



Office of the Health Complaints Commissioner 2007

February 2006

Investigation of a complaint against Mental Health Services proposed changes to a model of care

Section 23(1)(c) Access to mental health services and whether a provider “acted unreasonably in the manner of providing a health service – Whether the proposed change to the model of care and the disbanding of 3 teams in southern Tasmania would be to the detriment of a client population with severe, persistent mental illness – the adequacy of the consultative process

In late 2005 and early in 2006, complaints were lodged under the *Health Complaints Act 1995* against Mental Health Services (MHS) by staff members and family of MHS clients who were concerned about proposed changes to a model of care. The complainants were concerned that it was proposed to terminate the service provided by the Mobile Intensive Support Team (MIST) in southern Tasmania to a client population with severe, persistent mental illness and severely disabling disorders and that this would disadvantage that subgroup. Further that the Assertive Case Management (ACM) or Assertive Community Treatment (ACT) as it is referred to internationally, was not replicated in the new model of care and that it was confusing and misleading to use terminology representing that ACM or ACT would continue under the new model. The proposed changes were viewed as detrimental to the subgroup who were former clients of MIST and it was asserted that MIST under the ACM model and evidence based practice (EBP) had achieved positive clinical outcomes for this client group.

Concerns were expressed about the proposed transfer of some functions, programs or services operating out of the Peacock Centre to non-government organisations (NGO's) and whether these organisations had the capacity to deliver effective services. There was concern that the changes to the services and programs provided to the Peacock Centre breached the terms of the bequest granting the Centre to the Tasmanian Government and that the proposed changes disadvantaged those clients who attended the Centre for a range of activities and services. There were criticisms about the consultative process and whether accurate and clear information had been provided about these changes and how clients would be affected and which staff and activities would remain at the Centre.

Given the concerns raised and the representations made to the OHCC by clients, staff and family affected by these changes, the matter was investigated under Part 6 of the *Health Complaints Act 1995*. In summary the investigation was to determine whether the proposed changes to the model of care would be to the detriment of MHS clients and particularly the subgroup of the most seriously mentally ill living in the community who were clients of MIST, whether the new model of care was

represented as ACM/ ACT when it did not have fidelity to this internally recognised model and whether the new model utilised EBP, and was to examine the adequacy of the consultative process and the changes to services and activities at the Peacock Centre under the new model of care. MHS, the Department of Health and Human Services (DHHS) and the complainant (who was a staff member and represented the concerns expressed by a number of others), all made comprehensive submissions.

DHHS developed a new model of care in line with its Strategic Plan 2006-2011 and the National Health Strategy and having engaged in considerable research and a consultative process with stakeholders. The new model involved disbanding 3 service teams in the south and incorporation of the tasks and functions of these teams into multidisciplinary teams operating state-wide.

DHHS stated that the model of care is based on the 11 Principles specified in the Strategic Plan 2006-2011 and described the model as “*an integrated, standardised, evidence based, comprehensive and recovery-focused mental health model that incorporates key activities from triage to discharge and includes intake, crisis response, ongoing assessment and review, early intervention, psycho-education, bio-psychosocial treatment, family interventions and psychological, social, vocational and recreational skills development*”. DHHS submit that the principles not only reflect the National Mental Health Strategy, signed by Australian and State / Territory Governments, but are reflected in contemporary models of MHS around the world.

The critical issue for investigation was whether the proposed model would continue to provide effective treatment for a subgroup of the most disabled and seriously mentally ill clients in southern Tasmania. MHS maintained that the new model of care does not replicate the ACM/ACT model of care but has some features in common with that model. Further that the terminology “assertive case management” is used to describe the type of case management MHS wishes to see in practice and that the model will be evidence based.

It was concluded that there were two distinct models of care sharing some key characteristics and that there was no reason why the proposed model could not be effective in terms of service provision and positive clinical outcomes. MHS denied that the proposed changes would result in less effective treatment and a diminution of service to the former clients of MIST and considered that the clinical outcomes would improve. In order to ascertain whether this was so it was recommended that there be a clinical audit undertaken within the next 12 months, with the former clients of MIST forming a discrete cohort for evaluation purposes. DHHS accepted this recommendation.

There was a question of equitable access to MHS and the conclusion reached was that the new model, with aid of the additional funds allocated by Government, was more equitable in that it served people throughout Tasmania whereas previously the three teams - MIST, the Crisis Assessment Triage and Treatment (CATT) and Rehabilitation teams – served part of southern Tasmania. DHHS maintained that the functions of the three specialist teams in southern Tasmania would be embedded into three integrated teams available to all Tasmanians. One of these multidisciplinary teams would be located at the Peacock Centre and would deliver the full range of MHS to consumers in the Southern catchment area including former clients of MIST.

The investigation found that there could be some detriment to clients, particularly the clients of MIST, during the transition to the new model. Information was submitted about “unallocated cases” and waiting lists during the transition. However it was concluded that a distinction needed to be made between these problems during a short-term transitional phase and whether the model of care would be effective once operational. The clinical audit was to evaluate whether the change to the new model had improved the clinical outcomes for MHS clients.

It was accepted that there had been a comprehensive consultative process. However, there were flaws in the process when those who sought to retain the ACM/ACT model, EBP and the MIST team attempted to express those views and found the consultation was not as robust as it could have been. A warning was issued to one person under the *State Service Act* Code of Conduct and the conclusion was that this was inconsistent with open debate, the purpose of which is to arrive at informed decision making having had regard to alternative views.

Initially there was uncertainty expressed by families and the Friends of Peacock Association as to the information about the extent of the changes of services and activities to be provided from the Peacock Centre location. The State Manager of MHS met with Association members and information sheets were published. The concerns about insufficient information were resolved but it is expected that some dissension will continue as clients and their families are affected by changes in service provision.

The recommendations made are -

1. That over the two years following the introduction of the new model, clinicians conduct annual auditsⁱ of clients of MIST formerly under the southern ACM/ACT model of care to ascertain any variation in the outcomes for this group under the new model.
2. That MHS provide a progress report on the implementation of the Strategic Plan and the transition to the new model of care within 12 months of the date of this report.

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ⁱ Or utilise other evidence based methodology