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STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospital performance data

Melbourne — 17 August 2009

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Assoc. Prof. M. Hopwood, chairperson, Royal Australian and New Zealand College of Psychiatrists (Victorian branch).

The CHAIR — I welcome Associate Professor Malcolm Hopwood from the Royal Australian and New Zealand College of Psychiatrists. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Any comments made outside the precincts of this hearing are not protected by parliamentary privilege. All evidence is being recorded by Hansard, and you will be provided with a proof version of the transcript in the next couple of days for any corrections. I invite you to make any opening comments you would like before the committee proceeds to questions.

Assoc. Prof. HOPWOOD — Thank you for the opportunity to appear. I will speak briefly to some of the issues we covered in our submission and stress what we see as important. We of course see the burden of mental illness as a very important part of the health responsibility for Victoria, noting that one in five people in Victoria, and indeed nationally, will suffer from a major mental health problem during their life. One of the criteria we need to assess the adequacy of our performance against is that need. We also need to acknowledge that that need is undergoing change, not just due to the growth of the Victorian population but changes in some of the common presentations of mental health problems and our understanding of the needs. For example, we are aware that depression is growing as a cause of mental health-related disability in our community. It is estimated by the World Health Organisation that it will be the second leading cause of health-related disability in the world by 2020.

We also need to acknowledge that our understanding of mental health problems is undergoing considerable change. For example, older-style mental health services focused on, if one could use the term, custodial aspects of care. We have moved to a community-based model, but we need to embrace our recent understandings about the importance of early intervention.

Many mental health models emphasise now that mental health conditions often have a critical phase where the neurobiology of the condition is developing. If we do not intervene effectively during that point, we will be left with a chronic, often treatment-resistant, condition. So, again, our services need to be mapped against their effectiveness in meeting that group's demands. In Victoria in many ways we have led the development of some of the early intervention services, such as Orygen led by Professor McGorry, but it is interesting to debate to what degree that has become widespread through our service system — that sort of understanding.

On that background, I will make a few specific comments. Within our branch of the college of psychiatrists we remain concerned about to what degree the performance of the mental health system is regularly reviewed as part of the performance dataset. Certainly that aspect of our performance that attracts most scrutiny is the time that patients with mental health problems spend in emergency departments. That is a concern to us as an important aspect of our work but surely only one aspect. It is a concern that perhaps many of our efforts are reflected in the outcome there and there alone. We would support many of the recent initiatives to enhance emergency psychiatric services located within emergency departments, and no doubt that is part of the reason those figures have improved over the last year or two. But it remains a concern — and we fear — that our services are judged solely on that statistic and that other performance data from within the mental health service system is either not collected or not reviewed in a manner that we would think is appropriate, or indeed reviewed at all, perhaps I could venture to suggest. So one of our key recommendations is that collection of public hospital data needs to include a thorough and comprehensive inclusion of mental health illnesses and their management.

We also think at the same time that that emergency department data reflects some of the strengths and weaknesses of our current service system. About 25 years ago Victoria underwent a quite radical reform of its mental health services, and I think led Australia in perhaps the most radical reform. We moved to a predominantly acute bed system with community care, with units being dispersed to general hospitals. It is perhaps a comment on the progress that performance data for the mental health services, despite being located in general hospitals, is not routinely collected as part of that general hospitals performance data, which perhaps speaks to the dynamics of that relationship, at least at some sites perhaps.

We think that the emergency data presentation hides an issue about the availability of inpatient facilities within mental health, so a number of our recommendations relate to the availability of inpatient facilities. Calculations were made in the mid-1980s on acute inpatient needs for mental health in Victoria, and our bed numbers per 100 000, expressed as a unit of population, have actually fallen since that time. The bed numbers have not grown with the Victorian population since 1986. We are concerned that therefore the occupancy rates in our

area mental health service units, our acute adult units and our adolescent and psychogeriatric units are extremely high; they run at 100 per cent effectively the majority of the time. Most current hospital planners would say that to be an effective and responsive service a figure more like 85 per cent to 90 per cent is reasonable; it then gives the system capacity to respond. We do not have that capacity.

Part of the difficulties in managing that capacity for us are those patients who require longer term care, whose needs cannot be well met within our current 11-day state average length of stay within the acute mental health unit. It is quite a short time in mental health terms. It might be long in other people's terms but in mental health terms it is not terribly. Most of our medication treatments, for example, take at least a week to become effective, therefore 11 days is not a long period of time.

As part of the movement to a new form of mental health services in the mid-1980s the number of longer stay and rehabilitation facilities in our service system was reduced quite dramatically. That need has been picked up by some of the community services, but it is our proposition that perhaps we have gone just a little too far. It is a difficult proposition because of course if one were to open up long-stay mental health beds, we all know there is a risk that they would be filled very rapidly, and targeting those beds to those in strongest rehabilitation need is difficult.

Of interest and relevance, the Boston Consulting Group did an audit of Victoria's acute mental health services a number of years ago and identified that 40 per cent of acute adult mental health inpatients required longer-term care and that the main reason they were there was inability to access a rehabilitation resource. That would suggest that if that proportion of acute beds could be freed, the total number of acute beds may in fact be adequate to meet our needs. Those few longer-staying community-based rehabilitation facilities that exist are very slow in their turnover, and we are concerned that data relating to their performance is not reviewed as part of a systemic string of data that would tell us how a system is working. Without that systemic string we will also be unable to consider how we should meet these new evolving needs in a logical way, because our system remains very much crisis driven with that kind of stringency on capacity.

Amongst our recommendations is an increase in the number of adult inpatient beds. We believe the same is true in our ageing population — we should not ignore that group — and certainly in the adolescent area where that wave of early intervention resource is critically employed. The differentiation between adult and adolescent mental health services has formed a key part of the recommendations in the *Because Mental Health Matters* report. We are waiting with interest to see how that evolves over time. We would hope there would be some close mapping of the outcomes of that deliberation and the community need. It remains true that the community perception of mental health services, from those who have come into contact with us, is that we are profoundly difficult to access, and that is not a reputation we sit with very comfortably. That perception I think extends not just from consumers and their carers but through to primary care and other sectors within health. We are not happy with that reputation. We would like to believe that by and large it is despite our best efforts and represents a resourcing problem. One way to judge that better would be to develop a more comprehensive dataset that follows people throughout their course through our system.

They are some of the key points that I would like to make in reference to our submission. The recommendations are contained in a summary form at the end of our submission, and I would commend them to you.

The CHAIR — Thank you, Professor Hopwood. The committee appreciates receiving the college's submission and your evidence here today. I note reading the college's submission you have made a number of recommendations about the need to develop datasets. What type of data do you believe should be collected in respect of mental health performance in hospitals?

Assoc. Prof. HOPWOOD — I think one key part of any service analysis needs to be outcome data. There is a national mental health outcome dataset. The instruments used have their strengths and weaknesses but we are prepared to support them because they constitute some measurement of outcome — some measurement of outcome generally beating no measurement of outcome. However, when we look across the service system the rates of compliance with outcome measurement vary. Despite it being a mandatory set, the actual completion of the outcome measurements is variable. More importantly the utilisation of that data to inform service configuration has been quite limited. When I said it is better than no measurement, what is even worse, arguably, is measuring something and then not using the outcome of that measurement. Currently, whilst there

are concerns about how that information is used and used in a judicious way, we are probably not using it much at all. I think that is a failing.

The CHAIR — To take up your point, is the data, although it is mandatory, not being — —

Assoc. Prof. HOPWOOD — Completion rates are not universally 100 per cent.

The CHAIR — It is simply not being completed or it is being completed inaccurately?

Assoc. Prof. HOPWOOD — I think probably more often not being completed. The instruments used have been selected for their utility, so one of the main measures is the HoNOS — the Health of the Nation Outcomes Scale. It is a relatively simple measure to complete, and thus well chosen, but staff would report that they feel overwhelmed with other duties. It is a personal view that staff's engagement with any outcome measurement is directly related to what they feel they get out of the input they create. Currently I think many staff would feel remote from the outcome that is produced and would see it as having little relevance to the development of the service they are in. That may be a criticism of what happens at the service level, not just at an administrative level.

The CHAIR — And that should be collected on a service-by-service basis?

Assoc. Prof. HOPWOOD — Correct.

The CHAIR — And how is it currently reported, the national — —

Assoc. Prof. HOPWOOD — The commonwealth collects and does a state-by-state comparison and also a service style-by-service style comparison, so there will be an acute adult average measurement and a psychogeriatric average measurement, if I can give those examples. Again, does that translate into meaningful consideration of what that means in terms of the development of our services and how they are performing? I do not think so. It is not a consideration we routinely employ.

One of the aspects we think is relevant is the structure of the mental health workforce. Outcome measurement is a relatively routine concept to certain components of the mental health workforce but not all. It forms a strong tradition in medical practice and in psychological practice, with its strong background in statistics, but it is a major change in some of the usual patterns of nursing workforce development. We feel these were introduced with perhaps inadequate thought into the structure of the workforce if we are going to measure what we do meaningfully and to then implement that data. Obviously we would feel, being the college of psychiatrists, that an important component of that workforce change is encouraging psychiatrists to return to the public workforce. We currently have a major mismatch in our state with the greater proportion of psychiatrists — the majority — being employed in private practice, which does little to meet the public mental health needs of many Victorians. That relates to a series of matters, including conditions, which are clearly not the matter of today, but which we think are relevant to developing a better set of performance data for our mental health system.

The CHAIR — Would you care to comment on the distribution of psychiatric services between rural and metropolitan Victoria?

Assoc. Prof. HOPWOOD — I think there is an appropriate distribution of services; however, the distribution of the workforce is clearly much more problematic. The distribution of psychiatrists throughout Victoria, including those in the public system, is heavily weighted towards the metro region. In terms of private practitioners, who do ease some of the workload on the public system, the distribution is even more metro; I guess private practitioners exercise more choice. Many of the rural services are forced to recruit overseas-trained psychiatrists and rely heavily on that workforce. That brings many individuals with rich talent to the state but often their first exposure to Victorian public health is in an isolated setting, which to them will be culturally challenging. Our college has worked hard to look at training needs to assist them to gain Australian fellowship but it is challenging stuff. If I were to come from a quite different culture, to have my first practice in Echuca would indeed be challenging. I say that despite the founder of Echuca being one of my ancestors; I am entitled to say so.

I think those same comments would apply to other disciplines within the mental health workforce; I should not contain my comments to psychiatry. For rural services I am sure getting an adequate workforce in psychology,

other allied health disciplines and even nursing is a challenging thing, not just for mental health. Some of those issues are addressed in the recent ministerial mental health workforce paper that sits with the minister now.

The CHAIR — I just have one other question at this point. You referred to the average 11-day treatment period now. How does that compare to pre the deinstitutionalisation process?

Assoc. Prof. HOPWOOD — A dramatic reduction clearly.

The CHAIR — Or similar conditions?

Assoc. Prof. HOPWOOD — Yes. Really our treatment models are very different, so we need to be a little bit careful about comparing apples with oranges. If one were admitted to Mont Park, for example — I do not wish to stigmatise Mont Park more than any other place — the conception was that your care was likely to be relatively long term, so admissions in terms of many weeks, months and indeed on occasions years were part of the expectation. Clearly now in our system, partly driven by resource, we create an expectation that people will move on as soon as is potentially possible. I guess it is worthy of note that the pressure on our system is reflected by the fact that that length of stay has continued to decline since we first deinstitutionalised.

That may be a more active comparator. So when we first deinstitutionalised, statewide averages from recollection were more in the low 20s and they have come down now to 11 days. I think that reflects the failure of system capacity to continue to keep pace with changes in the population need.

The CHAIR — Does that merely lead to readmittance?

Assoc. Prof. HOPWOOD — It is clearly the concern that it will lead to both a higher readmission rate and also a higher adverse event rate through rapid discharge.

The CHAIR — So it is counterproductive in a sense?

Assoc. Prof. HOPWOOD — That is the risk. The state does maintain within mental health current 28-day readmission data, and they vary across the jurisdictions as to how they look. What is perhaps more difficult is the tracking of the individual who, following discharge, loses contact with the mental health system, so patients with mental health disorders clearly have a number of issues that influence their adherence to service contact. For some of them it is about their insight into their illness. For some of them it is about social issues such as homelessness and breakdown of families. They are quite likely to detach from services. We simply do not know what happens to someone who is discharged from hospital and fails to attend their subsequent clinic appointment. We have a set of clinical processes to attempt to contact them, but that is often extremely difficult.

One of our recommendations indeed relates to post discharge from service follow-up at a set of time epochs to give us a bit of a stronger sense, because for many patients, even those who adhere to contact, once their care needs have reduced a little further, the heavily laden community psychiatric services will aim to move them on back to primary care as soon as is possible. While some of that is good, we feel that system is stressed, too, with high case management loads for many of our community case managers, with the consequence that we worry even at that end that people are pushed out fairly quickly with a subsequent risk of relapse and so on.

The 28-day readmission data statewide — and I cannot recall the figure off the top of my head — does not look too bad by national and international standards, but it may not be telling us the whole story.

Ms BROAD — Thank you for the presentation, Professor Hopwood, and also the submission from the Victorian branch of the college. Can I take you to a couple of statements in the submission in the first instance, I think around page 3, where the Victorian branch of the college says:

> Effective psychiatric treatment requires coordinated interventions across a range of support systems.

And further on in the submission that is built on in relation to a commitment to developing effective partnerships with a range of mental health professions examining models of collaborative service provision all in the interests of coordinated and effective interventions. In the light of those statements and commitments from the college, can I ask you to comment on how you see that as aligning with the Victorian government's mental health reform principles of prevention, early intervention, recovery and social inclusion, given that that

spectrum clearly requires a whole range of professions to be involved and certainly involves coordinated approaches?

Assoc. Prof. HOPWOOD — I think our approach or our desire would align well with the principles outlined in Because Mental Health Matters, noting that that is a plan that is to evolve over a number of years. Like all plans, we await the full rollout, but I think it would align well. Equally the principles we are suggesting would align well with some of the initiatives undertaken by the commonwealth, such as the mental health plan items and the better mental health outcome items enabling access to psychology and other allied health services.

It is of some concern to us that they are largely two independent systems, and both are good developments and I would wish to support them both, but we currently have limited data about the crossover between those two systems.

There are a few services that are attempting to develop models. As one could imagine, that involves crossing considerable boundaries at times, and it would be highly desirable in our view to develop a better nexus between those two avenues. Our greatest problem in mental health remains adequate resourcing, full stop. I think there is a set of resources that can be provided through either channel; we would really like to be able to utilise them both seamlessly.

Ms BROAD — The second matter that I wish to invite your comment about is on page 7 of the submission. There is a reference to step care systems and to, for example, systems where GPs are supported and where step-up and step-down approaches are utilised, which may result in avoiding the need for admissions and also in making the transition on discharge more effective as well. Would you care to elaborate on those approaches?

Assoc. Prof. HOPWOOD — Yes. I think, given the frequency and diversity of mental health problems in our community, it is very important that we target specialist mental health resources well, and that involves supporting primary care to look after the broader range of problems. We also acknowledge that a range of approaches is required to treat mental health problems effectively. So when we discuss some of the pressure on our acute beds it may lead you to reaching a logical conclusion and saying, 'So you are suggesting, Professor Hopwood, that we in effect reopen the asylums by creating more long-stay beds', and that would clearly not be our desire. We would support strongly the evolution of a range of options.

Some of the recent development of PARC facilities that form part of the government's strategy as a way of negating, avoiding or supplementing inpatient admission — or full inpatient admission, if I can use that term — are very positive approaches, and we would love to see them become more widely disseminated. In aiming to ease the pressure on our acute beds, I would like to suggest that options like that are great and we would support them strongly, not just longer stay facilities and certainly not just longer stay hospital facilities either. We are concerned that, for example, the availability of community care facilities or indeed community care packages for individuals with severe mental problems remains quite limited, so we are keen to expand that range of options.

Ms HARTLAND — My experience with both my family and my constituents, especially with the carers who know their family member is psychotic, has been that when there is just nothing that can be done and they have actually become a danger either to themselves or to their family, when the CAT team responds they are told, 'No, everything's fine. You'll just have to ride it out', but there do not seem to be to my mind enough of those acute beds where, for the family's safety and for the person's safety, that person could be taken to. Also I cannot spot where that kind of incident is being recorded in the data or incidents where, in the case of a young person, the family repeatedly tries to get them assistance but either the young person refuses or there is not a service for them to go to.

Assoc. Prof. HOPWOOD — I think it is important to acknowledge that one of the other tensions in that sort of issue does relate to the Mental Health Act and the individual's consent to care, and of course the Mental Health Act is undergoing review as we speak, so that may be germane to some of the situations. It is true that in collaboration with the mental health branch, services are developing a time-to-response set of data, which I think is very appropriate. One of the criticisms has previously been, 'How long does it take to you respond?', and we have had complaints about prolonged periods to respond. So time to response is one.

Again, what we perhaps know less of is what happens with a person whose initial contact, for whatever reason, does not result in subsequent service. We need to be careful of assuming they have had a bad outcome, but we

simply do not know. On occasion one hears of very bad outcomes, but that is not a tested hypothesis then. That may be an individual case, but it is of concern to us, and I do not currently believe we have routine follow-up of those individuals. One could look at the data we have available about subsequent re-presentation to mental health services, and that may inform us. I do not believe we currently do that.

Ms HARTLAND — Do you keep any data about how often the police attend situations where it would actually be more appropriate for a CAT team or another psychiatric team to attend?

Assoc. Prof. HOPWOOD — I am well aware that such situations have often been the subject of heated debate and some controversy. I am not aware of any integrated dataset that examines that. Clearly it would involve the perceptions of both mental health services and the police, who may see an individual either separately, conjointly or however. I am not aware of any conjoint data that looks at that.

Mr DAVIS — First, I thank you for your submission and your presentation today. It is very important. I just want to come back to your point about bed numbers. It seems to me — and you seem to be saying there with your recommendations — that some lift in bed numbers is absolutely essential and that options such as step-down beds and so forth are also important. I am summarising some of what we have heard, including Mr Rich-Phillips's point that readmission rates may be higher because of early or potentially premature discharge. Also I wonder if you might give us some information on the number of patients who are admitted or receive treatment under the Mental Health Act as opposed to voluntary arrangements.

Assoc. Prof. HOPWOOD — Perhaps if I can walk through those. We certainly are submitting that more inpatient facilities are required. I guess we need to be cautious in directly drawing a link to readmission rates, because that is an inference. As I said, I would acknowledge that on paper our readmission rates do not compare that badly nationally and internationally. As I suggested, I wonder whether that is because it is only part of the story. Just because an individual is not readmitted does not mean they are doing well, so I think there may be a slightly untold story. Yes, we do support the need for a range of facilities. Sorry, I have lost the last bit of your question.

Mr DAVIS — About how people are admitted.

Assoc. Prof. HOPWOOD — Yes, under the Mental Health Act.

Mr DAVIS — Has there been growth in the percentage who are admitted?

Assoc. Prof. HOPWOOD — I am sorry, I cannot recall to quote you an absolute figure or a trend. My impression — and I would acknowledge that it is just that — is that the proportion of patients who are admitted involuntarily into our acute facilities is certainly the majority, if not the vast majority, and that that has been so for sometime.

Mr DAVIS — Growing?

Assoc. Prof. HOPWOOD — I would be speculating.

Mr DAVIS — I would be interested in any further data you might have on that. The other point I want to ask about is the position of the chief psychiatrist. What is the college's view on the position of the chief psychiatrist and his oversight of activity in the public sector and data, and do you think there are measures that be can taken to strengthen his position?

Assoc. Prof. HOPWOOD — We did discuss this in our submission to the Mental Health Act review. I should acknowledge for the record that the current chief psychiatrist is in fact a 'her'.

Mr DAVIS — Yes, indeed.

Assoc. Prof. HOPWOOD — Lest she correct me.

Mr DAVIS — A former bureaucrat.

Assoc. Prof. HOPWOOD — Indeed, and a psychiatrist. We support very strongly the role of the chief psychiatrist. We think that represents a very important clinically informed contribution to the development of

mental health policy and funding streams for the state, and also a very important part of the clinical governance of Victoria's public mental health services. A number of the components of the chief psychiatrist's data collection are governed under the Mental Health Act. We would wish to see that strengthened, and we believe the chief psychiatrist's office has a strong role in producing just the kind of data we have been talking about; indeed we are suggesting that that role could be expanded. To expand it to following up people outside the scope of public mental health services would clearly require more than just the chief psychiatrist. We believe it is very important that the chief psychiatrist also acts as an advocate for the consumers and carers where, sadly, they are affected by mental health problems.

Clearly that brings into question the most appropriate location of the office and its independence or otherwise from the mental health branch. We note that there are other models across Australia where the chief psychiatrist is an independent office that reports directly to Parliament. We are not sure if that is the most appropriate model, and obviously we are awaiting further information about the Mental Health Act review to perhaps make a final call on that. But we think that guarding of the independence of the chief psychiatrist is really important, as one would usually say about such positions.

Mr DAVIS — Given the data collection role and the central oversight role, it seems to me there is a tension with the chief psychiatrist being an employee of the department alone.

Assoc. Prof. HOPWOOD — Potentially there is. Equally the opposing tension is: if the office were removed from the mental health branch, does it therefore become less well informed about what is currently happening and less able to directly input into policy development? So we accept there are strengths and weaknesses with both positions. I think critical in the way we understand it is: how is the role of the chief psychiatrist going to be described and legislated within the new act? That is not yet completely clear to us.

Mr TEE — I think at the start of your submission you referred to the decline in the number of beds. I was just referring to the submission by the now Department of Health where it suggested there has been a 12 per cent increase in the number of beds from 1999 until 2007–08. We have gone from 822 to 925. I am just trying to see how we reconcile those two figures.

Assoc. Prof. HOPWOOD — Yes. There are different ways — I suspect there is more than one way and indeed more than two — of estimating bed numbers. For example, one needs to look at: are we talking about acute adult beds, are we talking about child adolescent — —

Mr TEE — Just to be clear, sorry, these are adult inpatient psychiatric beds, and they include 'adult acute, adult specialist, secure extended care units, short stay and forensic beds funded by the Department of Human Services'.

Assoc. Prof. HOPWOOD — The estimate I have relates to acute adult beds, as in area beds alone, which clearly form an important part of the kind of hard edge of our mental health system. We would acknowledge — and I think it is important to acknowledge — that there has been considerable expenditure in some building projects within mental health, particularly in the last two to three years. We welcome the continuance of that building effort in what is obviously a difficult time. There are some major developments occurring currently at Dandenong Hospital and at Northern Hospital. In the years prior to that there were also some very major developments — —

Mr TEE — And Maroondah? Sorry to interrupt. Maroondah is the other one.

Assoc. Prof. HOPWOOD — Yes, indeed; point well taken — and Casey before that — and we welcome those developments very much. Prior to that there were some developments in the specialist mental health services — the statewide mental health services — that may be reflected in those figures.

Mr TEE — Clearly, the government has a balance in trying to find resources and where to put them. But the mental health sector, again from the submission from the department, has done reasonably well in the sense that its submission was that mental health investment increased by 95 per cent — from $453 million in 1999-2000 to $884 million in 2008-09. So there has been, you would have to acknowledge, a considerable — in fact, a 95 per cent — increase in the investment.

Assoc. Prof. HOPWOOD — A 95 per cent increase over an eight-year period. That is an interesting way of presenting the numbers. We remain concerned, nevertheless, that there is a long way to go.

Mr TEE — Finally, we had some evidence about the issue of beds and so on. I will ask for your comments on the evidence we had from the department. They gave evidence that what they had done on the issue of beds was set up a statewide availability register, and they said this meant that the waiting times for beds had gone down by four times — from 1000, which I think is the figure they gave, to 250. It did not necessarily go to additional beds, but it went to the use of existing beds in a more efficient way.

Assoc. Prof. HOPWOOD — Clearly the efficient use of resources is a very reasonable target and should remain so, no matter what other developments occur. Nevertheless I would continue to contend that that does not tell us who is not getting admitted. My concern remains that there may be individuals who, even with the most efficient use of current resources, would clearly benefit from a psychiatric admission but are unable to access one.

Mr TEE — Just on the other matter, it seems to me that it is potentially a very exciting time in this area because for the first time we have a mental health minister and a review of the Mental Health Act — in my electorate there have been a number of consultations with the community that I was involved with in terms of how we ought to change our Mental Health Act and how we ought to better manage mental health — and we have the Victorian mental health strategy, which I think has been released. Would you concede that there are some very exciting things happening, which will hopefully position us — as you said, we were the leader in this area 30 years ago — as the leader in this area in the decades to come?

Assoc. Prof. HOPWOOD — We welcome those initiatives strongly. The development of a portfolio of Minister for Mental Health is something we support very strongly. The fact that there is a growth in policy work in this area is something we support very strongly, and we would offer no criticism of those developments. We have focused now on the development of clinical service and clinical availability.

Mr KAVANAGH — Thank you for your evidence today. Could I ask you for an opinion on why the incidence of depression is growing so much?

Assoc. Prof. HOPWOOD — It is a very interesting question. It needs to be acknowledged that they are worldwide figures and some of that increase is actually not in Australia but in some of the developing nations of the world, where previously other health problems meant that depression was either submerged or not recognised or that sadly on occasions people did not live to the age where it was likely to become a problem. A significant proportion of that increase is occurring outside this country, but most Western countries seem to be seeing an increase in rates of depression as well — it is just not as dramatic.

There is obviously a great deal of speculation about what that means, and I do not think there is one single answer. What remains of great concern to me is that this increase is occurring despite the availability now of a suite of well-validated, evidence-based treatments. We should be able to treat depression more effectively. We know that if we intervene well during the first one or two episodes of depression, the chance of subsequent episodes is dramatically reduced.

That evidence-based treatment is currently available within the primary care sector and within the private sector for those individuals who can access that. Depression-specific resources within our public mental health system are a little limited, in our view. That reflects many of the other competing demands with illnesses like schizophrenia and bipolar affective disorder; and that is one area, given the shift in need, where we would like to encourage development.

Mr KAVANAGH — Could I ask you about the trend in the influence or impact of drugs, especially ice, on mental illness?

Assoc. Prof. HOPWOOD — Yes. Across the state and indeed across the country most units show that more than 50 per cent of acute psychiatric inpatients have a current comorbid substance abuse problem, be that cannabis or other illicit substances; it is a profound part of our world. I would add that in that sense it is to us logical that the government mental health branch and the drug and alcohol sections have been combined; we welcome that union because it just makes such intrinsic sense.

Mr TEE — Do we know how much of it is people with mental illness self-medicating with drugs and how much of it results from the drugs bringing on the episodes?

Assoc. Prof. HOPWOOD — Yes. In our view that distinction has been overdrawn with the somewhat simplistic notion that one can be sorted into having a drug and alcohol problem or a mental health problem. That is a little like the divisions we sometimes have with other areas of disability like intellectual disability. So our view is that if you are presenting with current mental health symptoms, whether or not they be drug induced, they are significant and they require treatment. All the evidence now suggests that if you develop mental health symptoms in the presence of substance abuse that are significant enough to get you into a specialist mental health service, you probably have a mental health problem anyway; and in our view to treat you in a binary way as if you fit here or there is quite inappropriate.

Mr KAVANAGH — Given the importance of drugs to the mental health situation, does your college have any recommendations for the government on drug policy?

Assoc. Prof. HOPWOOD — We had not entered them specifically in this submission because we were obviously focused on performance data, but over the last decade there has been the development of an increasing skill base in the management of drug and alcohol problems within mental health. A number of schemes have been funded that have further enhanced our capacity to respond. We would wish that to continue, because I have no reason to believe that percentage will decrease — only a presumption that it will increase, in fact.

I think we would also welcome, as a down flow from the union of the mental health and drugs and alcohol branches, further thought to how they can be combined at the service level. In some of the early intervention services funded by the commonwealth there is a sense of a one-stop shop: if I am a youth with a drug or alcohol or mental health problem, there is one door I go through. Disability services in Victoria have very much focused on that one door — I think the correct term is 'There is no wrong door'. We would welcome the extension of that thinking to the boundary between mental health and disability so that I am not going to turn up to the emergency department and find out that neither this guy nor this guy wants me.

Mr KAVANAGH — Several years ago something became quite well known in Australia for a few weeks and then sort of dissipated — that is, what they called the Israeli treatment. I wonder if you have any knowledge of that, whether it is being used at the moment and whether it has been shown to be effective in the long run.

Assoc. Prof. HOPWOOD — I think mental health, where we do not always have the answers, is an area ripe for people to offer what seem on the surface like dramatic and powerful answers. The history of mental health is littered with suggestions that have fallen by the wayside, and I think that is probably one of them.

Mr KAVANAGH — One of your recommendations is that there need to be reports on the impact of treatment 3, 6, 9 and 12 months after the treatment. Surely you would have good evidence already about the efficacy of your treatments, would you not?

Assoc. Prof. HOPWOOD — I think there is a difference between efficacy and effectiveness. Efficacy studies are where the patient volunteers to be in a study and will allow themselves to be followed up. Effectiveness studies are those that look at the translation of that evidence base into the real world. Where a service system responds by tending to move people into another service system, effectiveness questions are difficult to answer. Part of our reason for asking for those time points is that we suspect that after 12 months a high proportion of individuals who have received care will have moved on, and we trust that they are doing well, but we do not necessarily know. That is it.

Mr KAVANAGH — Have these studies been done in other states or perhaps in other jurisdictions?

Assoc. Prof. HOPWOOD — I cannot recall any particularly good examples, but they are challenging to do because they obviously cross some traditional service boundaries and there are great issues about the mobility of people and their consent to be involved in such studies. Sometimes barriers can be a reason not to attempt something, but we think it is very important.

The CHAIR — You indicated in answer to Mr Davis's question that most acute admissions in the mental health area are involuntary under the Mental Health Act. Can you outline to the committee what process

typically leads a person to being admitted under that act? Typically is it through police, or how do they end up being admitted?

Assoc. Prof. HOPWOOD — Yes, of course. Individuals with acute mental health problems that are likely to require involuntary treatment may first meet the service system at a range of points. We outlined the presentation to the emergency department. Some present through contact with police, and although they often receive high publicity it is a minority, and I think it is important to acknowledge that fact; others present directly to the community mental health system; and still a significant proportion present through primary care, where the first person they see is their general practitioner, who will commence the process of involuntary treatment. The current standard process is that regardless of who completes the initial assessment, that individual must be reviewed by a consultant psychiatrist within 24 hours, which generally occurs once they have reached the acute inpatient unit.

Sometimes one of the tensions in the system is that because any medical practitioner can make you an involuntary patient, you may be brought from the general practitioner's rooms to the emergency department of a hospital that currently has no acute bed, and immediately we have created a tension. Of great concern to us would be where the capacity to admit that patient determines their treatment. One would assume that their involuntary status and indeed the treatment they receive otherwise should be determined not by that but by other factors, including predominantly their need.

It is inevitable that stresses and strains will occur within any system, but we feel ours is under considerable stress and strain, and it concerns us.

The CHAIR — In relation to the growth, the data given by DHS to us on inpatient psychiatric separations indicates there has been an increase in the order of 24 per cent over the last six years.

Assoc. Prof. HOPWOOD — Yes.

The CHAIR — Some of that could be population driven, but I would not have thought the majority would be population driven. Can you explain what factors are driving that seemingly dramatic increase?

Assoc. Prof. HOPWOOD — This is acute inpatient separations?

The CHAIR — Yes.

Assoc. Prof. HOPWOOD — Yes. I think the pressure on length of stay is relevant, is it not, because the more you turn over a bed in a given year, the shorter the length of stay. For example, if the length of stay is 11 days, you will turn over the bed twice as often as you will if the length of stay is 22 days. The question is what is the appropriate average length of stay. We are concerned that that is currently under considerable pressure.

The CHAIR — Are you suggesting that this may not reflect a growth in the number of patients but more a growth in the turnover of patients?

Assoc. Prof. HOPWOOD — I think it is all of those factors. There is some growth in specialist bed numbers, as outlined previously. There is definitely growth in demand. There is also growth in turnover. So all three of those factors together will contribute to that increased number of admissions.

The CHAIR — Thank you, Associate Professor Hopwood. The committee appreciates the submission from the college and also your evidence here this afternoon. We will have a draft transcript sent to you in the next couple of days for any corrections you wish to make. Thank you for your time.

Committee adjourned.