Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR VINAY LAKRA

I, Dr Vinay Lakra MBBS, MD, MHM, GAICD, FRACMA, FRANZCP, Clinical Director of North West Area Mental Health Service (**NWAMHS**), NorthWestern Mental Health (**NWMH**), Melbourne Health, of 130 Bell Street Coburg VIC 3058, say as follows:

1 I am authorised by NWMH to make this statement on its behalf.

2 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.

Background

Qualifications and experience

3 I hold the following qualifications:

(a) Fellow, Royal Australian and New Zealand College of Psychiatrists, Australia;

(b) Fellow, Royal Australasian College of Medical Administrators, Australia;

(c) Master of Health Management, University of New South Wales, Australia;

(d) Graduate, Australian Institute of Company Directors, Australia;

(e) Doctor of Medicine (Psychiatry), Central Institute of Psychiatry, India; and

(f) Bachelor of Medicine; Bachelor of Surgery, Jawaharlal Nehru Medical College, India.

4 Throughout my career, I have worked in all parts of the system: in the community, inpatient services and residential system. I am well versed in the way that the system works (or fails to work) together.

5 I completed my medical degree and psychiatry training in India. In India, I had worked in a reputed institute, the Central Institute of Psychiatry, initially as a junior resident trainee in psychiatry for three years and subsequently as a senior resident for one year and nine months. I was able to understand and contribute to a range of quality improvement initiatives in that role including but not limited to reducing seclusion, improving quality of care delivery and focusing on individual needs.

6 I migrated to Australia in 2004 and worked at Mid West Area Mental Health Service (**MWAMHS**), NWMH until 2010, initially as a senior registrar, then as a consultant

psychiatrist and then as deputy clinical director. I worked in a range of teams during this time including the mobile support team, continuing care team, community care unit, crisis assessment and treatment team, triage, Emergency Department and acute inpatient unit. I led the acute inpatient unit through a period of service redesign.

7 I was appointed as Medical Director, East Cluster Mental Health, Sydney West Area Health Service and served in that position for six months in 2010. During that period I was also the Medical Superintendent of the Cumberland Hospital and Westmead Hospital.

8 I returned to Melbourne in 2011 and subsequently took over my current role as Clinical Director of NWAMHS, NWMH. Since then I have also served as Director Clinical Governance, NWMH for around 12 months in 2012 – 13, and as Deputy Chief Psychiatrist of Victoria for a period of three years from 2016-2019.

9 I have been the President Elect of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) since 2019 and will assume the role of President in 2021 for a two year term.

10 I have been involved in a range of initiatives over years to improve the safety and quality of mental health service delivery through my work at the service, network, state and national level. I am a member of several national committees, which allow me to contribute to this area. I have also contributed to a number of other submissions to the Royal Commission as part of my role and association with professional organisations and other groups.

11 Attached to this statement and marked 'VL-1' is a copy of my curriculum vitae.

Current role and responsibilities

12 Currently, I am the Clinical Director of NWAMHS and I have been in this role since 2011. I also carried other duties from time to time as outlined above. I am supported by a Deputy Clinical Director. My responsibilities include providing clinical leadership to NWAMHS in collaboration with the Area Manager, who is the operational lead of the service. I am a member of the NWMH executive team and contribute to strategic planning, budgeting, workforce management, policy development & implementation, and safety & quality of service delivery.

13 My role as the President Elect of the RANZCP involves a number of responsibilities as a Board Member as well as representation on a number of national committees.

Community based mental health services

14 A community mental health service should be resourced so that it can deliver a range of supports, rather than just delivering acute and episodic care, especially for those with chronic and recurrent illnesses.

15 An effective community based mental health service would be one that is person-centred, involving long term, rather than episodic, care. In addition to the clinical staff (psychiatrists, nurses, psychologists, occupational therapists, and social work professionals with comprehensive generalist and specialist skills, for example drugs and alcohol), it ought to be staffed with a range of other support staff who have different skill sets and specialities, including for example, those with culturally appropriate skills, people who have knowledge of domestic violence issues, and peer support staff for consumers and carers. There should also be supports available in the areas of employment, vocation and housing as these social determinants are critical in overall recovery. Some of these supports must be provided in-house as part of the community team and others with strong linkages with other providers. Treatment and support should include addressing physical health and substance related issues.

16 Continuity and consistency of care is critical across the community mental health services. A key way of achieving this is to adopt a protocol-based system for responding to consumer needs. This would provide consistent methods of response to different presentations and permit a more proactive approach to the provision of supports and services. Such a service needs to be available in a way that is responsive to a person's needs.

17 Further, a community based mental health service should include a triage service which provides crisis services for acute issues on an *ad hoc* basis, such as support for relationship problems or other psychosocial problems and offer linkages with other services for provision of ongoing supports for such issues. A community based mental health service must include extended hours of service and be funded and resourced for a seven day model.

18 A community mental health service should work in close collaboration with primary care providers to enable seamless care for those who do not require long term ongoing treatment in the public mental health system. This applies to those who present in crisis but do not have underlying chronic or severe mental illness, or those with such illnesses but who have better psychosocial supports and can afford to engage in ongoing treatment in primary care with their general practitioner (**GP**) or psychiatrist in private practice.

Best practice models

19 In my experience, consumers are more likely to engage if there is a genuine interest in caring and treating them as people, rather than treating their symptoms episodically. Engagement can be further encouraged by the use of evidence-based specialist care.

20 Engagement is also facilitated by other means of outreach. The current pandemic has demonstrated that telehealth is more viable than that had perhaps been previously appreciated. Combined with text messaging follow-ups to treatment reminders, there are more options than ever for services to maintain contact, and therefore engagement, with mental health consumers.

21 It is important that those consumers can also be effectively referred to further services that they may require as they recover from the primary reason for their presentation. Establishment of well delineated and prioritised pathways between mental health services and other relevant agencies (e.g., housing, employment, etc.) would help to address psychosocial issues at community level in a timely fashion.

22 Readmission is a significant issue in psychiatric care, particularly for those with severe mental illnesses. While a previous research at NWAMHS found the readmission rate within 12 months of discharge as 46%,[1] a more recent audit of NWAMHS data for 2015-2018 for consumers with diagnosis of Schizophrenia and related disorders found a readmission rate at 70% (i.e.,110/156 consumers) following an index admission to Broadmeadows Inpatient Psychiatry Unit (**BIPU**) in 2015. While many had multiple admissions, the rate could have been even higher if we were able to capture admissions outside our NWMH network. This data also does not include relapses which did not lead to an admission but were referred for community treatment. This audit also highlighted a major systemic issue related to lack of interconnected data systems to provide rapid and meaningful information (it has been further discussed in a later section). Innovative solutions are needed to improve consumer engagement and reduce readmissions. The following two programs (Clozapine Program and Assertive Linkage Project) are examples for such innovations.

23 The Clozapine shared care program (the **Clozapine Program**) at NWAMHS has many of the hallmarks that I believe would make a successful community based mental health service for those with severe and chronic mental illnesses. The Clozapine Program is a holistic and integrated program between the mental health service and GPs and it focuses on consumer needs, and is strongly protocol-based, and provides ongoing support. Clozapine is a drug that is prescribed for consumers with treatment resistant

[1] Zhang J, Harvey C, Andrew C. Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: a retrospective study. Australian New Zealand Journal of Psychiatry, 2011; 45: 578-585.

schizophrenia. Consumers who attend the Clozapine Program have regular reviews with the treating team including a Psychiatrist for their medications as well as overall health and related psychosocial issues. For those in shared care, a psychiatrist conducts six monthly reviews supported by a Clozapine coordinator, and a GP provides care and treatment during the intervening period. Both the GP and the consumer have access to the mental health service during this intervening period for an earlier review or additional supports, when required. The protocol includes blood tests and regular monitoring of heart, cholesterol, and other related issues including Diabetes Mellitus. This holistic approach yields more effective results, particularly in consultation with a GP's involvement.

24 The combination of holistic, continuous care, combined with strong connections with primary healthcare has led to a strong program. The results for people with treatment resistant schizophrenia involved in the Clozapine Program are better than outcomes for consumers with the less intensive treatments provided for less serious examples of schizophrenia.[2]

25 I was also involved in the Assertive Linkage Project (a precursor of the current HOPE project) at MWAMHS over 12 years ago. That project focused on people who attended the emergency department after a suicide attempt but were subsequently deemed not suitable for further mental health care from the area mental health service and were discharged back to their GP. This was identified as a gap and led to the project. The clinical staff provided phone support or a home visit where needed, and ensured that the consumer received appropriate support including ensuring linkages with the primary care providers or other support providers, for example, relationship counselling or financial counselling. Through this simple protocol, engagement was increased, and re-presentations to the Emergency Departments during the subsequent six months were markedly decreased.

26 These interventions are relatively straightforward, but they are not available in the current model, because it is so episodic, and responsive to acute need, rather than proactive and forward-looking. The current HOPE program is more comprehensive than the Assertive Linkage Project and must be expanded to all mental health services.

27 Streaming is a model of care whereby consumers with particular treatment profiles are treated together. Streaming can be important and helpful for efficient service delivery as it allows staff to better perform in their scope of practice (generally or on that shift — a

[2] Murphy K, Coombes I, McMillan S, Wheeler AJ. Clozapine and Shared Care: The Consumer Experience. Australian Journal of Primary Health, 2018;24(6):455-462. Filia S, Lee S, Sinclair K, Wheelhouse A, Wilkins S, de Castella A, Kulkarni J. Demonstrating the Effectiveness of Less Restrictive Care Pathways for the Management of Consumers Treated With Clozapine Australasian Psychiatry, 2013;21(5):449-55.

nurse looking after consumers of one or two diagnostic stream is likely to provide better care and treatment than while looking after consumers of four or five diagnostic streams). It can enhance consumers' experiences by reducing exposure to difficult experiences, e.g., a consumer with depression or anxiety does not have to witness consumers who are more unwell or are aggressive. Consumers can be streamed by age (e.g., child, adult and aged), gender (e.g., male wards, female wards) or diagnosis type (e.g., respiratory wards, cardiac ward). In mental health settings this could mean consumers with psychotic disorders, mood disorders or those presenting with psychosocial crisis. In the design of future inpatient facilities, creating smaller pods can be helpful in addressing this issue. A state-wide data analysis of inpatient admissions could help to identify number and type of pods.

28 In exploring best practice, it is instructive to consider what constitutes an ineffective community based care. The most common hallmarks of ineffective community care are the episodic delivery of care, especially for those with chronic and recurrent illnesses. Episodic care reduces engagement because it is not person-centric. It focuses more on symptoms than cause, and it disengages with the person when their acute symptoms have abated, even if the person is best placed to engage further in their recovery. Even when a person is effectively discharged to primary care providers (like GPs), without proper follow up and engagement, their contact with supports will be lost, and negative outcomes are made more likely.

29 Further, I consider the general case management model for chronic and severe mental illnesses to be ineffective. The evidence base for the general case management model is poor. The more effective models are those which provide assertive community treatment both for those in crisis (Crisis Assessment and Treatment Team) as well as those require chronic disease management (intensive case management delivered by Mobile Support Teams). General case management might be suitable for those who are well enough to engage in treatment, but invariably they are discharged back to their GP due to the pressure of demand on the services. General case management on the lines of the Clozapine Program is likely to be more effective as it will then provide ongoing care and treatment and involve other providers in empowering the consumer on their recovery journey.

Service integration

30 Finally, it appears to me that segregating mental health and substance use has been unhelpful. It has been my observation that the majority of consumers with substance use problems have mental health disorders, and that separating these two matters creates an artificial distinction that obscures good health outcomes and prevents the holistic treatment of the person.

31 Similarly, mental and physical health outcomes could be improved by adopting a more integrated model. That is, by co-locating mental health clinics, with GPs, psychologists and other services to facilitate referral between systems. Similarly, advanced technologies provide an opportunity for interconnection between delivery of services. For example, interconnected data systems can allow a health professional to see at a glance whether a consumer that they have referred for investigations or provided a prescription for, has attended to those tasks or not in a timely manner. This allows for more active follow up in a way that can contribute to positive outcomes.

32 I do consider that there are roles for Centres of Excellence (similar to the Victorian Comprehensive Cancer Centre), and that such a centre would be appropriate for mental health. This would benefit the system as a whole by providing a connection point for the rest of the mental health system.

The intersection between physical illness and mental illness

33 I would like to illustrate two scenarios on this topic. In a recent study at NWMH, which explored the characteristics of consumers who died of natural causes, the life expectancy was 30 years shorter for mental health consumers and those who died from cardiovascular diseases were less likely to attend medical specialist appointment for their condition.[3] An integrated model of care such as Clozapine Program generally improves life expectancy for those who need Clozapine as evidence has shown that Clozapine reduces all-cause mortality.[2]

34 More broadly, there is no reason that physical health recommendations and interventions cannot accompany mental health treatment. An effective and combined general and mental health system has a number of advantages

(a) reducing stigma attached to psychiatric treatment;

(b) maintaining consistent records to ensure that physical health recommendations are taken into account in mental health treatments (and vice versa); and

(c) ensuring good communication connection between general health practitioners and mental health practitioners to ensure that there is proper consideration given to each.

Secure extended care

35 My role as the Deputy Chief Psychiatrist involved overseeing issues related to Secure Extended Care Units (**SECU**). I am aware that the Mental Health Branch along with the

[3] Suggett J; Foster K; Lakra V; Steele M; Furness T. Natural cause mortality of mental health consumers: a 10-year retrospective cohort study (submitted for publication).

Office of Chief Psychiatrist was involved in a review of the SECU model of care, but I do not have further information about its outcomes.

36 I also had further involvement with SECUs in my role as Deputy Clinical Director, MWAMHS and also in my current role. Our service initially accessed SECU beds at Sunshine SECU, but a later rearrangement led to us accessing SECU beds at Austin SECU.

37 The model of care in each of the SECUs in Victoria is variable and the review was an effort to understand the complexity better and make care more consistent. There is also a shortage to SECU beds in Victoria, which has been identified in other submissions to the Royal Commission.

38 The Sunshine unit operates with academic appointments and better Consultant Psychiatrist resourcing, which allows for translational research into how care and treatment is provided,. I suggest consideration of an academic appointment in each of the SECUs to enable this translational research in an ongoing manner to improve the quality of care for the most unwell and vulnerable consumers in the mental health system.

Quality and safety

39 A great deal of work has been done around suicide prevention in terms of ligature risks in inpatient units. However, our ability to predict a person's risk of suicide is very limited.[4] Many people who die by suicide have psychosocial stressors and many do not have contact with a health provider in the days and weeks prior to the suicide, although there are others who have accessed health care services in the days and weeks prior to their death. The RANZCP President has established an advisory group on suicide, the work of which will further contribute to policy development in this area.

40 There is a lack of system-based interventions to assist in determining a person's risk and devising appropriate interventions. Appropriate data needs to be collected and fed into the system in order to develop meaningful solutions. Establishment of clinical quality registries will provide meaningful information which can help us to untangle the issues related to suicide and self-harm as well as a number of other issues. As it presently operates, the medical system is mired in bureaucracy and paperwork. It means that we are spending lots of resources on the things that do not necessarily lead to better outcomes for consumers.

[4] Large M, Sharma S, Cannon E, Ryan C, Nielssen O. Risk Factors for Suicide Within a Year of Discharge From Psychiatric Hospital: A Systematic Meta-Analysis. Australian New Zealand Journal of Psychiatry. 2011;45(8):619-28. McHugh CM, Corderoy A, Ryan CJ, Hickie IB, Large MM. Association between suicidal ideation and suicide: Meta-analyses of odds ratios, sensitivity, specificity and positive predictive value. *British Journal of Psychiatry Open* 2019; 5(2): e18. doi:10.1192/bjo.2018.88

41 An important factor in safety is to prevent relapse of severe mental illnesses and address substance use issues. Every future relapse has the potential to increase the safety risks to the consumer, staff, and others. Prevention of relapse in those with a chronic recurring illness thus becomes an important tool to not only address safety, but also enable sustained recovery and improved quality of life.

42 Occupational violence is a major issue for many mental health services. The risk is the highest in the emergency and inpatient settings although it is a major problem in community clinics as well. NWAMHS has carried out a range of initiatives over the years to minimise occupational violence. These include better data collection about any occupational violence incidents, better risk assessment using available information, liaison with police to follow up the acts of violence, staff support, use of security staff in the inpatient unit as a member of the team (this has had a major impact not only in reducing violence but also improving staff morale), use of CCTVs to monitor and gather evidence and changes to infrastructure (although this is limited by our existing infrastructure). Each of these initiatives has contributed to make the service safer, although the occupational violence incidents continue to be of concern.

43 Safety for everyone is our number one priority. At Melbourne Health, the Safety First initiative focuses on safety for all. An enhanced awareness about safety has been important in addressing this issue. We undertake a range of initiatives to support consumer / carer safety and wellbeing as well as staff safety and wellbeing. Five ways to wellbeing (connect, be active, keep learning, be aware and help others) is an initiative of NWAMHS focused on enhancing everyone's wellbeing.[5]

44 NWAMHS has undertaken several initiatives to minimise the occurrence of harmful incidents. This includes individual incident reporting and a review process, besides a system level data collection and review on a monthly basis at the safety and clinical risk management committee. Initiatives to reduce harmful incidents have focused on self-harm as well as harm to others. An extensive ligature audit is conducted annually of the inpatient unit and improvements made accordingly. The initiatives mentioned in paragraph 42 focus on reducing harm to others. Staff are also provided with extensive support, including counselling, following an incident of harm.

45 NWAMHS provides annual complaints data to the Mental Health Complaints Commissioner (**MHCC**) and also respond to the complaints which are referred to us from the MHCC.

46 The service provides data about reportable deaths, electroconvulsive therapy (**ECT**) and restrictive interventions (seclusion and restraint) to the chief psychiatrist. The Chief

[5] https://5waystowellbeing.org.au/.

Psychiatrist also conducts audits (for example, an ECT audit) and the information and feedback is shared following that process. Finally, the Chief Psychiatrist also conducts an investigation, when necessary about particular incidents. The service provides all necessary information for such investigations.

47 The DHHS also receives data about a range of KPIs including seclusion, 28 day readmission, pre-admission contact and post-discharge follow up. The DHHS also has access to a range of data which is submitted via Client Management Interface including individual consumer outcome data. Although a range of data is collected, I am not aware of interconnectedness of that data to provide meaningful and timely policy guidance.

48 The real benefits of the interconnectedness of data sources are apparent by the establishment of a registry, such as already exists in general health. For example, there are registries for prostate cancer or breast cancer. Such a registry would allow for the identification of patterns of mental health outcomes, and provide real time data to drive our mental health policy decision making. A number of other countries have established such registries[6] which provide data about long term outcomes[7] as well as other related information in real time to enable evidence based policy decisions. There is evidence that establishment of clinical quality registries provide significant clinical and financial benefits.[8]

49 I am not aware of the details of the data collected by other jurisdictions, although the Australian jurisdictions are likely to collect more or less similar data. In recent times the Chief Psychiatrist in collaboration with Victorian Agency for Health Information (**VAHI**) has produced benchmarking reports from the data which is submitted to the DHHS. These reports are very helpful in making comparisons and enabling service improvement by reducing variations in care as well as other service improvement initiatives. Although helpful, there are a number of challenges to the utility of these reports as the data is not real time. In contrast, other jurisdictions, such as Denmark and Finland use registries to collect a standardised data set and are able to provide real time data to influence quality

[6] https://econ.au.dk/the-national-centre-for-register-based-research/danish-registers/the-danish-psychiatric-central-research-register/.

[7] Staudt Hansen P, Frahm Laursen M, Grøntved S, Puggard Vogt Straszek S, Licht RW, Nielsen RE. Increasing mortality gap for consumers diagnosed with bipolar disorder—A nationwide study with 20 years of follow-up. *Bipolar Disorders* 2019; 21: 270– 275. https://doi.org/10.1111/bdi.12684.

[8] https://www.safetyandquality.gov.au/our-work/national-arrangements-clinical-quality-registries#economic-evaluation-of-clinical-quality-registries; The Australian Commission on Safety and Quality in Health Care. Economic evaluation of clinical quality registries: Final report. Sydney: ACSQHC; 2016; Lee P, Chin K, Liew D*, et al,* Economic evaluation of clinical quality registries: a systematic review, *BMJ Open* 2019;9:e030984. doi: 10.1136/bmjopen-2019-030984.

improvement as well as policy decisions. I recommend we move towards establishing such registries as noted above.

50 Victoria like many jurisdictions follows an incident investigation and management framework utilising Root Cause Analysis and other similar approaches to investigate adverse incidents. The effectiveness of these approaches in organisations learning and preventing future incidents is limited[9] and require complementary approaches which focus on learning from what goes well in a healthcare system, which is likely to enable participation and ownership from healthcare staff.[10]

Compulsory treatment

51 I am aware of research about compulsory treatment by Steven Segal, a Professor at UC Berkley. This research is based on analysis of data from Victoria, utilising a number of data sources to examine the outcomes of compulsory treatment during 2000 - 2010. So far as he understands it, there is a role for compulsory treatment, and it does assist people in their recovery.[11] Research conducted at NWAMHS supports the role of community treatment orders in improving outcomes in a range of domains including reducing homelessness.[12] Another large study from New South Wales further reinforced the role of community treatment orders in increasing community care and delaying readmission while the community treatment order is in operation.[13] Establishing clinical registries would enhance this and other research.

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[9] Kellogg KM, Hettinger Z, Shah M*, et al,* Our current approach to root cause analysis: is it contributing to our failure to improve consumer safety?, BMJ Quality & Safety 2017;26:381-387.

[10] Sujan M. A Safety-II Perspective on Organisational Learning in Healthcare Organisations; Comment on "False Dawns and New Horizons in Consumer Safety Research and Practice". *International Journal of Health Policy and Management* 2018; 7(7): 662-666. doi: 10.15171/ijhpm.2018.16.

[11] Segal SP, Rimes L, Hayes SL, The utility of outconsumer commitment: Reduced-risks of victimization and crime perpetration, *European Psychiatry* 2019; 56: 97–104; Segal SP, Hayes SL, Rimes L, The Utility of Outconsumer Commitment: I. A Need for Treatment and a Least Restrictive Alternative to Psychiatric Hospitalization*, Psychiatric Services in Advance (doi: 10.1176/appi.ps.201600161)*, Steven P. Segal SP, Hayes SL, Rimes L, The Utility of Outconsumer Commitment: II. Mortality Risk and Protecting Health, Safety, and Quality of Life, *Psychiatric Services in Advance (doi: 10.1176/appi.ps.201600164)*; Segal SP, Hayes SL, Rimes L, The utility of outconsumer commitment: acute medical care access and protecting health, Social Psychiatry and Psychiatric Epidemiology https://doi.org/10.1007/s00127-018-1510-5.

[12] Muirhead D, Harvey C, Ingram G. Effectiveness of Community Treatment Orders for Treatment of Schizophrenia with Oral or Depot Antipsychotic Medication: Clinical Outcomes. Australian New Zealand Journal of Psychiatry 2006;40(6-7):596-605; Ingram G, Muirhead D, Harvey C. Effectiveness of Community Treatment Orders for Treatment of Schizophrenia With Oral or Depot Antipsychotic Medication: Changes in Problem Behaviours and Social Functioning. Australian New Zealand Journal of Psychiatry 2009;43(11):1077-83.

[13] Harris A, Chen W, Jones S, Hulme M, Burgess P, Sara G. Community treatment orders increase community care and delay readmission while in force: Results from a large population-

52 These evidence and my personal experience confirms that there is a role for compulsory treatment, especially early in the course of illness when the person lacks insight. Once the person improves, it is possible that they remain engaged in treatment if they were to receive ongoing long term treatment and care.

53 In some circumstances, it is necessary to use compulsory treatment as a bridge to voluntary treatment. With strong therapeutic engagement model, the consumer is more likely to move from compulsory treatment to voluntary treatment. Voluntary treatment results in superior outcomes for individuals, provided they are engaged. One of the reasons that voluntary treatment is superior is that it is less likely to lead to an oppositional response from the consumer.

54 An engagement model can be an alternative to compulsory treatment in some circumstances. For example, an evidence based case management model is the Assertive Case Management model. Many people in this system were being treated voluntarily, but did not have the capacity and ability to attend appointments due to the chronicity of their illness and its impact on their day to day circumstances. A more assertive outreach is helpful in the engagement process.

55 Compulsory treatment is not a disease-modifying intervention, although it might be a course modifying intervention.[14] That is, being compulsorily treated will not necessarily mean that a person will have recovered in two years. It is simply a means of initiating and maintaining treatment contributing to prevention of relapse.

56 In my opinion, a system with a long-term engagement model enhanced by supported decision making, would reduce the need for compulsory treatment leading to reduce rates of relapse and not requiring further compulsory treatment (and all the associated issues with a relapse including suicide, violence towards others and use of restrictive interventions, amongst others). In some cases, a longer-term compulsory treatment with adequate oversight and safeguards, can be more beneficial in facilitating sustained recovery, as a shorter-term approach might not prevent relapses. Repeated relapses are harmful to an individual's sustained recovery and can cause treatment resistance. Engagement of carers and family in the decision making can be an important ingredient for success here. A longer term supportive model might also facilitate those discussions better to stay engaged in treatment rather than needing compulsory treatment.

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based study. Australian New Zealand Journal of Psychiatry 2019;53(3):228-235. doi:10.1177/0004867418758920.

[14] Barnett P, Matthews H, Lloyd-Evans B, Mackay E, Pilling S, Johnson S. Compulsory community treatment to reduce readmissions to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis. Lancet Psychiatry 2018;5:1013-1022

Restrictive practices

57 I understand restrictive practices refer to restrictive interventions as that term is used in the Mental Health Act *2014* (Vic) (**Mental Health Act**), that is, as seclusion or bodily restraint. Seclusion in that context is understood as "the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave" (section 3 of the Mental Health Act). Bodily restraint, on the other hand, is "a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs" (section 3 of the Mental Health Act).

58 A number of factors impact on the practice of physical restraint and seclusion. These include consumer factors, staff factors and environmental factors. Consumers with a more severe relapse and in the context of substance use are more likely to be restrained or secluded. The culture of inpatient units and design and infrastructure issues, as well as use of appropriate medication, play an important role in preventing restrictive interventions. We have noted from our experience that design and infrastructure play an important role besides staffing issues. We found that introducing the role of a safety nurse in the Intensive Care area has made a significant positive impact on reducing the restrictive practices. The leadership displayed by that individual and supported by the psychiatrists contributed to safer care.

59 Issues around chemical restraint are more complex. The community understands chemical restraint to be a reference to the unnecessary use of medication to restrain people. The more appropriate area of concern is excessive or inappropriate use of psychotropic medication. There can nonetheless be varying views about safe prescription practices, and there is therefore value in having second opinions, and review regimes to ensure that medications are not over-prescribed. Medication protocols for managing acute agitation have demonstrated the effectiveness in leading to safe prescribing practices.

60 Advance statements are a helpful part of continuous care, by which a consumer can have a conversation with people, when they are well, about the level and kind of medical interventions that might be of assistance when they are unwell. It can be useful to understand the perspective of family, and to take account of their views in the treatment of a person. Once again, this is enhanced through a continuous care model where relationships of this kind can be developed, and the context is understood. A broad understanding of the person's personal context can assist in reducing the risk of over-prescription of medication, or of physical restraint or seclusion, through a more responsive and tailored approach to treatment. However, current uptake of advanced statements has been challenged by an episodic model of care, which allows only a limited time with consumer.

61 I understand that the private health services do not report to the Chief Psychiatrist in the same way that public services do. I am not aware of any restrictive practices being used in the private sector. If a consumer is unwell and needs restrictive practices, they will be transferred to a public facility.

62 The recent benchmarking reports from the Chief Psychiatrist and VAHI shared data on restrictive practices across the state of Victoria for all the services. It is useful data to look at the variation between services both in terms of seclusion and restraint (duration as well as number), and the variation between different age groups. Such data is helpful in understanding the context and developing effective quality improvement projects to reduce and work towards eliminating restrictive interventions.

63 Occasionally, restraint or seclusion are used to prevent self-harm by a consumer. It is a matter that is usually related to the model of care employed and lack of appropriate evidence based treatment. An episodic and purely reactive model is more likely to require a restrictive response to a concern about self-harm.

64 I am aware of studies exploring the effect of light on aggression and suicide.[15] Although with a small effect, such things can be cheap and innovative solutions to reduce aggression and self-harm and thus reduce the need for restrictive interventions. These are small design changes that can operate well to help health practitioners to better manage the health needs of our consumers. In many instances, optimal care is simply not available in the context of acute, episodic care.

Factors influencing the use of restrictive practices

65 There are three factors that influence when and how frequently restrictive practices are used within Victorian mental health services:

(a) legislative and policy settings;

(b) service operating models; and

(c) streaming. – refer to para 27

Legislative and policy settings

66 Legislation has a strong role to play, as it not only sets out the parameters of compulsory care, it has a role in health messaging, education and training.

[15] https://www.ncbi.nlm.nih.gov/pubmed/24074716.

67 In 2014, the Mental Health Act was enacted. It has an overarching governance over the use of restrictive interventions in managing consumers within public hospitals, including acute care settings and emergency departments.

68 An example of strong policy change through a quasi-legislative change is the policy directive that mandated seclusion to be undertaken only in purpose built and designed seclusion rooms within acute inpatient, forensic and secure mental health units. It could not take place in an emergency department or urgent care centres or rooms within the general hospital.[16]

Service operating models

69 As discussed above, I think that a long-term engagement model (such as that used in the Clozapine Program) can reduce the need for restrictive practices because it provides for continuity of care, leading to earlier identification of red-flags and earlier, more effective, interventions that prevent the escalation of the person to a point where they relapse requiring an admission and subsequently require restrictive practices.

Minimising the use of restrictive practices

70 There are strong reasons to minimise and work towards eliminating the use of restrictive practices. There is a great deal of literature about the psychological impact of those practices on consumers and mental health staff.[17] However, there does need to be a more nuanced understanding of the restrictive practice in question.

71 The balance is sometimes more difficult to strike than that might be immediately apparent. While an administration of a depot medication under a community treatment order might be restrictive, allowing a person to deteriorate without the assistance of that medication is likewise restrictive of their quality of life. There are therefore difficult balances to be struck, and the answer is not always entirely intuitive. I believe a broader view needs to be undertaken — which is truly possible only in the context of continuous care, and the establishment of a trusting, therapeutic relationship guided by a supported decision making framework.

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[16] Victorian Chief Psychiatrist Direction 2017/01: Appropriate locations for the use of seclusion in designated mental health services.

[17] Hammer JH, Springer J, Beck NC, Menditto A, Coleman J. The relationship between seclusion and restraint use and childhood abuse among psychiatric inconsumers. Journal of Interpersonal Violence. 2011; 26: 567-579; Theodoridou A, Schlatter F, Ajdacic V, Rossler W, Jager M. Therapeutic relationship in the context of perceived coercion in a psychiatric population. Psychiatry Research. 2012;200(2-3):939-944; Department of Health. Reducing restrictive interventions: literature review and document analysis. 2013. Available from https://www2.health.vic.gov.au/about/publications/researchandreports/reducing-restrictive-interventions-literature-review-2013

72 It is my observation that consumers will avoid returning to a facility if they have had a bad experience in a previous admission. It follows that where a consumer has had an experience of inappropriate or precipitous use of restraint or seclusion, they are less likely to engage in therapeutic interventions in the future.

73 The importance of a therapeutic-led approach is underscored by the approach taken by NWMHS to security staff. While we have security staff present, they are led by clinical staff, not the other way around. We find that this means that there is security involvement only so much as is necessary or appropriate having regard to the needs of everyone to feel safe, and only insofar as is clinically appropriate. Set up in this way, I have found the presence of security staff useful, and they often intervene in a way that prevents escalation, rather than precipitating it.

74 Oversight, monitoring and reporting of restrictive practices assists in minimising use of restrictive practices. The data that is available from mental health services assists, but it is necessary to look at a number of other variables which could be contributing to this issue. This is one of the reasons that I think a registry for mental health would be of use; it could record matters like this with greater precision and understanding and provide real time outputs.

75 I am not aware of any country presently using a “best practice” approach to restraint and seclusion. Some countries use more restraint and no seclusion, but these are matters that need to be evaluated in light of access to care, among other things.

Workforce supply and capabilities

76 There are many challenges to the recruitment of staff and mental health professionals. The workforce related challenges impact on rural services significantly, but they are also quite relevant for outer metropolitan services. There should be greater use of telehealth in this respect, and I expect that the current pandemic conditions will encourage uptake of telemedicine, and perhaps accelerate a cultural change.

77 In terms of attracting medical students to psychiatry, the RANZCP has been running successful programs to encourage them to pursue psychiatry as a career using a model called Psychiatry Interest Forum (**PIF**). I think that it is necessary to expand the scope of education around mental health careers, to include additional education for year 11 and 12 students interested in nursing, medicine and allied health, to increase their awareness of mental health career paths.

78 Workforce shortages impact on the capacity of the health service to meet the needs of consumers. The workforce report from the Victorian branch of the RANZCP in 2017

identified a range of recommendations to address workforce issues.[18] Of note, more psychiatrists are leaving the public system to work in the private system. The public system continues to rely on overseas trained psychiatrists as a result of the difficulty in retaining psychiatrists as well as inadequate numbers of funded training positions. Appropriate funding of training positions as well as appropriate remuneration are critical to retaining psychiatrists in the public system. It is important to explore models of service delivery which involve better integration of public and private psychiatry as well as further opportunities for people to work across the two sectors. NWMH has two private practice suites which have been useful in providing those opportunities for psychiatrists, psychologists and nurse practitioners. There is also a need to use data to appropriately resource mental health services so that there is equity in resources across area mental health services. The National Mental Health Service Planning Framework is one such tool available to help achieve this parity.

COVID-19

Emerging changes in mental health service delivery as a consequence of COVID-19

79 There has been a significant impact on mental health service delivery as a consequence of COVID-19. A number of things have become apparent as a result of this crisis. These include:

(a) There are opportunities to deliver services via telehealth, although there is realisation that services do not have the required infrastructure to deliver telehealth via videoconferencing. Most service delivery in this situation is via telephone. Enhancing the infrastructure will be critical if we are to carry forward positives about telehealth as an option for mental health service delivery.

(b) Service delivery is also limited by the fact that a number of consumers and carers do not have access to devices or internet connection/data to safely engage in telehealth services. Appropriate provision of information regarding telehealth is crucial for its success.

(c) Telehealth has its own challenges in conducting reviews and collecting appropriate information in making a decision and hence would not necessarily be suggested as sole method of service delivery.

(d) There are challenges in adhering to safe physical distancing measures in mental health facilities (inpatient as well as community) and this became quite apparent in this crisis. Inpatient units are not designed to allow cohorting of consumers and staff and presented significant challenges in managing issues related to

[18] https://www.ranzcp.org/files/branches/victoria/ranzcp-vic-psychiatry-workforce-report.aspx.

COVID-19. Suggestions to consider this in the design of future inpatient facilities would be an important step forward.

(e) The Australian Commission on Safety and Quality in Health Care is currently engaged in developing standards for digital mental health services, which will be useful for development and continuation of telehealth as an additional option to face to face review in future.[19]

(f) There have been efficiencies in reducing travel time for meetings as a result of use of videoconferencing options.

Longer term opportunities for new approaches to service delivery

80 There are longer term opportunities in using telehealth as an add-on to usual face to face service delivery for the benefit of consumers and carers. Telehealth can be beneficial not only for individual work, but also in liaison with carers / families as well as some group work. It is more efficient unlike face to face reviews which require travel, although there has to be appropriate balance of face to face and telehealth options.

Conclusion

81 There are a number of areas where we need to increase our capacity and alter direction. Primarily, it is necessary to establish a mental health registry (or multiple registries relating to mental health) which would provide potential answers to many of the queries raised in this statement. These registries should have the capability to provide real time data to enable data driven policy decision making. The evidence is quite clear that establishing clinical registries is cost effective and improves clinical care. This also then has the potential to enhance staff morale when they see real time long term positive outcomes.

82 The system as a whole would benefit from true integration with primary healthcare, including between service providers such as Medicare and NDIS. This integration can be supported by centres of excellence. The models to facilitate such an integration would be based on co-location where possible and also use of interconnected data systems including electronic medical records. There also needs to be better integration between the public and private systems so that consumers receive seamless care and treatment.

83 It is important to review models of care, with the Clozapine Program demonstrating a model of care that is consumer-focused, and practices a continuous care model, especially for those with chronic and recurrent illnesses. The benefits of long term engagement are manifest in the Clozapine Program and I believe key aspects of that

[19] https://www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards.

model can be successfully rolled out to other forms of mental health treatment. The model of care needs to consider streaming whereby acute issues secondary to psychosocial issues and chronic diseases can be provided individualised and efficient care and treatment. This has to be underpinned by evidence based care and models of effective involvement of peer support staff. Greater attention must be paid to provide long term engagement for consumers with severe and chronic illnesses and to enhance psychosocial support for consumers on compulsory treatment as a means to initiate treatment.

84 Recently the COVID-19 pandemic has shown us the usefulness of technology and digital platform in enhancing care provision. In this background, telehealth can be added to the face to face service delivery model if and when required.

85 Lastly, clinical leadership should be directed at implementing a person-centric, protocol based system (allowing opportunities for innovation); ensuring a focus on positive reinforcement that relies on system-based interventions. There is a need to move away from a fear driven system to a system of positive engagement. Adverse incidents and outcomes are likely to occur, which should not lead to defensive practice, instead such events should be seen as true opportunities to improve system based issues.

sign here ►

print name Vinay Lakra

date 22 June 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT VL-1

This is the attachment marked 'VL-1' refers to the witness statement of Dr Vinay Lakra dated 22 June 2020.

Dr VINAY LAKRA *MBBS, MD, MHM, GAICD, FRACMA, FRANZCP*

Qualifications

- **FRANZCP (2007)** Fellow, Royal Australian and New Zealand College of Psychiatrists
- **FRACMA (2016)** Fellow, Royal Australasian College of Medical Administrators
- **Master of Health Management (2016)** University of New South Wales
- **GAICD (2018)** Graduate, Australian Institute of Company Directors
- **MD (Psychiatry) (2002)** Central Institute of Psychiatry, India
- **MBBS (1997)** Jawaharlal Nehru Medical College, India

Current Position

Director Clinical Services
North West Area Mental Health Service, North Western Mental Health, Melbourne Health
130 Bell Street Coburg VIC 3058

- Leadership role to promote safe, effective, high quality and coordinated care for patients and their carers with 247 EFT, 300 plus staff, $38 m+ budget over 6 sites
- Leadership to number of other teams including MHFIT, SUMITT, Private Practice suites and Psychosocial Research Centre
- Contribution to the development of strategic direction, innovation and service development at the service, network and organisation level
- Authorised Psychiatrist under the *Mental Health Act 2014*
- Teaching, supervising, managing and mentoring medical and other staff
- Clinical role including ECT and on call duties

Recent Positions

1. **Deputy Chief Psychiatrist** (0.5) (May 2016 – June 19)
   Office of Chief Psychiatrist, Department of Health and Human Services (DHHS)
   50 Lonsdale Street Melbourne VIC 3000
   - Statutory role and clinical leadership to support the Chief Psychiatrist
   - Member, Chief Psychiatrist's Morbidity and Mortality committee
   - Chief Psychiatrist nominee, Forensic Leave Panel
   - Member, DHHS Medical Workforce Planning Advisory Group
   - Panel member, Chief Psychiatrist's audit of inpatient deaths 2011-14
   - Review of reportable deaths and restrictive practices under *Mental Health Act 2014*
   - Several other projects during this period including Co-Chair for the development of Victoria's physical health framework for specialist mental health services, additional funding for personality disorder service and residential services (CCU/PARC) etc.

2. **Director Clinical Services** (full time 2011-2016) (0.5 May 2016 – June 19)
   North West Area Mental Health Service, North Western Mental Health, Melbourne Health
   130 Bell Street Coburg VIC 3058

Key committee memberships

- Member, Mental Health Expert Reference Panel for The Fifth National Mental Health and Suicide Prevention Plan
- Member, National Mental Health Policy Renewal Project Steering Group
- Member, Digital Mental Health Advisory Group, Australian Commission on Safety and Quality in Health Care
- Chief Psychiatrist nominee, Victorian Forensic Leave Panel

Roles & affiliations with professional and other organisations

- Royal Australian and New Zealand College of Psychiatrists
  - President Elect, RANZCP (2019 – 21) to be followed by a term as President (2021 – 2023)
  - Chair, Audit Committee & Members' Advisory Council of the Board (2019 -)
  - Elected Director, RANZCP Board and various roles including Chair, Finance Committee of the Board and Member, Membership Engagement Committee & Audit Committee (2018 - 19)
  - Deputy Chair, member and various other roles, Committee for Specialist International Medical Graduate Education (CSIMGE) (2012-19)
- Council Member, Australian Medical Association Victoria
- Graduate member, Australian Institute of Company Directors (2017 -)
- Surveyor, The Australian Council on Healthcare Standards (2013 -)
- Associate Fellow, Royal Australasian College of Medical Administrators (2007 - 15)
- Life Fellow, Indian Psychiatric Society

Previous positions

- **Acting Director Clinical Governance** (2012 - 13)
  North Western Mental Health, Melbourne Health, Parkville VIC
  - Medical leadership role across the network including Chair of Clinical Directors' meeting
  - Chair, Safety & Clinical Risk Management committee, Clinical Improvement & Innovation committee

- **Consultant Psychiatrist** (2010 - 2011)
  North West Area Mental Health Service, Coburg VIC
  - Worked as a Consultant Psychiatrist in community and PARC setting. Involvement in development of model of care for PARC from its inception in collaboration with clinical and non-clinical support staff

- **Medical Director** (2010)
  Mental Health (East Cluster), Western Sydney Local Health Network
  Mental Health Network, Cumberland Hospital, Westmead NSW
  - Medical leadership role including Medical Superintendent role under the Mental Health Act
  - Mental health services include inpatient services (acute and rehabilitation – 290 beds) based at Cumberland Hospital, community mental health services (six sites including community rehabilitation) and speciality services at Westmead Hospital (Consultation Liaison, medically complex patients' inpatient unit, eating disorder, perinatal mental health and neuropsychiatry).

- **Deputy Director Clinical Services** (2007 - 2010), **Consultant Psychiatrist** (2004 – 2010), **Senior Registrar** (2004)
  Mid West Area Mental Health Service, Sunshine VIC
  - Clinical and leadership role including Director of ECT program
  - Development of the medical workforce, professional leadership of medical services; and directing, supporting and overseeing the clinical governance systems including application of Mental Health Act within the health service
  - membership of several service development and quality improvement committees (Access Improvement, Pharmaceutical Utilization Committee, Dual Diagnosis Implementation Committee, Assertive Linkage Service Project, Outcome Measurement Strategic Plan group etc)
  - Lead Consultant Psychiatrist (2007-2009) for the Sunshine Acute Adult Psychiatry. Led the unit during the Access Improvement Project and the unit was awarded the Melbourne Health Celebrating Excellence Health Care Award for the Experienced Based Design Project in 2008

- **Junior & Senior Resident in Psychiatry** (1999 - 2004)
  Central Institute of Psychiatry, India
  - Advanced training in Psychiatry following successful completion of MD. Role and responsibility included providing assessment and treatment of psychiatric disorders in hospital and community setting besides supervising junior trainees.
  - Three-year full-time work and training program for Doctor of Medicine (MD) in Psychiatry. Training was based in one of premier institute in India. Training program included a research thesis, written examination and a clinical examination

Key professional development activities

- Meeting professional development requirements of RANZCP and RACMA
- Company Director's Course, Australian Institute of Company Directors, 2017
- Melbourne Health / Advisory Board Company leadership program, 2012 - 14
- Melbourne Health / Melbourne Business School "Chameleon Program – Challenging Leaders" 2014
- Executive Clinical Leadership Program, Clinical Excellence Commission, NSW Health, 2010

Other activities

- Melbourne Health excellence awards & recognition for several improvement projects -
  - creating a safe environment – (addressing safety issues in NWAMHS)
  - reducing seclusion in inpatient setting
  - improving experience of care in inpatient unit
  - carer peer support initiative
  - redesign of committee structures to reduce waste and improve communication
- TANDEM award – First mental health service in Victoria to receive an award from a peak organisation for Carers
- Coaching and peer support program for junior doctors and specialists
- RANZCP examiner

Recent presentations

- Suggett, J., **Lakra, V**., & Barrowman, J. (2018, October). Influenza vaccination for consumers: Introducing a pilot program within a public mental health service. In *International Journal of Mental Health Nursing* (Vol. 27, pp. 46-46).
- **Lakra, V**., Rudolph, D., Jagadheesan, K., Mouat, S., Barrowman, J., Babb, J., Hope, J., Keks, N. (2019, May). Sexual safety in residential mental health settings. RANZCP Congress.
- **Lakra, V.** (2019, Dec). A Collaborative Approach to Improve Safety and Quality in Clinical Care. Invited presentation to Annual Scientific Symposium of the Hong Kong College of Psychiatrists.
- **Lakra, V.** (2020, Jan). Safety and quality in digital era – Global challenges, local solutions. Invited presentation to Annual National Conference of Indian Psychiatric Society.

Publications

- Hatcher, S., Handrinos, D., & **Lakra, V**. (2007). The first year of the RANZCP Exemptions Candidates Examination. *Australasian Psychiatry*, *15*(6), 494-498.
- Das, P., Jagadheesan, K., Walker, F., **Lakra, V**., Lautenschlager, N. T., Ferraro, A., & Rudolph, D. (2019). Is There a Change in Electroconvulsive Therapy Practice Following the New Mental Health Act 2014 in Victoria?: A Study at a Metropolitan Mental Health Service. *The Journal of ECT*.
- Natural cause mortality of mental health consumers: a 10-year retrospective cohort study (submitted for publication)

- Short-term and one-year outcome of patients with borderline personality admitted to a short term recovery oriented residential program (submitted for publication)
- Characteristics and clinical outcomes of patients attending a Victorian metropolitan crisis intervention team (submitted for publication)

Current projects

- Ultra-brief right unilateral electroconvulsive therapy for acute treatment in adult public mental health service
- STORI-30: a valid outcome measure of psychological recovery in prevention and recovery care (PARC) program
- Predictors of acute psychiatric readmissions to adult psychiatric units: a systematic review
- Life after clozapine cession: treatment choices and course of illness post cessation of clozapine – a retrospective follow up study