Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DEAN ASHLEY STEVENSON

I, Dean Ashley Stevenson, Clinical Services Director at Mercy Mental Health (Saltwater Clinic) of 94 Nicholson Street, Footscray, in the State of Victoria, say as follows:

1 I am authorised by Mercy Hospitals Victoria Ltd (**MHVL**) in respect of its service known as Mercy Mental Health to make this statement on its behalf.

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

Background

Please outline your relevant background including qualifications, relevant experience and provide a copy of your current CV.

3 I hold the qualifications of MBBCh, M.Med (Psych) obtained from the University of the Witwatersrand Johannesburg South Africa.

4 I registered as a specialist psychiatrist in 1994.

5 I worked as a consultant psychiatrist in South Africa from February 1994 to June 2002. During this period I worked in community psychiatric services and then moved to a large public psychiatric hospital where I worked predominately in forensic psychiatry.

6 I was promoted to the position of Principal Psychiatrist at this hospital in or around 2001.

7 During my time as a specialist psychiatrist in South Africa I held a joint position as a lecturer in the Faculty of Health Sciences, University of the Witwatersrand.

8 On relocation to Australia in July 2002 I took up employment with Mercy Health in the SouthWest Area Mental Health Service (now known as Mercy Mental Health) as a staff psychiatrist. I worked within the community teams and at the Community Care Units (**CCU**) until 2005 and then worked as a consultant psychiatrist on the Crisis Assessment and Treatment Team (**CATT**) until 2010.

9 I obtained Fellowship of the Royal Australian New Zealand College of Psychiatrists in 2005 and was appointed to the position of Director of Clinical Services, Mercy Mental Health in June of the same year.

10 In October 2012 I was appointed to the position of Clinical Services Director, Mercy Mental Health following a redesign of health services at Mercy Health.

11 I have been the Authorised Psychiatrist under the *Mental Health Act 2014* (Vic) (**MHA**) (both the 1986 and 2014 MHA) since my appointment to a director role in 2005.

12 I also hold the post of Clinical Associate Professor in Psychiatry at the University of Notre Dame Melbourne Clinical School since October 2009.

13 Attached to this statement and marked 'DAS-1 is a copy of my current Curriculum Vitae.

Please describe your current role and your responsibilities, specifically your roles as Clinical Services Director of the Mercy Mental Health Program.

14 As Clinical Services Director, Mental Health Services, I am responsible for the delivery of clinical mental health services within Mercy Health. These services are discussed in detail at paragraphs 18 to 21 below.

15 Mercy Mental Health seeks to provide care which is focused on each individual. We aim to work together with all people, patients, residents, families and carers to support the recovery of the person experiencing mental illness.

16 My responsibilities include oversight of service planning and delivery, quality control and risk management.

17 I am also responsible for appointment, management and supervision of clinical staff, teaching, and clinical work.

What is Mercy Mental Health and what services does it provide? Where does Mercy Mental Health fit within the mental health system?

18 Mercy Mental Health (**MMH**) is the tertiary provider for adult mental health services in Melbourne's South Western metropolitan catchment. MMH's adult mental health services are delivered across multiple sites, which are primarily located in the geographically defined Area Mental Health Service (**AMHS**) boundary across the cities of Hobsons Bay, Wyndham and Maribyrnong.

19 MMH is the tertiary provider for perinatal mental health services for South Western Victoria and provides inpatient consultation liaison services, outpatient services and inpatient services.

20 MMH also provides perinatal consultation liaison and perinatal outpatient services at Mercy Hospital for Women (**MHW**), located in Heidelberg.

21 The MMH portfolio is based on a recovery orientated approach, which involves working collaboratively with and for the consumer, carers and family to encourage the restoration of the consumer's self-confidence, self-esteem and self-awareness and acceptance. The current service delivery profile of MMH includes:

(a) Acute Mental Health Points of Care (**PoC**): The MMH bed profile includes 54 physical beds available in the Clare Moore Building (**CMB**) (50 operational as at June 2019), and 16 beds at the Ursula Frayne Centre (**UFC**), in the Footscray Hospital campus of Western Health. In addition, MMH has access to 2 beds at Wyndham Clinic Private Hospital (**WWP**), with additional capacity to flex up to 5 beds as required, subject to availability, until 30 June 2019.

(b) Community Care Unit (**CCU**): A 20 bed CCU is located in Werribee, and provides medium term residential rehabilitation and treatment and recovery support services for people with serious mental illness and significant psycho-social disability over a period of 6-12 months. The CCU is a home-like environment where consumers share a unit with one another and are given the opportunity to learn and/or re-learn everyday skills required for living successfully in the community whilst receiving continuing treatment to assist with recovery.

(c) Prevention and Recovery Care (**PARC**) Unit: MMH's 10 bed PARC Unit is located in Deer Park, outside of the MMH catchment area. The PARC Unit is operated in collaboration with a non-clinical Mental Health Community Support Service (**MHCSS**) partner, CoHealth. The PARC Unit aims to prevent acute admission into hospital ('step up') and/or seeks to support consumers to leave a mental health hospital unit, and to assist and prepare him/her for his/her return to independent living ('step down'), following an acute admission. Referral to PARC service is through a consumer's treating mental health clinician. Referrals are also accepted from general practitioners and psychiatrists in private practice involved in a consumer's care. Residents stay within the service between two and four weeks during which time they receive treatment and participate in psychosocial rehabilitation programs intended to assist recovery.

(d) Community Mental Health Team: Based in Wyndham and Maribyrnong, MMH's two community based clinics provide assessment, treatment and support via a clinical case management model. The team aims to work in partnership with the consumer, his/her family and general practitioner to reduce the impact of the consumer's mental illness, improve quality of life and promote recovery.

(e) Mother Baby Unit (**MBU**): MMH operates a six bed MBU on the Werribee Mercy Hospital site. The Mother Baby Unit has an extended catchment, including western metropolitan, regional and rural localities. The MBU is a mental health

inpatient unit where mothers and babies can be admitted when inpatient psychiatric treatment is required for a mother in her baby's first year of life.

(f) Further perinatal mental health services include: perinatal mental health outpatient services at Wyndham Community Clinic and Mercy Hospital for Women (**MHW**), perinatal consultation and liaison at MHW, and perinatal mental health research. This service at MHW does not have inpatient facilities, but if required a referral to an inpatient unit or a MBU can be arranged.

(g) Secure Extended Care Unit (**SECU**): MMH consumers have access to 5 SECU beds at Sunshine Hospital (plus one additional bed on rotation). These are managed by MidWest Area Mental Health Service (North West Area Mental Health, Melbourne Health).

(h) Community Based Acute Services: including CATT which provides acute assessment and home treatment in the community, a Post Admission Support Team (**PAST**) which provides follow up for consumers for up to four weeks following a discharge from an acute inpatient unit, and, the Hospital Outreach Post-suicidal Engagement Initiative (**HOPE**) which provides follow up and engagement with vulnerable consumers who have attempted suicide in the community and been treated within the Emergency Department at WMH.

(i) MMH provides emergency mental health services assessment services in the Emergency Departments of Werribee Mercy Hospital and Footscray Hospital.

(j) The MMH triage provides a 24 hour, seven day a week phone triage service available to people within the catchment area. The service is aimed at consumers who are aged 16 to 64 years, who are experiencing mental distress or crisis. This service provides advice and telephone assessment of those who may need hospital admission or treatment in the community. Carers of consumers with a mental health condition may also seek assistance from our triage line. The MMH triage service is staffed by a multidisciplinary team, including registered psychiatric nurses, social workers, occupational therapists and clinical psychologists.

(k) Consultation Liaison Psychiatric Services to Footscray Hospital and Werribee Mercy Hospital. This service provides a dedicated psychiatric assessment and consultative support to medical and surgical patients of these hospitals. This service aims to ensure timely psychiatric assessment for patients experiencing mental health problems whilst in the general hospital. We ensure the management of patients with mental health and/or behavioural problems in general hospitals is based on clinical and risk assessment in accordance with legislative and policy frameworks, and accepted standards of care. Where

clinically indicated the consumer may be transferred to a psychiatric inpatient unit for further psychiatric treatment on medical clearance.

Who receives Mercy Mental Health's services? What are the criteria for people affected by mental illness to access Mercy Mental Health's services? Must Mercy Mental Health's clients come from any particular geographic location?

22 Mercy Mental Health predominately provides tertiary psychiatric services to consumers aged 16 to 64 years old in its designated catchment area, as defined at paragraph 18 above.

23 The service provides treatment to consumers with severe mental health conditions who require acute inpatient care or continuing community support. The service treats a broad spectrum of mental health conditions including schizophrenia, bipolar disorder, severe major depressive disorder and personality disorders.

24 Access to treatment is determined by the presentation of the consumer, factoring in acuity of risk, severity of symptoms, presence of an associated psycho-social disability, and, consumers treated involuntarily under the MHA.

25 MMH also provides an out of catchment perinatal psychiatric mental health service to mothers up to 12 months post-partum who require psychiatric treatment. This service is based out of the MBU at Werribee Mercy Hospital but also includes inpatient and outpatient services to mothers who reside in south western Victoria (see paragraph 21 above). The perinatal consultation liaison psychiatric service at the MHW, a quaternary women's health service, provides non-catchment area based psychiatric services to women delivering at this hospital.

Does Mercy Mental Health assist people affected by mental illness with all degrees of severity and complexity? If not, what kinds of providers would meet the needs of those people outside of Mercy Mental Health's reach? What other parts of the mental health system are your patients likely to use (or want to use)?

26 MMH does not assist people living with mental illness of all degrees of severity and complexity.

27 Where consumers do not meet the threshold for treatment, and it is appropriate and safe to do so, care of these consumers is referred to one or more of the following services:

(a) General Practitioners;

(b) Credentialed Mental Health Nurses;

(c) Private Psychiatrists;

(d) Private Psychiatric Hospitals;

(e) Clinical Psychologists; and

(f) Community Mental Health Support Services (a majority of which have transitioned to National Disability Insurance Scheme (**NDIS**)).

28 Consumers from the MMH catchment area are more likely to access General Practitioners, Credentialed Mental Health Nurses and Community Mental Health Support Services (**CMHSS/NDIS**).

29 Consumer engagement with one or more of the above services does not necessarily exclude them from access to treatment at MMH. Each case is determined by clinical need. For example, a case managed community consumer may be referred to a CMHSS for psycho-social support. In this incidence a shared care model would apply. This is a collaborative model where mental health services remain the primary care givers and services such as psycho-social rehabilitation and physical care is provided by practitioners as outlined in paragraph 27.

Briefly, how is Mercy Mental Health funded?

30 Mercy Mental Health is publicly funded through Mercy Hospitals Victoria Limited (**MHVL**), MHVL is a registered charity with the Australian Charities and Not-For-Profits Commission. MHVL is regulated as part of the public health system in Victoria under the *Health Services Act 1988* (Vic) as a "denominational hospital" listed in schedule two of that Act. MHVL is part of Mercy Health, which, as a Roman Catholic health service, is referred to as a ministry of the Institute of the Sisters of Mercy of Australia and Papua New Guinea. Mercy Health has a long history of providing medical services to the people of Victoria.

31 This service is publically funded and funding is allocated per an input based funding model where the Department of Health and Human Services (**DHHS**) allocates a block of funding to a service. This funding is based on the number of inpatient beds and the previous year's number of achieved community contact hours. This is a measure of the number of service hours that consumers receive from mental health clinicians. Funding is not activity based as in the physical health sphere.

32 Funding increases at a rate indexed to inflation. Productivity savings as determined by DHHS may vary and impact on funding. From time to time funding methodology may change. For example a change in the bed day rate for acute inpatient services.

Running An Area Mental Health Service

Is supply keeping up with demand? What gaps have you observed?

33 In my opinion supply is not keeping up with demand. In addressing this I will consider acute care (bed-based and community) and community care (residential rehabilitation and case management).

34 In the case of bed-based acute care there is a high occupancy rate for acute inpatient beds in the range of 95-100% for most services.

35 Consumers face long waiting periods in the Emergency Departments prior to transfer to an appropriate psychiatric bed. As a result of the demand for inpatient beds in-patient stays are shortening and readmission rates to acute inpatient services are high.

36 Acute community services (**CATT** see paragraph 21 above) also carry high caseloads which limits their availability and response times to crisis situations.

37 Similarly community services, both bed-based and case management services, struggle with managing demand. In the case of MMH, there is a high turnover of case managed consumers which results in lower clinical contact time and, again, higher readmission rates. This high turnover is linked to the demand for community based recovery services and limited availability of resources in the community to provide the treatment required.

38 In my opinion, these are the following service gaps in the region:

(a) Invisible demand: Consumers with severe mental illness can be very difficult to engage in treatment and often do not access services willingly. This is a very vulnerable group of people with higher psycho-social problems, lower quality of life and poor motivation for treatment. It is difficult to capture the extent of this unmet demand.

(b) Consumers with chronic and unremitting symptoms. Some of these consumers may require longer term psychiatric inpatient care which is a limited resource and access is subject to long waiting periods. Consumers of this group in the community do not have their needs met by current community psychiatric service levels and require a much more intensive level of assertive outreach and support.

(c) Consumers with high prevalence disorders – such as anxiety disorders and depressive disorders – often don't reach threshold for treatment in public community mental health services. As such, these consumers are unable to access treatment in the public service and will need to seek management through their general practitioners.

(d) Treatment of consumers with co-morbid alcohol and other drug disorders is often fragmented across clinical mental health services and alcohol and other drug health services.

(e) The effective management of medical co-morbidities in consumers with severe mental illness. Barriers include the poor motivation often seen in consumers living with a severe mental illness, and, insufficient resources and community supports to assist in accessing appropriate medical care.

(f) Consumers with dual disabilities such as autism spectrum disorders and intellectual disabilities are not well catered for in the mental health system, and the transition to the NDIS has not supported this population well.

(g) Support to General Practitioners in the form of timely secondary consults and shared care must be improved.

(h) Limited service models in the community to deal with complex mental illness. For example MMH has lost the capacity for assertive community outreach to consumers with severe and complex mental illnesses. Community services have become predominantly clinic based.

(i) Lack of support to consumers who are discharged from hospital following a first episode psychosis in adulthood. These consumers are sometimes deemed to have sufficient community supports due to their life-phase. They are often in gainful employment and have family relationships. In light of the high demand for recovery community services, the above circumstances factor into the decision to not refer such consumers for case management.

(j) Concerning perinatal psychiatric services there are gaps with antenatal support to expecting mothers with a severe mental illness.

If there is unmet need, what needs are the most critical?

39 It is difficult to prioritise the greatest unmet need. Consumers living with mental health conditions are a vulnerable people. Of this group, those who – whether by reason of the acuity of their mental health condition or psycho-social difficulties – have a variety of treatment needs that the current system is unable to address are the most critical.

40 Those with complex comorbidities, for example low prevalence disorders such as schizophrenia with high psychosocial support needs including housing, indigenous status and chronic medical disease have very real unmet needs. This group does not have good treatment outcomes and will need ongoing supports due to the complexity of their mental health condition.

What are the key drivers of unmet need?

41 There are a number of factors which contribute to the unmet need discussed above. These include:

(a) Longstanding issues in mental health funding: the chronic underinvestment and underfunding of mental health services, combined with insufficient investment in capital infrastructure has restricted the ability of area mental health services to develop to meet the changing needs and growing populations of the regions they serve. This is particularly obvious in Melbourne's growth corridors.

(b) Workforce shortages: retention and development of the workforce is a challenge in maintaining and expanding mental health services.

(c) Catchment limitations: in the south west area of Melbourne, mental health service catchment area design is complex and contributes to gaps in service provision. In this region, the mental health provider does not service whole of age. Child, adolescent and youth services are accessed through two different service providers in the region which adds complexity to access and navigation for consumers in this age group. Old age psychiatric services for consumers older than 65 years of age through another service provider.

(d) Supply and demand mismatch resulting in the focus of treatment shifting to risk management and acuity of symptoms. The service is also very limited in its ability to provide evidence based psychosocial interventions that will benefit consumers living with a severe mental illness.

What kinds of impact does unmet need have on people affected by mental illness?

42 The impact of unmet need is complex but rooted in under treatment of the illness and the related psycho-social consequences. Such consequences include but are not limited to:

(a) Relapse of the condition;

(b) Progress to chronicity of symptoms;

(c) Loss of gainful employment;

(d) Breakdown of relationships and resulting social isolation;

(e) Inadequate housing and ultimately homelessness; and

(f) Increased risk to self and others in the community.

Are there enough beds to service demand for acute need? If not, why not?

43 The Victorian Auditor General's Office (**VAGO**) report into Access to Mental Health Services published March 2019 reports that Victoria has one of the lowest mental health bed bases nationally.

44 The lack of availability of acute beds in Victoria is evidenced by high occupancy rates generally above 95% across all services. This is well above the desirable level of 80-85% which would permit area mental health services to admit acute mental health consumers in a more timely fashion.

45 Other indicators of the shortage of acute beds are the diminishing length of stay in adult units, and the resultant fluctuating 28 day readmission rates, particularly across metropolitan Melbourne.

46 Contributors to the lack of acute psychiatric inpatient beds are likely to be:

(a) Lack of capital investment;

(b) Limited population-based planning in the growth corridors; and

(c) Ultra long stay consumers in acute inpatient units, being consumers with inpatient stays of 3 months or longer due to a lack of suitable care facilities outside of hospital causing bed blockages in acute inpatient psychiatric units.

In your experience, are clinical mental health services crisis driven? If so, in what respects and why?

47 In my opinion clinical mental health services are crisis driven and reactive. This is most prominent in the delivery of clinical services and service planning/program delivery.

48 Based on my experience as Clinical Services Director of an area mental health service, there are insufficient leadership and financial resources within the mental health program to enable area mental health services to strategically design and shift service functioning to more proactive future focused service delivery. This includes developing adequately resourced leadership and management structures within services, and, ensuring sufficient resources are available to support the planning and implementation of service redevelopment and change. To achieve this, services will require additional staffing in the form of project officers and like supports.

49 Certain clinical service models utilised by area mental health services are designed to provide crisis driven responses. For example CATT teams, although in my view a necessity in public mental health services, tend not to be focused on relapse prevention but are driven to contain risk and acuity of consumers in crisis in the community.

50 High thresholds for admission lead to consumers presenting only at a time when they are extremely unwell and require acute admission. There are limited resources within the community to provide relapse management and early intervention to prevent acute crisis driven admissions.

51 In my experience the high demand for crisis driven acute services in Emergency Departments and within the community has resulted in a shift of resources internally from community to acute services. This tends to perpetuate the crisis driven nature of the service as there are inadequate community resources to provide early relapse prevention treatments.

52 Demand is also more visible in Emergency Department than in communities. This is driven by performance monitoring by DHHS via hospital networks (National Emergency Access Targets (**NEAT**)) and draws attention and resources away from the less high profile community services.

What treatment is available for people who do not meet the criteria for treatment at the service? What are the barriers to people receiving appropriate treatment, from a systems perspective?

53 Increased demand for psychiatric services has resulted in a higher thresholds for consumers seeking to access treatment within an area mental health service.

54 Treatment alternatives available to consumers other than an area mental health service are as follows:

(a) General Practitioners;

(b) Private mental health specialists, including clinical psychologists and psychiatrists;

(c) Community Mental Health Support Services; and

(d) NDIS.

55 Barriers to accessing these services would include cost and accessibility, appropriate referral mechanisms and motivation of the consumer to access services.

56 Of note is that the capacity of community mental health support services to service their communities has been impacted and in part diminished by a shifting of resources to the NDIS. The NDIS does not support consumer access to early intervention services as eligibility criteria for access to such services requires determination of permanency of functional impairment in those living with a mental illness..

If a person has a chronic mental illness but is not in "crisis" where do they go for immediate support?

57 Assuming that the person with the chronic mental health illness is an adult and does not have a case manager from an area mental health service, there are, in my opinion, no other immediate supports other than the person's general practitioner and telephone services (For example Psychiatric triage, Lifeline and the like.).

58 CMHSS/NDIS have assessment and eligibility processes and subsequent wait lists to gain access to their support services. The NDIS only provides support to consumers with a recognised permanent impairment. This support may take the form of:

(a) Purchasing services to address capacity building such as therapeutic interventions – both group programs and individual – to address the psychosocial burdens of the illness.

(b) Provision of core supports to assist with daily living tasks including home visits from support workers.

59 Of course, carers, family and friends also play an important role in providing support to a person with a mental illness.

Do you have experience of the "missing middle" – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services?

60 I have limited experience of this group of people. My experience is limited to people who have presented episodically in crisis and are briefly managed by way of home treatment with the MMH CATT team. This group of consumers tend to present in the context of psycho-social crisis or have high prevalence disorders (as discussed above).

How does the complexity of the mental health system (variability between geographic areas, overlaps/duplications between different levels of government, and gaps) impact on people's ability to access services and navigate the system? What tools are in place currently to help people navigate the system? How effective are they?

61 I will address this question from the perspective of MMH and as represented in this service's submission to the Royal Commission.

62 Victoria's current system of area-based clinical mental health services is complex, fragmented, and difficult for consumers, carers, referrers and providers to navigate.

63 The lack of a systematic 'whole of life' approach to clinical mental health service provision in Victoria provides further challenges to service coordination and considerable risks to clients at key transition points (for example, youth to adult services).

64 In some regions, Victoria's clinical mental health service catchments are not well aligned with the broader health and human service system. Take for example the MMH catchment area, which overlaps with the broader physical health catchment area of Western Health. In this instance MMH provides mental health services to a hospital managed by a different health service.

65 The fragmentation of the clinical mental health service system has been exacerbated in recent years with reforms in key partner sectors, such as the non-clinical mental health system (MHCSS) transition to the NDIS, the Drug and Alcohol Treatment Services Reform, and Primary Health Networks (PHNs).

66 In the MMH catchment, challenges related to system complexity and fragmentation highlight the state-wide system challenges outlined above, for example:

(a) Multiple clinical mental health service providers are active within the catchment such as, MMH, Royal Children's Hospital, Northwest Area Mental Health Service's Orygen Youth Health, and, Aged Person's Mental Health;

(b) A whole of life approach to clinical mental health service provision is lacking in the catchment;

(c) Despite MMH's unique perinatal mental health service offering, funding is not adequate to ensure coverage of perinatal mental health services across the catchment. For example the inability to provide adequate perinatal consultation and liaison services at WMH, a level 4 Maternity Service, delivering 3,800 babies per annum;

(d) MMH's PARC service is located out of catchment, a problem exacerbated by public transport challenges in a developing growth corridor region;

(e) There are a lack of providers in key partner sectors in the catchment to support clients with mental health issues in the community, including private mental health providers such as Consultant Psychiatrists, Clinical Psychologists, Occupational Therapists, Social Workers, Drug and Alcohol services, NDIS providers, employment services and housing services.

67 This systemic complexity poses navigational challenges to the delivery of seamless person-centred care. There are no tools to assist the person to navigate the system, unless they have case manager within a mental health service who will perform this role.

How do your services deliver community-based care?

68 MMH provides community services across its acute, perinatal and recovery streams.

69 The bulk of MMH's community services are provided through its recovery mental health services. This primarily consists of two blended case management teams based at the Footscray and Hoppers Crossing sites which provide clinic based and outreach services. The blended model provides homeless outreach services and complex care clinicians in addition to recovery clinicians (case managers). Within the blended team there are specialist clinicians including a Families where A Parent has a Mental Illness specialist (**FAPMI**), a forensic clinical specialist team and Clozapine coordination.

70 The recovery stream provides two bed-based residential rehabilitation services (CCU and PARC).

71 In the context of acute community based psychiatric services the CATT team provides crisis assessment and home based treatment in the community.

72 MMH also provides a Police Ambulance Clinical Early Response (**PACER**) team working out of the Werribee Mercy Hospital Emergency Department. The PACER intervention provides more timely access to mental health assessment for the person in crisis. Involvement of PACER may also reduce the use of section 351 MHA apprehension of persons in crisis.

73 The PAST program provides 28 day post-admission support to consumers following discharge from one of the two acute inpatient units who will not continue as case-managed clients of the service.

74 The HOPE team similarly provides follow up over a three month period for consumers who have presented at Emergency Departments in the context of attempted suicide and will not progress to case management by this service.

75 The perinatal Mother Baby Services outpatient clinic, located at Hoppers Crossing, provides secondary consultation on referral.

How do CATT/ACIS teams work? What are the resourcing challenges with operating a CATT team? If there are barriers to their effectiveness, what are they?

76 Although MMH functions with blended teams it has elected to keep its CATT team as a separate entity.

77 The CATT team provides community based acute assessments of consumers presenting with acute psychiatric symptoms and home-based treatments as an alternative to

hospital. The CATT team also assists in early discharge management of consumers discharged from hospital. CATT clinical work is seldom focused on relapse prevention.

78 CATT teams work morning and afternoon shifts from a clinic based setting. They are not available over the night shift. Home treatment and home based assessments are conducted by a pair of clinicians travelling to the person's home during both the morning and afternoon shifts. Medical input is provided as needed by a consultant psychiatrist and registrar/medical officer. Clinical handovers occur at the start of the morning shift and the start of the afternoon shift.

79 Referrals for assessment and treatment by the CATT team are received through MMH's psychiatric triage and the response time is determined by reference to the state-wide mental health triage scale. Referral sources include inpatient units, emergency mental health services in Emergency Departments, community teams and self-referral from consumers and/or their carers and family.

80 In my opinion, these are effective teams. However their responsiveness will be impacted by the number of consumers they are treating at any given time as well as the distances they are required to travel between consumers for assessments and home treatment.

81 In terms of resourcing, CATT clinician positions are popular and the team is often well staffed. However, as the majority of clinicians are senior and receive penalty rates when working after hours CATT teams are a very expensive resource for area mental health services to run.

What are the critical things that contribute to the success of NorthWestern and Inner West?

82 I am answering this question on the basis that it is intended to refer to MMH, not NorthWestern and Inner West.

83 The success of MMH's services is attributable to the fact that:

(a) Mental Health funding is ring fenced by Mercy Hospitals Victoria Ltd and is not used to cross-subsidise services outside of Mental Health;

(b) There is strong support and interest in the development of mental health services from the Mercy Board of Directors;

(c) Mercy Health leadership provide an enabling environment to support senior leaders in MMH to pursue strategic service changes;

(d) Capital investment with the opening of the 54 bedded inpatient unit known as Clare Moore Building at Werribee Mercy Hospital has had a positive impact on access and flow from the two Emergency Departments to which MMH provides services at (Werribee Mercy Hospital and Footscray Hospital);

(e) The public/private bed initiative with Wyndham Clinic Private Hospital in Werribee has made up to 5 beds available to public patients at a fixed bed day rate which is funded by DHHS; and

(f) The CATT team operates as a distinct team.

Mental Health System and Reform

In your experience, how does the system we have now compare to what was envisaged in the 1990s?

What has been lost?

84 There has been a shift to the medical model with a focus on medication and risk management via a generic case management model. This has resulted in the narrowing of multidisciplinary inputs and the loss of discipline specific roles and functions into psycho-social management and treatments (for example, Clinical Psychology, Occupational Therapy and Social Work).

85 There has been a shift from community based care to acute inpatient based care. The original community care focused model had a solid basis with assertive outreach, acute assessment in the community and case management. We have lost the opportunity to further develop this model, instead dismantling it and pivoting towards a blended model in community teams with mixed functions. My experience of blended teams is that, again, the focus shifts to managing acuity rather than on rehabilitative and support services.

86 A reduced capacity to provide intensive community support/assertive outreach for people with complex low prevalence disorders has occurred because of the development of blended community teams and the subsequent dismantling of the mobile support team models.

87 Further, there has been a loss of support to the primary health care sector through the dismantling of primary mental health teams within services

88 More commonly, mental health services now have increasing workforce issues, recruitment challenges and a junior workforce which has not been given the opportunity to develop the skillsets to manage the complex mental health illnesses which area mental health services now increasingly service.

89 There has been a push to area mental health services to provide specialised services to consumer groups such as the forensic population and within the field of eating disorders. These consumer groups had previously been serviced by specialist programs. Very small amounts of clinical hours have been provided to support the capacity building of the workforce within these specialised areas. This increased capacity has yet to be realised across the sector.

What has been gained?

90 Services have moved towards practicing within the recovery paradigm which is supported by the introduction of the MHA 2014. The new legislative regime is consumer rights centric and reinforces the autonomy of consumers subject to the Act.

91 The increased oversight of restrictive interventions in hospital settings and the 'reducing restrictive interventions' initiative from DHHS is also having a positive impact on protection of the rights of the consumers.

92 Public awareness campaigns and advocacy within the community has reduced the stigma previously associated with mental illness and opened the conversation around mental health. This has probably had the best impact for high prevalence disorders.

93 The introduction of new programs in mental health services which have had positive outcomes. These include forensic clinical specialist program, the PACER program and HOPE program as well as capacity building initiatives such as FAPMI.

What new trends have impacted on community needs since the 1990s?

94 Within the community to whom we provide services, the following trends have impacted on community needs:

(a) Settling of refugee populations with extensive trauma histories;

(b) Migration in general with large population growth resulting in increased demand;

(c) The Ice Epidemic;

(d) Homelessness and lack of public housing;

(e) A service wide recognition of the impact of family violence;

(f) Lack of recognition and engagement of the mental health needs of the indigenous population;

(g) Cost of living increases have not been commensurate with the increase in New Start Allowance and Disability support pensions adding to the cycle of poverty and homelessness;

(h) Technology and automation have led to the loss of jobs that in the past were available to consumers with disabilities. This has reduced their capacity for economic participation; and

(i) Increasing evidence of the impact of loneliness on people's mental health and the population we treat who already have significant problems with creating and maintaining community and social connections.

How has the system got to where it is now?

95 The changes in the system since the 1990s is in part attributable to a lack of:

(a) investment in service growth and in service model development;

(b) capital investment in facilities;

(c) development of housing services for disadvantaged groups including consumers with a mental illness;

(d) workforce development and/or opportunity for upskilling of current workforce to meet the demands arising in the field of public mental health; and

(e) recognition that mental health is not only a health issue and requires strategic alignment with other sectors outside of health such as housing, employment and education.

96 Further, due to the disparate needs of different area mental health services across the state, the DHHS's "one size fits all" approach to the development of new services restricts the ability of area mental health services to respond to their identified needs within their specific catchment.

Are there ways in which you think the demand for services of the kind that Mercy Mental Health provides is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

97 MMH currently services consumers in the community between the ages of 16-64. By 2031 we are expecting a population growth of 43.3% in this age range within our catchment area.

98 Predicted changes to population demographics within the catchment also show significant growth in areas of the population we currently do not have the mandate to service including child and youth and aged persons services.

99 Population forecasting also indicates on average an 87% increase in the number of residents aged 65 and over and 51% increase in residents aged 0-15 by 2031.

100 Current services to these groups within our catchment are fragmented across 4 different providers (Mercy Mental Health, Orygen Youth Health, Royal Children's Hospital and North Western Mental Health Aged Persons services). Unification of these services to a single service provider will assist in planning and developing of these services to meet predicted demands.

What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental ill health?

101 As identified in MMH's submission to the Royal Commission, there are four key themes applicable across the Victorian mental health system, including in the MMH catchment. Each is set out and examined in greater detail below.

System complexity and fragmentation

102 As noted at paragraph 63, Victoria's current system of area-based clinical mental health services is complex, fragmented, and difficult to navigate. It challenges the notion of person-centred care by creating barriers to system entry. Very often, the consumer is not the navigator in the current Victorian mental health system; nor is the system easy for the consumers, carer, referrers and providers to navigate.

103 In Victoria, AMHS are currently managed by catchment based public health services. In some areas, multiple clinical mental health service providers are responsible for different age cohorts. In the metropolitan area, there are 13 adult, nine aged persons and five child and adolescent services. In some cases, overlays with health service providers are not well aligned; exacerbating navigation complexities and posing governance challenges.

104 As noted at paragraph 63, the lack of a systematic 'whole of life' approach to clinical mental health service provision in Victoria provides further challenges to service coordination and considerable risks to consumers at key transition points (for example youth to adult services).

105 Further, clinical perinatal mental health services are not currently distinguished as a key component of mental health care provision

Person-centred service access, clinical models and funding

106 There is a lack of transparency and much variation between catchments regarding base level mental health service provision; including the ability to deliver assessment, interventions and subspecialty care (such as care delivered for eating disorders and perinatal mental health).

107 The roll out of additional funding over time has been piecemeal rather than system designed and restricted with respect to allocation specifications, rather than being consumer centric.

108 In the MMH catchment person-centred service access, clinical models and funding are particularly challenging. MMH is located in a growth corridor area. Over time, funding has not kept pace with population increases.

Mental health workforce

109 Ensuring a sustainable, skilled and appropriate mental health workforce remains a significant challenge across Victoria.

110 A secondary workforce challenge affecting the mental health sector is in relation to further skills development and specialisation. Emphasis on safety and risk management in clinical mental health services as the main mode of delivery of treatment impacts on the continuous skill development of clinical mental health staff.

111 Occupational violence is also a significant issue of concern for the mental health workforce across the state.

Partnerships in care

112 The clinical mental health service system is nested within the broader non-clinical mental health as well as the health and social support services systems.

113 Meaningful and functional partnerships with providers across the spectrum are required in order that all services operate optimally to deliver enhanced person-centred care and client outcomes.

114 Key challenges inherent in the domain of partnerships within the complex matrix of providers that support mental health clients include:

(a) determination, availability of, and access to partner support providers;

(b) variability in the type and quality of service provided;

(c) information sharing between partner service providers over multiple platforms, including e-capability levels of sophistication between services and sectors;

(d) transfer of care at key transition points between partner agencies; and

(e) development of relationships between services.

What do you think are the critical elements of a well-functioning mental health system?

115 A well-functioning mental health system is comprised of a number of components, all operating in unison to provide optimal care. Critical elements of such a system include:

(a) Timely access to recovery focused services which is easily navigable for persons with mental health conditions, their families and carers.

(b) Flexibility in the allocation of funding packages, such that area mental health services are able to innovate in new ways for improved outcomes.

(c) Acute and community based mental health services are evidence based, person-centred and recovery focussed and tailored to individual needs. Mental health services need to be adaptable to meet changing demand needs over time.

(d) Clinical mental health funding is population based, transparent, and adequate to meet the mental health needs of catchment populations.

(e) The met and unmet mental health needs of the population are monitored and implications understood.

(f) Service and capital planning (infrastructure) is proactive and future facing. Investments in infrastructure aim to prevent losses to bed stock ratios as the population grows, with a view to maintain acute bed based occupancy rates at approximately 80-85%.

(g) A renewed and concerted strategic approach to the training and development of the mental health workforce across all disciplines.

(h) Strengthening of key partnerships including between area mental health services and other mental health service providers, and acute, community and primary health care providers, and other social support services. Recognition and guidance is provided to clinical mental health leaders to develop and maintain these partnerships.

(i) Recognition that mental health is not only a health issue and requires strategic alignment with other sectors outside of health such as housing and employment.

(j) Whole-of-life catchment based AMHS exist to support continuing care provision to consumers throughout their lives.

(k) Perinatal mental health services are recognised as a fourth key element of whole-of-life clinical mental health service provision

(l) AMHS are of a suitable size to allow for operational economies of scale and service delivery efficiencies

What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to access to treatment and services and getting help to people when they first need it?

116 The following changes are needed to bring about lasting improvements to the mental health system regarding early treatment and access to services and treatment:

(a) Development of evidence based treatment models. For example the provision of a dialectical behavioural therapy program for consumers with borderline personality disorder. Also close adherence to treatment guidelines in managing major mental illnesses like schizophrenia such as the recent Royal Australian New Zealand College of Psychiatry guideline.

(b) Further development of mental health emergency hubs within hospital Emergency Departments to provide a more appropriate setting for assessment and treatment;

(c) Re-establish assertive outreach models of care to include enhanced outreach capacity of the CATT/ACIS teams;

(d) Extended outreach support and early intervention services to support consumers already linked to area mental health services;

(e) Enhanced shared care models with primary health networks to support consumers in accessing treatment when required;

(f) Investment in catchment based partnerships with the measure of success of these partnerships being positive consumer outcomes and experience of care;

(g) Extension of psychiatric triage services with further training of the workforce; and

(h) Ensuring that whole of age services are consolidated and provided by one service provider within catchments.

What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to navigating the mental health system?

117 The following changes are needed to bring about lasting improvements to the mental health system in relation to navigating the system:

(a) Ongoing development of the peer/lived experience workforce as supports for the consumers as co-navigators;

(b) Reduction in complexity of service provision, particularly in catchments with multiple mental health service providers to ensure ease of navigation at key transition points;

(c) Investigate the use of technology aides to consumers, families and carers to educate/support navigation of service systems; and

(d) Develop a welcoming and hospitable framework of service provision to consumers and families by identifying reasons to provide support rather than deeming them ineligible for services.

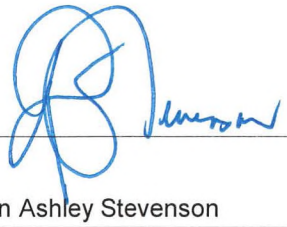
Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

118 The Royal Commission into Victoria's Mental Health System provides the impetus for a renewed and concerted strategic state-wide approach to the training and development of the mental health workforce across all disciplines.

119 In order to make more than incremental change, the process must be transparent, apolitical, and consider a broad range of views and experiences, ranging from service providers to carers and consumers. Doing so will provide a unique information base from which to develop new and innovative service models that address the mental health and social determinants of mental health needs of the consumer group.

120 Further, the Royal Commission can and should provide direction that future service planning and funding provision to area mental health services be equitable across catchment areas and determined with respect to demand and population growth.

121 To ensure ease of implementation and uptake by area mental health services and the DHHS, recommendations from the Commission should be delineated against short term and long term reform with appropriate timelines provided.

sign here ► 

print name Dean Ashley Stevenson

date 4 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT DAS-1

This is the attachment marked 'DAS-1' referred to in the witness statement of Dean Ashley Stevenson dated 4 July 2019.

Curriculum Vitae

General and personal

Name:	Dean Ashley Stevenson	
Date of birth:	15 January 1962	
Work Address:	Mercy Mental Health Saltwater Clinic 94 Nicholson Street Footscray 3011	
Contact Numbers:	Work Mobile	(03) 9928 7483 0407 684 808
Email:	Work:	dstevenson@mercy.com.au

Educational qualifications

Tertiary education

University:	University of the Witwatersrand Johannesburg South Africa
Qualifications:	1. MB BCh 1985 2. MMed(Psychiatry) 1994 Thesis title: "Current prescribing practices in a Psychiatric Community Clinic."

Royal Australian and New Zealand College of Psychiatrists:

Qualification obtained: FRANZCP Feb 2005

Registration details

Specialist Registration as a Psychiatrist with the Australian Health Practitioner Regulatory Agency
Registration No: MED 0001199980

Employment history

Oct 2012 to present

Employer: Mercy Public Hospitals Inc.
Position: Clinical Services Director
Mental Health Services

Main work functions:

- Provide clinical and strategic leadership to the Mental Health Services within Mercy Public Hospitals Inc.
- Develop and maintain high quality, effective and efficient mental health services to the community.
- To keep abreast of trends and developments in the field of mental health and advise the organization on opportunities to provide new and innovative services.

June 2005 to Oct 2012

Employer: Mercy Mental Health
Position: Director of Clinical Services

Main work functions:

- Provide clinical and strategic leadership to the Mental Health Program.
- Develop and maintain high quality, effective and efficient mental health services to the community.

February 2005 to May 2005.

Employer: Werribee Mercy Mental Health Program
Melbourne
Positions held: Deputy Director of Clinical Services
Consultant to CAT Team

Main work functions:

- Administrative and organisational responsibilities as delegated by the Director of Clinical Services
- Clinical and organisational co-management of the CAT team
- Assessment and management of clients of CAT
- Clinical supervision of trainees

February 2003 to January 2005

Employer: Werribee Mercy Mental Health Program
Melbourne

Positions held: Deputy Director of Clinical Services
Consultant in charge of CCT
Consultant to the Community Care Unit in Werribee

Main work functions:

- Administrative and organisational responsibilities as delegated by the Director of Clinical Services
- Clinical and organisational collaboration within the leadership structures of CCT and CCU
- Assessment and management of clients of CCT and CCU
- Clinical supervision of Medical Officers

July 2002 to January 2003

Employer: Werribee Mercy Mental Health Program
Melbourne

Positions held: Consultant in charge of CCT
Consultant to the Community Care Unit in Werribee

Main work functions

- Assessment and management of clients of CCT and CCU
- Clinical supervision of Medical Officers
- Partake in the academic programme.
- Provide after-hours consultant cover to the service on a rostered basis.
- Partake in the ECT programme on a rostered basis

September 2000 to June 2002

Employer: Sterkfontein Hospital
Gauteng Department of Health
Johannesburg
South Africa

Positions held: Principle Psychiatrist (appointed 1 Nov. 2001)
Acting Principle Psychiatrist
Head of Forensic Unit

Main work functions:

- Co-ordination and supervision of clinical services at Sterkfontein Hospital.
- Representation of the clinical departments (psychology, occupational therapy and social work) at top management level.
- Management of clinical services rendered by the Forensic Unit.
- Clinical assessment and report writing in terms of section 77 and 78 of the Criminal Procedures Act.
- Giving expert evidence in the higher and lower courts of South Africa.
- Liaison with the Director of Public Prosecutions
- Liaison with the Department of Psychiatry, Wits Medical School.
- Supervision and teaching of registrars and intern clinical psychologists.
- Teaching of medical students

September 1996 to August 2000

Employer: Sterkfontein Hospital
Positions held: Senior Psychiatrist
Head of Forensic Unit (from 1998)

Main work functions:

- Clinical assessment of patients referred under the Criminal Procedures Act.
- Assessment and treatment of state patients and certified patients.
- Preparation of medico-legal reports.
- Giving expert evidence in the lower and high courts of South Africa.
- Supervision and teaching of registrars and intern clinical psychologists.
- Liaison with the Director of Public Prosecutions
- Management of the Forensic Unit from 1998

April 1995 to August 1996

Employer: Sterkfontein Hospital
Gauteng Department of Health
Position held: Psychiatrist

Main work functions:

- Clinical assessment of observation patients
- Treatment of state patients and certified patients.

- Medico-legal report writing.
- Giving expert evidence in the lower and high courts of South Africa.
- Supervision and teaching of registrars.

January 1993 to March 1995

Employer: Community Psychiatric Services
TPA/Gauteng Department of Health
Positions held: Acting consultant (January 1993 to February 1994)
Consultant psychiatrist

Main work functions:

- Rendering psychiatric evaluation and treatment in various clinics on the West Rand of Johannesburg. This included psychiatric services to the aged and the intellectually disabled.
- Development of a child psychiatric service at the Krugersdorp Clinic.
- Development of a community psychiatric clinic at Khutsong, Carltonville.

January 1989 to December 1992

Employer: Sterkfontein Hospital
Position held: Registrar in psychiatry
Main work functions:

- General psychiatric clinical duties at the teaching hospitals of the Department of Psychiatry, University of the Witwatersrand.

January 1987 to December 1988

Employer: National Military Service
South African Medical Services.
Position held: Medical Officer
Main work functions:

- St Andrews hospital, Harding, Natal; general clinical duties in a rural hospital.
- Pietersburg Air force base; general clinical duties (general practice).

January 1986 to December 1986

Employer: Addington Hospital, Durban
NPA Department of Health
Position held: Intern

Main work functions:

- Intern rotation; General surgery - 2 months
  Urology - 2 months
  Orthopaedic surgery - 2 months
  Psychiatry -2 months, General medicine -4 months

Academic appointments

October 2009 to present: Clinical Associate Professor
University of Notre Dame Australia
Sydney School of Medicine

Discipline leader: Psychiatry
University of Notre Dame Australia
Melbourne School
Werribee Mercy Hospital and Mercy Mental Health

November 2006 to October 2009: Adjunct Associate Professor
University of Notre Dame Australia
Sydney School of Medicine

February 1994 to June 2002: Joint appointment
Lecturer in the Department of Psychiatry
Faculty of Health Sciences
University of the Witwatersrand
Johannesburg South Africa

Departmental responsibilities:

a) Member of the Department Executive Committee.
b) Chairperson of the Undergraduate Teaching Committee (1999-2002).

Faculty of Health Science activities (Faculty committee's 2000-2002):

a) Member of the Ethics and Professional Standards Committee.
b) Member of the MBBCh Undergraduate Committee.

Publications

a) "Institutional victimization in post-apartheid South Africa"
Marilyn Lucas, Dean Stevenson
South African Journal of Psychiatry
Vol 11, issue 3, Dec 2005, pg 90-94.

b) "Violence and abuse in psychiatric in-patient institutions: A South African perspective"
Marilyn Lucas, Dean Stevenson
International Journal of Law and Psychiatry, 29 (2006) 195-203