited contribution to the RAE returns. However, these posts provide the seed corn for future academic staffing in clinical medicine.

In academic pathology, 40% of all academic posts have been lost and there are now only 12 remaining lecturer posts in England and Wales.

All these changes have occurred in the midst of a substantial increase in medical student numbers, when academic staff numbers should have been increased.

Those responsible for funding tertiary education in the UK have consistently failed to understand that the role of clinical academic staff is to integrate the practice of medicine with research and teaching. This means that at least a third of their working hours will be taken up with clinical practice; therein lies the strength of clinical academic medicine.

The RAE has effectively engendered a split in the roles of clinical academics and, by so doing, has seriously jeopardised the future existence of clinical academic medicine.³

The damage that this exercise in academic self-interest has caused has now been recognised at the highest political level, with a recommendation that the RAE be discontinued as from 2008.

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³ Symonds EM, Bell P, Banatvala J. Five futures for academic medicine: future of academic medicine looks bleak. *BMJ* 2005; 331: 694. □

High-cost users of hospital beds in Western Australia

Chris Holmwood

TO THE EDITOR: Now that Calver and colleagues have unequivocally established that "High costs appear to be needs-driven",¹ can we dispense with the Orwellian language used in this article?

"High-cost users" can now become "high-needs patients".

The language in the article subtly reflects a view that is often adopted by senior non-clinical health service administrators, who are themselves usually in robust good health. This view is that people with high levels of health service need are merely rapacious consumers of rare health dollars, of which the administrators are guardians.

For those of us providing services in primary (mostly ambulatory) care, life is complicated enough choosing between "patient", "person with", "client", "consumer" or "punter". Can we please avoid adding "user" to the already overcrowded lexicon of nominals used for patients?

I am sure if we changed the terminology then those "high-cost users" would feel a bit more valued when they read this article.

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¹ Calver J, Brameld KJ, Preen DB, et al. High-cost users of hospital beds in Western Australia: a population-based record linkage study. *Med J Aust* 2006; 184: 393-397. □

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The Medical Journal of Australia (MJA) is published on the 1st and 3rd Monday of each month by the Australasian Medical Publishing Company Proprietary Limited, Level 2, 26-32 Pyrmont Bridge Rd, Pyrmont, NSW 2009. ABN 20 000 005 854. Telephone: (02) 9562 6666. Fax: (02) 9562 6699.

E-mail: medjast@ampco.com.au. The Journal is printed by Offset Alpine Printing Ltd, 42 Boorea St, Lidcombe, NSW 2141.

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27,649 circulation as at
24 April, 2006



ISSN 0025-729X

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