

shown a decrease in the prevalence of reported sharing from 31% in 1995 to 15% in 1997.¹

However, there is evidence that among some subpopulations, especially those of Indo-Chinese origin, unsafe injecting practices remain common. In a survey of Indo-Chinese IDUs in Sydney and Melbourne, Maher et al reported that 22% of those surveyed had shared needles and syringes in the preceding month.² Although the Indo-Chinese community is becoming increasingly aware of issues related to drug use, IDUs are under-represented in drug treatment programs.³ There is also evidence that parents send their children back to their country of origin to escape the Australian heroin scene. In a Melbourne survey of Vietnamese IDUs, Kelsall et al reported that 19% of their sample (38 of 200) had returned to Vietnam during the previous five years for drug-related reasons. Of these, 24 reported using heroin in Vietnam, a disturbing finding given that HIV prevalence among IDUs in parts of Vietnam is greater than 50%.⁴

We analysed HIV surveillance data in Victoria to investigate whether there was an over-representation of Indo-Chinese-born IDUs. Country of birth has been collected as part of HIV notification in Victoria since January 1996. Since then, there have been 38 notifications of HIV infection in individuals reporting intravenous drug use as a risk factor. Of these 38, 11 (29%; 95% CI, 15%–46%) reported an Indo-Chinese country of birth — a higher proportion than expected given the 1996 census finding that 1.5% of Victoria's population was born in an Indo-Chinese country.⁵ These 11, all men, were significantly younger than other IDUs notified in this time (mean, 23.3 years v 31.3 years, respectively; $P < 0.05$).

Although these numbers are small, they highlight a group at increased risk of HIV who are not currently being effectively reached by prevention services. These data also suggest a hidden route for spread of HIV from Asia into the Australian community. There is an urgent need to provide culturally relevant education and harm-reduction programs to prevent transmission of HIV within this group. The Victorian Department of Human Services is allocating additional resources to working with culturally and linguistically diverse communities on prevention activities to address this issue.

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Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program

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TO THE EDITOR: On reviewing the results of the Wimmera clinical risk management program,¹ we are prompted to ask whether the model can be generalised to a tertiary hospital. The program outlined by Wolff and colleagues is a good model for local quality improvement and provides a foundation for developing a model for tertiary hospitals. However, in considering its applicability to tertiary hospitals, a number of issues must be addressed.

The number of separations and emergency department presentations at tertiary hospitals does not lend itself to review of all medical records. Such review is time- and resource-intensive and probably unrealistic in a tertiary setting. A sampling strategy might be more suitable, but would introduce the possibility of sampling error and missing adverse events.

The availability of medical staff to review records is also limited, with clinicians often having public, private and teaching commitments. It would also not be feasible for a medical director to be involved regularly in the day-to-day tasks of the process. Nevertheless, these issues could be addressed by allocating the review process to a dedicated, trained team. Development of a review pathway would ensure participation of senior medical or management staff when necessary.

The interface between tertiary hospitals and local general practitioners is broader and less defined than in rural areas, making the involvement of GPs difficult.

The clinical mix and complexity of patients requiring tertiary care differ significantly from those at a rural base hospital, and restricting screening criteria for adverse events to eight items, as in the Wimmera program, would likely result in adverse events being missed. In addition, the clinical structure of tertiary hospitals is not uniform, and specific criteria may need to be developed to address the clinical specialties of the hospital.

Lastly, in this era of cost containment in healthcare, Wolff et al did not address the cost of its clinical risk management program. While this is not a fault in the study, cost would be an essential consideration in generalising the program to a tertiary hospital.

The model used in the Wimmera program has limitations when considering adaptability to tertiary hospitals, because of issues of scale and day-to-day practicalities. Further examination of the costs involved in ongoing operation of the program and a cost-benefit analysis are required. In addition, investigation is needed into feasible options that deliver *useful* results in a tertiary setting before a quality improvement model can be developed that is relevant, appropriate and cost-effective for tertiary hospitals.

1. Wolff AM, Bourke J, Campbell IA, Leembruggen DW. Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program. *Med J Aust* 2001; 174: 621–625. □

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IN REPLY: The model developed in the Wimmera hospital for clinical quality improvement has formed the basis for quality improvement systems in several regional and tertiary hospitals in Australia. The resources required to implement the model have been costed, and the Victorian Department of Human Services has allocated \$4.8 million to establish clinical risk management programs based on the Wimmera model in every Victorian public hospital in 2001–2002.¹

Whichever programs are implemented, some adverse events will be missed. However, not all medical records need to be reviewed, nor all adverse events found. Regular identification of some events provides significant opportunities to improve care.

As clinician time is limited, some hospitals that have implemented the Wimmera model have paid clinicians with existing appointments for extra hours to participate in risk-management programs. Although feedback to general practitioners is logistically more difficult in a tertiary centre, it can still provide valuable information if limited to only a sample of inpatients. We agree that some departments in tertiary hospitals, because of their specialised nature, would need to develop additional screening criteria.

The actual cost of running a clinical risk-management program based on the Wimmera model depends on how many components of the model are implemented, but in our experience should not exceed 0.5% of a hospital's total budget. Cost-benefit analyses are difficult to undertake, as some adverse events arise through underuse of available evidence, and additional resources would be needed for full implementation of the evidence (eg, giving prophylactic antibiotics immediately before surgery to prevent postoperative infection,¹ or low molecular weight heparin postoperatively to prevent thromboembolism²).

We believe that in any institution, whatever its size, the initiation of effective programs for clinical quality improvement needs both enthusiastic

support from the highest level of management and champions at the “coalface” of patient care. If these two elements are present, adequate resources will often be found. However, providing resources without appropriate clinical and administrative support is unlikely to improve patient care.

1. Victorian Government Department of Human Services. Victoria — public hospitals policy and funding guidelines 2001/2002. Melbourne: Victorian Government Department of Human Services, 2001.
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3. Therapeutic Guidelines Limited. Therapeutic guidelines: cardiovascular. 3rd ed. Melbourne: Therapeutic Guidelines Limited, 1999. □

SPHERE: A National Depression Project

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TO THE EDITOR: The recent supplement by Hickie et al looking at the mental health of Australians attending general practice¹ would have us believe that we are quite a mentally unwell nation indeed!

The authors propose a broad concept of “mental disorder” which they found in 49% of general practice attenders based on 12 questionnaire items (the SPHERE-12). These 12 items include six relating to psychiatric symptoms (PSYCH-6) and six relating to somatic symptoms (SOMA-6).² The SOMA-6 items are muscle pain after activity, needing to sleep longer, prolonged tiredness after activity, poor sleep, poor concentration, and tired muscles after activity. Patients with a total score of two or more in PSYCH-6 and/or three or more on SOMA-6 were classified as having a “mental disorder”.

Firstly, the SPHERE-12 is grossly oversensitive, as the six somatic items detect many medical conditions, glandular fever being just one example. Other validity issues include the two-week cut-off for symptoms (further adding to the overinclusiveness because of temporary distress and minor illnesses), and the lack of discussion regarding transcultural and inter-rater reliability, particularly with so many general practitioners involved.

Secondly, the authors' interchangeable use of neurasthenia and chronic