Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF SHITIJ KAPUR

I, Shitij Kapur, Dean of the Faculty of Medicine Dentistry and Health Sciences and the Assistant Vice Chancellor for Health, of the University of Melbourne, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 I am giving evidence to the Royal Commission in my personal capacity and not on behalf of any of my employers or any organisations that I am a member of.

Background

3 I am a physician and a psychiatrist by training. I trained as a physician at the All India Institute of Medical Sciences in India, and as a Psychiatrist at the University of Pittsburgh in the USA. I undertook a Fellowship and PhD in Neuroscience at the University of Toronto, Canada.

4 I am currently the Dean of the Faculty of Medicine, Dentistry and Health Sciences and Assistant Vice-Chancellor (Health) for The University of Melbourne. I have held these positions since October 2016.

5 I am also a current board member for each of:

(a) Aikenhead Centre for Medical Discoveries;

(b) Florey Institute of Neuroscience and Mental Health;

(c) Melbourne Academic Centre for Health;

(d) Melbourne Health;

(e) Murdoch Children's Research Institute;

(f) Royal Children's Hospital Campus Council;

(g) St Vincent's Research Institute for Medical Research;

(h) Peter Doherty Institute for Infection and Immunity Council; and

(i) Walter and Eliza Hall Institute of Medical Research.

6 Prior to my current roles, I was:

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(a) the Executive Dean of the Institute of Psychiatry, Psychology and Neuroscience (**IoPPN**) London between 2010 and 2016. IoPPN is also known as 'the Maudsley' and is Europe's largest and leading centre for mental health research;

(b) the Dean of the Institute of Psychiatry (2007), Vice-Dean of Research (2008-2009) and Dean (2010) at King's College London;

(c) a Board Member of the South London and Maudsley NHS Foundation Trust (**NHS Trust**) between 2010 and 2016. The NHS Trust is the most prominent and prestigious mental health system in the United Kingdom known for its history of contributions to research and education and professional development in the area of mental health;

(d) the Vice President for Research for the Centre for Addiction and Mental Health ("**CAMH**") in Toronto between 2003 and 2007. CAMH is a large hospital and university affiliated research institute. It is considered Canada's leading centre for mental health and was cited as one of the exemplars in the Royal Commission into Victoria's Mental Health System's Interim Report; and

(e) a qualified psychiatrist and academic at The University of Toronto, Canada between 1996 and 2007.

7 My main research interest is in understanding schizophrenia and its treatment. I have published over 300 peer-reviewed papers and my work has been cited over 25,000 times.

8 Attached to this statement and marked 'SK-1 is a copy of my biography.

Future needs and trends in mental illness

Future trends or changes that may alter the community's need for mental health services

9 In my view, based largely on epidemiological trends and from a sociological perspective, increasingly over the last 30-50 years we have become a more mentalising species. In other words, we tend to think of issues in much more psychological terms than we did in the generations before. People in their 30s and 40s think much more in psychological terms than previous generations did. It is a sociological observation that 150 years ago, what we would currently list as depression was probably experienced slightly differently and labelled much more in psychosomatic terms. In those times, people might have complained much more about sleep, appetite and energy, but not see it in terms of a depressed mood.

10 These are big shifts and broad sociological trends. What that means is that there is going to be greater conceptualisation of human distress in terms of psychological symptoms, which will, in clinical terms, lead to a big increase in mild and moderate mental illness.

When you couple this with the very positive efforts being made to decrease the stigma of these conditions – they are now experienced more and we allow people to express them more – this leads to a huge increase in the perceived need for mental health services.

11 Furthermore, while resilience probably grows as we age, the fact that people are living longer and living longer with multiple chronic conditions, coupled with age related decline in neurological capacity (whether you have dementia or not), is another factor for an increase in the need for mental health services. Each of these is a secular tectonic trend that we will not be able to stop.

12 For these reasons, in my view, there will be increasingly greater pressure for the provision of mental health services for the mild to moderate range of mental illness in the future. If one is planning for the next 50 years, I would be mindful of these factors.

13 While there is not much evidence about the impact of the above sociological changes on severe mental illness (bipolar disease and schizophrenia), my sense is that severe mental illnesses are less vulnerable to these sociological changes. Anxiety and depression are much more psychologically malleable or vulnerable to sociological changes than severe mental illness. In my view, the figures of around 1% of the population worldwide having schizophrenia and around 1.5% having bipolar disorder will probably remain the same over time and probably have remained relatively the same over the last 100-150 years or so.[1] If there are a more cases of severe mental illness than there were 50 years ago, however, that is because previously there was under-diagnosis.

Potential impacts of future changes on different groups of Victorians

14 Traditionally, mild and moderate mental illness has expressed itself more in women. In my opinion this is likely to continue. There may be some biological reasons for this and there are also certainly sociological and cultural reasons. The difference is related to power and inequality in society, dominance and helplessness patterns, and acceptable forms of externalising distress.[2]

15 This is also the case in marginalised communities. Careful and systematic studies show that marginalised communities have much higher rates of mental ill health than average. However, marginalised communities do not like talking about depression or psychological symptoms because it leads to stigmatisation and perception of weakness. It is only when

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[1] Steel Z, Marnane C, Iranpour C, Chey T, Jackson JW, Patel V, et al. The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. Int J Epidemiol. 2014;43(2):476-93; Tandon R, Keshavan MS, Nasrallah HA. Schizophrenia, "just the facts" what we know in 2008. 2. Epidemiology and etiology. Schizophr Res. 2008;102(1-3):1–18.

[2] Neitzke AB. An Illness of Power: Gender and the Social Causes of Depression. Cult Med Psychiatry. 2016;40(1):59-73; Parker G, Brotchie H. Gender differences in depression. Int Rev Psychiatry. 2010;22(5):429-36.

a community or its members first start emerging and becoming open to discussing mental health that higher rates of mental illness are noticed

Preparing for and responding to mental illness trends

16 It is hard for anyone to precisely predict what the trends might be. However, in order to prepare for and respond to any mental illness trends there needs to be monitoring and sensing systems for constant surveillance. This is what is done for infectious diseases and other forms of chronic illness. In my opinion, longitudinal, state-based, comprehensive surveillance of mental illness patterns is needed and any policy and healthcare responses should be determined by reference to surveillance findings.

Model for community-based care

The distinguishing factors between community-based settings and hospital settings

17 The key distinguishing factor between community-based care and hospital based care is driven by the same factor, which is true of all medicine, and that is severity. However, what is unique in the mental health context is the additional issue of risk of self-harm or harm to others. A person may have a relatively moderate illness with depression, but the moment suicidality is a factor, there is a need for inpatient care. This makes mental health fundamentally different from the rest of health.

18 In my view, this is unlikely to change in the future. For reasons we don't fully understand, suicidality and suicide attempts (not always completed suicides) are increasing. Insofar as suicidality continues to rise, it will be a further multiplier to the 'need equation' and have implications for inpatient care.

19 Around the world, as the number of beds for inpatient care has decreased, the character of inpatient units has changed. Having worked in these units for over 25 years, I have noticed they have become increasingly riskier, more dangerous and threatening places. I sometimes worry about taking our first year medical students to see that kind of environment because I think they will find it very confronting. They may come to view Psychiatry as a custodial and containment discipline. It was not like this 25 years ago when I started practice. There were people who were suicidal, but the proportion of persons on the wards who are suicidal, have behavioural issues or are on confinement orders has increased.

20 For example, in an 18 person unit, back then, there would be one person or two people who might be suicidal, there might be one person who was on a confinement order and there might be one person on every third day who might have a major disruptive behavioural issue. Today, the picture (depending on the particular ward) is very different.

Often, around half of people on the ward are on confinement or treatment orders, around half of them are suicidal, and around half of them are having behavioural issues. This is not sustainable. These are not healing or comforting environments. If we continue like this, we will find it very difficult to attract people to work in these settings. Nursing turnover is already very high – nurses are typically the most giving and generous people – however nurses are increasingly finding it hard to continue to work in these settings.

Technology as a potential distinguishing feature of inpatient care

21 In the rest of medicine, technology distinguishes community care and hospital based care. In other words, in a hospital there are special investigations, tests and other technological interventions that cannot be undertaken in a community-based setting. However, in psychiatry, that difference is not as pronounced. At present, the major difference between the community and hospital based settings is the provision of continuous, supportive care in a safer setting; not the intensity of technology or biomedical interventions.

22 Over time, intensive or invasive technological service provision might become a distinguishing feature of inpatient care. However, technology is not yet a distinguishing feature of inpatient care, with the rare exception of electroconvulsive Therapy ("**ECT**"), which is a very small percentage of the treatment provided in an inpatient setting.

23 In my view, the reason that technology is not yet a distinguishing feature between community-based and hospital-based care is because we have not yet found any technology that is inpatient intensive and has the right cost-effectiveness.

24 There are a couple of interesting treatments on the horizon, however these are better suited to outpatients than inpatients:

(a) First, we are increasingly giving infusions of drugs like ketamine and LSD to see if they work.

(b) Second, there are new forms of brain stimulation that could replace ECT.

With the exception of those possible changes, I do not envisage any large scale technological revolution that would by itself become a major component or driver of inpatient care. On the other hand I can foresee large scale eHealth changes that could replace some elements of hospital care, for example the European Commission's MasterMind Project.[3]

[3] MASTERMIND "MAnagement of mental health diSorders Through advancEd technology and seRvices – telehealth for the MIND" GA no. 621000, http://mastermind-project.eu/wp-content/uploads/2017/08/MMind_Policy-brief.pdf

Supporting people to self-manage their mental illness in the community

25 In my view, we simply cannot meet demand for mental health services if we cannot come up with a better protocol of self-management.

26 A lot of mental health care today is provided by the practitioner. I do not think the practitioner will be easily replaced. I do not think a utopia where a computer will do the entire course of psychotherapy and the person will go home happy is achievable and realistic, or indeed desirable. However, I certainly see a place for a better *balance* of digital technology and self-management. I believe this is how we will deal with the burgeoning need for mental health services.

27 In my opinion, we will increasingly have to build models that have three elements to them:

(a) more onus on the patient for self-management, self-practice, and self-development;

(b) the practitioner rather than just being the provider of clinical care, could provide modules which increasingly rely on digital technology and self-management, with a very careful mechanism of monitoring, ideally remote ones; and

(c) if the above is not enough, a process where a person attends a full in person consultation with the best trained professionals who can use the information learned from the failed self-management and digital management to inform their approach. These consults with practitioners will be the most precious resource of the strained system, and therefore will have to be used most selectively.

28 There are some existing models that incorporate digital technology with self-management. The best of these are hybrid models, which allow the user to speak with a psychotherapist for assessment, undertake some computer modules and agree to a treatment plan, before speaking or electronically chatting with the psychotherapist again. However, these models are all at early stages and none have been scaled to a national level to change the face of everything. Some good examples of the use of digital technology and self-management are found in the UK[4] and also in Scandinavia.[5]

29 I could see this use of digital technology and self-management being adopted within 10 years, but these are tools that will have to be extensively trialled and tested before they can be rolled out in the field. And then they will need to be enmeshed with face to face care.

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[4] https://pubmed.ncbi.nlm.nih.gov/30821079/?otool=iaumelblib
[5] https://norden.diva-portal.org/smash/get/diva2:1297054/FULLTEXT01.pdf

Coordinating services within the mental health system

30 Services within the mental health system should be coordinated. However, there is no one ideal way to do that. Having worked in four countries and three continents I have not seen an ideal example that I would recommend for Victoria.

31 This is because the way in which services within the mental health system are coordinated has to be contextualised. You cannot build a mental health coordination system without a view to the larger background of society, the place of primary health care, and an understanding of the rest of the physical health system. These are the different components that need to be brought together. Focusing just on the mental health system and coordinating it might give you a perfectly well coordinated mental health system, but the outcome for the patients would not dramatically change unless it is linked with social care, primary care and physical health.

Social care involves the broader public element, and includes all the social services that meaningfully engage with people with different difficulties, for example housing and income support and services that promote active, healthy lives.

Research

The major priorities for mental health research

32 I am a great proponent of fundamental or discovery research - which will require basic breakthroughs in molecular neuroscience, systems neuroscience and cognitive psychology. There is a great need for this kind of research, and we cannot lose focus of it. For example, for polio we could have still been building iron-lung machines. It was only when people discovered the vaccine that we really advanced in the fight against that disease. That is an example of discovery research in action. This must continue. But, it will take time.

33 In the short to medium context of mental health, there should be a focus on two major aspects of research.

34 Firstly, there should be a focus on what I call translational research, or what is often also called translation. Translation is taking the mass of discoveries, concepts and advancements that have already been made and putting them together to test new interventions in patients.

35 Secondly, there should be a focus on implementation science research. There are many proven interventions that provide value for money, but do not get implemented into service at scale. The reasons for this are not necessarily scientific or technical aspects of the intervention; they are really reasons relating to complex organisational levers, human

behaviour, professional identity, or just simply reimbursement and incentives. Implementation science is about answering these questions. It provides a set of approaches and tools which we use to try to understand why something is happening (or not happening) and then design solutions. For example, a problem we could tackle using implementation science is, *"We have these beautifully written guidelines that everyone agrees with, but yet our practice does not change. Why is that? And what are we going to do about it?"*

36 The point of implementation science is not just investigating and writing a paper on why, an intervention has not been implemented or has not been effective. Rather, it is to investigate the reasons and based upon your findings, identify and put into practice changes that can lead to results. It's not just implementation science, it is the practise of implementation driven by principles of implementation science. For example, this may include doing a pilot of an intervention, and after it has been tried in one hospital it can be implemented across the 50 hospitals in the state.

37 While there are some exceptional medical doctors and healthcare workers who engage in implementation science, it is usually done by people with a background in organisational management, operations, psychology and communications. It requires a different kind of orientation to other types of research. One of the world's leading units in this area is the King's Implementation Science unit at King's University in London, which has brought together a diverse multidisciplinary team that conducts their studies right in the middle of a working healthcare system.

38 While Victoria's universities are world leaders in many areas of research, I am not aware of many large world leading groups doing this kind of work out of Victoria. Therefore I think these should be the priority areas for mental health research in this State.

My observations of major medical and research institutes, including in the United Kingdom and Canada

39 I have been privileged to work in what most would agree are the top research centres for mental health in Canada and the United Kingdom. However, their ability to drive collaboration and service delivery was challenged even in those circumstances. Below are the two examples that I am familiar with where an effort has been made to bring together multiple professions, mental health and alcohol and drug services, and infuse them with research and innovation and reach out to the system of health as best as we can.

40 The CAMH in Canada is run through the fusion of four different entities that have existed for decades – the Queen Street Mental Health Centre (which was at one point in time a 500 bed mental health facility), the Clarke Institute of Psychiatry, the Addiction Research

Foundation and the Donwood Institute, the latter two being substance misuse research and inpatient facilities. CAMH has been a pioneering centre for bringing together drugs and alcohol services and mental health services under one provider, together with research, innovation and translation.[6]

41 It has been difficult for that centre to transform community services. Being a large, independent entity which just focusses on mental health and addictions makes it challenging to build links with the broader community (which you don't control) and the physical health services (which you are not aligned with). However, CAMH does very well with what it has.

42 The experience in the UK is slightly different. In the UK, the South London and Maudsley NHS Foundation Trust involves several mental health hospitals, some mental health units in general hospitals and almost 140 different community mental health sites. This makes it possible to provide not only in-patient care but also community care in a more seamless manner. Furthermore, because the Trust's major research institute is on the campus of the main hospital of the Trust, there is very good integration of the academic and clinical elements. That is one step ahead, but is of course not linked to physical health service.

43 While I worked at the Trust, we formed a collaborative continued health partnership that tried to link together this mental health system with its two enabling physical health systems (the King's College Hospital and the Guy's and St Thomas' Hospital). It helps that the NHS is organized around a formal concept of "catchment" areas, which allows for a greater integration of primary, secondary and mental health care in defined geographies.

Comparison of the Canadian and United Kingdom mental health systems to the Victorian system

44 In contrast to the UK, in the Victorian mental health system, primary care is run by the Commonwealth through the Medicare Benefits Schedule. The hospitals are all independent boards commissioned by Statements of Priorities (SoPs) with the state. There is no major freestanding mental health hospital and most major inpatient facilities are within major secondary hospitals. In one sense, the system in Victoria could perhaps mean that integration of mental health within hospitals with physical health is better because they're all under the oversight of the same CEO. However, the divide between primary and secondary is problematic for integration, not just for mental health, but for all health areas.

[6] I explain what I mean by "translation" at paragraph 34.

45 The lack of a major mental health hospital impacts the provision of mental health services as there is no beacon for mental health. In London, Toronto and New York, the Maudsley, CAMH and the NYSPI, respectively, play a very critical convening role. In my opinion, Victoria needs to find a way to create a mental health beacon – ideally without creating a behemoth.

46 A good working example of collaboration in Victoria, although not in the mental health services sector, is the Peter MacCallum Cancer Centre, because it is a single provider which manages multiple services and conducts research using the translational and discovery research models I described above. An even better example might be the Children's Campus at RCH, which brings together the hospital, the Murdoch Children's Research Institute, the University and the Foundation into one effective collaboration in a spectacular facility. That is what world class looks like. Not surprisingly, by almost any measure that Children's Campus would rank in the top 5 in the world. And that is no mean feat for a relatively small city.

47 While Victoria does have psychiatric research of a very internationally competitive quality, Victoria does not have the critical mass, that is the collection of a large number of world class multidisciplinary researchers under one roof and one banner, as both Toronto and London do. The University of Melbourne is the leading centre in Victoria for psychiatric research, but in terms of size if would probably be only half of the output in Toronto and London. It is of course not just about size; it is the way that a research institute is structured and the way its outputs are used. The issue is not just that Victorian research might be smaller in size, the more critical issue is that there are few centres with critical mass. Youth mental health is one example where do we have critical mass and you can see what world-class impact and reputation it has. This is important as impact on the ground is not governed by academic papers; what makes the difference to impact is the integration of that critical mass with decision making. For example, when I was the Vice President for Research for CAMH in Toronto, I sat on the executive committee of the hospital, and the research was right there when all the decisions were being made. In my experience, that is not the case here in Victoria.

The fundamental principles that should guide public investment in mental health research

48 Complementarity and Mission are the fundamental principles that should guide public investment in mental health research. In other words, we should recognise what we are already good at and build upon that, guided by our mission to improve the outcomes for patients and their family. This is what translational research and implementation science are about.

Leveraging national and international research priorities

49 Victoria should leverage national and international funding resources where they align with our priorities. We already do that. My sense is that approximately 80% of what takes place in the name of mental health research in Victoria is funded by sources outside Victoria, whether this be national, philanthropic or occasionally international funding.[7] I am not aware of much state-driven investment in mental health research in Victoria and believe this is likely true for most Australian states.

50 While it is great that we are already leveraging national and international funding in Victoria, we are not really leveraging funding for translational and implementation science research. The reason for this is that there are currently not many national or international agencies that will fund that research. Therefore, if Victoria wants translational and implementation science research, if it is a priority, Victoria will need to pay for it.

Supporting research into the side effects of drugs used to treat mental health, and new emerging therapies

51 The type of support needed for research into the side effects of drugs used to treat mental health, and new emerging therapies, will depend on where in the area of discovery that work is. Research at the very early discovery level in Australia is largely supported through federal sources and grants. As the work gets closer to translation and implementation, that is where the role of the state might become more important. As research comes closer to application on a large scale, that's where support is really missing. That is where we can use implementation plans.

The role of the Victorian Collaborative Centre for Mental Health and Wellbeing in advancing mental health research

52 The Collaborative Centre could play a tremendous role in harnessing collective intelligence and expertise across the mental health sector to advance mental health research. While the Victorian Universities and Orygen are highly ranked in terms of published research papers as discussed above, there is a lack of critical mass and research is not brought together to impact clinical work in the impressive way that, for example, the Peter MacCallum Cancer Centre, the Royal Children's Hospital and Murdoch Children's Research Institute bring together research in their fields. Currently, mental health research just does not have the "clout" to make a significant difference.

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[7] This 80% figure is based on my general knowledge of where money for most research in Victoria comes from; I have no reason to believe that the sources of funding for mental health would be any different.

53 The Collaborative Centre should be:

(a) finding a mechanism of greater complementarity and cohesion between what is already going on in the mental health system;

(b) supplementing that with what is missing; and

(c) finding the way of using all of that energy to make an impact on the health system that serves Victorians through education, workforce development and the implementation of research and innovation.

54 In thinking about the vision for the Collaborative Centre, it is helpful to think about the vision of two other great institutions.

(a) The IoPPN in London was originally set up by a visionary named Henry Maudsley in 1907. At that time the big question was, *"How can we get out of the asylums and start dreaming the beginning of community mental healthcare?".* That big question was built deeply into the design of IoPPN.

(b) The Clarke Institute of Psychiatry in Toronto which subsequently became part of CAMH was founded in 1966. At that time, psychiatry had very little to do with medicine – it was off in its own psychoanalytic work – and the big question was, *"How do we get psychiatry to connect with medicine and the brain again?".*

55 In my view, the big lessons that motivated those institutions and changes have been learnt. No one doubts the value of community, or the brain-basis of psychiatry. While no one doubts the importance of translational research or implementation science either, making this research and science real in a healthcare system is a wholly different matter.

56 If we wish to take a bold step and make Victoria a visionary state, we have to do something demonstrably different and world class.

57 A centre can try to be everything to everyone and solve the last 200 years of unsolvable problems or a centre can become a beacon and a leading light by focusing on a few areas of expertise – there is no place that becomes a world leader by doing everything. So we should focus.

58 There are two distinguishing features that I think should be woven into the "DNA" of a Collaborative Centre: (a) the ethos and importance of the lived experience; and (b) technological leadership. Special attention should be given to these areas, and expenses or investment should prioritise them.

(a) **Lived experience:** The first feature is the importance and integration of the lived experience. Integration of the lived experience has many meanings, all of which would have to be worked through. The Centre would of course need to practice

Co-design. Integration is not just about adding a "Co-" to everything. Often too much emphasis is placed on joint-chairing. It is more about a shared perspective informing decisions that needs to be deeply embedded into the DNA and design of the Collaborative Centre.

(b) **Digital mental health:** The second feature is digital. At the moment there is no centre which specializes and shines in digital mental health. The Black Dog Institute in Sydney is an emerging player, and I think Orygen in youth mental health is getting there. But, for most of mental health in Victoria we only have small boutique initiatives. We do have big national initiatives like Beyond Blue and others, and while they are innovative and effective and play a very useful role – they are not enough. While each centre may have one or two researchers in this space, there isn't as yet a Silicon Valley of digital mental health. Our colleagues in Toronto and London are not naïve to this digital opportunity and the field is expanding so quickly that there is a real opportunity to be the world leader.

Digital mental health will not necessarily need someone to come up with the fastest computer. Digital is not about well written apps (that is the easiest part). For these apps to be useful, they have to be integrated into the health care system. The challenge will therefore be much more about implementation, ethics, engaging people in the right way, changing habits and linking up systems in the right way. It's about addressing the hard questions*, "What is the right behavioural design of digital technologies? How can an app be integrated into the health care system and the life of a patient? How do you get patients to accept it? How do you get the doctors and health workers to change their ways? What are the economic implications?".* There are decades worth of work to be done.

59 Digital technology cannot be successfully implemented without connecting the entire health care system. I believe Victoria is an appropriately sized jurisdiction for that kind of system wide commitment; it is not too small that the world would not notice and it is not too large that it would be too complex. We are about the size of Scotland, which has done some great things in the digital health space. Just because we are not the Silicon Valley, it does not mean we cannot lead in this area. I think we can, but it requires real leadership and real commitment to making this happen.

60 The integration of lived experience and digital including technological leadership could place the Centre at the cutting edge. This is very important, because the only way to continue to grasp the interest and the resources of subsequent generations is by staying at the cutting edge. If a centre like this one is not at the cutting edge, 20 years from now, a political or professional lethargy will let it wither away.

61 I think it is feasible for us to be at the cutting edge of digital mental health here in Victoria. It is not just about medicine, it is about getting a lot of input from our sociologists, our

historians, our ethicists, our lawyers, and of course our mental health professionals, along with the community of people with lived experience. We have a strong tradition of it in Australia and I think Victoria could amplify it.

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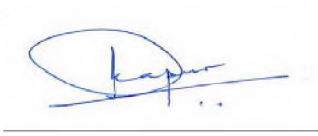

print name Shitij Kapur

date 8 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SK-1

This is the attachment marked 'SK-1' referred to in the witness statement of Shitij Kapur dated 8 May 2020.

Professor Shitij Kapur, MBBS, PhD, FRCPC, FMedSci
Dean, Faculty of Medicine, Dentistry and Health Sciences
Assistant Vice-Chancellor (Health), University of Melbourne

Professor Shitij Kapur, FRCPC, PhD, FMedSci is Dean of the Faculty of Medicine, Dentistry and Health Sciences and Assistant Vice-Chancellor (Health), University of Melbourne. The Faculty comprises over 1700 academic and 800 professional staff serving over 8800 students and is consistently recognised internationally for its leading role in clinical and pre-clinical teaching and research.

Professor Kapur's background is as a clinician-scientist with expertise in psychiatry, neuroscience and brain imaging – having published over 300 peer-reviewed papers that have been cited over 30,000 times with an H-index of 90. Before moving to Australia, he was Executive Dean of the Institute of Psychiatry, Psychology and Neuroscience, Europe's largest and leading centre for mental health research, and prior to that, Vice-President (Research) for the Centre for Addiction and Mental Health Toronto, Canada's premier centre for research into mental health and addictions.

He currently serves as a director on the boards of the Royal Melbourne Hospital, Walter and Eliza Hall Institute of Medical Research, St Vincent's Research Institute, and Aikenhead Centre for Medical Discoveries and Florey