Submission to the Victorian Legislative Council Standing Committee on Finance and Public Administration Inquiry into Public Hospital Performance Data

December 2008

1. INTRODUCTION

This submission is made by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Victorian Branch to the Legislative Council Standing Committee on Finance and Public Administration Inquiry into Public Performance Data with respect to the Terms of Reference: To inquire into and report on the capacity of hospitals to meet demand, standards and quality of care, resources and access levels, and the accuracy and completeness of performance data for Victorian public hospitals.

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for setting the training program, examining and providing access to Fellowship of the College to medical practitioners. There are approximately 1000 Fellows of the RANZCP in Victoria.

Concerns are often raised that medical colleges are ‘closed shops’ interested in maintaining ‘market control’ by limiting the number of new doctors and specialists being trained. It is important to note that while the RANZCP sets the curriculum and administers the examination processes for its trainees, it is the State Government who controls the funding for training places. Indeed, as self-funding entities, medical colleges such as RANZCP rely on the goodwill and donation of their members’ own time. Members are concerned that safeguards are in place to meet the standards set by governments to protect the health of the Australian community.

Private mental health services are funded through private contribution, Medicare rebates and insurance industry financing. Public mental health services are funded primarily by state governments with contributions from the Australian Government via Australian Health Agreements. Public and private psychiatrists operate largely
independently of each another. The division between sectors means that non-medical staff in state services are likely to have limited knowledge of the working environment of private psychiatrists or GPs, and vice versa. Public sector work practices and attitudes may perpetuate these structural divisions.

This submission focuses on the Terms of Reference issues, namely, 1. the capacity of hospitals to meet demand, 2. the standards and quality of care, 3. the resources and access levels, and 4. the accuracy and completeness of performance data for Victorian public hospitals.

2. CONTEXT

Society's understanding of mental health and mental illness is not comprehensive. Most people can not correctly recognise mental disorders and do not understand the meaning of psychiatric terms. Many people do not distinguish between the terms mental health and mental illness. The World Health Organisation (WHO) is appealing to countries to increase their support for mental health services.¹ This section of the submission is included to provide background information about mental illness and the work of psychiatrists.

Mental disorders such as depression are among the 20 leading causes of disability worldwide. Depression affects around 120 million people worldwide and this number is projected to increase. Fewer than 25% of those affected have access to adequate treatment and health care.²

Stress, depression and anxiety can all create dramatic, stereotypical images. The general public often has a distorted view of mental illness and its treatment due to the way it is portrayed in fictional media. People who have direct experience of mental illness have a better understanding of what is occurring and how it can be managed. They attain a more balanced view of mental illness, the importance of mental health treatment and the way that it is carried out.

2.1 The nature of mental illness

Mental illness is common but is still widely misunderstood. Mental illness may also be referred to as psychiatric disorders and can take many forms, just as physical illnesses do. Mental illnesses are still feared and misunderstood by many people, including health workforce personnel. Words like "crazy," "psycho," and "nuts" are words that keep the possible stigma of mental illness alive. The stigma experienced by people with a mental illness can be more destructive than the illness itself. According to the Australian Institute of Health and Welfare, mental illness is the

¹ http://www.who.int/mental_health/en/
leading cause of disability burden in Australia,\(^3\) however, effective treatment exists for almost all mental illnesses.

In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer. This data underscores the importance and urgency of treating and preventing mental disorders and of promoting mental health in society. Mental health illnesses are projected to be highly significant contributors to the 2020 global burden of disease. Mental illnesses are expected to increase their proportion of total global burden of disease from 10.5 percent in 1990 to 15 percent by 2020.\(^4\)

Current statistics show that one in every five Australians will have a mental health problem at some point in their lives. The most common and disabling mental health problems are anxiety disorders (characterised by feelings of unease, tension and distress with an exaggerated fear of possible danger or misfortune), depression (a lowering of mood which includes feelings of sadness, despair and discouragement, which range from mild to severe and is sustained over a long period of time.), and psychotic disorders (a condition in which a person is unable to tell what is real from what is imagined). Many people suffer a mental illness for a long time before they seek help. Furthermore, alcohol and drug problems frequently occur with depression, anxiety and psychosis.

### 2.3. Psychiatry

Psychiatrists are medical practitioners with a recognised specialist qualification in assessing, diagnosing and treating mental disorders. By virtue of their specialist training they bring a comprehensive and integrated bio-psychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of mental illness. Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual’s social context. They provide clinical leadership, with many working in multidisciplinary team settings. Psychiatrists treat patients and work with the patient’s general practitioner, other health care providers, families and carers of patients, and the general community.

Effective psychiatric treatment requires coordinated interventions across a range of support systems. A bio-psychosocial approach encompasses treatment with medication (the biological component), psychological therapies, and social interventions such as work programs. This multifaceted approach to treating mental illness is analogous to the approach used to treat other common conditions such as heart disease, which is treated with both medication and lifestyle changes.

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In 1999 a RANZCP/ Australian Medical Workforce Advisory Committee (AMWAC) survey indicated that 57.1% of RANZCP Fellows worked predominantly in the private sector, 38.3% in the public sector and 4.5% divided their working time equally between the private sector and the public sector. Subsequent RANZCP surveys have shown that the number of RANZCP Fellows working in private psychiatry is relatively unchanged, however, public psychiatry practitioner numbers have decreased significantly.

4. TERMS OF REFERENCE

4.1 Accuracy and completeness of public hospital performance data

A major concern for the Victorian Branch of the RANZCP is the apparent lack of specific reference to, and data available concerning mental illness in public hospital performance data. For example, the only reference to mental illness specifically in the 2006 – 2007 Public Hospital Statistics is to the National Health Priority of “depression”\(^5\). In addition, The Burden of Disease (Victoria) project is intended to provide a comprehensive assessment of the amount of ill health in Victoria, (measured in disability-adjusted life years-DALYs) arising from most diseases and injuries, however, it needs to be noted that much of the burden of disease data are estimations based on overseas prevalence as no local source of data exists. \(^6\) Any detail of the burden of mental illnesses is notably absent from the data that RANZCP has had access to.

- **RANZCP Victorian Branch recommends that the collection of public hospital data needs to include a thorough and comprehensive inclusion of mental health illnesses and their management**

The issue of psychiatric presentations to public hospital emergency departments requires special mention. The RANZCP Victorian Branch wishes to draw attention to the findings of the Victorian Auditor General’s performance audit report into Managing Emergency Demand in Public Hospitals (2004).

A hospital emergency department cannot be viewed in isolation from the wider health system. Typically, patients move from one part of the system to another for example: from emergency department to inpatient bed or to a short stay unit; from hospital to aged care or rehabilitation beds. The ability for patients to move from one part of the system to the next depends both on their treatment in that phase being completed, and on the availability of resources in the

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next part of the system to accept the patient. If one part of the system does not have the resources to accept the patient, then movement through the system stops.\textsuperscript{7}

Most importantly, the report recognised the need for a stronger understanding of the presentation of psychiatric illness at public hospital emergency departments. Indeed, Recommendation 16 of the report states:

\emph{DHS should sponsor further work, including needs analysis into the issue of psychiatric presentations and long stays in emergency departments.}\textsuperscript{8}

The RANZCP Victorian Branch has been unable to determine the specific outcomes of this recommendation and therefore would recommend clarification through the Inquiry process.

There are no public psychiatric hospitals in Victoria and emergency departments cannot refuse to treat any patient who arrives. As there is a recognised growth in presentations to emergency departments,\textsuperscript{9} it is reasonable to assume that a proportion of the patients will be attending due to acute or chronic mental illness. In 2004, The Secretary, Department of Human Services, reported that a Mental Health Demand Strategy had been developed for hospital emergency departments. He also advised that:

\ldots hospitals were required to report long stay mental health patients in ED in order to monitor the impact this had on access. In addition, a number of projects have been funded exploring more effective ways of working with people with complex psychosocial needs presenting to EDs.\textsuperscript{10}

The nature of an emergency department is such that data will not necessarily be collected or recorded as staff do not necessarily have the time for detailed administrative tasks. This begs the question on the completeness of any statistics concerning mental illness presentation and continuing care in the public health system. The RANZCP Victorian Branch therefore recommends that there is a need to review of data collection methods applied in EDs to determine the completeness of data that is reported and recommended methodologies.

\begin{itemize}
\item[\textsuperscript{7}] Managing Emergency Demand in Public Hospitals (2004), Auditor General Victoria, Government Printer for the State of Victoria, 2004, p. 11
\item[\textsuperscript{8}] Managing Emergency Demand in Public Hospitals (2004), Auditor General Victoria, Government Printer for the State of Victoria, 2004, p. 25
\item[\textsuperscript{9}] Managing Emergency Demand in Public Hospitals (2004), Auditor General Victoria, Government Printer for the State of Victoria, 2004, p. 37
\item[\textsuperscript{10}] Managing Emergency Demand in Public Hospitals (2004), Auditor General Victoria, Government Printer for the State of Victoria, 2004, p. 96
\end{itemize}
• **RANZCP Victorian Branch recommends urgent work, including data collection and comprehensive needs analysis from the clinician and client perspective, into the issue of psychiatric presentations and long stays in emergency departments.**
4.2. Capacity of public hospitals to meet demand

It is now widely accepted that there is a discrepancy between the available psychiatric workforce and the mental health needs of the population. The national Mental Health Report 2007 shows that inpatient beds in Victoria have dropped from 21.6/100,000 in 1992-93 to 19.9/100,000 in 2004-05\(^\text{11}\) in a period of rapid population growth and improving diagnosis of mental illnesses, such as depression. With this in mind, it is the considered opinion of that Branch that there is currently a grave shortage of acute public hospital beds. There are anecdotal reports of hospital bed occupancy rates of 101% that require investigation. There is urgency about having this information clarified and the issues resolved because when a patient presents in the acute phase of mental illness they are at great risk of their condition worsening if treatment is delayed. They may also become a more troublesome patient if required to wait for extended periods before a bed is available or treatment is commenced.

Bypass is unacceptable for a patient in the acute phase of mental illness. It should be noted that this problem is exacerbated by a shortage of psychiatrists and mental health nurses – even if a bed is available, there will not necessarily be the skilled staff to provide the required support and treatment.

- **RANZCP recommends an immediate increase in acute public hospital beds by a factor of at least 25%**

The RANZCP believes that it is necessary to review the application of Case Management Funding as it is applied to mental illness. The concept of Case Management is based in service provision arrangements that require different responses from within organisations and across organisational boundaries. It is thought of as a boundary spanning strategy to ensure service provision is client rather than organisationally driven. The Case Management approach assumes that clients with complex and multiple needs will access services from a range of service providers via seamless service delivery. The issue to be clarified is how well patients with mental illness are able to traverse the various services that they need while unwell and in recovery.

- **RANZCP Victorian Branch recommends a review of the funding provided and models of service used in crisis teams in emergency departments as it applies to mental illnesses**

- **5.3 RANZCP Victorian Branch recommends that any formal process of mental illness treatment data**

collection and reporting needs to include the impact and outcomes of occasion service perhaps at 3, 6 and 9 and 12 months (if not longer)

+ **RANZCP Victorian Branch recommends an increase in funding for long stay community beds of at least 20%, increases in aged and child and adolescent beds by at least 15% and an increase in resourcing for community-based general and forensic psychiatric services**

+ **RANZCP Victorian Branch recommends a broadening of the resources provided for depression and related data collection as it is predicted to be a predominant global burden by the year 2020**

### 4.3 Standards and quality of care in public hospitals

To effectively manage access issues it is imperative to scope and benchmark the mental health service system and come to agreement on what constitutes an adequate level of care. At present no such benchmarks exist and this makes workforce planning an exercise in guesswork.

Very few mental health services have developed “stepped care” systems linking specialist care to primary care in a systematic way. In such systems GPs and specialists (private or public) develop shared protocols where GPs are supported in the care of simpler clinical problems and more complex or non-responding clinical problems receive preferential access to specialist assessment or treatment. Such approaches have been implemented in health systems where primary and specialist care sectors operate under one organisational structure. They have been shown to be effective in the care of depression and other mental illnesses.

The National Quality Measures Clearinghouse (U.S. Department of Health and Human Services database and web site for information on specific evidence-based health care quality measures and measure sets) might be a useful resource in addressing this issue. For example, it is stipulated that:

> In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the patient's treatment course during hospitalization including rationale and target symptoms for medications changed, discharge medications and next level of care recommendations.”

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The RANZCP is of the opinion that it is imperative that quality, safety and legal obligations must be addressed as the basis for determining minimum numbers of specialists within services. As a demonstration of commitment to practice standards, the RANZCP has been funded by the Australian Government Department of Health and Ageing through an initiative of the Mental Health Workforce Advisory Committee (MHWAC) to develop and pilot a framework for the implementation of the National Practice Standards for the Mental Health Workforce (Practice Standards) in adult acute mental health inpatient units. The project aims to develop comprehensive detailed guidance to services on how the Practice Standards could be practically implemented for different levels of workers and the various disciplines commonly working within adult acute mental health inpatient units, specifically: psychiatrists; psychologists; mental health nurses; social workers and occupational therapists. In recognising the current workforce limitations, the RANZCP is committed to developing effective partnerships with the range of mental health professions and examining models of collaborative service provision.

Strengthening the psychiatric workforce involves clarification of the role of the psychiatrist and building on capacities for high-level consultancy, leadership and management, and intervention in complex mental health problems. Effective functioning in these roles requires appropriate training, systemic support for leadership functions and acknowledgment of the psychiatrist as the specialist who integrates bio-psychosocial care within an appropriate cultural framework.

- **RANZCP Victorian Branch recommends that consultation is undertaken to reach agreement on what constitutes an adequate level of care and the consequent data collection required**

4.4 Resources and access levels

Data developed by the massive Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, accounts for over 15 percent of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers. There is a known and acknowledged discrepancy between the available psychiatric workforce and the mental health needs of the population. People suffering acute or chronic mental illness are most likely to attend their general practitioner, hospital emergency department or outpatient clinic in the first instance. The RANZCP was unable to access detailed data on hospitals stays due to mental illness, however, given there are no public psychiatric hospitals in Victoria it is reasonable to assume that mental illnesses accounts for a significant

percentage of hospital stays every year given the WHO Burden of Disease estimates.\textsuperscript{15}

Specialist mental health services provided by the State have tended to focus on a narrow band of illnesses with a high level of complexity. In many the concept of “serious mental illness” has shifted from its original broader meaning to become equated with psychotic disorders, a difficulty recognised in the second National Mental Heath Plan. Many non-emergency referrals to state community mental health services are initiated by the patient, family or friends. Therefore public mental health services provide both primary and secondary care. Few other specialist services allow self-referral without a gate keeping or referral function by a primary care provider. In many State services referrals must pass not only through the filter of diagnostic assumptions about “serious mental illness” but also through intake, triage and assessment services provided with limited skills or organisational support.

The second National Mental Health Plan emphasises partnerships between the public and private sectors, and, when surveyed, both public and private psychiatrists are in favour of better public–private collaboration and supported the concept of shared care arrangements. The MBS (Medical Benefits Schedule) provides little financial incentive or support for collaboration between the private sector and the public sector or primary care. Flexible employment practices are needed to encourage greater collaboration.

Continuity of care is important for all patients treated not just those identified as being at particular risk. For example, when a patient is discharged after the current 11 day mean length of stay (LOS) what is the follow up on the patient? What back up sources are provided to the patient to ensure the best recovery outcomes? Simple, automated means of providing discharge summaries and data collection are needed to ensure that this becomes a priority. Building continuity of care with the primary care and community sector is an important element in preventing re-presentations to a hospital emergency departments.\textsuperscript{16}

- RANZCP Victorian Branch recommends a review of compliance rates to mandated outcomes data with a view to increasing the availability of psychiatrists and other mental health workers for treating and monitoring mental illness

\textsuperscript{15} http://www.who.int/mental_health/en/

5. CONCLUSION AND RECOMMENDATIONS

Psychiatric illness accounts for a large amount of our society’s disease burden. It is under-diagnosed, undertreated, under-resourced and under reported. The rapid growth in Victoria’s population has meant that already inadequate resources have become more inadequate.

- **RANZCP Victorian Branch recommends that the collection of public hospital data needs to include a thorough and comprehensive inclusion of mental health illnesses and their management**

- **RANZCP Victorian Branch recommends urgent work, including data collection and comprehensive needs analysis from the clinician and client perspective, into the issue of psychiatric presentations and long stays in emergency departments.**

- **RANZCP Victorian Branch recommends an immediate increase in acute public hospital beds by a factor of at least 25%**

- **RANZCP Victorian Branch recommends a review of the funding provided and models of service used in crisis teams in emergency departments as it applies to mental illnesses**

- **5.3 RANZCP Victorian Branch recommends that any formal process of mental illness treatment data collection and reporting needs to include the impact and outcomes of occasion service perhaps at 3, 6 and 9 and 12 months (if not longer)**

- **RANZCP Victorian Branch recommends an increase in funding for long stay community beds of 20%, increases in aged and child and adolescent beds by 15% and an increase in resourcing for community-based general and forensic psychiatric services**

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collection as it is predicted to be a predominant global burden by the year 2020\textsuperscript{17}

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Signed \\
Date: 18 December 2008

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\textsuperscript{17} Murray, Christopher J. L., and Lopez, Alan D., The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020
ADDENDUM
Submission to the Victorian Legislative Council Standing Committee on Finance and Public Administration Inquiry into Public Hospital Performance Data

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The case is somewhat understated by the error in lifetime prevalence of mental illness (those surveyed only), which was reported in the 2007 National Survey as 45% (the 'one in five' figure is the annual prevalence).

Also the Australian Burden of Disease Study figures for disability are more telling that the US figures, 24% of overall non fatal disease burden (i.e., disability) in Australia is due to mental illness

Signed  

Date: 23 December 2008
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