“IT’S ALL IN YOUR HEAD”
A Comprehensive Policy Response to Somatisation in Victoria

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graphic by Hyun Jae Nam
Introduction

Somatisation is a common presentation in the Australian healthcare system that engenders a significant health and economic burden on patients and health systems. To date, the policy response to somatisation has been fragmented and ineffective. This article outlines how somatisation is managed in Australia, using Victoria as a case study, and considers a comprehensive policy response to it.

The impacts of somatisation

Somatisation encompasses the relationship between mental processes and physical symptoms. It is most commonly associated with physical symptoms that have been directly drawn to a mental process, such as palpitations and breathlessness in panic disorder.[1] However, there is an increasing awareness of the capacity for mental processes to produce or enhance physical symptoms associated with so-called physical diseases.[2, 3] It has long been acknowledged that symptoms of fibromyalgia, irritable bowel syndrome, and chronic pain syndrome are greatly influenced by psychological factors.[4, 5] From a public health perspective, medically unexplained symptoms (MUPS) are the most important form of somatisation, encompassing a spectrum of presentations that range from very mild to severe.[6-8]

Irrespective of the psychological or physical origins of a physical symptom, it is experienced identically.[9, 10] Consequently, MUPS produce significant distress for patients, and are associated with reduced participation in employment and social activities.[11-13] Despite this, patients with MUPS face significant stigma that restricts their access to evidence-based care.[4, 14-18]

Where somatisation does not occur in the context of a diagnosable mental health disorder, it is associated with an increased risk of developing anxiety or depression.[19, 20] Risk factors of somatisation are shared with these disorders.[3, 19, 21] Family and social stress are important predisposing and precipitating factors of somatisation, whilst the social isolation somatisation often produces and the stigma associated with it are perpetuating factors.[22, 23]

From a health systems perspective, patients with somatisation are super-users of health resources.[24, 25] Over-investment and unnecessary treatments constitute a significant risk to patients’ health and waste limited healthcare resources.[24, 26, 27] Estimates of the costs associated with MUPS have been varied, with one British case study estimating the annual cost for one patient at £209,000 ($522,000 AUD) in 2004.[24]

The epidemiology of somatisation

There is little evidence regarding the prevalence of somatisation in Victoria, owing to the large degree of heterogeneity in definitions of somatisation, the still murky relationship between physical and mental health and the exclusion of somatisation from surveys of mental health and wellbeing.[28-31] Estimates of the prevalence of MUPS in primary care range approximately 5-50% of all presentations.[8] Though most patients experience mild MUPS, its high prevalence has significant public health consequences. Diagnosable somatisation disorders are rarer, with an estimated prevalence of less than 1%.[1, 7, 32-35] These data highlight the need for better research; however, even the most conservative estimates make clear the enormous scale of the problem.

Treatment of MUPS

Evidence-based care for somatisation takes a stepwise approach.[6, 14, 22] Psychoeducation is the most important component of therapy, with an empowering diagnosis that allows the patient with somatisation to take ownership of their diagnosis and practise self-care, a critical first step.[14, 15, 22] Patients requiring care beyond psychoeducation will often be referred for specific therapy, for example, cognitive behaviour therapy.[36, 37] Emerging therapies for somatisation include short-term dynamic psychotherapy and family therapy for children and adolescents.[38-42] Low dose antidepressants are indicated for patients with severe somatisation, including chronic MUPS.[43, 44] The following principles form the mainstay of therapy and appear in many guidelines.[15, 22, 45]

1. Successful communication is therapeutic.
2. Somatisation exists on a continuum.
3. A targeted and tangible explanation of the relationship between the mind and body should be given that is mindful of the patient’s language and cultural model.
4. The aims of therapy should be symptom management and self-care.
5. Therapy should understand the predisposing, perpetuating, and precipitating factors of somatisation.
6. A safe and therapeutic environment should be promoted.
7. A broad, biopsychosocial approach should be taken.

Health systems response

Although the subject of some criticism, the World Health Organization building blocks of health systems provides a framework with which to describe the health system response to somatisation.[46, 47]

Service delivery

Patients with mild to moderate somatisation often follow the clinical pathway typical of those with the physical complaint that characterises their illness. [48, 49] Consequently, care is often delivered by the specialist or general practitioner managing the patient’s physical complaint.[2] When a diagnosis of somatisation becomes clear, the patient is often retained by the medical service they were sent to rather than being discharged to primary care or a mental health service.[2]

Mild to moderate somatisation is best managed in the community with a general practitioner to coordinate care.[50, 51] This facilitates access to psychology, as well as fostering the continuity of care that is vital to the treatment of somatisation. [52] Victoria has an extensive primary care network with low barriers to access, especially in metropolitan regions.[53, 54] Primary care providers can coordinate care for patients with somatisation and arrange mental health care plans for access to community mental health services.[10, 54, 55] Primary care is widely accepted as being best-placed to manage somatisation; therefore, a realignment of services in a primary care model is necessary and feasible.[6, 10, 50]

Health workforce

Most care for patients with somatisation is delivered by specialist doctors or general practitioners, often in the context of a long relationship to investigate a physical complaint.[56, 57] Consequently, care is often delivered by medical practitioners without sufficient training to treat somatisation.[58, 59] Care for somatisation is straightforward and, when supported by training and clear guidelines, can be implemented by a wide-range of clinicians, especially in a primary care setting.[6]

Retaining a professional, effective, and appropriate mental health workforce has long been a challenge in Victoria.[60] Shortages of allied health, nursing, and medical professionals are persistent and efforts to develop and retain a full workforce are failing. [61, 62] Care for patients with somatisation is best coordinated by primary health services in conjunction with community-based mental health services. Making use of the primary care sector and facilitating digital-delivery of CBT to mitigate the need for face-to-face psychology provide significant opportunities as measures to address somatisation.[36, 63, 64]

Health information systems

The Australian government is rolling out My Health Record (MHR), a medical record system designed to harmonises patients’ medical records so that they can be accessed wherever a patient presents.[65] Consumer concerns about privacy, as well as concerns from health professionals about the legal implications and utility of MHR have plagued the rollout.[65, 66] Nonetheless, uptake has been high, and technological advances have seen MHR become increasingly useful as a tool for accessing medical information.[65, 67, 68]

In the context of treating and preventing somatisation, MHR presents opportunities and threats. MHR can be used to flag somatisation early and divert patients from unnecessary and harmful investigations and treatments. This facilitates an early transition to proper care.

The presence of a diagnosis of somatisation on a patient’s MHR may see them exposed to the stigma associated with somatisation.[17] Consequently, the perception of the patient as a malingerer without ‘real’ symptoms may see them diverted from necessary treatment for a physical illness.[10, 11]

Access to essential medicines

Access to medicines in Victoria is generally excellent, owing to their availability on the pharmaceutical benefits scheme.[69, 70]

Financing

Financing of Victoria’s mental health system is fragmented and inefficient.[71, 72] Hospital-based care in the public system derives the majority of its funding from the state government and, in the private system, from private health insurers.[71] Medicare, which is funded by the federal government, supports the majority of primary care services, including some allied health services.[73, 74] Patients contribute to the funding of mental health services by means of co-payments at general practices, allied health services, and for medications and via pri-
vate health insurance premiums.[71]

Victoria’s mental health system is widely regarded as underfunded.[75] However, the federal and state government have committed to significant funding increases in mental health and have included it as a priority in their health planning.[76, 77] Many mental health programmes in Victoria attract only short-term funding, making long-term planning challenging.[78]

The availability of increased mental health funding presents an opportunity for policy makers to introduce new programmes.[79] However, fragmented financing, significant cost-shifting, and the short-term nature of health budgets provide significant barriers to the effective planning of mental health programmes.[72, 80]

**Leadership and governance**

There is strong pressure for the reform of Victoria’s mental health system, with the federal and state governments both flagging mental health as a policy priority.[76, 77] Victoria is currently undergoing a Royal Commission into Victoria’s Mental Health System.[81-83]

Somatisation has not featured in discussions about mental health system reform in Victoria.[84, 85] The only time somatisation has featured in the national debate is in the context of Australian Lyme disease. [86] External groups such as BeyondBlue and SANE, which provide leadership in mental health, do not have policies on somatisation and only refer to it in the context of other mental health disorders. International action on somatisation has been limited, although the Dutch and British health systems provide guidelines for addressing somatisation.[14, 15]

Reorganisation of the mental health system is a significant opportunity for meaningful action on somatisation. The under-recognition of somatisation as an issue in mental health and the failure of governments and NGOs alike to provide leadership on the issue is an important barrier to reform.

**Analysing the response**

The response of the health system to somatisation is poor, relying on the provision of wasteful specialist care in the context of a system with a fragmented funding model and poorly defined responsibility for somatisation as a health issue.

Nonetheless, the Victorian health system provides several avenues for addressing somatisation. It is well-resourced, with a large primary health workforce and consistent access to medical resources. Moreover, there is active and significant reform of the mental health system, which could provide the basis for a response to somatisation.

**Policy recommendations**

Somatisation has a corrosive impact on the psychosocial and physical wellbeing of many Victorians. Moreover, it constitutes a significant burden on the health care system, with healthcare resources wasted on unnecessary and ineffective treatments. These issues occur despite the existence of robust and effective treatment for individuals with somatisation, which could be delivered in the context of Victoria’s healthcare system. Consequently, the following policy recommendations are made.

1. Design and implement a Somatisation Action Plan, including clear referral pathways for primary care doctors and a prevention plan.
2. Improve access to mental health services for patients with somatisation across the full spectrum of severities.
3. Implement a prevention strategy for somatisation.
4. Facilitate innovative research into somatisation as a public health issue.

These policy recommendations target the various barriers in the Victorian health system to addressing somatisation. They are framed on a Somatisation Action Plan, which clarifies the primary care response and introduces public health responses to somatisation.

The delineation of referral pathways for primary care doctors makes use of Victoria’s excellent primary care system, whilst ensuring that the bulk of the care for somatisation is shifted away from hospitals to the community. With the aid of treatment plans for somatisation, primary care doctors are best placed to deal with the majority of patients with somatisation. This provides effective, evidence-based care and reduces the health and economic consequences of over-testing and misdiagnosis. Moreover, it frees limited mental health resources that should be reserved for cases of somatisation with the highest acuity.

There is scant evidence for public health respons-
es to somatisation. Nonetheless, public health responses have a long history of success in dealing with complex health problems; consequently, it is recommended that, in addressing somatisation, public health responses be considered.[87] The implementation of any public health response for somatisation would need to occur in the context of a careful evaluation of its effectiveness.

**Conclusion**

Somatisation is a significant public health issue that diminishes the health of the community and constitutes a significant economic burden. Despite this, the policy response to somatisation in Australia has been poor. This article describes a set of evidence-based policy recommendations to map out a healthcare response to somatisation in Victoria.

**About the Author**

Travis Lines is the National Policy Officer at the Australian Medical Students’ Association and a final year Doctor of Medicine and Master of Public Health student at the University of Melbourne. He has an abiding interest in evidence-based public policy and health economics.

**Conflicts of Interest**

Travis Lines is a member of the Australian Medical Students’ Association’s rapid response team, which advocates on issues relevant to medical students and the communities they live in, including mental health systems. The views expressed are his and not those of AMSA.

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