WITNESS STATEMENT OF DR MARGARET GRIGG

I, Dr Margaret Terese Grigg, Chief Executive Officer, of Thomas Embling Hospital, Yarra Bend Road, Fairfield VIC 3078, say as follows:

1 I am authorised by the Victorian Institute of Forensic Mental Health (**Forensicare**) to make this statement on its behalf.

2 I make this statement based on 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

3 My full name and title, together with postnominals, are as follows: Dr Margaret Terese Grigg, PhD, MS (Health Policy & Administration), MBio, BA, RN, RPN.

Qualifications and experience

4 I am an experienced senior executive and mental health professional with extensive experience across the health and mental health sectors.

5 My qualifications are as follows:

(a) Ph.D. Department of Psychiatry, Melbourne University;

(b) Master of Science (Health Policy & Administration);

(c) Master of Bioethics;

(d) Bachelor of Arts;

(e) Registered Psychiatric Nurse; and

(f) Registered General Nurse.

6 My previous roles include the following:

(a) Executive Director, Health Service Policy and Commissioning, Department of Health and Human Services (**DHHS**);

(b) Director, Mental Health, DHHS;

(c) Deputy Chief Executive, Mind Australia; and

(d) Senior Mental Health Nurse, DHHS.

7 Attached to this statement and marked 'MG-1' is a copy of my Curriculum Vitae.

Background in mental health

8 My background in mental health began many years ago when I trained as a mental health nurse at Plenty Psychiatric Hospital. Since then, I have held numerous roles across the health and mental health industries, including the roles set out in paragraph 6 above. As Executive Director, Health Service Policy and Commissioning at DHHS, I had responsibility for governance, performance and policy within Victorian health services, including mental health. I have also been involved on a national and international scale, including at the World Health Organization (**WHO**) in Geneva for the WHO's Department of Mental Health and Substance Abuse on mental health policy and legislation.

Current role and responsibilities

9 In my current role as CEO of Forensicare, I am responsible for the overall operations of Forensicare and lead an executive team to ensure the strategic objectives of the organisation are achieved.

PANEL QUESTIONS

Designing a graduated system of mental health services and supports for different levels of need

The following questions are directed to the design of the future community mental health system. In your responses, please identify any examples of best practice in other jurisdictions.

Question 1: What is needed to support people to self-manage their mental illness (where appropriate) in the community?

10 In order for consumers living with a mental illness to successfully self-manage their illness in the community, they need to have access to a comprehensive suite of services that address not only their mental illness but also their community support needs (such as housing, alcohol and other drug needs, education and training, employment and living skills).

11 At Forensicare, we support our patients to self-manage their mental illness as an integrated component of their rehabilitation process, which is recovery-oriented and aims to support them to return to the community. This rehabilitation process includes individual therapy and a structured group program that focuses on areas such as mental health, substance misuse and offending behaviour, as well as links them with community support services such as housing and employment. In addition, we support our patients to rebuild

their natural support systems (including supporting their ongoing relationships with families and friends).

12 When I was working for Mind Australia, we established a recovery college. A recovery college has three important elements:

(a) it has a focus on using education principles to assist people to develop the self-management skills required to manage their own mental illness;

(b) it is co-designed by people with lived experience who have the knowledge and skills that people living with a mental illness would want to know; and

(c) the education is co-delivered by people with lived experience.[1]

13 In the United Kingdom, the recovery college model is very active and there are established programs in the delivery of forensic mental health services. These programs use co-design principles to develop and deliver educational programs that support people within the forensic mental health system to develop the skills needed to self-manage their mental illness when they leave hospital. To date, there have been limited examples of recovery colleges in Australia, noting that the Western Australia government announced in 2019 that a recovery college is to be established.

14 Should the Royal Commission support the establishment of a recovery college in Victoria as part of a future mental health system, Forensicare is ready and willing to assist with this, as an adjunct to our existing rehabilitation services.

Question 2: What is needed to make specialist mental health expertise available to general practitioners and other service providers?

15 There have been attempts at making specialist mental health expertise available to General Practitioners (**GPs**), but they have not been sustained.

16 Victoria established primary mental health teams to support GPs over ten years ago, but the increasing demand for acute services has resulted in many mental health services redirecting these resources away from supporting primary care to responding to acute or urgent demand.

17 I was previously the Project Manager at St Vincent's Mental Health Service for the 'Partnership Project', which was a joint trial between the Commonwealth and State governments that aimed to improve the coordination of services across public and private psychiatry and general practice. This project was successful in strengthening the

[1] Sarah Pollock, Robyn Callaghan and Craig Hodges, 'Research, Development and Advocacy: Establishment of the Mind Recovery College' (Research Report, Mind Australia, October 2013).

relationship between public and private mental health services and providing additional support for GPs, and was evaluated in several publications.[2] However, the improvements were not sustained when funding for the project ceased.

18 The project also explored strengthening the linkages between public and private mental health services to increase choices for patients and better manage demand within the public services. However, we identified limited options for the transfer of patients from public services, as public and private services tended to provide services to people with quite different needs, there was a high proportion of patients in the public system on involuntary orders (who had to receive treatment in public services), and private services tended to have a lower risk threshold of suicidal and self-harm behaviours.

19 Building on the experience of primary mental health teams, the Royal Commission should explore service design principles that would increase the support available for primary care to more effectively treat people with a mental illness with support from secondary care providers (such as area mental health services and private psychiatrists).

The Commission's Interim Report defines community-based clinical mental health services as 'services that are made available to people outside hospital settings—often in their own homes, in community facilities or by phone'. These include specialist mental health services and psychosocial supports.

Question 3: Considering a future mental health system (10 years into the future), what types of care, treatment and support should most appropriately occur:

a. in hospitals?

20 There will always be a need for hospital-based care to provide assessment, treatment and care for people who are unable or do not want to be treated in the community.

21 My aspirations for the future include having a variety of hospital-based treatment options available for people, including short-term treatment options that people could access earlier in their episode of care to prevent them from becoming acutely unwell. Inpatient units should provide a therapeutic environment that promotes healing and recovery for patients as well as the safety of staff, consumers and visitors. There should be a multi-disciplinary workforce that includes peer workers. Length of stay should reflect people's needs. In particular, a person's length of stay should not be curtailed to enable the

[2] Pirkis J, Livingston J, Herrman H, Schweitzer I, Gill L, Morley B, Grigg M, Tanaghow A, Yung A, Trauer T and Burgess P, 'Improving collaboration between Private Psychiatrists, the Public Mental Health Sector and General Practitioners: Evaluation of the Partnership Project' (2004) 38(3) *Australian & New Zealand Journal of Psychiatry,* 125–34;
Pirkis J, Herrman H, Schweitzer I, Yung A, Grigg M and Burgess P, 'Evaluating complex, collaborative programs: The Partnership Project as a case study' (2001) 35 *Australian and New Zealand Journal of Psychiatry*, 639–46.

admission of others who may be more acutely unwell (which is largely a result of demand outstripping supply in the current system).

22 Currently, the combined impacts of very short lengths of stay, heterogeneity of patient's needs, high levels of interpersonal violence and funding constraints have undermined the therapeutic nature of acute inpatient care. In stark contrast to many acute environments, Thomas Embling Hospital (**TEH**) offers green space, partial segregation of genders and a structured, recovery-oriented rehabilitation program with a strong focus on ensuring patients can engage in meaningful activities. The long lengths of stay for our forensic patient cohort contribute to a strong sense of collegiality between patients. Similarly, the relative stability of our workforce facilitates positive therapeutic relationships between patients and staff.

23 There is also a role for low security hospital units outside the TEH facility that offer an extended length of stay of between two and five years. Such units should cater for consumers with complex needs, including those discharged from TEH, thereby reducing the demand for acute inpatient units. The units should support the treatment and rehabilitation of consumers whose behaviour poses a significant risk to others, with a model of care informed by the principles of forensic mental health but without the high security restrictions of TEH.

b. in the community?

24 Acute mental health care can be delivered across a range of settings including hospital, residential (for example, through Prevention and Recovery Care services and Community Care Units) and in the home (for example, through crisis teams). The site of care is less important than ensuring that the intensity and focus of care can meet the needs of the person. As people's needs become more complex and risks increase, they are more likely to need hospital care.

25 It is possible to deliver complex, specialist services to people at home. However, this relies on rebuilding a comprehensive community-based service that is able to deliver intensive acute treatment to people in the community. In the early 2000s, Victoria's network of crisis assessment and treatment services that were available in the community were the envy of many jurisdictions. Reduced funding and increasing demand for acute care has resulted in the demise of this service model in most areas. The re-establishment of 24 hours, 7 days per week crisis support services across all regions should be considered by the Royal Commission.

26 Hospitals need to retain strong linkages and connections with community-based services, to ensure that the transition of consumers back to community care is effective and care is continuous. For example, at TEH, forensic patients on custodial supervision orders

have extensive transition planning and preparation to get them ready to return to the community; this includes providing graduated leave from TEH, identifying community supports and linkages, and transitioning the provision of care to area mental health services. This ensures that there is no disruption to consumers' recovery as they leave hospital, which gives them a greater chance to thrive in the community. The linkages between hospitals and community-based services are critical in the successful transition of consumers back to the community.

STREAMING

Question 4: Considering how the mental health system might be designed around streams of care for people with different types of strengths, needs and characteristics:

a. Should there be different streams of care (e.g. for age, severity, diagnostic group, stage of care, gender)?

i. If so, along what criteria and why?

Rationale for streaming

27 Streaming (by way of age, gender, culture, disease or stage of care) occurs when there is a sufficient number of patients with similar needs that allows for the development of a standardised model of care, and it can occur in both hospital and community settings. It is a strategy used not only in mental health services, but also across the health system more broadly. Based on all available evidence, treating consumers with like needs in a similar way delivers more effective and efficient care because the model of care can be better tailored to the consumers' needs and reduces unnecessary variation in care.

28 In acute physical health, the evidence for streaming has often focussed on the relationship between the volume of activity and patient outcomes (for example, whether a surgeon needs to do a certain number of operations per year to be able to perform them safely). System capability frameworks, in areas such as maternity and newborn care, have been developed by the DHHS to support this.

29 In mental health, we already see some streaming in mental health services such as by age (for example, child units), diagnosis (for example, eating disorders) and occasionally gender. There has, however, been less evidence of the relationship between volume of activity and patient outcomes, and streaming approaches have focussed more on balancing the efficiency of services with accessibility. For example, it may be possible in a large metropolitan area to have separate inpatient units for men and woman, but this may not be possible in smaller rural communities.

Addressing the potential negative impacts of streaming

30 Streaming approaches can increase the inefficiency within the system if it cannot adapt to changing client needs and mixes. For example, it would be inefficient if beds in one unit are left empty through lack of demand among one cohort, while another unit has excess demand and people in need of care. Contemporary approaches are trying to tackle this problem through infrastructure design that creates greater flexibility in the use of space.

31 Specialisation encourages the development of specific skills to provide effective treatment for specific cohorts of consumers, enables research and supports innovation. However, there are negative impacts including:

(a) Specialisation can cause fragmentation of skills, with the workforce becoming more specialised and consequently less able to provide effective care for people with different or broader needs.

(b) Specialisation can drive inequity. Concentrating specialised services in one or two geographical areas may result in these services being less accessible, especially to consumers in rural and regional areas.

32 The development of mental health capability frameworks would provide a system architecture to describe the services that should be available at a local, regional and state-wide level, and which includes referral and support processes. For example, in forensic mental health, a capability framework would clearly articulate the services to be provided directly by Forensicare, the services to be delivered in partnership with area mental health services and the services to be provided directly by area mental health services. A capability framework would also include details of workforce capabilities to inform education and training initiatives.

Criteria for streaming

33 In my experience, most people accept that there should be age-based streaming, although how the age groups are divided is more contested. The age of a consumer has some impact on what mental health disorders are likely to present and therefore the models of care. For example, eating disorders do not commonly present in people of older ages while dementia does not commonly present in people of younger ages. What is contested are the boundaries of the age streams.

34 Gender-based streaming has also been widely supported, although there are limited examples in Victoria. I am very persuaded by evidence that women in the mental health sector have often been victims of sexual violence, mixed-gender residential services have increased risks of sexual violence, and concerns about sexual safety in such services can

be re-traumatising and triggering for many female consumers. Many female consumers have told me they would prefer to be treated in a women-only hospital setting. The development of a women-only precinct is a priority for the redevelopment of TEH (please see paragraphs 133 to 135 below).

35 Streaming may also be available for the stage of illness – for example, community care units are typically utilised by people who have substantial disability associated with their mental health issues.

36 There are limited streaming options currently available for adults in the acute phase of their illness, despite significant differences in their needs. As a result, the risks to vulnerable people are increased if they are treated alongside others who pose, for example, a risk of violence or exploitation. In particular, there are advantages of separating people with significant substance use problems from people who do not have such problems, particularly if they are at an increased risk of violence. Streaming options in acute mental health settings should be considered by the Royal Commission.

b. What are the alternatives to streaming (e.g. individualised packages)?

c. What are the strengths and weaknesses of these alternatives?

37 As long as there are bed-based services, some streaming will be needed. While other options such as individualised packages may support some people to avoid hospital, they will not avoid all admissions. However, streaming should be designed with as much flexibility and choice as possible, particularly to ensure that consumers in rural and regional areas are not disadvantaged. For example, a female consumer in Mildura could have a choice between a gender-segregated service in Melbourne and a mixed gender unit in Mildura. Infrastructure design, could also be used more effectively to support streaming (for example, using swing beds or pods to create flexible spaces).

38 Options for more individualised approaches may be more possible in less acute care or community settings (for example, a consumer may be provided the option of intensive home support rather than being admitted as an inpatient). Individualised packages are another way of increasing the choices for a consumer.

CATCHMENTS

Question 5: Should mental health services in Victoria continue to be delivered on a geographic catchment basis?

a. What are the advantages and disadvantages of catchments?

39 The catchment approach provides a strong basis for population planning and creates a safety net for vulnerable consumers to ensure that there is clarity on which service is

responsible for providing care. Catchments are also useful for considering resource allocations and monitoring population outcomes such as suicide rates.

40 While catchments are useful, there needs to be more options for individuals to choose the service they want to receive care from so as to provide consumer choice that is equivalent to that available in acute physical health care – that is, individuals should be able to decide which mental health service they want treatment from, and they are not forced to receive care from a service because of their home address. This could also provide an opportunity for greater subspecialisation, with mental health services developing specific services in response to consumer demand.

41 However, mental health services cannot pick and choose who they will treat and need to be responsible for any consumer that they come into contact with. This includes consumers who may have complex needs, pose risks to the health services or are high service users. Mental health service catchments should provide a safety net for service delivery so that every single person has access to mental health care.

42 One of the practical limitations of increased consumer choice is the current funding model, which is largely input-based and does not allow funding to be shifted from one mental health service to another.

43 Another significant limitation of geographic catchments that are based on an individual's residential address is that not everyone has an address. There is often a lack of clarity as to which mental health service is responsible for people who are homeless or have unstable housing.

44 Homelessness or unstable housing is often a significant issue for people living with a mental illness. This is particularly the case for those people living with a mental health issue who are leaving prison. In 2018, 54% of prisoners expected to be homeless upon release from prison.[3] The current catchment approach makes it difficult to link people leaving prison without a permanent address to mental health services to facilitate continuity of care. Treatment discontinuity increases the risk of both relapse and recidivism.[4]

b. Could these advantages be achieved through alternatives to catchments?

45 It would be possible to design a system that provides greater certainty and choice for people, without necessarily eliminating all aspects of the catchment-based approach.

c. What are the risks of abolishing catchments for mental health services?

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3 Australian Institute of Health and Welfare, *The health of Australia's prisoners* (Report, 2018) 22–5.

4 Kinner SA, Streitberg L, Butler T and Levy M, 'Prisoner and ex-prisoner health: improving access to primary care' (2012) 41(7) *Australian Family Physician*.

46 The biggest barrier to removing catchments is developing a funding model that funds services by reference to both the number and complexity of the consumers they support. While this is a significant barrier, I don't believe that these issues are insurmountable and have been solved in other areas of health care.

Question 6: If catchments are to remain an element of the mental health system, how should they be configured?

a. What are the risks and benefits associated with larger regional catchments such as the Primary Health Network (PHN) catchments?

47 Larger catchments are better for service planning, commissioning and resource allocation because of scale, but tend to be less useful for service delivery and governance where an understanding of local issues is important. For example, the Western Victorian PHN currently covers three catchments and has acute inpatient beds in three regional cities. There is some argument for this area to be the basis for planning and commissioning. From a governance perspective, there are already three acute health providers involved in acute service delivery within the PHN catchment to diverse communities. Integrating these providers into one provider risks undermining mainstreaming and delivering services out of step with community needs. However, it would be possible to develop partnership approaches to better link planning, governance and delivery.

48 The issue of governance of mental health services is an important consideration for the Royal Commission. The complexity of the mental health system is that there is no single agent that can be responsible for all the mental health outcomes of a community. Many organisations (including public and private mental health services, non-government organisations, community services and general practitioners to name a few) will need to play a role in a new system. System design should consider not only the allocation of responsibilities to different parts of the system, but also the incentives for the different parts to work together to deliver better outcomes for the community.

b. What are the risks and benefits associated with only using catchments for planning and resources allocation (i.e. similar to the broader health system), rather than for determining consumer eligibility for services?

49 This is discussed in paragraphs 40 to 46 above. Whilst there is more room for consumer choice, there needs to be clear obligations on mental health services to ensure they respond to the needs of their community, including by providing services to consumers with complex needs.

SERVICE PROVIDERS AND DELIVERY MODELS

Question 7: In service 'hubs' a range of services are co-located in the same geographical area. What are the strengths and limitations of service 'hub'?

50 The idea of a hub is an attractive design feature but the devil is in the detail – a hub can be very effective in providing more integrated services for people living with a mental illness or can simply be what we already have today, but called a different name. There needs to be clarity on the purpose of the hub – that is, whether the purpose of the hub is to develop access points to navigate the mental health system or to deliver integrated health and social services (or both).

51 There are currently many versions of hubs that exist today such as Headspace, the Orange Door and Melton Health and Community Services health hub. Each of these hubs operates with a different emphasis on access and navigation as well as a different approach to service delivery.

52 Designing a hub to support people experiencing mental ill health is complex. People with mental health issues typically have multiple needs. They need help with navigating the mental health system, connecting with other services and accessing evidence-based treatments. A hub should ensure people have access to a broad range of treatments, including psychological treatments, as well as broader psychosocial supports such as housing and employment.

53 A hub should also have clear and accessible entry and navigation mechanisms, as well as access to key interdependent services. This ensures that people living with mental ill health are empowered to take charge of their own recovery. A hub should be a place that is properly incentivised to connect people to the services that support recovery (for example, connections with physical health services, non-governmental organisations, National Disability Insurance Scheme services and Centrelink).

Question 8: How should services within the mental health system be coordinated?

54 In designing a mental health system, it is important to consider the coordination of services within the system in two ways:

(a) the coordination of health and social care services at local levels; and

(b) the coordination of an individual's mental health care.

55 There have been many approaches to system coordination over the past 20 years. More recently, PHNs have played an increasingly important role in system coordination. Similarly, there is evidence that roles such as patient navigators or care coordinators can contribute to the coordination of a person's care where they are interfacing with multiple health and social care systems.

a. To what extent should consumer choice determine the nature and volume of care received?

56 Consumer choice should, as far as possible, determine the nature and volume of care received. This needs to be balanced against the severity of the illness and the risks to themselves and others including staff.

57 It is more difficult to have choice when services are provided compulsorily under the *Mental Health Act 2014* (Vic) (**Mental Health Act**). Advanced directives and supported decision-making have gone some way to providing greater choice for consumers subject to involuntary treatment, but further improvement is possible.

b. What are the merits and challenges of a 'single care plan' approach to coordinating services?

58 Coordinating care through a 'single care plan approach' is desirable and increasingly feasible. Much was learnt through the 'Partners in Recovery' program, a Commonwealth-funded complex care initiative.[5] The development of a 'single' care plan across different providers was central to the 'single care plan approach' in this program.

FORENSICARE'S SCOPE, FUNCTION, GOVERNANCE AND ACCOUNTABILITY

Forensicare's services and programs

59 Forensicare is the state-wide specialist provider of forensic mental health services in Victoria. Our services include a range of forensic mental health programs for consumers in contact, or at risk of being in contact, with the justice system. We provide services for people with varied needs who are at different stages of recovery: from assessment, early intervention and prevention, to inpatient care, rehabilitation and community support. As required by the Mental Health Act, we are also responsible for research, education and training in forensic mental health.

60 These services are delivered through:

(a) TEH: a 136 bed secure forensic mental health hospital that provides acute, sub-acute and rehabilitation services in separate male and female units as well as mixed gender rehabilitation units;

(b) Prison Mental Health Services: a range of mental health services are provided (including screening and, if appropriate, triage at reception, suicide and self-harm (SASH) risk assessments and support, and forensic mental health services) for 141 prisoners within specialist custodial units and through outpatient assessment and treatment, intensive case management and a community integration

[5] Jones A, Purcal C, valentine k and Aadam B, 'Partners in Recovery Evaluation' (SPRC Report 20/16, Social Policy Research Centre, UNSW Sydney, November 2016).

program. Services are available at most Victorian prisons, although the volume and mix available to individual prisoners varies across prison sites; and

(c) Community Forensic Mental Health Service: a suite of mental health services are provided for individuals living in the community (including those affiliated with key mental health, justice and community agencies) in the form of advice and consultation, supervision, care coordination, and treatment.

61 We also work in partnership with Swinburne University of Technology through the Centre for Forensic Behavioural Science (**CFBS**) to deliver a comprehensive forensic mental health research program, specialist training and ongoing professional education.

62 As part of the development of an investment proposal for the redevelopment of Forensicare's TEH site, Forensicare has commissioned PriceWaterhouseCoopers to commence the development of a new service plan. The objectives of this project are to:

(a) develop a demand model that builds on historical and current accepted projections for bed-based services and develops a wider focus on all points of service delivery within the scope of Forensicare's service remit;

(b) evaluate Forensicare's needs and objectives of future service design to re-envisage a patient-centric care model and to explore the impact of current and future state demand using a fit-for-purpose model (based on Forensicare's historical and current projections for bed-based services). This model will be able to test the impact of various scenarios, including identifying early prevention opportunities to maximise efficiency and to meet demand;

(c) document a preferred option for bed-based care in the service plan based on the findings and consultation process. The service plan will comment on key inputs relating to Forensicare's overall layout, types of treatment settings and the relationship between treatment units; and

(d) document a high-level design for integrated models of care in the service plan.

63 The first deliverable of the project is the bed-based service plan. This service plan is yet to be endorsed by the steering committee for the investment proposal but does make recommendations on the number and mix of beds needed at TEH. The bed-based service plan aims to:

(a) clearly delineate requirements by security, patient needs and acuity;

(b) increase capacity, particularly for sub-acute (2-5 years) care;

(c) meet current and projected gap in available beds;

(d) support optimal length of stay for patients;

(e) provide separate units for female patients;

(f) provide transition support for forensic patients returning to the community; and

(g) provide appropriate capacity for frail patients with medical co-morbidities.

64 Previous demand modelling conducted by the Victorian Health and Human Services Building Authority (**VHHSBA**) in 2019 has estimated a current deficit of 53 beds which is forecast to grow to at least 103 beds by 2025/26 and 139 beds in 2035/36.

Role of forensic clinical specialists in area mental health services

65 The Forensic Clinical Specialist Program (**FCSP**) was established to build forensic expertise and capacity in Victoria's specialist mental health system. Forensic clinical specialists are experienced forensic clinicians who are embedded within, and employed by, area mental health services to enhance sector capacity to support, manage and treat clients with co-existing vulnerabilities of serious mental illness and risk of contact with the justice system. Forensicare coordinates the FCSP and provides advice, training and support to the forensic clinical specialists.

66 The role of forensic clinical specialist has not substantially changed over time, although the number of positions available across the system have grown in response to the increasing demand by area mental health services for forensic capability within their services. There were 6 to 8 specialists when the FCSP were first introduced, and there are now 23 specialists.

Effectiveness of forensic clinical specialists in supporting consumers with forensic mental health issues

67 The FCSP is partially effective in that it does embed forensic mental health expertise in area mental health services, which better enables the services to effectively manage people with complex mental health needs. A small number of services have extended the role of forensic clinical specialists to help prisoners prior to their exit from prison, although this remains ad-hoc and inconsistent.

68 The most significant barriers to the forensic clinical specialists effectively supporting consumers are their workload and the limited support currently available to them from Forensicare. Area mental health services have reported that the growth in the number and complexity of consumers with forensic needs is placing significant strain on the capacity of forensic clinical specialists. This is exacerbated by other system issues, such as:

(a) the limited ability for Forensicare to support area mental health services in delivering care to clients with complex needs (other than through the FCSP) – for

example, such clients are unable to access specialist forensic beds at TEH). Perversely, Forensicare's specialist forensic mental health services can often only be accessed by those who are already engaged within the justice system; and

(b) the increasing number of consumers leaving prison on Inpatient Assessment Orders.

69 In addition, the role of forensic clinical specialists is designed predominantly to provide primary and secondary consultation, and there is limited opportunity for them to work directly with complex clients. Their role should be expanded to better support the transition of mental health care from prison to the community when a person with a serious mental illness leaves prison and needs to be linked to an area mental health service. The current handover of care that happens when the person is exiting prison is often nothing more than a passive handover of information, with the person themselves responsible for contacting the area mental health service to request treatment and support. Consequently, many people fall out of mental health treatment at this stage.

Enabling forensic clinical specialists to function more effectively in the future

70 The redesign of the role of forensic clinical specialists should be done in the context of system reform that provides increased options for the provision of forensic mental health services within area mental health services. This could include Forensicare playing a bigger role as a shared care partner in respect of complex cases.

71 Forensicare's Non-Custodial Supervision Order (**NCSO**) Consultation and Liaison Program (**NCSO Program**) provides an example of an integrated service where Forensicare and the area mental health services work together to ensure that consumers receives access to care close to their homes (through the area mental health service) and the specific risks associated with their offending are effectively managed (through oversight by Forensicare). Currently, this program is only available to a small number of consumers who are on a NCSO under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (**CMIA**); however, the model could be used to inform shared care models for complex cases in a redesigned mental health system.

72 The Forensicare Serious Offender Consultation Service (**FSOCS**) provides advice and consultation to Corrections Victoria (**CV**) in relation to consumers who pose a high risk of serious violent or sexual offending, so as to facilitate greater engagement between CV and area mental health services. This program provides an important role in facilitating better integration of the services delivered by CV and area mental health services, although it is small and there are likely to be significant opportunities to expand the program. Again, one of the critical weaknesses is there is limited access to forensic mental health treatment options.

73 From a system design perspective, a more planned networked approach to the delivery of forensic mental health services across the State would build on the learnings of both the FSOCS and the NCSO Program. Within a networked approach, Forensicare (as the State-wide forensic mental health provider) would ensure that forensic mental health capability is embedded within area mental health services, play an active role in the delivery of specialist interventions, manage and oversee risks, and support capacity building across more generalist mental health services.

Delivery of forensic mental health services in the future

Role of Forensicare

74 Forensicare plays an important role in providing mental health care to very vulnerable people. Forensicare needs to be agile so that it can respond to the challenges of the existing system and any recommendations from the Royal Commission. Forensicare provides several key functions within the system:

(a) Forensicare is a forensic mental health service providing integrated recovery-oriented services to people who have mental health issues and offending behaviour, as well as consultation and support to other providers. These services are described in paragraphs 60 to 62 above.

(b) Forensicare supports the broader mental health and justice system through knowledge generation, translation and innovation. A key role of the CFBS is to deliver this function.

(c) As the only Victorian health service that is focused exclusively on mental health, Forensicare has an important leadership role across the Victorian government, the mental health sector and the community more generally. In a redesigned mental health system, there is an opportunity for Forensicare to make significant contributions to improving mental health and community safety outcomes for all Victorians.

75 The Victorian Public Sector Commissioner's review of the capability of Forensicare provided us with a range of recommendations in respect of leadership, strategy, systems and stakeholder engagement.[6] These recommendations present an important opportunity for us to understand our current strengths and weaknesses as an organisation and are assisting us to develop a roadmap for the future, particularly in preparing for the Royal Commission's final report.

[6] Victorian Public Sector Commission, *Forensicare Capability Report* (Report, January 2020).

Key aspects of the forensic mental health system

76 The forensic mental health system in the future should:

(a) focus on preventing people living with a mental illness from becoming involved in the justice system;

(b) when people do become involved in the justice system, provide diversion options to support engagement with treatment and focus on rehabilitation rather than punishment;

(c) in circumstances where people are in prison, ensure prisoners can access the right treatment at the right time during their incarceration; and

(d) when people leave prison, ensure they are reconnected with mental health services to facilitate continuity of care and mitigate the risk of reoffending.

77 In relation to the delivery of forensic mental health services, there is no example of an ideal system from another jurisdiction that Victoria could adopt, although there are forensic mental health service systems in other jurisdictions that Victoria could learn from in designing a new system. Generally, the most effective systems are those with forensic mental health services that are provided through a specialist network with differing levels of security and that ensure criminogenic needs are addressed alongside the mental health and related needs (for example, comorbid substance abuse) – this ensures that the needs of people with complex issues who are likely to offend receive an effective and integrated service response.

78 As discussed in paragraphs 69 to 73 above, the embedding of specialist forensic mental health services within area mental health services to address the needs of people who are at risk of entering (or re-entering) the justice system would be a significant enhancement.

Enhanced therapeutic pathways

79 Enhanced therapeutic pathways for offenders living with mental health issues (for example, increased access to therapeutic courts and community-based sentencing options for offenders living with a mental illness) would provide increased options for diverting people into a treatment pathway rather than a punitive pathway. Ideally, such pathways would enable those offenders living with a mental illness to remain in the community (where possible) with access to services that both address the underlying circumstances of the offending and support rehabilitation and recovery. The expectation is that these pathways will better address mental health issues and simultaneously reduce the risk of reoffending.

80 Whilst the CMIA provides a legislative framework that recognises those who are mentally impaired when they offend should not be criminally responsible for their conduct, it sets a high threshold for the mental impairment defence and consequently diverts only a very small number of people from prison into treatment. Consequently, the CMIA does not provide a panacea for diverting those offenders with a mental illness into a therapeutic regime.

Current challenges

81 Insufficient beds in both the civil and forensic system, lack of appropriate models of care for people with complex needs who pose a high risk of interpersonal violence, lack of an integrated system across the mental health and justice systems, and siloed information systems that inhibit information sharing are also key issues the Royal Commission should consider.

82 A redesigned mental health system would ensure that access to TEH is available for the group of people with complex needs who pose a high risk of interpersonal violence and need medium or high security facilities. As well as addressing the immediate gap of 53 beds at TEH, expanding access to security inpatient units within the community that provide longer term rehabilitation (two to five years) based on best practice forensic mental health principles would fill a significant gap in the system (please also see paragraph 23 above).

83 Mental health care in prisons has not been planned as part of the broader mental health system. Programmatic service responses have been developed often in response to service gaps. This has resulted in a lack of consistency in mental health care within prisons. In particular, treatment options vary by location (which can result in disruption of care as prisoners move between prisons), there is poor integration between primary and secondary care, and linkages to ongoing mental health treatment are ad-hoc when people leave prison. For some prisoners, brief intervention is not effective, and there is limited opportunity for longer term treatment and rehabilitation in an inpatient setting such as TEH. Many of these issues are a consequence of historical underinvestment and lack of mental health system design within a correctional setting.

84 There is a lack of integration between the State-wide mental health information system, the Client Management Interface/Operational Data Store (**CMI/ODS**), and Justice Health's information system (which collects information on prisoners' mental health care). Information on prisoners' mental health care is not routinely collected in, or shared to, the CMI/ODS – this creates discontinuity in the prisoners' records of mental health care, as their receipt of prison-based services are not recorded. In a recent coronial investigation into the death of a prisoner shortly after their reception into Melbourne Assessment Prison, of which Justice Health, CV and Forensicare (amongst others) were all interested

parties, the Coroner found that the death would have been preventable if there had been a higher standard of information sharing between the parties. As a result, the Coroner made a recommendation for the parties to conduct a review and consider having a single source of health records.[7] The parties are currently considering this.

Diminished capacity for Forensicare to provide treatment for civil patients with very complex needs

85 TEH is currently the only forensic mental health facility available for:

(a) people placed on a custodial supervision order under the CMIA because of their mental illness (forensic patients); and

(b) Victorian prisoners requiring either compulsory treatment under the Mental Health Act or mental health treatment that needs to be provided in a hospital (security patients).

86 With TEH operating at capacity and increasing demand for treatment by both forensic and security patients, TEH has been unable to meet the demand of civil patients in recent years.[8]

87 Forensicare is currently working with the Victorian Health and Human Services Building Authority (**VHHSBA**) to finalise an investment proposal for the Victorian government that would support an expansion of forensic mental health beds (please see paragraphs 133 to 135 below).

Consequences of Forensicare's diminished capacity for area mental health services

88 As a result of Forensicare's diminished capacity to provide treatment for civil patients with very complex needs, area mental health services increasingly provide support for people with very complex needs (including those with substantial risks of interpersonal violence) with inadequate infrastructure, service models and specialist expertise. This has contributed to high levels of occupational violence, and conflicts and disagreements regarding where people can be safely and effectively managed. This problem has been exacerbated by the significant number of people who require hospital treatment when they leave prison and are released on an inpatient assessment order.

89 While the FCSP has provided some support in dealing with these issues, the problems identified in paragraphs 68 and 69 above have limited the effectiveness. In addition, a lack of appropriate bed-based options worsens the difficulties for area mental health services that are required to manage patients for lengthy periods in acute inpatient

[7] Finding into the death with Inquest of Brandon, Darren (COR 2018 2778) (6 April 2020).
[8] Victorian Institute of Forensic Mental Health, *Submission to the RCVMHS: SUB.0002.0030.0126* (5 July 2019) 4.

options, or provide limited support often focused on crisis management in the community (often resulting in the person reoffending).

Addressing the consequences of Forensicare's diminished capacity for area mental health services

90 There is a need to increase access to both acute and extended care beds for people who pose a high risk of interpersonal violence. Some of these beds will need to be in a medium or high security setting such as TEH. However, as part of a system redesign, the Royal Commission might consider having additional beds in low secure units that are able to provide longer term rehabilitative care for some to the consumers with complex needs currently being treated by area mental health services.

91 Appropriate building design and infrastructure is required to better enable treatment and care to be tailored to a contemporary and evidence-based model of care. A contemporary stepped model of care considers both the security risk and clinical acuity of patients – it requires that:

(a) consideration be given to the development of separate facilities for female and male consumers to allow for greater movement, reduced risks and improved ability to undertake care guided by trauma-informed principles. Female consumers at TEH are currently restricted in their ability to move across units, with only a single 12-bed unit dedicated to the acute, sub-acute and extended care of women;

(b) there is capacity to meet increasing demand for prison patients, civil patients and individuals living in the community. Access to an adequate number of high secure and medium secure beds remains central to the efficiency and effectiveness of community forensic programs. In the instances when community forensic programs (such as the NCSO Program, the Victorian Fixated Threat Assessment Centre, the Community Transition and Treatment Program) and Problem Behaviour Program) identify high risk individuals who require intensive treatment provided in a secure setting, the role of these programs is currently made impotent in the absence of access to beds. As a result, risk is shifted to the community rather than being addressed and contained in hospital, and adequate treatment for patients is not provided;

(c) consideration be given to different degrees of security in a single building or care stream. Ideally, each stream would consider variation in acuity design such as having two different bedroom layouts with different levels of observation for patients as the severity of their illness fluctuates, rather than transitioning patients to other units for increased observation or safer physical security. This should include the capacity to segregate consumers who pose a very high risk of

interpersonal violence to other consumers, so as to reduce the use of seclusion and ensure that vulnerable consumers are able to live with an appropriate level of freedom and amenity; and

(d) building design allows for flexibility in therapy space, with opportunities for consumers to access treatment, therapy and care across a range of therapeutic settings. These settings must consider the opportunity for individual and group therapy/programs that are accessible primarily from a therapy/programs hub, with accessibility to space in the unit for those who may not be able to move to such a 'hub'.

Most effective settings for compulsory treatment

92 Under the Mental Health Act, involuntary care can only be provided in a designated mental health service. I support this legislative provision, as it ensures that there is appropriate oversight of the treatment and care of people whose human rights are impacted by involuntary treatment.

93 People unfamiliar with the prison environment can confuse a custodial mental health unit with a mental health inpatient bed. Custodial mental health units in prison provide an opportunity to cluster people living with a severe mental health issue in one area to provide additional mental health treatment (like that of a community crisis team) and to separate vulnerable prisoners from mainstream prison populations. It is not a therapeutic environment and custodial officers remain responsible for the safety, security and welfare of the prisoner. In addition, there are significant limitations on the types of mental health treatment that can be safely provided in a prison environment. For example, the range and doses of psychotropic medication for people with acute mental health symptoms are limited by the inability to effectively monitor the physical side effects of the treatment, particularly when the person is in 23-hour lockdown. Risks are greatest for those medications given in psychiatric emergencies and in clozapine initiation; consequently, their use in a prison environment is limited.

94 Hospitals, such as TEH, provide a therapeutic environment, where a range of recovery-oriented interventions are available to the consumer. Many of these interventions are not available in prison. For example, a significant number of prisoners in a forensic mental health custodial unit will be held in 23-hour lockdown, impacting on the development of the therapeutic relationship between the prisoner and the treating team. Broader rehabilitative interventions, such as learning to interact safely with other people, are also absent.

Consumers with a disability and a mental illness

95 Whilst some of Forensicare's programs do not cater for those consumers with both a disability and mental illness (for example, the Problem Behaviour Program), Forensicare does support forensic disability services through provision of specialist psychiatric services to their consumers. As part of the redevelopment of the TEH site, we have also developed integration principles. These principles recognise the unique needs of our different consumers (including those with a disability), foster integrated models of care where possible, and support opportunities for strengthened partnership and collaboration.

96 Although collaborative arrangements between Forensicare and forensic disability services could always be improved, there are broader policy and system barriers to ensuring consumers with a disability and a mental illness receive the care they need. The recent ombudsman investigation into the imprisonment of a woman found unfit to stand trial highlighted many of the gaps in the mental health system.[9]

GOVERNANCE AND ACCOUNTABILITY

Forensicare's statement of priorities

97 The Statement of Priorities provides an important opportunity for Forensicare to understand the priorities of the Victorian government and to ensure Forensicare is focused on delivering the outcomes the government is seeking. To this end, it forms a key part of our annual operational priorities.

98 We report our progress on the Statement of Priorities to the DHHS on a quarterly basis and in our Annual Report. The Statement of Priorities is also included in my performance plan, and the Forensicare Board holds me accountable for achieving the agreed outcomes in it.

Forensicare's accountabilities to Justice Health for delivery of services

99 Justice Health is responsible for oversight of the delivery of health services within CV, including the delivery of forensic mental health services provided by Forensicare. The services provided by Forensicare are articulated in a range of contracts with both the Minister for Corrections as represented by Justice Health and private prison operators.

100 There are a range of key performance indicators and operational requirements that are routinely monitored and reported as part of the contractual arrangements. Justice Health contributes to the development of Forensicare's Statement of Priorities and attends the

[9] Victorian Ombudsman, *Investigation into the imprisonment of a woman found unfit to stand trial* (Report, October 2018).

quarterly performance meetings we have with DHHS. In addition, we have a monthly meeting with Justice Heath to discuss strategic issues.

Adequacy of the current public reporting available in relation to provision of prisoner health services

101 Public reporting can always be improved. I am concerned that prisoner mental health outcomes are not consistently included in the reporting of broader mental health outcomes to the Victorian community. The inclusion of prisoner mental health outcomes in existing public reporting would be an immediate and straight forward improvement.

OUTCOMES, QUALITY AND SAFETY

Assessment of clinical outcomes (including quality and safety outcomes) by Forensicare

102 Forensicare has a Clinical Governance Framework that describes its approach to quality and safety. This framework is consistent with the State-wide guidelines that have been developed by Safer Care Victoria.[10]

103 The Board oversees Forensicare's compliance with its Clinical Governance Framework and focuses on safety and quality issues though the Board's Safety and Quality sub-committee (previously known as the Clinical Governance sub-committee), which is currently chaired by Dr Ruth Vine. The Board receives a wide range of information related to safety and quality, including key performance data that the sub-committee uses to monitor Forensicare's clinical performance.[11]

104 Forensicare's Executive Director of Clinical Services is responsible for clinical outcomes across the organisation. These are monitored as part of the collection of routine outcome measures and through regular programs of audit and review that are a component of the Clinical Governance Framework.

105 Forensicare has identified opportunities to strengthen our Clinical Governance Framework and will be reviewing it in 2020 to ensure that it is aligned with our strategy and model of care.

106 Additionally, Forensicare is accredited by the Australian Council on Health Care Standards against national standards as part of a regular cycle of self-assessment and independent review.

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10 Safer Care Victoria, *Delivering high-quality healthcare: Victorian clinical governance framework* (Framework, June 2017).

11 Forensicare has produced details of the quality and safety information monitored by its Board in response to a Notice to Produce issued by the Royal Commission.

Assessment of consumer experience outcomes by Forensicare

107 Consumer experience is monitored through annual consumer experience surveys that are conducted at TEH, community forensic mental health services and prisons. In 2020, we will (COVID-19 permitting) participate in the *Your Experience of Service* survey that will allow us to benchmark consumer experience with other mental health services.

108 The monitoring of complaints is also an important window into consumer experience. Consumer complaints are monitored at the executive level and reported to the Board.

Public reporting of patient experiences and outcomes

109 Public reporting can always be improved and the public reporting of patient experiences and outcomes is important. Improvement in reporting necessarily requires investment in information systems that allow for the reporting of accurate and timely information.

Strengthening existing regulatory frameworks or independent oversight mechanisms to improve quality and safety

110 The State has made substantial improvements to the regulatory and oversight functions of Boards in response to the 'Targeting Zero' review,[12] particularly in strengthening the role of Boards in oversight of quality and safety. Forensicare has focused on ensuring its compliance with the recommendations set out in the report of this review.

111 Forensicare also has benefited from governance-related legislative reforms that were made to the Mental Health Act (in parallel with changes made to the *Health Services Act 1988* (Vic)).

YOUTH FORENSIC MENTAL HEALTH SERVICES

Current forensic mental health services provided for children and young people

112 Forensicare is one of six organisations delivering the Youth Justice Mental Health Program. Forensicare established this program in 2010 to improve access of young people (those aged 18-24 years) to mental health services, and to support the capacity of youth justice staff and mental health staff to effectively meet the needs of young people with mental health issues. Six dedicated clinical positions were funded to work with custodial and community youth justice services. One of these positions is the Forensicare Youth Justice Mental Health Coordinator, who provides support into the Parkville Youth Justice Precinct, as well as coordinates the program.

[12] Department of Health and Human Services, *Targeting Zero: Report of the Review of Hospital Safety and Quality Assurance in Victoria* (Report, October 2016).

113 In redesigning Victoria's mental health system, the Youth Justice Mental Health Program could be repositioned to take on a more active leadership role that better supports the capability of youth justice staff to understand and respond to the mental health needs of young people. Similar to my discussion in paragraphs 69 to 73 above in relation to the FCSP, there is an opportunity to better embed forensic mental health youth expertise across youth mental health services.

114 Forensic mental health services for children and young people are also provided by Melbourne Health (through Orygen's Forensic Youth Mental Health Service) and the Alfred Child and Youth Mental Health Service (**CYMHS**). We have a strong collaboration with Orygen, and provide additional specialist forensic support to Orygen as required. Orygen provides forensic youth mental health services in custodial settings and the Children's Court setting (including liaison services).

115 I understand that Orygen is currently commissioning three secure beds to provide acute mental health treatment to young people within the youth justice system under secure treatment orders.

116 There is currently no dedicated forensic mental health facility for children or young people who are found unfit to plead under the CMIA in the Children's Court.

117 The establishment of an appropriate model of care for children and young people under the age of 18 who are under the CMIA should be a priority. The model of care is particularly complex for this group, as the number of people in this group is small, their needs (gender, developmental, educational, criminogenic and mental health) are diverse, and there is a need to safeguard vulnerable children and young people. Currently, the only custodial setting available is a Youth Justice correctional facility which does not meet the treatment or therapeutic needs of the child or young person. Services should be provided within a mental health setting that supports recovery and ensures children and young people have access to the same range and quality of services as their non-CMIA peers living with mental ill health and those in the adult forensic system under CMIA.

Improving forensic mental health services for children and young people

118 Forensic mental health services for children and young people can be improved by ensuring that children and young people in custody have access to the same level of mental health care as they would in the broader community. A stronger focus on neurodevelopmental disorders and earlier intervention is also critical.

Specialist forensic mental health service for children and young people

119 It is important that there is a specialist forensic mental health service that can bring both best practice forensic mental health care and a strong understanding of the needs of

children and young people. Consistent delivery of routine, high-quality mental health care across all settings to justice-involved young people, who have been historically marginalised from the CYMHS system, would provide opportunities to improve long-term mental health outcomes and reduce the likelihood of these people reoffending. It is also important that the linkages with the adult system are strengthened to ensure effective transitions, and that there is investment in the development of a multidisciplinary workforce. Forensicare would welcome opportunities to support the strengthening of services for children and young people.

FUTURE COMMUNITY-BASED MENTAL HEALTH SYSTEM

Ideal mental health service response to an individual in crisis

120 The ideal mental health response to people being in crisis would be to respond before they are in crisis. An ideal mental health response service would be available 24 hours, 7 days per week, be available where the person is located, and have access to a range of options to support the person. It would also provide the person with options for accessing services other than through an emergency department, and would provide access to peer support to both that person and their carer. The use of technology could be explored further to improve access to, and efficiency of, this response service.

121 Mental health triage systems should be reformed so that there is easy access to assistance when needed and a consistent response across Victoria.

Role of clinicians

122 Clinicians need to provide assessment, treatment and support. Ensuring access to broader psychological and psychosocial interventions should be a priority; this would minimise the reliance on medication as the only treatment option.

Role of police

123 The role of police should be limited to circumstances where there is an immediate risk of harm to the person, their carers, a healthcare worker or the community.

Role of emergency departments

124 Emergency departments need to be able to provide comprehensive mental health assessment and immediate support for people who attend emergency departments. While there are opportunities to provide alternatives to emergency departments for many people, emergency departments will continue to be an important part of the system. There should be an evaluation of the Mental Health Emergency Department Crisis Hubs to inform future models.

Role of community-based services

125 Community-based services can provide important early intervention or alternative acute treatment options. There is significant evidence that crisis assessment and treatment teams offer safe and effective models of community-based acute care.[13]

Reducing the gap in community mental health services between service need and supply

126 Without additional funding, it will be hard to change a system that is struggling to meet demand, and which is focussed on a crisis response rather than prevention. The Royal Commission should consider how proportionally small investments can provide the levers for broader system change.

127 There is always room for greater efficiencies in the current approach to delivery of community mental health services, but it is difficult to realise them without increased investment. Areas for consideration for greater efficiencies could include growing peer workforces, redefining the role of non-government providers, exploring substitution models to reduce the need for bed-based services, and strengthening the capacity of other sectors (in particular, the primary care sectors) to support the needs of people with a mental illness.

Screening and triage services

128 The centralisation of triage would promote efficiency, could improve access particularly in regional areas, and would support greater consistency in the service response.

129 There is substantial evidence that screening and triage can effectively be provided through both the telephone and other digital mediums.[14] There has been a proliferation of more electronic interventions in triage services, including the New South Wales mental health triage services.[15] Systems that are developed within a robust clinical governance framework should not present any additional risk as compared to face-to-face assessments.

130 Specialised on-the-ground providers can deliver screening and triage functions with greater efficiency and quality, but they will need to ensure that treatment remains coordinated and responsive. There is much to learn from the role Ambulance Victoria plays in the triaging of, and response to, general health problems (in particular, their responsibility for managing the nurse on call).

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13 For example, see Smyth MG, Pelosi AJ, Hoult J, Jackson GA, 'The home treatment enigma. Home treatment—enigmas and fantasies' (2000) 320 *BMJ* 305.

14 Margaret Grigg, 'The pathway from demand to supply: an evaluation of three mental health triage programs in Melbourne, Australia' (PhD Thesis, University of Melbourne, 2003).

15 Lal S and Adair C, 'E-Mental Health: A Rapid Review of the Literature' (2014) 65(1) *Psychiatric Services* 24.

Supporting the mental health of communities in the aftermath of emergencies and natural disasters

131 There was a wide range of resources that informed my previous role as Assistant Director, Bushfire Psychosocial Recovery Team in supporting the mental health of communities after the 2009 Victorian Bushfires, including a rapid evidence review that was commissioned early in DHHS' response.[16]

PHYSICAL INFRASTRUCTURE

132 While I would agree with the critique of the current physical infrastructure in inpatient units, I am not an expert in design.

INFRASTRUCTURE PLANNING

Forensicare's infrastructure planning

133 Forensicare is working in partnership with the VHHSBA to advance an investment proposal to redevelop our TEH site and expand our bed-based capacity. This follows several previous proposals which have not proceeded. Currently, a capital and business case development team is engaged to complete master planning validation, a feasibility study and other work which is proposed to be submitted for consideration in due course.

134 In late 2019, a proposal was developed to seek clarity on key strategic options, including redeveloping the TEH site and inclusion of forensic disability capacity within the redevelopment. The proposal was developed through the auspice of a steering committee made up of the CEO of the VHHSBA (as the Chair of the committee) and representatives from Forensicare, the Mental Health and Disability branches of DHHS, Justice Health, the Department of Premier and Cabinet and the Department of Treasury and Finance (**Steering Committee**).

135 Forensicare is also undertaking critical work to finalise a renewed model of care and service plan (please see paragraphs 62 to 64 above), both of which will be key drivers in shaping our service delivery models and capital solutions.

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16 Penelope Hawe, *Community recovery after the February 2009 Victorian bushfires: a rapid review. An Evidence Check rapid review brokered by the Sax Institute for the Victorian Government Department of Health* (Report, 2019).

Future demand projections for forensic mental health services

136 Demand projections for bed-based services were finalised based on a demand model agreed to by the Steering Committee in late 2019. This now forms the basis of the proposal for the redevelopment of our TEH site and expansion of our bed-based capacity. The modelling process involved consultation with, and agreement between, DHHS and the Department of Justice and Community Safety, and is robust and in line with future requirements up to 2036.

137 Demand models are always limited by the assumptions of each model. They are sensitive to any policy settings that impact on future need. Nevertheless, I believe with the demand model agreed to by the Steering Committee is accurate in noting a substantial current gap of 53 beds in Forensicare's available services. Forensicare's current service planning aims to build upon and enhance modelling, while taking into account the breadth of Forensicare's services. This work is being undertaken in consultation with VHHSBA, Justice Health, area mental health services and other key parties.

Optimal settings for future delivery of forensic mental health services.

138 The future delivery of forensic mental health services should focus much more on prevention and early intervention, including greater access to specialist services in community settings. Further**,** Forensicare's services should be adapted to contemporary models of care, and Forensicare should have sufficient capacity to ensure access and equity of services to our clients. Please also see paragraphs 74 to 84 above.

RESTRICTIVE PRACTICES

Factors that influence the use of restrictive interventions

139 Leadership is one of the most critical factors in influencing the use of restrictive interventions within mental health services. In addition, a comprehensive approach that considers model of care, workplace characteristics (including peer workforce), infrastructure and culture is essential.

140 Workplace characteristics are important and include the confidence and capability of workforce, multidisciplinary engagement of peer workforce, culture of the unit, routine and activities for patients, and the availability of tools that assist early intervention.

141 One such tool is the Dynamic Assessment of Situational Aggression (**DASA**) which has been developed by the CFBS to assist in the predication and prevention of interpersonal violence in mental health settings.[17] Structured tools such as the DASA can assist

[17] Ogloff J and Daffern M, November 2006, 'The Dynamic Appraisal of Situational Aggression: An Instrument to Assess Risk for Imminent Aggression in Psychiatric Inpatients' (2006) 24 *Behavioral Sciences & the Law*, 799–813.

clinicians to identify aggression early and assist in the implementation of interventions that can assist in avoiding the use of more restrictive interventions.

142 The Safewards initiative has clearly demonstrated the effectiveness of culture in reducing the use of restrictive interventions (please see paragraph 148 below).

Actions service providers can take to reduce the use of restrictive interventions

143 Service providers need to engage in a multifaceted program to reduce the use of restrictive interventions. In the late 2000s, Forensicare had one of the lowest incidents of seclusion in the State, partially because of their participation in the Mental Health Beacon Project (one of the early systematic interventions that tackled seclusion).[18]

144 In 2019, following several years of increasing seclusion rates, Forensicare undertook a comprehensive external review of the use of seclusion across the organisation.

145 We are in the process of implementing all the recommendations of the review; while we have had no reduction in our overall seclusion rate to date, we have seen substantial improvements in seclusion practice.

Difficulties in reducing restrictive interventions

146 In the context of Forensicare, there are a number of factors that make it difficult to reduce restrictive interventions – these include:

(a) inadequate infrastructure that does not allow us to segregate consumers at risk in areas such as high dependency units;

(b) the significant delay in access to treatment for some prisoners, which limits opportunity for earlier interventions that would assist in avoiding seclusion; and

(c) some of the criminogenic characteristics of a small number of our consumers who have embedded behaviours that put staff and other consumers at an ongoing risk of violence.

Enabling staff to use restrictive interventions as a last resort

147 Leadership and workplace culture is critical in ensuring that staff use seclusion and restraint as a last resort.

148 Safewards is an evidence-based program that is currently available to support staff to reduce the use of restrictive interventions. This program includes a strong focus on both procedural and relational security. Forensicare has implemented it across all TEH units

[18] McKenna B, McEvedy S, Maguire T, Ryan J, Furness T, 'Prolonged use *of* seclusion and mechanical restraint in mental health services: A statewide retrospective cohort study' (2017) 26(5) *Int J Ment Health Nurs*, 491–499.

and is currently evaluating its impact. More broadly, we are engaged in an international study of its applicability in forensic mental health settings and are likely to adapt the program in the medium term to have a stronger focus on our consumers' criminogenic needs.

Consumers who experience multiple instances of restrictive practices

149 In Forensicare, there is a small number of consumers who are in longer term seclusion and would benefit from access to a segregation area – this would provide a more humane and therapeutic environment, while still protecting staff and other consumers from a high risk of interpersonal violence. These infrastructure needs are being considered in our capital planning process.

RESEARCH AND KNOWLEDGE TRANSLATION

Access to data to improve future services and outcomes

150 There are considerable opportunities for data linkage for service planning. Registries also play a critical role in monitoring outcomes for patients. Given the high cost of establishing registries, consideration should be given to ensuring prisoners are well linked into existing registries before considering the establishment of a new registry. In the context of mental health, ensuring all mental health information within prisons is recorded into the State-wide mental health information system (CMI/ODS) would be a cost-effective improvement.

151 The Royal Commission should also consider opportunities to improve information sharing between DHHS, Victoria Police, Courts and CV (please see paragraph 84 above).

Research outcomes of the CFBS

152 There is limited investment in the translation and scaling of CFBS' world leading research outcomes into practice. Insufficient research infrastructure and the high levels of competition for health research grant funds are substantial barriers to this. Forensicare is working closely with CBFS to strengthen the translation of their research outcomes into practice through, for example, the recent appointment of a joint nursing role across both organisations.

153 It is critical that the new Collaborative Centre levers off and coordinates existing research effort, including that of the CFBS.

WORKFORCE

Embedding continuous learning and improvement in professional practice

154 Continuous learning and improvement are hallmarks of professional practice. There are many structures currently in place to support professional practice, but it remains ad-hoc and service-dependent.

155 The perspective of lived experience should be provided throughout the learning process of professionals (beginning with undergraduate training) and integrated into all training programs. This will require significant investment to ensure that there is a lived experience educator workforce who can provide these services, and that professional training programs are incentivised to invest in utilising this expertise.

156 While forensic mental health is recognised as a specialist area of training for some disciplines (for example, psychiatry, nursing and psychology), there is still work to be done to build the workforce capacity of some of the smaller disciplines such as Social Work and Occupational Therapy. This should include the funding of educators who can support both the transition to practice and the development of discipline-specific skills.

157 Clinical supervision is '*a special type of professional relationship in which supportive direction, facilitative activities, and instructive critique is given by the supervisors to help the supervisee achieve their professional goals*'.[19] These professional goals should meet the identified operational needs of the organisation (or the organisation's discrete programs) in the continued development of profession-specific skills. Clinical supervision is also important in supporting teams and reducing some of the longer term risks of burnout among staff.

158 Forensic mental health emphasises the use of Structured Professional Judgement (**SPJ**) assessment tools to assess clinical risks such as violence and aggression. This approach is empirically based and encourages clinical expertise with the structured application. The results of this approach yields far more accurate results than an unstructured clinical prediction approach, which is highly subjective and inconsistent.

Forensicare's role in supporting practice and training

159 Forensicare plays a major role in supporting practice and training in the development of forensic mental health skills. These include:

(a) Undergraduate programs: Forensicare provides undergraduate programs across the disciplines forming part of its multidisciplinary treating team, including nursing, psychology, social work and occupational therapy. These programs expose

[19] Psychology Board of Australia, *Guidelines for Supervisors* (Guidelines, 1 August 2018) 8.

students to a variety of forensic mental health settings. The success of these programs is demonstrated by having graduates subsequently enrolling in Forensicare's transition to practice programs.

(b) Transition to Practice: Forensicare provides transition to practice programs across most key disciplines frequently combining these programs with a post-graduate qualification in forensic mental health. These programs are popular and numbers are usually limited by the amount of funding provided. Forensicare has recently expanded these programs to include enrolled nurses and nurses with experience in mental health and who want to transition to a forensic setting.

(c) Postgraduate programs: Forensicare partners with Swinburne University of Technology to provide postgraduate forensic mental health programs, particularly in nursing, such as the Forensic Education for Registered Nursing (**FERN**) program based on the Forensic Nursing Standards of Practice (2012) and Graduate Diploma of Forensic Behavioural Science.

(d) Continuous education opportunities: Forensicare, through CFBS, provides a significant number of short courses on forensic mental health issues to external agencies such as area mental health services, CV and private practitioners.

(e) Consultation and support: Through programs such as the FCSP, Forensicare supports the development of forensic mental health skills across the area mental health services.

(f) Support for non-mental health workforces: Forensicare supports the development of non-mental health workforces such as correctional officers. We also provide education, support and liaison services to our community service providers (including volunteer agencies, employment agencies and educational organisations) to support them in being able to work more confidently with people with a mental health history.

COVID-19

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

160 The mental health sector has demonstrated significant agility to adapt quickly in response to the challenges presented by the current COVID-19 pandemic. For example, Forensicare has adapted its service delivery model where possible to ensure continuity of service delivery through increased use of telehealth, and has increased hygiene practices across its sites (including TEH) to prevent the risk of an outbreak.

161 I think it is still too early to confirm my view on the emerging changes in mental health service delivery, as the pandemic is still ongoing. While, for example, increased teleconferencing is promising, I am aware that many of our consumers lack access to the

required technology and already experience substantial social isolation that may accentuate their feelings of loneliness.

Longer term opportunities for new approaches to service delivery

162 The emerging changes in mental health service delivery, as a consequence of COVID-19, will definitely lead to longer term opportunities for new approaches to services delivery. The increased use of technology provides an opportunity to strengthen both access to, and efficiency of, mental health services. If there has been a silver lining to this pandemic, it has been a great opportunity to shift care from emergency departments to other settings (including consumers' homes).

Adapting suicide prevention strategies in light of the COVID-19 pandemic

163 The pandemic will result in people who have had limited experience of mental health issues developing significant symptoms. Depression and anxiety are likely to grow. During times of crisis, it is important to ensure that there is adequate support available to people as soon as they develop symptoms. Consequently, it is an important time to increase support to primary mental health services, who will likely see this group in the first instance.

164 Substance use services should also get particular attention, as the pandemic has disrupted some treatment options. In addition, social isolation is likely to drive problematic substance use (noting that there is strong relationship between substance misuse and suicide).

sign here ►

print name MARGARET TERESE GRIGG

date 28 May 2020

ATTACHMENT MG-1

This is the attachment marked 'MG-1' referred to in the witness statement of Dr Margaret Grigg dated 28 May 2020.

Curriculum Vitae - Dr Margaret Grigg

PhD, MS (Health Policy & Administration), MBio, BA, RN, RPN

Summary of Skills

I am an experienced Senior Executive and mental health professional with extensive experience across the health sector. I am currently on CEO of The Victorian Institute of Forensic Mental Health (Forensicare). My previous role was Executive Director Health Service Policy and Commissioning with responsibility for governance, performance and policy within Victorian health services, including mental health. My key strengths are an inclusive transformational leadership style, strategy and policy development, system design, partnership development and financial management. I have excellent communication skills and has well established networks across government and the health and mental health sector. In 2017 I was named as one of Victoria's top 50 Public Sector Women by the

Professional experience summary

2019	**The Victorian Institute of Forensic Mental Health):** CEO
2017 – current	**DHHS:** Executive Director Health Services Policy and Commissioning
2016 – 2017	**DHHS:** Director Mental Health
2011 – 2016	**Mind Australia:** General Manager Research Development & Advocacy/Deputy Chief Executive
2012 – 2016	**Kyneton District Health Service:** Board Member and Deputy Chair
2004 – 2011	**Victorian Department of Health:** Senior Nurse Advisor/Asst. Director
2003 – 2004	**World Health Organization:** Technical Officer
2001 – 2003	**Bendigo Health Care Group / La Trobe University:** Senior Lecturer
1997 – 2001	**St Vincent's Mental Health Service:** A/Manager / Team Leader
1994 – 1996	**Mental Health Services, Darwin:** Assistant Director of Nursing
1990 – 1994	**Fairfield Hospital:** Clinical Nurse Consultant
1989 – 1990	**Peter James Centre:** Community Psychiatric Nurse
1987 – 1989	**Alfred Hospital:** Nurse Educator/Staff Nurse

1985 – 1986 **Bundoora Extended Care:** Community Psychiatric Nurse

1984 – 1985 **Plenty Psychiatric Hospital**: Psychiatric Nurse

1982 – 1983 **Alfred Hospital**: Staff Nurse

1979 – 1982 **Geelong Hospital:** Student Nurse

Education

2000 – 2004: Ph.D. Department of Psychiatry, University of Melbourne

1995 – 1999: Master of Science (Health Policy & Administration), Wollongong University

1993 – 1996: Master of Bioethics, Monash University

1986 – 1989: Bachelor of Arts, Swinburne Institute of Technology

1983 – 1984: Psychiatric Nurse Training, Muriel Yarrington School of Psychiatric Nursing

1979 – 1982: General Nurse Training, Geelong Hospital

Professional Experience

Department of Health and Human Services (2016- 2019)

Executive Director Health Service Policy and Commissioning/Director Mental Health

In 2016, I returned to Government as the Director Mental Health. I was responsible for 60 EFT and a budget of $1.2 billion providing leadership and direction on the implementation of the 10 year mental health plan and fostered linkages with key intersecting reforms including NDIS, rough sleeping strategy and Road Map to Reform.

In 2017 I was promoted to Executive Director responsible for 360EFT and a budget of $12 billion. My responsibilities broadened to include health services governance, performance, key policy and programs such as mental health, emergency, elective surgery and medical research.

Achievements

- Delivered priority health service performance targets in 17/18
- Led health system NDIS mainstream interface issues for Victorian Government
- Achieved priority health targets across ambulance, emergency and the elective surgery waiting list
- Strengthened governance and oversight of mental health within overall health system
- Finalised first Mental Health Annual Report and outcomes framework
- Delivered key government priorities including Suicide Prevention Plan

- Developed consultation strategy for the Victorian Royal Commission into mental Health
- Victorian representative on the Mental Health Principal Committee, sub committee of AHMAC and Chair of the advisory committee for the development of a National Suicide Prevention Implementation Strategy

Mind Australia (2011- 2016)

Mind Australia is one of the largest community managed mental health services in Australia.

Deputy Chief Executive (2013 – 2016) and General Manager Research, Development and Advocacy

As Deputy Chief Executive I oversighted operations across 4 states, with 500 operational staff supporting more than 2000 people with mental health issues. I led key areas of operations, safety and quality, business development, human resources and information management. During my time with the organization, revenue grew by more than 30% and the service footprint was expanded to an additional 2 states. I also led the research portfolio, establishing a Director of Research role in partnership with Melbourne University.

Achievements

- Implemented a quality and safety framework across the organisation
- Led successful accreditation process
- Successfully tendered for new services in Queensland and WA
- Coordinated Victorian and South Australian re-commissioning processes which impacted upon more than 100 employees and hundreds of clients

Victorian Department of Health (2004- 2011)

The Victorian Department of Health is responsible for the planning, funding and delivery of health services.

A/Director Performance, Acute Programs and Rural health, Manager[1] Rural Health (March 2010) & Honorary Professor Nursing James Cook University (2008)

At the completion a short term assignment coordinating the psychosocial response to the Victorian bushfires, I was requested to take on the role of Manager of Rural Health. This was a newly created executive role that resulted from the restructure of the Department of Health. I was also appointed as an Honorary Professor of Nursing at James Cook University. I completed a number of academic activities including a monograph on mental health nursing for the International Council of Nursing and a training program on psychosocial issues and emergencies. I was a reviewer for a number of academic journals and an editor of 'Mental Health in Australia', an inter- disciplinary mental health textbook.

Assistant Director, Bushfire Psychosocial Recovery Team (May 2009 – March 2010)

[1] Note that the Department of Health changed naming conventions for positions, and this role is equivalent to Assistant Director

Following the 2009 Victorian bushfires, I was seconded as Assistant Director Bushfire Psychosocial Recovery Team. Reporting directly to the Executive Director, Mental Health and Drugs this position was responsible for leading psychosocial recovery services across government.

Achievements

- Developed a strategic framework to guide psychosocial recovery activities
- Implemented a whole of government approach, integrating activities across different levels of government (State and Commonwealth) and across different portfolios (eg health, human services, education)
- Obtained additional funding to implement innovative programs
- Managed sensitive and complex issues
- Developed an monitoring and evaluation framework
- Successfully mainstreamed the psychosocial response to the Victorian bushfires to ensure ongoing sustainability of programs

Assistant Director, Access and Metropolitan Performance Branch (Nov 2007 – 2009)

Reporting to the Director, Access and Metropolitan Performance Branch, I was accountable for the leadership and management of emergency, surgical and critical care programs.

Achievements

- Integrated acute health programs into a single acute health service program
- Contributed to meeting State and Commonwealth elective surgery targets
- Completed strategic plans for intensive care and trauma services
- Conducted review implementation of Better Faster emergency Care
- Established Emergency Clinical Network
- Invited to attend the Asia Pacific Emergency and Disaster Nursing Network and Health Emergency Partners Meetings in Bangkok, Thailand and Jinan, China
- Conducted training for volunteers in China on psychosocial issues
- Conducted review of mental health services for Hong Kong Health Authority and Hamad Medical Centre (Qatar).
- Co-authored a a monograph on mental health nursing for the International Council of Nurses

Senior Nurse Advisor Mental Health (2004 -2007)

Reporting to the Director of Mental Health, I was responsible for providing advice to the Victorian Government on mental health nursing issues, representing government in national and international forums, coordinating workforce planning, supporting research and providing leadership to mental health nurses in Victoria. As the first permanent appointment to the role in many years, I embedded the role within government and established a wide range of cross-departmental relationships. I had an active involvement in National activities such as the National Mental Health Workforce Advisory Committee, National Mental Health Nursing Network.

Achievements:

- Contributed to the development of a strategic mental health workforce strategy and initiatives such as increased uptake of post-graduate scholarships, increased graduate nurse position, rural-metropolitan medical workforce project and increase in use of VET trained workers

- Led a project on developing National benchmarks for inclusion of mental health in undergraduate nursing courses.
- Invited by the International Council of Nurses to be a key note speaker at their conference in Japan in May 2007
- Invited by Hong Kong Health Authority to review mental health services in Hong Kong.

World Health Organization (2003-2004)

The World Health Organization (WHO) is the United Nations specialised agency for health. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. WHO is governed by 193 Member States through the World Health Assembly (www.who.int).

Technical Officer

I was recruited from Australia to work at WHO headquarters in Geneva, Switzerland with the Mental Health Policy and Service Development Team. WHO's work in this area aims to help policy makers and planners develop a comprehensive strategy to improve the mental health of the population, using existing resources to achieve maximal benefits, provide effective services to those in need, and assist reintegration of people with mental disorders into community life. I worked with senior government officials and mental health professionals from diverse countries. In addition to technical skills, the role required excellent communication and diplomacy skills in ensuring that any conflict between stakeholders was minimized. For example, during a workshop in South Eastern Europe I facilitated a workshop between participants from countries with a recent history of armed conflict.

Publications

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