

# EXECUTIVE SUMMARY – JUNE 2008

## REVIEW OF THE FORMER CLIENTS OF THE MOBILE SUPPORT TEAM (MIST) FOLLOWING THE CHANGE TO THE MENTAL HEALTH SERVICES (MHS) MODEL OF CARE

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In October 2006 an integrated model of care was introduced for community based Mental Health Services (MHS). The model integrated the Crisis Assessment Triage and Treatment (CATT) Team, Mobile Intensive Support Team (MIST) and Rehabilitation Teams into the existing Adult Community Mental Health Teams.

Prior to changes being introduced complaints were made to the Health Complaints Commissioner expressing concern in relation to the proposed changes. In particular concerns were raised in relation to clients of MIST. After investigation of complaints the Health Complaints Commissioner upheld the right of MHS to propose and implement service changes however, the critical issue was deemed to be whether or not the proposed model would continue to provide effective treatment to the seriously mentally ill. To determine the impact of the transition to the altered model of care and to mitigate against long term disadvantage for clients with serious mental illness, particularly those who had been clients of MIST prior to the changes to the model of care. The Health Complaints Commissioner made the following recommendations;

- 1. That clinicians over the 2 years following the introduction of the new model conduct annual audits 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 of care.*
- 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 (report into the investigation of the complaint relating to MHS proposed changes to a model of care).*

This report is provided in response to recommendation one and is not considered to provide any form of response in relation to recommendation two. The report is specific to the client cohort identified as being former clients of MIST and the information presented is not intended to provide information for any other purpose. However, the Oversight Committee recognise that in conducting this audit, of the specified client cohort, some information presented may touch on broader matters resulting from the changes to the model of care that are not only specific to the identified client cohort. The Oversight Committee also notes that in providing this audit it has not enquired into the reasonableness of expectations of the level of care and support that should be provided by the current model of care. The Oversight Committee has simply considered the information provided and has not attempted to make any assessment of the appropriateness of the level of service expectation.

The report is not intended to be a clinical research document however, it does offer a mix of quantitative and qualitative information in an attempt to examine the experience of changes to the model of care for the identified client cohort. Instead the report provides an examination of the identified client cohort and attempts to identify variations in the outcomes for the client cohort under the new model of care and includes the following primary components –

- A clinical file audit providing a needs assessment comparison for former clients of MIST prior to and following the changes to the model of care
- Analysis of clinical data for former clients of MIST prior to and following the changes to the model of care
- Analysis of data collected from survey responses (client and third party), individual interviews (client and third party) and focus groups (clients and third party). It should be noted that qualitative findings from staff, clients and third parties surveys, focus groups and interviews reflect input from a relatively small group of possible participants.

An Oversight Committee was convened by the Health Complaints Commissioner to report to the Commissioner in relation to the former clients of MIST and any variations in the outcomes for this group under the new model of care. The Oversight Committee is a committee of the Health Complaints Commissioner and was convened to provide a level of independent evaluation and transparency to the process and ensure appropriate engagement of all key stakeholders in the review process. In particular the Oversight Committee oversighted data collection, data analysis and proposed recommendations in relation to findings as a result of the review process.

The Oversight Committee comprised –

- A Consumer Consultant engaged by the Office of the Health Complaints Commissioner to inform the Oversight Committee on consumer issues relevant to the review of former clients of MIST following the change to the MHS model of care and to provide a level of independence to the Oversight Committee (Attachment 2 – Role of the Consumer Consultant).
- A representative from the Office of the Health Complaints Commissioner to represent the Commissioner and to provide a level of independence to the Oversight Committee.
- The Director Mental Health Services and the Chief Psychiatrist. Although it was noted these members may be viewed to have a conflict of interest it was considered these members were necessary to provide the required mental health expertise and an insight into the integrated model of care. It was considered any potential conflict of interest would be balanced by independent representation provided by the Consumer Consultant and the representative from the Office of the Health Complaints Commissioner. All members were required to agree on the final report provided to the Health Complaints Commissioner. It should also be noted that during the audit process the Director Mental Health Services moved from MHS to take up employment elsewhere with the Department of Health and Human Services. After this time the Director's delegate assumed the role on the Oversight Committee.

## **Findings**

After conducting the audit the Oversight Committee did not consider analysis of the information collected demonstrated significant benefit or detriment for the client cohort since the changes to the model of care. This may have been symptomatic of the small client sample group and the small number of participants throughout the audit process. However, the Oversight Committee considered the information provided indicators of changes in the level of

service provision which could potentially be indicative of improvement or reduction in level of service delivery to the client cohort.

### ***Indicators of improvement***

Areas of potential improvement indicated by the data collected during the needs assessment process included; an increase (although at times very minor) in relation to the number of clients with individual service plans, discharge plans, relapse plans and recovery plans, reduction of case managers involved in managing the financial affairs of clients. There was also an increase in occasions of service occurring for case management and psychiatric review suggesting a shift away from occasions of service being predominantly for psychiatric medication. This may be indicative of a focus of Mental Health Services on a recovery model.

The clinical data indicated areas of improvement for the identified client cohort and generally did not identify any areas of significant determinant since the changes to the model of care. Oars and Homer data showed a decrease in the inpatient episodes of care for the identified client group and a decrease in the number of individual clients from the cohort who have had inpatient admissions. The total number and duration of service contacts had also increased and a change in the location of service delivery was evident with an increase in occasions of service occurring in client residences.

The average length of stay, in inpatient units, for the identified client group had decreased as had the total bed days. It is acknowledged that reduction in average length of stay and bed days cannot in isolation be considered an indicator of improvement however, the combination of reduction in all related factors (inpatient episodes of care, individual admissions, total bed days and average length of stay may be indicative of improvement).

A decrease in the number of emergency presentations to the Royal Hobart Hospital for the identified client cohort was also indicated since the changes to the model of care. However it is acknowledged that this by itself may not be indicative of improvement however, in conjunction with decrease in the other related factors may also be indicative of improvement.

The clinical data also identified that the average HoNOS scores for the client cohort indicated a significant level of improvement since the changes to the model of care however, it is acknowledged that HoNOS data is subject to inter rater reliability issues. This is due to its relatively subjective assessment processes therefore differences in scores may occur when assessments for the same client are undertaken by different case managers. The clinical data also demonstrated that readmission rates for the client cohort had shown a decrease in the number of individual clients readmitted within a 28 day period, an overall reduction in the number of client admissions for the reporting period and a decrease in the 28 day readmission rate.

Incident reporting data demonstrates a decrease in significant incidents for the identified client group since the changes to the model of care. However, it is noted that a SAC I incident occurred during T2 which related to the unexpected death of a client from the identified cohort. The cause of death has yet to be determined and the matter is before the Coroner. As the matter is the subject of a coronial inquiry specific information cannot be provided. However, an internal review was undertaken by MHS and not root causes were determinable. It is also acknowledged that the incident reporting framework for MHS was implemented in late 2005 and there were a number of deaths of MIST clients, during the operation of the MIST

program which were not reported due to the incident reporting framework not being in place prior to late 2005.

### ***Identified changes in service provision and potential areas requiring improvement***

Information collected also indicated changes in the level of service provided. These changes could be indicative of client improvement and clients not requiring the level of care previously provided. Equally it could be indicative of a reduction in level of service provision.

The needs assessment indicated there had been a reduction in the number of clients receiving greater than one occasion of service in a week and a minor increase in clients receiving occasions of service one or less times per week. This could be indicative of deterioration in the level of care provided or alternatively it could be indicative of clients progressing in their recovery and subsequently requiring less frequent occasions of service.

The needs assessment also indicated an increase in the number of clients in inpatient care at the time of the assessment (post the changes to the model of care). This could be indicative of assessment at a point in time as clients concerned have had inpatient admissions prior to and post the changes to the model of care. However, it could also be indicative of the identified client cohort not receiving the level of clinical care required necessitating inpatient care. Historical comparison of inpatient admissions for the client cohort suggest a definitive determination cannot be made.

Information provided by client and third party feedback surveys and focus groups suggested common concerns in relation to the level of care or support provided, ease of accessing help in a crisis (in particular there was a common theme of concerns in relation to the MHS telephone Helpline not providing direct access to mental health case managers familiar with the client cohort, as had occurred prior to the changes to the model of care, ease of accessing a case manager, level of support from case managers (in particular the number of case managers, high client case loads, proposed model of assertive case management not occurring and lack of individual service plans including discharge plans to assist clients with their recovery).

Staff focus groups presented a common theme of concern in relation to a focus on “rehab readiness”, particularly by the non government sector, and the need for resultant through put as compromising the level of care and support provided to clients with high needs. Consequently it was considered there was a lack of focus of service delivery to the long term seriously mentally ill who required a slow stream long term rehabilitation recovery process. Concerns also included a move away from specialist services with the requirement now for clinicians to be generic workers, loss of practical support (meals, financial support, housing tenancies), loss of activities for the former MIST clients and a loss of community that was previously provided at the Peacock Centre. Feedback presented suggested this had resulted in a reduction in intensive support for clients with serious mental illness and in particular former clients of MIST.

It is proposed the concerns raised throughout the audit process can be categorised in three primary areas –

- Level of case management
- Accessing help in a crisis

- Service provision to people with serious mental illness (in particular former clients of MIST)

The Oversight Committee has proposed the following recommendations in response to these identified areas –

### ***Level of Case Management***

1. That Mental Health Services review current case loads, establish base line case loads in consideration of all variables and implement a process to monitor and review case loads.
2. That Mental Health Services benchmark current community fulltime equivalent (FTE) positions in consideration of those benchmarks provided for in the *Bridging the Gap* report into Mental Health Services and Mental Health Services work to address any identified gaps in current community FTE positions and those benchmarks proposed in the *Bridging the Gap* report.

### ***Accessing help in a crisis***

3. That Mental Health Services provide clarification to key stakeholder groups in relation to access points for crisis and after hours response.

### ***Service provision to people with serious mental illness(in particular former clients of MIST)***

4. That Mental Health Services undertake the same audit process at the 24 month mark to ascertain any variations in the outcomes for the identified client cohort under the new model of care.
5. That Mental Health Services identify and implement processes that better support continuity of care and the recovery approach for clients of Mental Health Services with serious mental illness including former clients of MIST.
6. That Mental Health Services undertake a process to improve collection and completion of BASIS 32 to enable collection of client perceptions/satisfaction with level of service provided.
7. That Mental Health Services assess the feasibility of implementing a consumer feedback tool such as the MH-CoPES tool (Measuring and Responding to Consumer Perceptions and Expectations of Services) to provide consumer feedback that is facilitated by consumers.
8. That Mental Health Services determine the impact of the integrated model of care on the broader client group through the establishment of KPI's which enable a meaningful measure of benefit v. detriment and client outcomes.