A second direction to consider involves implementing strategies for improving mental healthcare delivery within a web or telecounselling framework. There is a range of educational initiatives that allow high quality, evidence-based interventions to be delivered by non-specialists. This direction may involve integrating web or telecounselling with internet therapy and psychoeducation.

A third clear direction is the need to evaluate the effectiveness of web and telecounselling. Fee-based web counselling with specialists and non-specialists is readily available to users, and these services are likely to accelerate, driven by a body of consumers who use internet resources. There is now the opportunity to test the usefulness and effectiveness of web counselling before this proliferates further. The emerging managed-care models delivered by an engaged and organised workforce of experienced telecounsellors is an exciting research opportunity not to be missed.

Before the web and telecounselling review, no one knew the extent, quality or standards of delivery of these services, or even who used them. Now we know that these services are used frequently, both by the community and by healthcare agencies, and that they play a major role in managing vulnerable individuals with mental health problems. If telecounselling services are found to be effective, there is an urgent need to adequately support the sector and improve continuity of care between the systems. To date, telecounselling has been seen as non-core — a poor cousin to mental health services. However, given the development of communication technology, consumer empowerment, and the infrastructure, workforce, and capacity in the web and telecounselling sector, we foresee a central role for these services in delivering flexible, evidence-based, cost-effective help to the community.

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Assessing bronchodilator reversibility: agreed standards are urgently needed

Only when spirometry is performed in a uniform way can we expect its widespread use in primary care

SPIROMETRY APPEARS TO BE AN UNDERVALUED INVESTIGATION in general practice, despite its capacity to inform clinicians about diagnosis, severity assessment, and optimal treatment for airways disease. The omission of spirometry from a thorough assessment of patients with breathlessness seems just as inappropriate as failing to measure the blood sugar level in a patient with thirst, polyuria and blurred vision. There are substantial individual and community risks in not performing a simple diagnostic test such as spirometry. In Australia, underdiagnosis of chronic obstructive pulmonary disease (COPD) and asthma is a documented consequence of this. Yet, anecdotal reports from general practitioners suggest that it is difficult to incorporate spirometry into the consultation, and there have been variable outcomes after systematic efforts to teach optimal performance of the test.

There are many reasons for this, including the complexity of properly performing the test, the cost of equipment, the time taken to perform bronchodilator reversibility testing, and controversy regarding interpretation of results. Although Australian guidelines for the diagnosis and management of asthma and COPD clearly define the central role of spirometry in making a diagnosis and assessing severity, the practical implementation of the test remains a challenge.

Bronchodilator reversibility testing should inform the clinician about the presence and severity of airway obstruction and its reversibility in response to a standard dose of bronchodilator. Once this information is reported, the clinician can determine — in combination with the other information available — whether asthma or COPD is likely. There is considerable overlap in the bronchodilator responsiveness of these two diseases, so that spirometry may not be diagnostic. However, the consistent performance and interpretation of any test is essential to maximise its value, allow comparison of results and to ensure its sensitivity and specificity are maintained.

In this issue of the Journal (page 610), Borg et al report the results of a survey of 60 lung-function laboratories in Australia and New Zealand, and highlight marked differences between laboratories in performance and interpretation of bronchodilator reversibility testing. These variations, in a
there is no clear consensus on what constitutes reversibility in subjects with airflow obstruction". Nevertheless, agreement should be reached regarding the way in which a standard test is performed, even if reaching agreement on its interpretation is difficult.

The article by Borg et al highlights the urgent need for agreed standards in Australia for spirometry. The TSANZ and the Australian and New Zealand Society of Respiratory Scientists are in the best position to take up this urgent task. Transferring this expertise into community practice, either in specialist or in primary care, remains a challenge that must be met if we are to maximise the possibilities for diagnosing and managing airflow obstruction.

The availability of a wide range of affordable, electronic spirometers with built-in software for determining reference values, along with a "Buyers guide to spirometry", currently being written, will add to the educational resources needed to help GPs in their use of spirometry for assessing patients with breathlessness. Standardised guidelines should greatly assist the implementation of spirometry in primary care and result in more appropriate treatment and better outcomes for patients.