Pathways to Community Living Initiative

EVALUATION REPORT 1

Building the foundation for transformational change

October 2018

NSW GOVERNMENT

This report has been prepared by the Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong for the NSW Ministry of Health.

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The NSW Ministry of Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Preface From NSW Ministry of Health

This is the first of several reports of the four-year independent evaluation of the Pathways to Community Living Initiative (PCLI) by the Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

Established by the NSW Government in 2014/15 the PCLI builds on the work that Local Health Districts (LHDs), consumers, carers and advocacy groups have been undertaking for many years. These efforts have been about improving practice in health care settings (both hospital and community based) to enable people with Severe and Persistent Mental Illness (SPMI) who have long hospital stays to live meaningful lives in the community.

What the PCLI provides is an opportunity to extend and build upon this work. It aims to:

- facilitate the transition of long-stay patients (over 365 days) in our hospitals to move to the community, including the development of appropriate services, and
- support practice change to decrease the number and length of long-stay admissions.

This preface is written by the NSW Ministry of Health who commissioned the evaluation. It is an introduction to the wider evaluation, and to this first report. It highlights the main findings and the recommendations and briefly notes how these will be monitored for progress.

Purpose of PCLI Evaluation Report 1

This report outlines the scale of effort and investment in the establishment and initial three years (mid-2014 to December 2016) of the PCLI both at LHD and Ministry levels. It is intended as information for staff, consumers, families and carers and the broader public.

The PCLI: building on concurrent and previous work

The PCLI does not sit in isolation. No 'new' developments ever do. It could not occur without what has gone before or continue without the ongoing engagement of the mental health workforce, consumers, families and carers.

These previous influences include, the:

- early changes in institutional care arising from the 1983 Richmond Report and national inquiries
- gradual downsizing of bigger hospital sites over the years hence
- co-location of non-acute and acute mental health inpatient services with general acute hospitals, and
- significant advocacy work by consumers, families and carers and the NSW Ombudsman and the Mental Health Commission of NSW.

The PCLI is built on transformation processes at the larger hospital sites including Macquarie, Bloomfield, Cumberland, Kenmore and Morisset. It is growing alongside developments in the National Disability Insurance Scheme (NDIS). It is also predicated on programs that now form a foundation for work with people with complex mental illness. Examples of this are the NSW Health Housing and Accommodation Support Initiative (HASI) program and the Ministry of Health Older People's Mental Health (OPMH) program.

In June 2014, NSW had the highest number of long-stay patients in Australia at around 380. While change had occurred and was progressing, there was a need for greater leadership at a State level in collaboration with LHDs to address this level of institutionalised care.

Commissioning of the evaluation

At the start of the PCLI the NSW Government funded the commissioning of a high-grade quantitative and qualitative independent evaluation including formative and summative components. The purpose was to assess the extent to which the PCLI is meeting its aims, identify opportunities for refinement, and to inform future investment and practice change.

A key objective was to enable continual feedback and reflection as the program developed. Evidence from similar work overseas shows that where de-institutionalisation is stalling (or number of long stays increasing), is where reflective practice is not being progressed. The evaluation at this high-grade was also envisaged as placing this work by the NSW Government on the international research agenda, adding value to the evidence base for transitioning people to community care.

The Ministry conducted a competitive Australia-wide tender process and the evaluation was awarded to the Australian Health Services Research Institute, University of Wollongong under the leadership of Professor Kathy Eagar.

Main findings and recommendations of Evaluation Report 1

This report provides a reference point for subsequent reports. It details the preliminary planning, context, history, and early stages of program development and implementation.

The evaluators note that the PCLI has 'spotlighted' at a system-wide level the needs of a group of people who are still experiencing long periods of institutionalisation. It is seen as renewing a focus on this group and their rights and desires for self-determination. The PCLI is establishing robust systems to address the support needs of these people and enable them (in many cases) to achieve a life outside hospital for the first time in years.

It is emphasised that to further build system change and transform people's lives, requires sustained energy, vision and commitment. The report recommends that the NSW Ministry of Health and collaborating LHDs:

- Continue to foster the distributed leadership model over the ensuing years
- Renew the Communication Plan to extend the reach and reflect the stage of PCLI development
- Assist stakeholders to understand the nature of evaluation and to be involved
- Influence change through consistent messaging, evidence of success and program adaptations in response to unforeseen challenges and stakeholder feedback
- Sustain current approaches to consumer and carer engagement
- Support LHDs to further build recovery focused practice in front-line staff.

Since the period of this report many of these issues have been addressed as the PCLI has developed. All issues raised in the report will be followed up and monitored for progress through the PCLI Steering Committee. Renewing the communication strategy is a key project for 2019. Further information about the ongoing evaluation and the findings detailed in subsequent reports will be disseminated to key stakeholder groups throughout the initiative's implementation.

We have made significant progress. However, there is still much to be done to build a mental health system where we all accept, using the words of the PCLI consumer lead, that 'a hospital is not a home', and work collaboratively to achieve sustainable improvements in mental health service delivery.

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CHSD
centre for health service development

Acknowledgements:

The authors acknowledge the mental health professionals, consumers and families that have contributed to resources produced throughout the Pathways to Community Living Initiative, as these documents have informed the development of this report.

We particularly acknowledge the lived experience of people with a mental illness; your preferences, wishes, needs and aspirations are at the heart of this program, your perspective is essential to defining and achieving the goals of the Pathways to Community Living Initiative.

We would also like to thank staff from the funding body, the Ministry PCLI team and wider Mental Health Branch, NSW Ministry of Health, for their enthusiasm, assistance and ongoing commitment to this evaluation.

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Executive summary

The Pathways to Community Living Initiative (PCLI) was established to support the transition of long-stay mental health patients into appropriate community-based services. This is occurring as part of a decade-long whole-of-government enhancement of mental health care under the NSW Mental Health Reform 2014-2024, with significant investment by the NSW Government. The PCLI is led, funded and coordinated by the NSW Ministry of Health in collaboration with Local Health Districts.

The PCLI represents a system-wide transformational change for consumers and their families and the mental health workers who care for them. It is a significant investment in redesign of the way that mental health services are being delivered, particularly for consumers with long-term needs.

This is a challenging initiative, requiring sustained dedication and commitment as it involves:

- changing the knowledge, skills and attitudes of staff within mental health services;
- establishing new and/or enhanced partnerships with other organisations and sectors;
- introducing new models of care with adaptations to existing work practices; and
- sustaining a recovery-oriented and person-centred approach to working with consumers and their families/carers.

Purpose of this report

This document is the first evaluation report for the PCLI and is intended for a broad audience. It covers the period from mid-2014 to December 2016. It is the foundational report and as the first in a series, provides a reference point for all subsequent evaluation reports. The report captures the preliminary planning, context, history, and early stages of program development and implementation. It articulates the depth and complexity of this major program of practice redesign, changing practices from the usual ways of doing things that have been in place for many years. Through a focus on formative evaluation issues it highlights program achievements from conceptualisation and development, planning and the initial implementation phase.

The report has been produced by the evaluation team from the Centre for Health Service Development at the University of Wollongong, commissioned to undertake a formative and summative evaluation of the program. It is the product of a collaborative approach with the Ministry PCLI team.

Aims and scope of the PCLI

The PCLI has the twin aims of:

- transitioning 380 long-stay patients who have been mental health inpatients in either acute or non-acute inpatient units for over 365 days to appropriate community based service models; and
- providing improved and sustainable care pathways that embed a recovery approach for people with enduring mental illness.

The 380 people within the original cohort reflect two distinct groups:

- Adults with issues of ageing, approximately 100 (Stage One)
- Adults without issues of ageing, approximately 280 (Stage Two)

The PCLI is being implemented across NSW from mid-2014 to the end of 2020; however, a transformational change of this scale will require the best part of a decade to embed the patient pathways and service models.

There are six primary implementation sites: Macquarie Hospital, Cumberland Hospital, Morisset Hospital, Bloomfield Hospital, Concord Mental Health Centre and Liverpool Hospital. Liverpool was the last to join the PCLI.

State of play

The analysis draws on data from the Health Information Exchange collated by InforMH. The PCLI became operational in Local Health Districts in mid-2015 with early efforts invested in patient assessment and pre-transition planning. By October 2016 more than 200 long-stay consumers had been assessed and transitions were gradually building.

According to data from InforMH the mental health information unit, in the Ministry of Health (reported by hospital) for the period mid-2015 to December 2016, the size of the PCLI cohort decreased by 3%. There was an increase in the cohort at Liverpool Hospital but this was from a low base and may reflect local factors, a similar explanation is proffered for the long-stay cohort scattered across multiple 'other' facilities which also slightly increased. Three of the other main sites achieved a reduction in the PCLI cohort over this time period and there has been no change overall in two sites. More comprehensive reporting on assessments and transitions will be included in Evaluation Report 2 (up to June 2018) and updated in Evaluation Report 3 (up to December 2018).

Methods

The evaluation team's engagement commenced in January 2017. As the period of this report precedes this, the data sources for Evaluation Report 1 are documentary. Websites have been accessed to verify events and the evaluation team has had the opportunity to engage stakeholders in informal conversations about the early days of program development. The recent release by the Mental Health Commission of NSW (2018) of, *Paving the way home, Lessons from My Choice: Pathways to Community Living Initiative, Spotlight on Reform* has provided a useful touchstone to compare the findings of this report.

Transformational change

The PCLI meets the working definition of large system transformation as it represents a coordinated, system-wide change affecting multiple organisations and care providers. The purpose of the initiative is improvement in the health outcomes of the current cohort of long-stay mental health patients through introducing new models of care and permanently changing the pathways of care for people with persistent and complex mental illness.

The Mental Health Commissioner has referred to the PCLI as 'transformational' because it will change the lives of people with mental illness, and will also be transformational for the staff and workers in mental health (NSW 2017a, p.9).

Policy environment

The receptive context for change arose from a confluence of policy developments which contributed to the NSW Government's investment in this initiative. The PCLI is a key component of the Strategic Plan for Mental Health in NSW 2014 – 2024 and aligns with the major recommendations of the NSW Mental Health Commission document Living Well, A Strategic Plan for Mental Health in NSW 2014 – 2024.

- The development, implementation and evaluation of the PCLI has to be understood in terms of the prevailing contextual conditions.
- Changes in NSW mental health policy provided the impetus for change.
- Identifying differences in local context (the PCLI implementation sites), contributes to understanding how and why the program works, or doesn't.
- NSW Health is a decentralised organisation and can be characterised as a complex adaptive system.
- The behaviours of complex adaptive systems can usually be more easily influenced than controlled, consequently introducing change in a complex adaptive system is unlikely to work with a command and control approach to leadership.

Using the lens of complexity may help our understanding of some of the challenges facing implementation of the PCLI.

Program development

The genesis of the PCLI, like many transformational changes in mental health care, built slowly over several years from discussions amongst passionate mental health workers, clinicians, consumers and carers who fundamentally understood that 'a hospital is not a home' (a phrase attributed to the PCLI consumer lead). This willingness to challenge what was an accepted paradigm or model of care for long-stay patients with enduring mental illness and explore more contemporary pathways of care led to the PCLI.

The impetus for change came from a confluence of factors including:

- analysing the available data on long-stay patients in NSW mental health facilities;
- assessing the needs of long-stay patients with complex mental illness;
- recognising a receptive policy context supportive of complex care individuals, where possible having the right to live in the community;
- synthesising the evidence to inform new models of good quality community care;
- modelling different service options and preparing costings;
- leveraging off the experience of others through cross sectoral partnerships and advocating for bipartisan support;
- communicating with State agencies, regulatory bodies and other potential stakeholders;
- embracing the advent of the NDIS shifting the focus for service provision to a wider and more integrated community responsibility;
- harnessing the vision of committed individuals in LHDs who needed support; and
- adopting a planned approach to initiating the change.

Achievements in program development

The process of program development has been characterised by vision, energy and commitment.

This has spanned preliminary design and development work that began in May/June 2014 which includes:

- recognising a program's 'time has come' and initiating action for change;
- establishing an implementation team for the PCLI both within the Ministry and through funding positions in the Local Health Districts;
- reviewing the evidence about models of care and patient outcomes; ways to measure readiness to transition as well as barriers to transition for this patient cohort;
- communicating extensively with Chief Executives and Mental Health Directors of Local Health Districts; drafting media releases for the Minister; producing fact sheets targeted at staff working in mental health care in NSW and for consumers their families and carers; and presenting extensively to various stakeholder audiences, forums and conferences;
- building on the lessons from previous experiences, such as the development of Specialist Mental Health Services for Older People in NSW over the last 10-15 years and the experience of successful transitioning of long-stay mental health patients from Kenmore Hospital;
- developing initial costings to Treasury and internal business cases to inform the NSW whole-of-government reform process Strengthening Mental Health Care in NSW, announced in December 2014 and contributing to the Mental Health Reform Business Case that was submitted to the Economic Review Committee of Cabinet in August 2015;
- securing the inputs for the program (i.e. the resources that are invested to make the policy or program happen). Examples of such inputs include new policies, additional funding, additional staff and the establishment of partnership arrangements;
- identifying the PCLI patient cohort and through segmentation facilitating a staged approach to service development (Stage One and Stage Two); and
- establishing the six primary implementation sites.

Program implementation

The planning and initial implementation period extends up until December 2016. A detailed work plan is produced annually and used to monitor program milestones, as at December 2016 program implementation is on track.

The Ministry PCLI team is driving this complex change initiative using the mechanism of the PCLI quadrant model which depicts the four implementation components or 'quadrants' of action.

The four quadrants comprise:

- 'project/program processes' including governance and leadership, communication mechanisms, change and innovation management and workforce development;
- 'getting to know you' referring to individual planning and assessment; pre and post transition and transitions to community living;
- 'service development' comprising modelling, enhancements and tenders and partnerships, and
- 'information and evaluation' consisting of the PCLI program logic, data collecting and reporting and evaluation.

Achievements in program implementation

The major achievements in this period include:

- implementing effective underpinning program processes such as governance and leadership of the PCLI, communication, change and innovation management and workforce development;
- working collaboratively to build a distributed model of leadership with clear roles for the Ministry PCLI team and Local Health District partners;
- initiating pre-transition assessments across the six primary implementation sites and transitioning 3% of the long-stay patient cohort to appropriate community living;
- completing the procurement plan and releasing tender documents for Mental Health - Residential Aged Care Partnership Services (an expansion under the PCLI) and Specialist Residential Aged Care Facilities. This process was informed by a costing study of mental health residential aged care services;
- planning for the second stage of service development for people who are younger, aged 18 years upwards without issues of ageing;
- facilitating partnerships with diverse stakeholders to speed implementation, for example partnerships with NGOs and aged care providers;
- finalising the PCLI program logic which sets out the strategic objectives, performance activities, outputs and intended outcomes of the PCLI;
- building the initial data repository for PCLI specific data items and subsequently transferring this to an Access database to improve usability;
- establishing the Data and Information Management Group to ensure that data is collected and available for health planning purposes, reporting and evaluation of the PCLI program;
- developing the Evaluation Framework Model and engaging an external and independent evaluation team.

Summary of challenges moving forward and recommendations

Issues emerging through the evaluation process are summarised below using constructs to symbolise the five 'simple rules' that can enhance success in transformational change. Recommendations for addressing each challenge are included.

Leadership

Simple Rule 1: Engage individuals at all levels in leading the change

The PCLI currently has a model of distributed leadership in place. The pressure to generate momentum required a more directive approach in the early phase of the program. Over time the pendulum has swung back to the distributed leadership model and this has been demonstrated by communicating widely the aims, vision and strategies at the core of the PCLI and the focus on developing shared leadership of program processes.

What is clear is that in a distributed leadership model the change still needs to be managed actively and the Ministry continues to do this through supporting implementation sites and working hard to influence the wider NSW mental health service delivery system.

Recommendations

1. **Continue to foster the distributed leadership model throughout implementation of the PCLI.**

Collaborative monitoring and measurement

Simple Rule 2: Establish feedback loops

Routine reporting and celebrating program successes provides fuel to sustain implementation. The PCLI is a complex intervention and ongoing monitoring and evaluation is essential to ensure that the program is feasible, appropriate and acceptable and that program activities are being implemented as intended.

Those engaged in the PCLI and external stakeholders need to receive information about intermediate outcomes, for example completed assessments, training of LHD personnel or evidence of changes in work practices to facilitate new and improved care pathways. The Ministry PCLI team has used the six-month reporting template to capture achievements and the Dialogue Days to celebrate successes, both are useful measures. The PCLI Collaborative Group weekly teleconference is another important mechanism.

The challenge ahead is to sustain implementation and keep LHD personnel and other stakeholders involved as the PCLI 'is a marathon and not a sprint' and there is a real risk of 'change fatigue'. There is an ongoing need for training and vigilance in communicating the aims, purpose and processes of the PCLI. Providing feedback to mental health personnel about the PCLI evaluation is also imperative as their participation in interviews, surveys and observational site visits is essential to the evaluation.

Recommendations

2. **Review the PCLI Communication Plan to extend the reach to stakeholders within and external to NSW Health and ensure that messages reflect the stage of program development.**
3. **Assist those engaged in the PCLI to have realistic expectations about the trajectory of the evaluation and encourage their full participation.**

History and context

Simple Rule 3: Attend to history

Success depends on local history and a careful analysis of what has gone before. At the time of development the Ministry PCLI team demonstrated a sophisticated understanding of the prevailing mental health policy context and the role of the PCLI in meeting high level mental health reform objectives.

Each implementation site has its own local history, culture and unique mix of challenges. The patient cohorts also differ significantly between the sites and this means that various resources will be needed to manage patients effectively in the community.

Recommendations

4. **Influence entrenched cultures through consistent messaging, evidence of success and program adaptations in response to unforeseen challenges and stakeholder feedback.**

Clinical engagement and co-design

Simple Rule 4: Engage physicians

Doctors are of crucial importance to health system transformation because of their positional power and influence as opinion leaders. Appointing the NSW Chief Psychiatrist as the program sponsor reflected awareness of the need for medical leadership as did the engagement of a program clinical lead. However in an initiative of this scale wide engagement with the full spectrum of mental health workers is essential.

There is a need to balance achievement of program objectives and targets with maintaining service delivery. Similarly a balance has to be struck between standardising processes across the State and allowing flexibility to accommodate local needs.

Recommendations

5. **Identify opportunities for further engagement of medical personnel as the program progresses.**
6. **Maintain existing mechanisms to share lessons about local implementation, including the development or adaptation of processes.**

Patient and family centred involvement

Simple Rule 5: Involve patients and families

Ongoing program involvement of consumers and families is essential. Authentic engagement with consumers and carers in all aspects of the PCLI is one of its most important achievements. While there is strong leadership for a recovery focused approach this will take time to filter through to front-line staff and become apparent in day-to-day practice.

Recommendations

7. **Sustain current approaches to consumer and carer engagement.**
8. **Build ownership amongst front-line staff for recovery focused practice.**

Conclusion

This cohort of 380 long-stay patients has experienced long periods of institutionalisation due to their enduring, severe mental illness and high support needs.

The PCLI has shone a spotlight on this group and their rights and desires for self-determination. This reform initiative is establishing sustainable, robust systems to address support needs and enable these people to envisage and (in many cases) achieve a life outside hospital for the first time in many years. The PCLI is building the foundation for transformational change but there is much still to do, requiring sustained energy, vision and commitment.

The essence of leadership is bringing about change in complex systems (Minas 2005, p.33).

1 Background

1.1 Introduction

The Pathways to Community Living Initiative (PCLI) was established to support the transition of long-stay mental health patients into appropriate services as part of a decade-long whole-of-government enhancement of mental health care under the NSW Mental Health Reform 2014-2024. This initiative is evidence based and a key component of the reform underpinned by substantial investment from the NSW Government. The PCLI is led, funded and coordinated by the NSW Ministry of Health in collaboration with Local Health Districts (LHDs).

1.2 Purpose and scope of this report

This document is the first evaluation report for the PCLI and is intended for a broad audience. It provides a reference point for all subsequent evaluation reports. This report addresses preliminary formative evaluation issues but principally aims to capture the history, context and early stages of the development of the PCLI. It covers the period from mid-2014 to December 2016 and provides a detailed understanding of the genesis and design of the program, its structure and mechanisms and anticipated outcomes, concluding with the authorisation of contracts for the Stage One service development.

The report illustrates the significant investment of effort and early achievements of the initiative in building the foundation for transformational change, establishing how people with severe and persistent mental illness in NSW can be transitioned from a long-stay hospital environment to a 'home' in the community. The heterogeneity and differing needs of this long-stay patient cohort means that the most appropriate 'home' will differ for various patient groups.

1.3 Methods

The evaluation team's engagement commenced in January 2017. As the period of this report precedes this, the data sources for Evaluation Report 1 are documentary. The Ministry PCLI team facilitated access to program documentation and was available to respond to any points requiring clarification. Various websites have been accessed to verify particular events, for example policy developments.

During the course of producing this report the evaluation team has had the opportunity to observe interactions between program stakeholders and to engage with them in informal conversations about the early days of program development. The recent release by the Mental Health Commission of NSW (2018) of, *Paving the way home, Lessons from My Choice: Pathways to Community Living Initiative, Spotlight on Reform* has provided a useful touchstone to compare the findings of this report.

1.4 Planning for transformational change

Within NSW mental health practitioners, policy makers and consumers have been contributing to service developments and practice improvements over many years. Frequently these initiatives may be small in scale, focus on a particular component of a service or be implemented in relatively few locations. The PCLI is evidence based, complex, multi-pronged, encompasses all of NSW and will need to extend over a ten year time frame to ensure sustainability. It has clear aims (outlined in Section1.5.2) and an aspirational vision coined by the PCLI consumer lead: 'a hospital is not a home'.

The Mental Health Commissioner has referred to the PCLI as 'transformational' and not only because it will change the lives of people with mental illness, but also it will be transformational for the staff and workers in mental health (NSW Health 2017a, p.9).

Best, Greenhalgh et al. (2012, p.422) provide a working definition of large-system transformation:

Large-system transformations in health care are interventions aimed at coordinated, system wide change affecting multiple organizations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes.

A recent review of the literature on large-system transformation in health care identified five 'simple rules' that can enhance success (Best, Greenhalgh et al. 2012, pp.433-442). These are reproduced below:

1. Engage individuals at all levels in leading the change efforts (we have framed this as 'leadership').
2. Establish feedback loops (we have framed this as 'collaborative monitoring and measurement').

3. Attend to history (we have framed this as 'history and context').
4. Engage physicians (we consider this issue more broadly as 'clinical engagement and co-design').
5. Involve patients and families (we refer to this as 'patient and family centred involvement').

These simple rules and the framing concepts are used to structure our discussion of the challenges moving forward and associated recommendations to strengthen program implementation and evaluation (refer to Section 4).

1.5 Overview of the PCLI

The NSW Government has funded the PCLI to provide pathways out of long term hospital care to a home in the community for people with enduring and complex mental illness. A group of patients (approximately 380 individuals) with various levels and types of debilitating illness will co-design with the PCLI representatives, their clinicians, families and friends, a way of moving into the community. These pathways will be developed with each individual having an opportunity to create a vision for their future (NSW Health 2016d, p.7).

1.5.1 Philosophy and vision

The philosophy behind the initiative is that everyone has the right to live in a community setting. Evidence shows that people with enduring and severe mental illness can experience better quality of life and improved social and health outcomes by living in the community (NSW Health, undated-a).

The PCLI supports an increased focus from hospital to community-based services across all mental health services in NSW and has a vision to:

- transition long-stay patients out into the community; and
- improve care pathways for people with enduring mental illness to decrease long-stay admissions (NSW Health 2016d, pp.9-10).

1.5.2 Aims of the PCLI

In collaboration with LHDs and other partners, the PCLI is a coordinated State-wide initiative led by the Ministry to:

1. Create contemporary, recovery-oriented services for around **380 people** who have been mental health inpatients for 365 days in:
   - Acute inpatient units (around 40, 3% of acute beds)
   - Non-acute inpatient units (around 340, 50% of non-acute beds)
2. Improve care pathways for people with enduring mental illness to decrease long admissions (NSW Health 2016d, p.9).

The 380 people within the original cohort reflect two distinct groups:

- Adults with issues of ageing, approximately 100 (Stage One)
- Adults without issues of ageing, approximately 280 (Stage Two)

The strategic outcomes of the PCLI at completion will include:

- **Long-stay patient transition**
  - The number of long-stay patients in mental health facilities in NSW will have decreased.
  - Individuals will have transitioned successfully to high quality community placements with individually tailored 'wraparound' clinical and support services, and with permanent accommodation options and will show improved health outcomes.
- **Improved care pathways**
  - A gap analysis and a future service spectrum will have been delineated for people with enduring mental illness across all settings and sectors.
  - Services will be supported to implement a re-configuration of existing resources, and/or additional service pathways.
  - Services will have developed a contemporary model of care across inpatient and community to embed a recovery approach,
  - There will be a decrease in the build-up of long-stay admissions (NSW Health 2016d, pp.9-10).

Successful implementation of the PCLI may improve access to mental health beds; however this is dependent on factors such as future population growth, trends in demand for services and the availability of an appropriately skilled workforce.

1.5.3 Structure of the program

The PCLI is a complex, multi-faceted and large-scale intervention. It is structured in a series of phases as outlined in Figure 1 below (NSW Health 2017b). The initiative commenced in June 2014 and while the work is articulated over a 5-8 year time period, in reality it is likely that a decade long period of implementation will be necessary to effectively embed and sustain the new models and pathways of care for long-stay mental health patients.

Figure 1 PCLI Phases June 2014 – December 2020

1.5.4 NSW Treasury Key Performance Indicators

The NSW Mental Health Reform Monitoring Framework included two key performance indicators (KPIs) for the PCLI based on the Mental Health Reform in NSW Business Case submitted to NSW Treasury in May 2015:

Outputs - Years 1 – 3:

- Number of long-stay clients assessed[1].
- Number of local health service clients transitioned to the community.

These KPIs provided an imperative for the speedy development and implementation of individual planning and assessment processes. Further funding remains reliant on achieving certain targets and expected outcomes against these KPIs.

1 There was an expectation that all 380 long-stay clients would be clinically assessed by June 2018.

1.6 Mental health policy and service delivery environment

At a national level mental health reform was in the spotlight in the early 1990s with the then Australian Health Ministers' Conference endorsing the *National Mental Health Strategy* in 1992. The strategy integrated mental health policy, a national mental health plan and mental health statement of rights and responsibilities. The strategy has four core aims:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental disorder;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental illness (Department of Health 2014).

The mental health policy landscape in Australia has evolved since the *National Mental Health Strategy* was endorsed by the Australian Health Ministers in 1992. From that time several *National Mental Health Plans* have been released with mental health reform shifting the focus from institutional care to supporting individuals in the community with greater emphasis on prevention and early intervention (Parham 2007).The *National Mental Health Policy* was revised in 2008 and the *Fourth National Mental Health Plan* was released in November 2009. The *Mental Health Statement of Rights and Responsibilities* (first adopted in 1991) was revised in 2012 to reflect modern mental health care concepts and contemporary human rights legislation (Department of Health and Ageing 2012). It was envisaged that states and territories would consider the statement in the context of their mental health operations. In January 2012 the federal government established the National Mental Health Commission to monitor and evaluate the national mental health system and provide policy advice to government. A draft *Ten Year Roadmap for National Mental Health Reform* was released for consultation and recommended increasing access to various levels of stable accommodation to assist people with severe and persistent mental illness and complex care needs (NSW Ombudsman 2012, p.12).

The implementation focus at a national level has been on 'changing systems and structures to create better environments for health and enhancing resilience in order to promote positive health and prevent mental illness' (Parham 2007, p.175). While policy at a national level can provide impetus this is accelerated when alignment occurs with State and Territory government policies as it is this latter tier of government that funds hospitals and health services and their associated workforces.

1.6.1 Policy context

NSW has a long history of mental health care. The Mental Health Act 2007 (and subsequent amendments) provides the legislative framework within which service delivery is provided. It is beyond the scope of this report to provide a detailed history of NSW mental health policy implementation however three pivotal developments are briefly discussed as they provide important context about the genesis of the PCLI. These include the 2012 NSW Ombudsman Report *Denial of rights*; the establishment of the NSW Mental Health Commission and release of the *Living Well* strategic plan and companion report and the NSW Government's response, *Strengthening Mental Health Care in NSW*.

1.6.1.1 NSW Ombudsman Report 2012

In November 2012 the NSW Ombudsman tabled a Special Report to Parliament under s.31 of the Ombudsman Act 1974. The report entitled *Denial of Rights*: *The Need to Improve Accommodation and Support for People with Psychiatric Disability* focused on 'people who live in mental health facilities beyond the point at which they to need to be there; and the multiple barriers that prevent them from leaving.' (NSW Ombudsman 2012, p. i).

The report arose from an inquiry commenced by the NSW Ombudsman in June 2011 in response to concerns raised by the Public Guardian and other stakeholders about the number of people living in mental health facilities who no longer needed to be there. Amongst the 95 patients included in this review, over half had been admitted to a mental health facility for between two and ten years. The inquiry found that two people were admitted as teenagers and had remained in hospital for over 40 years (NSW Ombudsman 2012, p.1).

The report identified the impending National Disability Insurance Scheme (NDIS) as a mechanism to prompt greater inter-agency cooperation. It argued for a genuinely collaborative and person-centred approach to supporting people with

psychiatric disability that could be implemented sustainably. The primary findings of the review suggested that an estimated one-third of people currently living in mental health facilities in NSW could be discharged to the community, if appropriate accommodation and supports were available. However appropriate community-based accommodation and support options were scarce and in combination with the other multiple barriers to discharge within the health and community service system, transitioning people with severe and persistent mental illness was difficult.

The report referred to the *NSW Community Mental Health Strategy 2007-2012* which had outlined the directions for community mental health services in NSW over a five year period. Particular reference was made to the Housing and Accommodation Support Initiative (HASI), a partnership established in 2003 between NSW Health, Housing NSW and the Non-Government Organisation (NGO) sector to provide stable and secure accommodation with psychosocial rehabilitation accommodation support (NSW Health 2017d). This was subsequently expanded to include 'HASI in the Home'. (NSW Ombudsman 2012, p.13). The development of the HASI Plus program for consumers with severe or persistent mental illness who require higher levels of accommodation and support services than those provided by HASI was perceived as a positive development. While the HASI was seen to be an effective model of supported accommodation and agency partnership for people with severe mental illness and associated disability, the number of places was insufficient to meet demand, as was the number of hours per day support (NSW Ombudsman 2012, pp.3-4).

The review concluded that there was a need for community-based accommodation and support models for people with severe mental illness and associated disability, as well as flexibility in the system to respond to changing needs. Mental health staff also consistently told the reviewers that the range of community accommodation and support options needed to expand in order to give individuals real choices and to facilitate the discharge of people to less restrictive options (NSW Ombudsman 2012, p.58).

In its response to the 2012 report by the NSW Ombudsman, the NSW Government had already committed to resolving the systemic issues leading to these circumstances, and to developing appropriate care plans to support these individuals' transition into the community. However there was understanding that there was still a long way to go and the process of de-institutionalisation must address the community-based support services needed by each individual (NSW Ombudsman 2012, p.92).

1.6.1.2 NSW Mental Health Commission

The NSW Government established the Mental Health Commission of NSW in 2012. It was tasked with the role of monitoring, reviewing and improving mental health and wellbeing for the people of NSW (NSW Ministry of Health 2015).

The NSW Mental Health Commission released *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024*, in 2014. It was supported by a companion report *Living well: Putting People at the Centre of Mental Health Reform in NSW*: A Report. This strategic plan and report demonstrated the Commission's deep respect for the lived experience of those with mental illness and the centrality of these perspectives as well as those of families and carers to the strategies outlined. It emphasised that the agenda for change must 'put people at the heart of its thinking' (NSW Mental Health Commission 2014).

In the strategic plan's introductory letter from the Commissioner is the following statement:

Many positive changes are already under way. In NSW, government agencies and community organisations are enthusiastically embracing new approaches that acknowledge that people who experience mental illness can and should expect to live well on their own terms, in their own homes, and be empowered to make their own choices. (NSW Mental Health Commission 2014, p.5).

The magnitude of the change required to achieve this was described as a reorientation of the system from a focus on hospital beds to other forms of support offered in or close to people's homes. The Commissioner also recognised the imperative of laying the groundwork for change within the mental health sector and the importance of a person centred, strengths based and recovery oriented approaches to reform. The Commissioner called on the NSW Government to complete the process of reform that began with the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (Richmond Report) in

the 1980s through taking action to 'close the remaining stand-alone psychiatric institutions and shift the focus of mental health care from hospitals to the community' (NSW Mental Health Commission 2014, p.4). The strategic plan reported that long-term institutionalisation was a continuing practice and reported on the numbers of mental health inpatients in the NSW public health system that had been in hospital for more than a year noting that the majority of these people (87%) were accommodated in older, stand-alone psychiatric institutions know as Schedule 5 hospitals (NSW Mental Health Commission 2014, p.60).

The Mental Health Commission recognised that the NSW Government was committed to supporting the transition of these long-stay patients into the community but to achieve this individuals would require personalised support, appropriate community-based services and purpose-built accommodation. The mental health workforce would need training and support 'to work in the community-based mental health sector of the future' (NSW Mental Health Commission 2014, p.61).

1.6.1.3 NSW Mental Health Reform 2014-2024

In response to the *Living Well* strategic plan and companion report, the NSW Government announced in 2014 a decade-long whole-of-government reform process *Strengthening Mental Health care in NSW* (NSW Health undated-b). A central plank of this reform was assisting long-term patients to live in the community, with the announcement that:

New community residential options will continue to be designed for the 380 people currently receiving long-term hospital care in non-acute and acute units in NSW. Each long-stay patient will be clinically assessed and staff will work with each and every person to create a plan based on their individual needs. (NSW Government, Health 2014).

A series of fact sheets and media releases were issued in late 2014 that outlined the reform directions proposed by the NSW Mental Health Commission and embraced by the Government. The major reforms were summarised as:

- Strengthening prevention and early intervention
- Shifting the focus to community based care
- Developing a more responsive system
- Working together to deliver person-centred care
- Building a better system.

The reform 'Shifting the focus to community based care' specifically referred to the transition of patients in long-stay psychiatric hospitals into community based residential options, supported by strengthened specialist community mental health services. (Q1 14c).

An inter-departmental Mental Health Reform Taskforce was established under the leadership of the Secretary of NSW Health to oversee implementation of these reforms. The NSW Mental Health Commission was also tasked with monitoring implementation.

The PCLI is a major element of the *Strategic Plan for Mental Health in NSW 2014 – 2024* and aligns with the recommendations of the NSW Mental Health Commission in *Living Well*, A *Strategic Plan for Mental Health in NSW 2014 – 2024*. It is a key component of the 'Reform' underpinned by substantial investment from the NSW Government.

1.6.1.4 National Disability Insurance Scheme

In 2010 the Australian Government asked the Productivity Commission to carry out a public inquiry into a long-term disability care and support scheme. The clear and over-arching finding was the current system did not work. In March 2013 the National Disability Insurance Scheme (NDIS) Act 2013 was passed and the scheme itself created along with the National Disability Insurance Agency. The NDIS will provide all Australians under the age of 65 who have a permanent disability with the reasonable supports they need to live an ordinary life. Funding is provided to eligible people based on their individual needs, it is goal oriented and outcome focused. The NDIS represents a fundamental shift in the way disability supports are provided for Australians who have a significant and permanent disability as it aims to be person-centred. Participant choice and control are core features of the scheme's design.

For the purposes of the NDIS disability is defined as follows:

Disability: total or partial loss of the person's bodily or mental functions (the Disability Discrimination Act 1992). Describes a person's impairment of body or function, a limitation in activities or a restriction in participation when interacting with their environment (NDIS 2018 p.130).

The scheme does not replace mainstream health services and it is not intended that all elements of a

person's support needs are met through NDIS funded support. The NDIS funds reasonable and necessary non-clinical supports that focus on a person's functional ability (NSW Health 2018a). The National Mental Commission considers the NDIS to be an important initiative with its promise of individualised care and choice for eligible people with psychosocial disability (National Mental Health Commission 2018). The strategic focus of the NDIS on individual care, choice and control fits well with the national and state mental health reforms.

1.6.2 Service delivery environment

The NSW Ministry of Health has the role of 'system manager' and through the NSW public health system it provides the people of NSW with hospital-based, community health and public health services. Service delivery occurs through a network of LHDs with specialty networks and non-government affiliated health organisations, known collectively as NSW Health. The Ministry of Health ensures that service developments and investments align with the government's strategic priorities (NSW Health 2018b). Eight LHDs cover the greater Sydney metropolitan regions and seven cover rural and regional NSW. In addition, two specialist networks focus on children's and paediatric services, and justice health and forensic mental health. A third network operates across the public health services provided by St Vincent's Hospital, the Sacred Heart Hospice at Darlinghurst and St Joseph's at Auburn (NSW Health 2018c).

NSW Health has a devolved governance structure that joins local decision making with a strong accountability framework. LHDs are responsible for providing health services to defined geographical areas of the state through their respective Boards and Executive teams and enter into service agreements with the Ministry of Health. They are supported by the Clinical Excellence Commission, Agency for Clinical Innovation, Health Education and Training Institute, Bureau of Health Information, Office of Health and Medical Research, Cancer Institute of NSW and the NSW Mental Health Commission (NSW Health 2017c).

While there are structural similarities amongst LHDs each has a unique service delivery context that is a product of its population, geography, history, organisational culture, strategy, leadership, infrastructure and resources. This decentralised organisational structure poses particular challenges for the implementation of transformational change initiatives. To effectively implement transformational change in a large, complex and decentralised organisation requires deep engagement and collaboration with diverse stakeholders at multiple levels of the organisation. The assimilation of a significant change by an organisation is an organic process and often messy as the organisation moves 'back and forth between initiation, development, and implementation, variously punctuated by shocks, setbacks and surprises (Greenhalgh, Robert et al. 2004, p.601).

1.6.3 Complexity of health care

Any discussion of the context for implementation of the PCLI would be incomplete without reflecting on the complexity of health care. It has been argued that Australia's mental health system can be conceived of as a complex adaptive system and that such a conception provides useful guidance for leadership for change. Not only is the Australian mental health system 'complex in the everyday sense of being complicated, the system is complex in the more formal sense of having the features of a dynamical or complex adaptive system' (Minas 2005, p.34). The same could be argued for NSW Health and its components (for example the Ministry and LHDs) also represent complex adaptive systems.

Complex adaptive systems are to be found everywhere. They are composed of subsystems and are part of supra-systems. They are nonlinear and dynamic; consequently, system behaviours can appear to be random or chaotic. They include multiple levels of organisation and open boundaries, meaning people can belong to multiple subsystems or groups, and membership of the system changes as individuals move in or out of the system. The agents in the mental health system are individuals (clinicians, managers, clerical and other support staff) and organisations (hospitals, community mental health centres, NGOs, academic departments, mental health branches of health departments, etc.) The agents and the system are adaptive. The behaviour of a system emerges as a result of the rich interaction over time of multiple component agents and of the system within its context (Minas 2005, p.38). Importantly, the behaviours of complex adaptive systems can usually be more easily influenced than controlled (Rouse 2008). Using the lens of complexity may help our understanding of some of the challenges facing implementation of the PCLI.

1.7 Summary of key points

- The development, implementation and evaluation of the PCLI has to be understood in terms of the prevailing contextual conditions.
- Changes in NSW mental health policy provided the impetus for change.
- Identifying differences in local context (the PCLI implementation sites), contributes to understanding how and why the program works, or doesn't.
- NSW Health is a decentralised organisation and can be characterised as a complex adaptive system. Introducing change in a complex adaptive system is unlikely to work with a command and control approach to leadership.

2 Program development - Phase 1

The genesis of the PCLI, like many transformational changes in mental health care, built slowly over several years from discussions amongst passionate mental health workers, clinicians, consumers and carers who fundamentally understood that 'a hospital is not a home'. This willingness to challenge what was an accepted paradigm or model of care for long-stay patients with enduring mental illness and explore more contemporary pathways of care led to the PCLI.

Several of the strategic drivers are depicted in Figure 2 (NSW Health 2016d).

Figure 2 Strategic drivers for the PCLI

The impetus for change came from a confluence of factors, including:

- analysing the available data on long-stay patients in NSW mental health facilities;
- assessing the needs of long-stay patients with complex mental illness;
- recognising a receptive policy context supportive of complex care individuals, where possible having the right to live in the community;
- synthesising the evidence to inform new models of good quality community care;
- modelling different service options and preparing costings;
- leveraging off the experience of others through cross sectoral partnerships and advocating for bipartisan support;
- communicating with State agencies, regulatory bodies and other potential stakeholders;
- embracing the advent of the NDIS shifting the focus for service provision to a wider and more integrated community responsibility;
- harnessing the vision of committed individuals in LHDs who needed support; and
- adopting a planned approach to initiating the change.

2.1 Undertaking preliminary design and development

Against the dynamic NSW mental health policy background (refer to Section 1.6), experienced mental health clinicians and policy officers within the Ministry of Health had been anticipating recommendations from the Mental Health Commission's *Living Well* report. Consequently, an internal scoping paper was produced in March 2014 outlining the breadth and complexity of work required to transition long-stay hospital patients into community care. An implicit assumption was that to develop an appropriate initiative of the scale needed to address this issue of long-stay patients would ideally require a minimum of 12 months.

A project team was formed including representatives from Mental Health and Health System Management (including InforMH) to undertake the initial program development work that would culminate in the PCLI.

The Ministry PCLI team identified that:

In June 2014, out of a total of 2,123 patients aged 18 and over (excluding forensic units), there was a group of around 380 people who had been patients in a mental health inpatient unit for over 365 days. Data shows a similar quantum for the past few years. There is some movement in and out of this group. Some people are very long-stay, sometimes over 20-30 years (NSW Health 2016d, p.12).

The majority of people were on five major hospital sites: Macquarie Hospital, Cumberland Hospital, Morisset Hospital, Bloomfield Hospital and Concord Mental Health Centre.

The analysis of the long-stay mental health patient cohort identified two distinct patient groups:

- People with issues of ageing (Stage One)
- People (adults) without issues of ageing (Stage Two)

This led to a decision to focus initially on long-stay mental health patients with issues of ageing and new models of care with residential aged care facilities. The decision to focus on this group first was due to the fact that there were already mental health-residential aged care partnership models developed and evaluated under the NSW Older People's Mental Health (OPMH) program, and these were part of ongoing OPMH service models and strategic directions. PCLI would give impetus and support to expansion of these models, and established OPMH service structures and leadership, experience and directions would support successful PCLI implementation. This subsequently came to be known as the 'Stage One Service Development Phase' and will be discussed in detail in Section 3.3.

The *My Choice: PCLI Project Development Guidelines* (NSW Health 2016d) and the associated *Appendices* (NSW Health 2016e) provide a comprehensive overview of how patient needs were analysed to refine the patient cohort, the evidence-based approach using previous program evaluation findings, national and international literature, and how broad service models were determined. The investment of effort to complete the planning and development work within extremely tight timeframes is an indication of the commitment of the Ministry PCLI team, Mental Health Branch and LHD colleagues.

2.2 Synthesising the evidence base

The Ministry PCLI team ensured that evidence was gathered about the outcomes arising from evaluations of long-stay patient transition programs around the world, predominantly in the United Kingdom, United States and Canada. The evidence was summarised in an annotated bibliography. This preliminary work fed into a commissioned evidence check (the first of two produced to guide program development), *Transitioning long-stay psychiatric inpatients to the community* (Matheson and Carr 2015). The authors searched academic databases and grey literature to investigate models of care and patient outcomes, ways to measure readiness to transition, and barriers to transition for this patient cohort.

The review identified the importance of the following:

- A readiness-for-transitioning program that commences in hospital;
- The availability of suitable and secure housing in the community;
- Access to the post-discharge services likely to be required by people with complex needs, including 'ongoing psychosocial rehabilitation that is consistent with a recovery model, and disability support that aims to equip patients with living skills and promote independence';
- Implementation of a recovery focused model which includes ongoing training of clinical and non-clinical staff;
- A well-articulated model of care which includes the roles and responsibilities of stakeholders and formal partnership agreements to facilitate integration of services;
- 'Strong political and senior management commitment and leadership, clear and open communication and clarity in expectations' (Matheson and Carr 2015, p.22).

A second evidence review completed later in the program is referred to in Section 3.3. This was a necessary investment to engage health professionals, large-scale healthcare interventions that aim to influence treatment or care of people require compelling evidence and systematic evaluation (Crump 2008).

2.3 Communicating and partnering

While the evidence base was being assembled, advice was sent by the Deputy Secretary, System Purchasing and Performance to Chief Executives of LHDs announcing the *Mental Health: Hospital to Community Initiative*, outlining progress and flagging the need for further planning and input from LHDs. Subsequently, meetings were arranged with Mental Health Directors in each LHD by the project team.

Extensive communication occurred over the ensuing period; internally within the Ministry and externally with Chief Executives and LHDs. The Ministry PCLI team was keen to engage and harness the expertise of the broader NSW Health mental health workforce and learn from the experiences of the existing acute and non-acute units with long-stay patients. An expert reference group was established and LHD Mental Health Directors asked for their leadership and support.

Wide-ranging issues were raised that had to be addressed within the context of the proposed initiative, for example, the projected impact of the introduction of the National Disability Insurance Scheme (NDIS); implications for the mental health nursing workforce; why social impact investment was not a feasible strategy for this patient cohort, and so on. The communication with mental health personnel in LHDs with higher numbers of long-stay patients and the plethora of other stakeholders led to the development of the PCLI Communication Plan. This was an important step as it provided a planned approach to engaging important government and NGOs as well as professional organisations and industrial bodies (for details, see Section 3.1.2.1).

Meetings and correspondence occurred between Ministry representatives and LHD Mental Health Directors to engage them in the initiative and ensure they were informed prior and subsequently to the NSW Government announcing its response to the *Living Well* report. Several media releases were issued by the Minister in December 2014 about mental health reform and the long-stay patient program. Fact sheets were produced, targeted particularly at staff working in mental health care in NSW, consumers, their families, and carers. An extensive series of presentations were delivered to various stakeholder audiences, forums and conferences. These were delivered by members of the Ministry PCLI team, particularly the PCLI Program Manager and Clinical Lead with assistance from LHD representatives.

2.4 Building on what has gone before

There were several factors that contributed to a receptive context for the PCLI. Many pre-dated the PCLI, and allowed the Ministry PCLI team to 'build on the shoulders of others'. This willingness to learn from previous successes and failures helped the team to focus on the segments of the patient cohort where early successes were likely.

For example, the development of the OPMH services (formerly Specialist Mental Health Services for Older People; SMHSOP) in NSW over the last 10-15 years provided a strong platform (NSW Department of Health 2006) that facilitated the focus on consumers with issues of ageing in Stage One of the PCLI. The 2004 report of the *Severe and Persistent Challenging Behaviours Project*, was undertaken by the Faculty of Psychiatry of Old Age (FPOA), Royal Australian and New Zealand College of Psychiatrists, New South Wales, with funding by NSW Health. This report was deemed an important precursor to the establishment of two pilot services within residential aged care facilities in NSW (Faculty of Psychiatry of Old Age 2004). These pilot services were funded under the Mental Health Aged Care Partnership Initiative (MHACPI) and would subsequently provide the evidence base for the MHACPI units in the PCLI (Health Policy Analysis 2013). One of these services, in Sydney Local Health District, had involved the transitioning of a significant number of long-stay patients from Rozelle Hospital into a MHACPI unit within a residential aged care facility. The HASI program (referred to in Section 1.6.1.1) has expanded considerably in the intervening years and the lessons learnt from the HASI evaluation have informed the development of the PCLI (Bruce, McDermott et al. 2012).

The Ministry PCLI team looked for LHDs that had experience with this patient cohort and organisational support (such as an executive lead) for transitioning long-stay mental health patients. They recognised the importance of early collaboration with the LHDs with the highest numbers of long-stay mental health patients.

They were particularly interested in learning the lessons from the experience of Kenmore Hospital, a specialist psychiatric hospital in Goulburn, NSW. Between 2012 and 2014, prior to the commencement of the PCLI, a team had successfully transitioned a small group of long-stay mental health patients from a psychogeriatric unit (the David Morgan Centre) into community-based accommodation. The success of this LHD-based initiative demonstrated that transition for an older patient cohort was possible and many valuable lessons were learned from this early experience.

2.5 Securing funding

The Ministry was tasked with proposing initial costings to Treasury for transitioning long-stay consumers to the community. Throughout August to October 2014, intensive effort was invested by the Mental Health Branch in developing internal business cases. They were essential to inform the NSW whole-of-government reform process *Strengthening Mental Health Care in NSW*, announced in December 2014 as the government's response to the Mental Health Commission *Living Well* report. The imperative to meet Treasury timeframes generated significant pressure to produce preliminary Models of Care for Stage One services and indicative Models of Care for Stage Two, as well as costings and proposed cash flows. The cost modelling for Stage One services built on the experience with the pilot MHACPI units and an economic evaluation of these.

Subsequently, the Ministry developed a detailed Mental Health Reform Business Case, successfully submitted to the Economic Review Committee of Cabinet in August 2015.

2.6 Identifying the patient cohort

The patient cohort includes people who have enduring mental illness and complex care needs and includes approximately **380 people** who have been mental health inpatients for 365 days in:

- Acute inpatient units (around 40, 3% of acute beds)
- Non-acute inpatient units (around 340, 50% of non-acute beds), (NSW Health 2016d, p.9).

The people who are long-stay form only a proportion of patients on the major mental health sites. This is reflected in the indicative data in Table 1 that was used to inform the internal business cases. As patients' care needs change they can move in and out of facilities and this means that patient numbers may fluctuate slightly when reported at different time points (NSW Health 2016d).

Table 1 Total funded beds on major mental health sites in NSW – June 2014

Facility	Total beds	Number of long-stay patients
Bloomfield	235	34
Concord	177	31
Cumberland	261	111
Kenmore	54	4
Macquarie	195	117
Morisset	130	39
Total - Major Sites	1052	336
Other facilities		44

Note. Data sourced from InforMH, 2014. At this time, Liverpool was not yet a primary implementation site for the PCLI.

As noted in Section 2.1, for service development purposes this cohort was sub-divided:

- People with issues of ageing, approximately 100 of the original patient cohort (Stage One)
- People (adults) without issues of ageing, approximately 280 of the original patient cohort (Stage Two)

2.7 Primary implementation sites

Phase 1 culminated with the funding of PCLI Project Manager positions in six LHDs (Northern Sydney, Western Sydney, Hunter New England, Western NSW, Sydney and South Western Sydney LHDs). This formed a State-wide 'virtual team' to support the implementation of the PCLI.

These six primary implementation sites were chosen because the hospitals in these LHDs house most long-stay mental health consumers in NSW public hospitals. Between them, these six sites had an average of 10,705 mental health admissions each year between 2012 and 2016, ranging from 82 at Morisset to 5,868 at Concord (Table 2).

Table 2 Annual mental health admissions to the six main hospitals involved in PCLI, 2012-2016

Hospital	2012–13	2013–14	2014–15	2015–16	Average
Bloomfield	1,125	1,121	1,060	1,008	1,079
Concord	6,190	5,818	5,723	5,742	5,868
Cumberland	1,874	1,890	1,949	1,922	1,909
Liverpool	1,126	1,444	1,720	1,527	1,454
Macquarie	337	243	306	369	314
Morisset	93	84	87	63	82
Total	**10,745**	**10,600**	**10,845**	**10,631**	**10,705**

Note. Data sourced from My Hospitals website (https://www.myhospitals.gov.au/hospital).

These sites consist of a number of psychiatric units within or co-located with a large public hospital, with several of these units being a focus of the PCLI. The main groups of psychiatric units housing PCLI consumers within the six primary implementation sites are listed in Table 3.

Table 3 Primary implementation sites

Local Health District	Primary site	Hospital type	Main units
Western NSW	Bloomfield Hospital (Orange Health Service)	Psychiatric units within large public hospital	Manara Turon Castlereagh Canobolas
Sydney	Concord Hospital	Psychiatric unit within large public hospital	Broughton
Western Sydney	Cumberland Hospital	Specialist psychiatric hospital	Acacia Boronia Willow Banksia Waratah
South Western Sydney	Liverpool Hospital	Psychiatric units within large public hospital	North Ward South Ward
Northern Sydney	Macquarie Hospital	Specialist psychiatric hospital	Lavender Manning Hamilton Cottages
Hunter New England	Morisset Hospital	Specialist psychiatric hospital	Clinical Rehabilitation Unit Ibis Rosella

To provide context for the evaluation, the next sections give a general description of each of the six main sites and the other facilities involved in the implementation of PCLI.

2.7.1 Bloomfield Hospital

Bloomfield Hospital (originally Orange Mental Hospital) is located approximately 4km from the city of Orange in western NSW. The land was secured in 1889 and the facility was originally planned in the early 20th century as one of three psychiatric hospitals to serve rural populations of NSW. Construction was delayed by the First World War and it opened in 1925. The scientific theories of the time influenced its design, with separate accommodation for short-term and long-term patients, gardens and parklands to facilitate recuperation, and farming activities such as vegetable gardens, a dairy and a piggery to provide occupation for patients as part of their rehabilitation (as well as making the hospital self-sufficient). Patients transferred from the Gladesville Mental Hospital took part in constructing the original buildings. The site is listed on the NSW State Heritage Register (NSW Government Office of Environment and Heritage, undated-a).

In March 2011, the new Orange Hospital was opened on an adjoining site and was amalgamated with Bloomfield Hospital. Collectively, the hospitals are known as the Orange Health Service. They are managed by the Western NSW LHD, which serves an estimated 276,000 people (Western NSW Local Health District, undated-a).

The Older People's Mental Health (OPMH) service at the Bloomfield campus is a focus for Stage One PCLI activities. There is a large community mental health service at Orange that provides outreach to the surrounding region, and community mental health services based at Bathurst (about 50km south-east of Orange) and Dubbo (about 150km north-west of Orange) serve the outlying regions of the LHD (Western NSW Local Health District, undated-b).

Activities of the PCLI focus on Canobolas (a 20-bed long-stay unit) and the three State-wide units located at Bloomfield:

- Turon, a 16-bed female rehabilitation unit
- Manara, a 16-bed male rehabilitation unit
- Castlereagh, a 20-bed medium secure rehabilitation unit.

Western NSW LHD hosted the first PCLI Dialogue Day on 4 August 2015. At that time, early steps and preparation for the PCLI included work on the assessments and dialogue with local Residential Aged Care providers (NSW Health 2015).

At the end of June 2015, 35/360 consumers (9.7%) eligible for PCLI were housed at Bloomfield.

2.7.2 Concord Hospital

Concord Repatriation General Hospital (Concord Hospital) was established in 1941 as a general hospital for the Australian Army. It is now a 750-bed teaching hospital of the University of Sydney. The hospital is managed by the Sydney LHD, which serves approximately 600,000 people across Sydney and the inner-western areas of the city.

In 2008, the Concord Centre for Mental Health opened at the northern end of the hospital precinct. Patients and services were transferred from Rozelle Hospital to the new facility, which became the focus for inpatient mental health services in the LHD. Acute inpatient facilities are also provided at the Professor Marie Bashir Centre adjacent to Royal Prince Alfred Hospital.

Consumers in the 35-bed Broughton extended recovery unit at Concord are eligible for the PCLI. Broughton is an open, rehabilitation ward for people experiencing mental distress, with different levels of functional capacity, from quite dependent to moderately independent. Five of the beds are for forensic patients. A small number of PCLI consumers are housed in other units: Kirkbride (an acute-rehabilitation hybrid), Jara (for older persons) and Norton (an acute unit). Kirkbride is a locked ward designed as transitional accommodation for people with ongoing symptoms and vulnerabilities who need to move out of acute care but are not yet ready for Broughton. Support for consumers living in the community is available through five community mental health services and an assertive outreach team.

Sydney LHD hosted a Dialogue Day on 26 April 2016. At that time, the Director of Clinical Services in Mental Health, Dr Andrew McDonald, explained that the district already had experience of moving large numbers of long-stay consumers to the community due to the transfer of services from Rozelle to Concord in 2008 (NSW Health 2016b).

In 2004, when the transfer process began, there were 98 non-acute beds at Rozelle Hospital. Staff conducted personalised assessments and began working with families to identify options for the long-stay consumers. By 2005 the number of beds had been reduced to 50 and one of the original (pre-PCLI) Mental Health Aged Care Partnership Initiative (MHACPI) units opened at Holy Spirit, run by Catholic Healthcare. This new facility accepted a number of the long-stay consumers from Rozelle. Thirteen beds at Holy Spirit were reserved for consumers with challenging behaviours, and medical staff from Rozelle were the conduit for referrals to those beds and provided weekly, in-reach support. Other long-stay consumers were moved to community accommodation supported by HASI packages. Eight of the original long-stay consumers were transferred from Rozelle to Concord when the new facility opened in 2008, only one of whom remained at Concord at the time of Dr McDonald's presentation in 2016 (NSW Health 2016b).

This meant that the site had a somewhat different starting point to some of the other hospitals involved in the PCLI. There is a smaller group of long-stay consumers, and these are mainly younger people with greater comorbidity who might not spend more than a year in hospital at one time, but who have a series of long admissions due to limited options in the community (NSW Health 2016b). This group of consumers will be targeted by Stage Two of PCLI.

At the end of June 2015, 21 consumers (5.8%) eligible for PCLI were housed at Concord.

2.7.3 Cumberland Hospital

Cumberland Hospital is a 261-bed, specialist mental health facility in Westmead, managed by the Western Sydney LHD (https://www.wslhd.health.nsw.gov.au/Mental-Health-Services/About-us).
It provides primary and secondary mental health services to the local population of around 946,000 residents, and tertiary acute, extended and forensic mental health services to greater western Sydney and NSW.

The hospital is on the site of the former Parramatta Female Factory, a residence for female convicts established by Governor Macquarie in 1817. The site has been in use continuously as a psychiatric facility since the mid nineteenth century and was renamed Cumberland Hospital in 1983. It is now a teaching hospital for nursing, social work, occupational therapy and psychology students.

Five units are the focus for the PCLI efforts at Cumberland Hospital: two sub-acute and three rehabilitation units. The campus also houses three specialist admissions units, a forensic unit and a specialist high-dependency unit, community mental health residential facilities and recovery support services (https://www.wslhd.health.nsw.gov.au/Mental-Health-Services/About-us).
The LHD is served by five community-based mental health teams (Western Sydney Local Health District, undated).

According to the first Dialogue Day report, preparation and early work for PCLI included the establishment of a working group and review of the community mental health model of care (NSW Health 2015). The site hosted the second Dialogue Day on 9 December 2015. At that time, they reported that the multi-disciplinary working group had been operating for eight months, and a full-time PCLI project manager had been appointed in October 2015. At the time of the Dialogue Day, major redesign projects were under way at Cumberland which focused on rehabilitation services and a whole-of-service change program to adopt contemporary models within recovery frameworks (NSW Health 2016a).

A MHACPI unit at Governor Phillip Manor, run by RSL LifeCare, was established with PCLI funding in the neighbouring Nepean Blue Mountains LHD. This unit is intended to accept Stage One consumers from Western Sydney LHD.

At the end of June 2015, 90/360 consumers (25.0%) eligible for PCLI were housed at Cumberland.

2.7.4 Liverpool Hospital

Liverpool Hospital is the largest hospital in NSW and the major health service within the South Western Sydney LHD, which serves approximately 820,000 people across seven local government areas (South Western Sydney Local Health District 2018). It was established in 1813 on the banks of the Georges River as a three-room, 12-bed hospital for soldiers and convicts. Work on a larger hospital, the Liverpool Asylum, began in 1822, and the site was subsequently home to the Liverpool State Hospital and the Liverpool District Hospital. The current building was refurbished in the past decade, and funding has recently been announced for a major redevelopment and expansion (South Western Sydney Local Health District, undated). Liverpool is a teaching hospital for the University of New South Wales and the University of Western Sydney.

PCLI consumers are housed within two adult mental health units at Liverpool Hospital: North (extended recovery) and South (sub-acute care). There are community mental health teams based at Liverpool, Fairfield, Bankstown, Campbelltown and Bowral. An assertive outreach team is available to help consumers with persistent mental health conditions who require intensive support in the community. In addition, the LHD has a Community Mental Health Emergency Team to address urgent, acute needs, in partnership with emergency care services (South Western Sydney Local Health District 2018).

Liverpool was the last of the six primary implementation sites to join the PCLI. One of the original (pre-PCLI) MHACPI units, Linden, is operated by HammondCare at Hammondville, within the South Western Sydney LHD. Early work towards the PCLI – reported at the first Dialogue Day – included increased community focus, funding for the assertive community treatment teams, greater engagement with community-managed organisations and developing recovery orientation (NSW Health 2015).

At the end of June 2015, 11/360 consumers (3.1%) eligible for PCLI were housed at Liverpool.

2.7.5 Macquarie Hospital

Macquarie Hospital is a 195-bed specialist mental health facility in North Ryde. It is managed by Northern Sydney LHD and serves the local population of approximately 910,000 people across nine local government areas (Northern Sydney Local Health District 2017). The hospital opened in 1959 and was formerly known as North Ryde Psychiatric Centre. Since 1969 it has been a teaching hospital for psychiatry at the University of Sydney (The University of Sydney, undated).

The hospital has eight mental health rehabilitation units: two short-term, two dual-diagnosis, and four extended care units. The extended care units – Lavender House (for older persons), Hamilton Hostel, Manning and the Cottages (which are open) – are the focus for PCLI activities. There is also an acute unit (Parkview) and a community health service based on the site (Northern Sydney Local Health District, undated).

A MHACPI unit within the Tobruk Unit at RSL LifeCare, Narabeen, was established with PCLI funding to accept Stage One consumers from Northern Sydney LHD.

At the end of June 2015, 117 consumers (32.5%) were housed at Macquarie.

2.7.6 Morisset Hospital

Morisset Hospital is a specialist mental health facility located on the western shore of Lake Macquarie, about 125km north of Sydney and 45km south-west of Newcastle. It is situated on a very large, bushland site and comprises almost 100 buildings constructed over the course of a century, beginning in 1906. It was the second largest psychiatric hospital in NSW built outside Sydney and was the site of the state's first prison for the criminally insane, opened in the 1930s and closed in 1991. In the 1960s the site housed more than 1400 people including psychiatric patients and people with developmental and intellectual disabilities (NSW Government Office of Environment and Heritage, undated-b). Some publicly funded accommodation for people with disabilities is still provided on the site.

Inpatient services at Morisset Hospital are managed and delivered by Hunter New England LHD. The hospital serves the local population of around 920,000 people (NSW Health, undated-e). These

units, particularly Kestrel, have longstanding supra-Local Health District functions (not formally state-wide functions but they have a history of admitting people from out of area). Several inpatient units house consumers who are potentially eligible for PCLI: Ibis (for older people), Rosella (high support unit), Kestrel (medium-secure), and the Cottages, a series of open units of decreasing levels of support and increasing independent living that prepare consumers to transition to the community (Hunter New England Local Health District undated). Once in the community, support is available from the LHD's community mental health services. The LHD has a long-standing Collaborative Care Arrangement that promotes partnerships between local public mental health services and community-managed organisations (NSW Health 2016c).

A MHACPI unit was established at Charles O'Neill Hostel (a residential aged care facility) in Newcastle by Catholic Health Care with PCLI funding, and this has accepted a number of Stage One PCLI consumers. Hunter New England LHD was a trial site for the National Disability Insurance Scheme (NDIS), which provided an avenue for obtaining accommodation and support in the community for some younger people with complex and persistent mental health issues and other needs, including Stage Two PCLI consumers.

At the end of June 2015, 60 consumers (16.7%) eligible for PCLI were housed at Morisset.

2.7.7 Other facilities

A small number of long-stay consumers are housed in other public mental health facilities around NSW, mostly in acute units. According to the Project Development Guidelines Version 1 (NSW Health 2016d), 44 of the original (June 2014) cohort of 380 consumers were spread across another 13 sites (the original six sites included Kenmore at Goulburn and excluded Liverpool Hospital). At the end of June 2015, 26 consumers (7.2%) eligible for PCLI were housed in facilities in other LHDs apart from the six primary implementation sites.

Other LHDs around NSW are been actively involved with PCLI. For example, the first Dialogue Day report included a summary of preparatory activities at South Eastern Sydney, Illawarra Shoalhaven and Mid-North Coast LHDs (NSW Health 2015).

2.8 Summary of key achievements

The process of program development has been characterised by vision, energy and commitment. Preliminary design and development work that began in May/June 2014 includes:

- recognising a program's 'time has come' and initiating action for change;
- establishing an implementation team for the PCLI both within the Ministry and through funding positions in the LHDs;
- reviewing the evidence about models of care and patient outcomes; ways to measure readiness to transition as well as barriers to transition for this patient cohort;
- communicating extensively with Chief Executives and Mental Health Directors of LHDs; drafting media releases for the Minister; producing fact sheets targeted at staff working in mental health care in NSW and for consumers their families and carers; and presenting extensively to various stakeholder audiences, forums and conferences;
- building on the lessons from previous successes and failures, for example such as the development of SMHSOP in NSW over the last 10-15 years and the experience of successful transitioning of long-stay mental health patients from Rozelle and Kenmore Hospitals;
- developing initial costings to Treasury and internal business cases to inform the NSW whole-of-government reform process Strengthening Mental Health Care in NSW, announced in December 2014 and contributing to the Mental Health Reform Business Case that was submitted to the Economic Review Committee of Cabinet in August 2015;
- securing the inputs for the program (i.e. the resources that are invested to make the policy or program happen). Examples of such inputs include new policies, additional funding, additional staff and the establishment of partnership arrangements;
- identifying the PCLI patient cohort and through segmentation facilitating a staged approach to service development (Stage One and Stage Two); and
- establishing the six primary implementation sites.

3 The implementation journey

This section of the report describes in detail the activities and effort invested to date in implementing the PCLI and driving this complex change initiative, using the mechanism of the PCLI quadrant model. The planning and initial implementation period extends from June 2015 – December 2016 (Phase 2 and part of Phase 3 in Figure 1).

The Ministry PCLI team developed the PCLI Framework to depict the four components or quadrants of implementation action underpinning the initiative. This framework is used to structure reporting on the implementation journey until December 2016. Within each quadrant are examples of relevant activities, and these are explained more fully in the following sections of this report.

Figure 3 PCLI Framework

3.1 Project/program processes

From mid-June 2015 to December 2016, particular energy was invested in foundation project or program processes including governance and leadership of the PCLI, communication mechanisms, change and innovation management and workforce development.

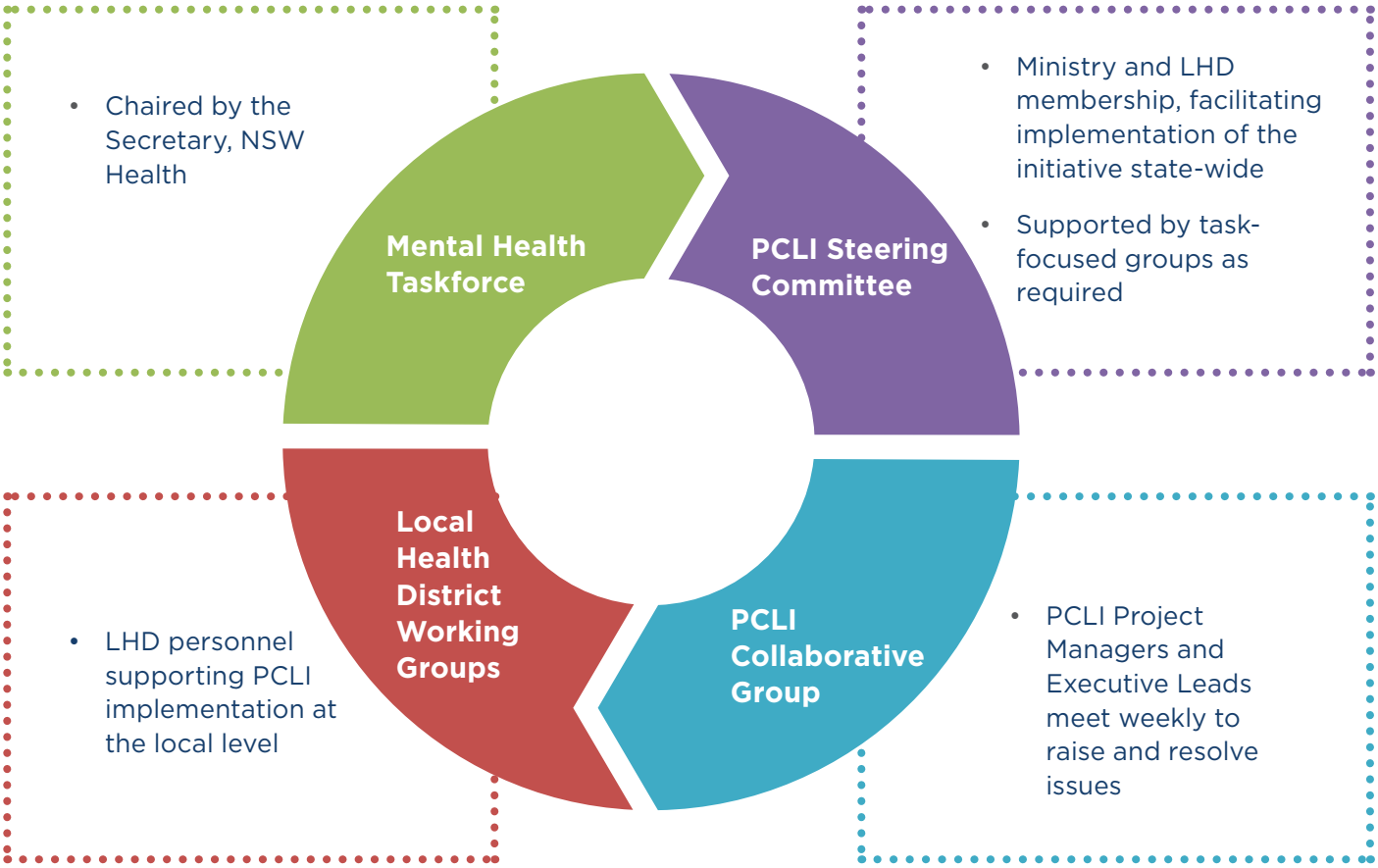
3.1.1 Governance and leadership

A program of large-scale transformational change requires strong governance. Good governance promotes coordination and contributes to integrating efforts across the diverse stakeholders involved in a program of the scope of the PCLI. The PCLI Steering Committee was established in August 2015 with a three-year term. It has documented *Terms of Reference* and its role is to facilitate the implementation of the initiative and to ensure program activities are evidence-based. Membership is broad and includes representatives of the Ministry of Health, LHDs, Mental Health Discipline Leads and Content Experts (NSW Health 2018d).

3.1.1.1 Committee structure

The PCLI Steering Committee sits within a framework of governance functioning at State and LHD levels. Overarching monitoring of the implementation of the PCLI is the responsibility of the Mental Health Taskforce, which is chaired by the Secretary, NSW Health (NSW Health 2018d). The Taskforce has representation from multiple NSW Government agencies and the Mental Health Commission and is overseeing the whole-of-government NSW Mental Health Reform 2014-2024 (NSW Health undated-c). LHDs have established working groups to guide implementation of the PCLI at the local level that report to their respective Chief Executives. A Collaborative Group of PCLI project managers and executive leads meets weekly to raise and resolve issues. Task-focused groups have also been established.

Figure 4 Governance components of the PCLI



PCLI Steering Committee

Correspondence was sent to LHD Chief Executives outlining the proposed governance structure and requesting nominations to the PCLI Steering Committee. The committee meets three times per year and the Terms of Reference of the committee state its purpose as:

- Facilitating implementation of the program, and
- Ensuring that activities under the program are evidence-based (NSW Health 2018d).

The PCLI Steering Committee includes representatives from rural and remote LHDs, regional LHDs, metropolitan LHDs, clinical discipline leads, content experts and members of the Ministry PCLI team. Throughout the remainder of 2015 and all of 2016 the PCLI Steering Committee considered major pieces of work completed during the course of implementation. Its role varied between commenting on documents that were tabled, endorsing planning documents and advising on strategic and operational issues influencing implementation. For example, at the December 2015 meeting, the committee endorsed the proposed measures for assessing ability, capacity and function throughout the program; subsequently the program logic was reviewed and the recommendations of the 'Transition Design Training Needs Analysis Report, Core Tools and Routine Outcome Measures' endorsed. In November 2016 the Steering Committee endorsed the inclusion of an acknowledgement of Lived Experience of Mental Illness in the Chair's opening remarks at meetings. Three PCLI Dialogue Day reports were tabled, providing opportunity for discussion of any emerging risks or issues and proposal of mitigation strategies. A risk register was part of the Steering Committee agenda from early on, and was reviewed at each meeting to monitor and mitigate program risks.

Task-focused Groups

The work of the PCLI Steering Committee is supported by task-focused groups. An example of this is the Data and Information Management Group that was set up in 2016 as an internal Mental Health Branch and InforMH group meeting monthly to

discuss issues of database development, monitoring of indicators and data and reporting requirements. The PCLI Assessment Task Group was tasked to develop the core set of objective clinical measures and tools used to assess the transition needs of each long-stay patient. It provides another example of how groups of people with particular expertise are brought together to support the work of the broader initiative. The Transition Design Implementation Task Group was established to build on the work of the Assessment Task Group to support LHDs in transition design, including training needs analysis and rollout of targeted training.

PCLI Collaborative Group

The PCLI Collaborative Group commenced meeting in January 2016 and meets weekly. This group of PCLI project managers, executive leads and Ministry personnel focuses predominantly on implementation, data and reporting issues and maintaining program momentum. The PCLI Collaborative Group Log of Issues is reviewed and updated regularly and captures emerging issues, discussion points and follow-up actions (with the person/s responsible listed). Issues remain on the log until they are resolved with a 'date resolved' recorded. Where appropriate, issues papers are developed from the log for escalation to the Steering Committee.

LHD Working Groups

The LHD Working Groups operate at a local level to support PCLI implementation. The first LHD-based PCLI working group began in Orange (Western NSW LHD) in May 2015. Each primary implementation site has established an LHD working group. Their Terms of Reference are generated by the LHDs and align with those of the PCLI Steering Committee. The working groups meet monthly or bi-monthly. They are able to seek the advice of the Collaborative Group or Ministry PCLI team (through their PCLI project manager or executive lead), should issues arise that have implications beyond their own LHD. Their reporting line is within their respective LHD.

Maintaining a robust governance structure requires time and effort. The Ministry PCLI team has invested in this governance structure that operates at both the State and LHD levels to support effective program implementation. The initiative's peak committee is the PCLI Steering Committee and the PCLI Collaborative Group provides a mechanism to link LHD-based project managers and executive leads with the Ministry PCLI team on a weekly basis. The minutes of the Steering Committee tracks significant decisions and the PCLI Collaborative Group Log of Issues monitors emerging risks and issues.

3.1.1.2 Leadership

The PCLI is led, funded and coordinated by the NSW Ministry of Health in collaboration with LHDs. Leadership needs to reach up, out and down in an initiative of this scale. The new program directions and services need to be embedded into state-wide policy and existing programs. This has occurred, for example, with the Stage One service developments and the Older Persons Mental Health program. The role of the Secretary, NSW Health, as Chairperson of the NSW Government Mental Health Taskforce is opportune and provides a conduit for the PCLI Steering Committee not only to the Secretary but to other senior agency representatives on the taskforce.

Leadership of the PCLI originated within the former Mental Health and Drug & Alcohol Office, with the PCLI sponsor the Chief Psychiatrist, NSW Health. From its beginning, Co-Chairs were established for the PCLI Steering Committee: the A/Executive Director of MHDAO (now Executive Director, Mental Health Branch) in tandem with the PCLI Clinical Lead. The PCLI Clinical Lead was appointed in early 2015 and had experience as a Mental Health Director; this may have helped to send a message about the importance of links with services in LHDs. By broadening the membership of the PCLI Steering Committee, influential experts from other parts of the Ministry could be included. In June 2015 a consumer lead was appointed to the program. This individual came from a rural and remote LHD and was chosen because of her previous experience with the Kenmore Hospital transitions.

The Ministry PCLI team comprises the clinical lead, information lead (from InforMH), project manager, Director, OPMH, consumer consultant, senior project officers and project managers or leads from the LHDs. Several clinical advisors with expertise in older people, younger people and research are also part of the team. The Ministry PCLI team meets weekly and monitors progress of the initiative against a comprehensive annual work plan to ensure program planning, development and implementation activities occur on schedule. Ongoing communication occurs with the Executive Director, Mental Health Branch, about emerging issues and planning further work.

From the outset, the Ministry has strived for a distributed leadership model. This is why the decision was made to fund six project managers in the primary implementation sites and asked for nominated executive leads from these sites. All LHDs were invited to join the PCLI Steering Committee as the PCLI is working to improve care pathways for all people with enduring mental illness who experience long hospital stays. The Dialogue Days (refer to Section 3.1.2.4) are a critical mechanism to foster this distributed leadership model as they provide an opportunity for different LHD personnel to take the lead in discussions and actions arising from the Dialogue Days and seek to build the capacity of all participants. LHD project managers were also provided change management support through attendance at specific 'Program Manager days' to strengthen integration with the Ministry PCLI team. The input from mental health personnel working in LHDs has influenced the assessment tools and process, models of care and other core project processes.

In any organisation, informal leaders emerge and are tacitly recognised by their peers. The experience of members of the Ministry PCLI team gained over many years of working with LHDs meant there was a reasonable level of insight as to who these informal or peer leaders were and steps were taken to engage them in the work of their LHD. The decentralised nature of the NSW health system, coupled with the complex adaptive system that is the mental health system, means that a distributed model of leadership is essential.

3.1.2 Communication mechanisms

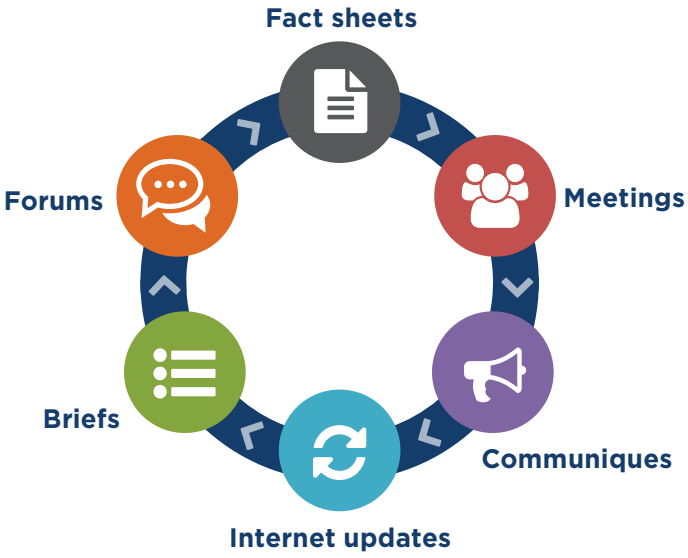
The successful implementation of change requires clear, consistent and trustworthy communication. Communication is a foundation stone of effective change management. Communicating organisational change is challenging, in part because it is a never-ending task. In the health care system, communication must reach people at multiple levels, from diverse stakeholder groups internal and external to the organisation.

3.1.2.1 PCLI Communication Plan and materials

As previously mentioned (refer to Section 2.3) a PCLI Communication Plan was developed in the initial planning stages by the Ministry PCLI team. Extensive and multi-pronged communication strategies were (and continue to be) deployed. Communication materials have targeted consumers, their carers and families; service providers, particularly those working in facilities with long-stay patients; professional associations and colleges; and diverse stakeholders from the health and aged care sectors. Wide use has been made of printed materials such as Factsheets, Dialogue Day reports, training and guidance materials as well as web-based resources.

The methods used are depicted in Figure 5 (NSW Health 2016e).

Figure 5 Communication Methods



3.1.2.2 Web-based portals

The PCLI website (hosted by NSW Health) has information for consumers and carers, staff and other interested individuals. Several video vignettes are included with patient stories. As new resources are approved they are uploaded to the site.

A secure internal NSW Health PCLI drop-box site and an on-line PCLI networking forum were established in early 2016, referred to as basecamp. This provides an easy point of reference for LHD PCLI leads/project managers and opportunity for collegial dialogue.

3.1.2.3 Presentations

A large number of presentations were delivered by the Ministry PCLI team to LHD Boards, State-wide meetings of Mental Health Directors, Clinical Advisory Councils, professional meetings, symposia and forums. On occasion, copies of these presentations were made available to LHD project personnel to assist with communication in their LHD.

3.1.2.4 Dialogue Days

The Dialogue Days were introduced as a means of bringing together people with an interest and/or involvement in the PCLI. Staff from the primary implementation sites were targeted; however, as approximately 40 of the long-stay patients in the PCLI cohort are accommodated in other LHDs, a much wider audience of mental health professionals is included. This is appropriate as the PCLI aims to introduce a new system of care that provides better integration and early intervention responses to prevent long-stay hospitalisations in the future. It is about large-scale transformational change across the NSW mental health system, therefore all LHDs need to be engaged.

The Dialogue Days provide a mechanism to:

- inform participating personnel about the initiative
- strengthen implementation fidelity through developing a shared understanding of what, how and why certain actions had to be taken and aligning implementation efforts
- establish a dialogue to promote collaborative action and joint problem-solving
- learn from each other and share challenges and successes; and
- inspire the mental health workforce through reinforcing the vision of the PCLI.

There is a deliberate engagement strategy of rotating the venue for the Dialogue Days among the six primary implementation sites with the dual purpose of increasing the opportunity for executives and mental health workers from the hosting LHD to attend and to expose personnel from other implementation sites to the host site. The dates and venues for Dialogue Days held up until the 31 December 2016 are listed in Table 4, and they have continued subsequently. Engagement to date has been high with between 70 to 100 participants attending each Dialogue Day. Issues raised at Dialogue Days are communicated to the PCLI Steering Committee. Originally the plan was to facilitate four such days each twelve months (NSW Health 2015a); two days each twelve months has resulted in practice and is probably a more realistic commitment.

Table 4 Dialogue Days up until 31 December 2016

Date	Number	Host
4 August 2015	Dialogue Day 1	Western NSW LHD
9 December 2015	Dialogue Day 2	Western Sydney LHD
27 April 2016	Dialogue Day 3	Sydney LHD
16 August 2016	Dialogue Day 4	Hunter New England LHD

Dialogue Days are well planned, the program including a mix of State-wide and LHD presentations. They are interactive in style, using panel discussions and small group work. At each Dialogue Day professional photography and filming is completed to generate marketing materials for use by program staff to promote the PCLI. A user-friendly report is produced at the conclusion with a summary of presentations and outcomes recorded. Each Dialogue Day has a slightly different focus.

For example, Dialogue Day 1 was about:

- setting the scene of the initiative
- engaging with the target groups - consumers, carers and mental health workforce
- understanding the complex needs of consumers, and
- introducing and commencing a dialogue about the assessment process and measures to ensure an industry-wide common framework (NSW Health 2015).

At Dialogue Day 2 there was discussion about considerations for how service users and families could be engaged and assisted, and approaches that could deliver transition solutions were explored. The importance of preventing long-stay admissions in mental health facilities in the future was acknowledged as a vital focus of the initiative.

Examples of issues that Dialogue Day 2 focused on:

- broadening community engagement and integration

- delivering transition solutions through co-design approaches that elicited service users' needs whilst respecting their rights, will and preferences
- maximising success through respectfully working with service users involved in the transition process and creating models that are not a 'one size fits all' solution
- acknowledging biases and existing mindsets that prohibit transformative treatment
- planning appropriately and using evidence-based and standardised tools and assessments
- monitoring, reporting and analysing processes and outcomes to improve decision-making (NSW Health 2016a).

The report of Dialogue Day 3 (NSW Health 2016b) shows that at this meeting, time was spent reflecting on the outcomes from previous Dialogue Days. A strong platform had been created to position the PCLI for success and many consumers had been assessed with a suite of tools. Already several consumers were living safely in the community and the communication and collaboration among program stakeholders was perceived to be working well. There were three messages about managing the change process:

- recognising that collective effort is vital (across LHDs and with non-government partners)
- being open to new ways of working (reflecting that there will be resistance from some mental health workers and accepting that things won't always be right the first time so an iterative approach is needed)
- ensuring consumers and families are at the centre (through tools and frameworks to engage with families in development, planning, delivery and evaluation of services and improving training for staff who are actively spending time with families).

The fourth Dialogue Day in this reporting period occurred on 16 August 2016 and 'in-depth and granularity' was the focus (NSW Health 2016c). The day included interactive sessions such as a Q & A panel about two case histories, a powerful consumer story, important reflections on the lessons from previous dialogue days and how these can be embedded as the program moves forward (NSW Health 2016c). Each Dialogue Day included a 'State of the Nations' address which consists of a blend of motivational messages (for example, about program momentum) and strategic imperatives (for example, that consumer and family engagement is critical; NSW Health 2016c).

3.1.3 Change and innovation management

In the early program phases, although many actions were initiated and led by the Ministry PCLI team, there was significant work occurring within LHDs. This was (and continues to be) because of the developmental nature of the work. LHD project managers coordinate local meetings to disseminate information about the PCLI.

Introducing a change of the magnitude of the PCLI requires strong local engagement by those involved in the day-to-day care of long-stay mental health patients. The work required to communicate the change can leverage off the support provided at a central level. In established units where personnel may have worked in a particular way for many years, more personal engagement strategies are needed. It can be a time- consuming process but research has shown that 'face-to-face communication is the richest medium' and that large scale changes should be communicated preferably face-to-face (Richardson and Denton 1996, p. 207). Several implementation sites developed newsletters and issued updates on local implementation of the PCLI; for example the Hunter New England LHD issued Ibis Lodge News June 2016, and the team from Macquarie Hospital in Northern Sydney LHD also produced newsletters.

To support the LHD implementation sites in change and innovation management and to facilitate consistency in implementation, the Ministry PCLI team produced the *My Choice: Pathways to Community Living Initiative Project Development Guidelines* with a supporting volume of appendices, *Project Development Guidelines – Appendices*. These communication tools were auspiced by the NSW Health PCLI Steering Committee for guiding the implementation of the initiative across the State and LHDs. The guidelines booklet was referred to as a 'living document' with the first version issued in April 2016 as a working 'trial' document for three months to encourage an iterative approach to its development. Originally it was intended that feedback would be requested to amend the document, based on the experience of users; however, over time this document was superseded by other program documents.

The PCLI Project Development Guidelines consistently emphasise that personnel must focus on 'the person at the centre' - referring to the individual and their family/carer. The guidelines address the:

- drivers for the PCLI, the aims and NSW Government's funding commitment;
- development of the project by the Ministry and the evidence and data used to understand the patient cohort (380 long-stay patients) and their different needs for the Treasury business cases;
- development of the models of care that were costed for the business cases;
- governance, business and communication processes and tools for engagement, screening, assessment and information that have been developed;
- development of the aged care PCLI services;
- progress made to date and directions moving forward; and
- supportive processes for LHDs.

The processes that LHDs need to put in place to support implementation are described, with extensive supplementary resources, in the Appendices (NSW Health 2016e).

3.1.4 Workforce development

In June 2016, a PCLI Training Needs Analysis of the PCLI assessment tools and routine outcome measures was completed by the Transition Design Implementation Task Group. The results indicated that the number of staff requiring some form of training in the tools and measures exceeded one thousand, with the two tools with the greatest number of requests for training being the Recovery Assessment Scale and the Camberwell Assessment of Need. The report of the training needs analysis included three recommendations with regards to the training needs of those involved in PCLI:

- That the training modules address the need for broad training, discipline-specific training and LHD-specific training.
- That LHDs adopt a champion/train the trainer approach to build a knowledge base within LHDs, and to disseminate knowledge and understanding within the LHD.
- That a PCLI Resource List be developed, including online, written and human resources.

The resources developed for the PCLI focused particularly on the 'Getting to Know You' process including the use of PCLI assessment tools, planning care based on those tools and providing a recovery-oriented approach to practice. Examples of these resources include the 'Planning and Assessment Booklet' (NSW Health 2015b) and the 'Resource Book' (NSW Health, undated-d).

An array of training has been developed and implemented throughout the life of the initiative with the PCLI training modules depicted in Figure 6. As could be expected a major investment of training occurred during 2016 to support individual planning and assessment pre- and post-transition. The strategy was to offer initial training in common to all LHDs and for LHDs to be encouraged to then consider their specific needs going forward and to plan accordingly with the support of the Ministry PCLI team.

Figure 6 PCLI Training Modules

Table 7 summarises the program-wide training organised by the Ministry until December 2016 (Evaluation Report 2 will describe training initiatives after December 2016).

Table 5 PCLI Training until December 2016

Date	Training programs	No. of attendees
April to December 2016	Everyday activities and functional cognition (2 sessions).	58
May to November 2016	Risk of violence screen.	Not available
July 2016	PCLI in my LHD[2] .	16
August 2016	Routine outcome measures (delivered on six occasions).	142
September 2016	CAN-C and CANE.	10
December 2016	3-day workshop on the Allen's Cognitive Disability Model* and other PCLI tools[3].	24
December 2016 to March 2017	Being person centred and recovery focused, delivered on 5 occasions (as per description previously for consistency).	179

2 This session and the separate CAN-C and CANE training were provided in response to individual LHD requests as per the three recommendations of the Training Needs Analysis.

3 The 'Everyday activities and functional cognition' training and this workshop had the same content, there was a name change for this module resulting from the module set developed in response to the Training Needs Analysis.

The three-day workshop for occupational therapists in December 2016 focusing on the Allen's Cognitive Disability Model was evaluated using an online survey which resulted in a 58% response rate. The report of the evaluation found that 'the majority of respondents felt that they better understood their role in PCLI, would be better able to fulfil their role after attending training, and would know where to get more information from within their LHD' (Scanlan 2017). The presenter of the workshop noted that, in her opinion, attendees appeared to have a better understanding of PCLI and a greater acceptance of the use of standardised assessment tools as a result of the workshop.

The *Being Person Centred and Recovery Focused* training program was designed to support mental health clinicians in adopting a more person-centred and recovery-focused approach to practice. The program also sought to increase understanding and confidence is using some of the PCLI assessment tools, particularly the consumer-rated Recovery Assessment Scale – Domains and Stages (RAS-DS) and the Camberwell Assessment of Need. The program comprised five sessions:

1. Orientation to PCLI and where this module fits
2. Recovery principles
3. Recovery-oriented practice: collaborative communication and changing the power
4. Using the RAS-DS to support person-centred planning
5. Using the Camberwell Assessment of Need to support person-centred planning

Participants completed a survey at the beginning and end of the training program, with 159 participants providing feedback. In general, participants provided positive feedback about each session and felt that what had been learnt would be useful for their practice. However, there were exceptions, such as the last of the five training programs, delivered at the Mater Hospital Campus in Newcastle (Scanlan 2017).

The Dialogue Days are also an important input to workforce development, as are opportunities to participate in task-focused groups. These activities provide opportunities to learn from other experts and implementation sites.

3.2 Getting to know you

Essential to the success of the PCLI is the tailored assessment process for each individual wishing to transition from hospital to community living. The assessment process also aimed to:

- underpin the program logic framework (refer to Section 3.4.1) in line with NSW Ministry of Health reporting
- form part of a data and information gathering plan, and
- align with the evaluation structure (NSW Health 2016e).

A checklist was developed to clarify the steps in the 'Getting to Know You' process, to monitor progress of information collection and transition design at individual, unit and facility levels. It was initially provided as an Excel spreadsheet then translated into an Access database by InforMH. The intention was for assessment tools to complement and extend existing NSW Health mandated outcome measures (formerly Mental Health Outcomes and Assessment Tools; MH-OAT) and the PCLI individual information collection process by providing a clinical profile of each individual person's strengths, capacities and functioning from which change and well-being can be objectively monitored (NSW Health 2016f).

3.2.1 Individual planning and assessment

The PCLI Planning and Assessment Booklet *Getting to Know You* was developed by a senior practice group of experts with representatives from LHDs and academia in NSW. It was developed around a new suite of PCLI assessments, in addition to the mandated ones. A draft was issued in late 2015 for implementation and further iteration of suggested processes. A second version was subsequently developed and issued in April 2016. The LHD process is summarised in Figure 7 and the consumer's process is illustrated in Figure 8 (NSW Health 2015b). 'Getting to Know You' included three stages of assessment and planning: information gathering processes; assessing, ability, capacity and function; and routine outcome measures (NSW Health, undated-d).

The *Planning and Assessment* Booklet notes:

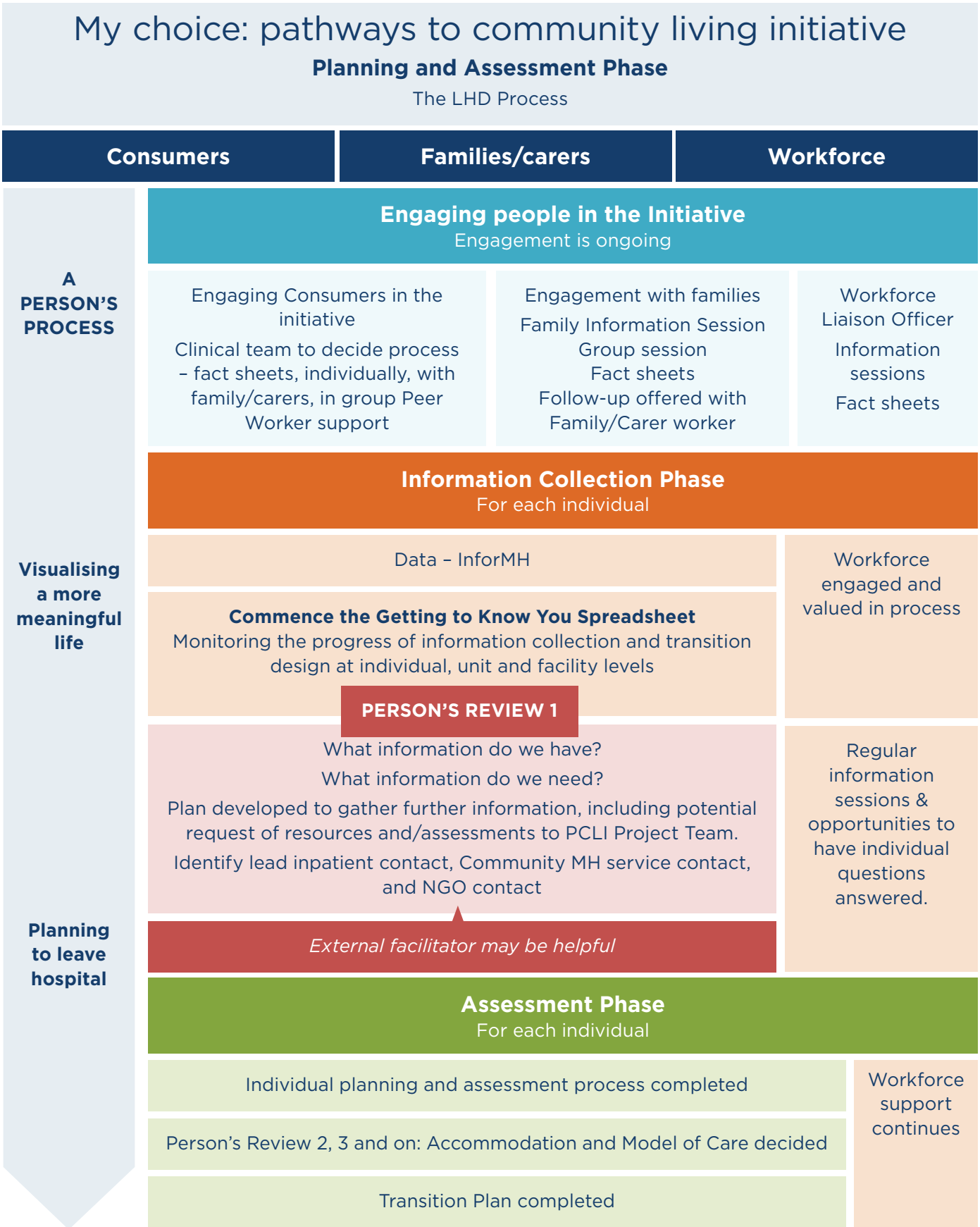
This process is not entirely linear and the transition from one phase to another will often include a lot of forward and backward movement whilst the person and their supports reflect on their wishes and preferences, develop new understandings about themselves and the potential options available, and puzzle over what will give them the best opportunities to realise their dreams (NSW Health 2016f).

The majority of the assessment process occurs in the first two phases of 'visualising a meaningful life' and 'planning to leave hospital'. There are multiple assessment tools for use with consumers, as listed in Table 6. These were made available electronically via an interactive table that provided a brief description of the tool and how to access it.

Table 6 Assessment tools for the PCLI

Assessment Tool	Description
Recovery Assessment Scale (RAS-DS)	Functioning, personal, clinical, social
Camberwell Assessment of Need (CAN-C)	Needs and support actions
Modified DAD (Disability Assessment for Dementia)	Independence in ADL and IADL skills
Health of the Nation Outcome Scales (HoNOS)	Health and social functioning
Kessler Psychological Distress Scale (K10)	Psychological distress
Life Skills Profile (LSP-16)	Basic life skills
Resource Utilisation Groups - Activities of Daily Living (RUG-ADL)	Activities of daily living
Living in the Community Questionnaire (LCQ)	Explore aspects of life in the community including social activities, participation in employment or study, living situation and physical health care
Dem QOL	Health-related quality of life of people with dementia
Neuropsychiatric Inventory Nursing Home Version (NPI-NH)	Assess psychopathology of residents with dementia in nursing homes
Repeatable Battery for Assessment of Neuropsychological Status (RBANS)	Assess cognitive impairment
Trail Making Test (TMT) Parts A and B	A neuropsychological test of visual attention and task switching
Historical Clinical Risk Management-20, Version 3 (HCR-20v3)	If the PCLI risk screen is positive, the HCR-20v3 is completed

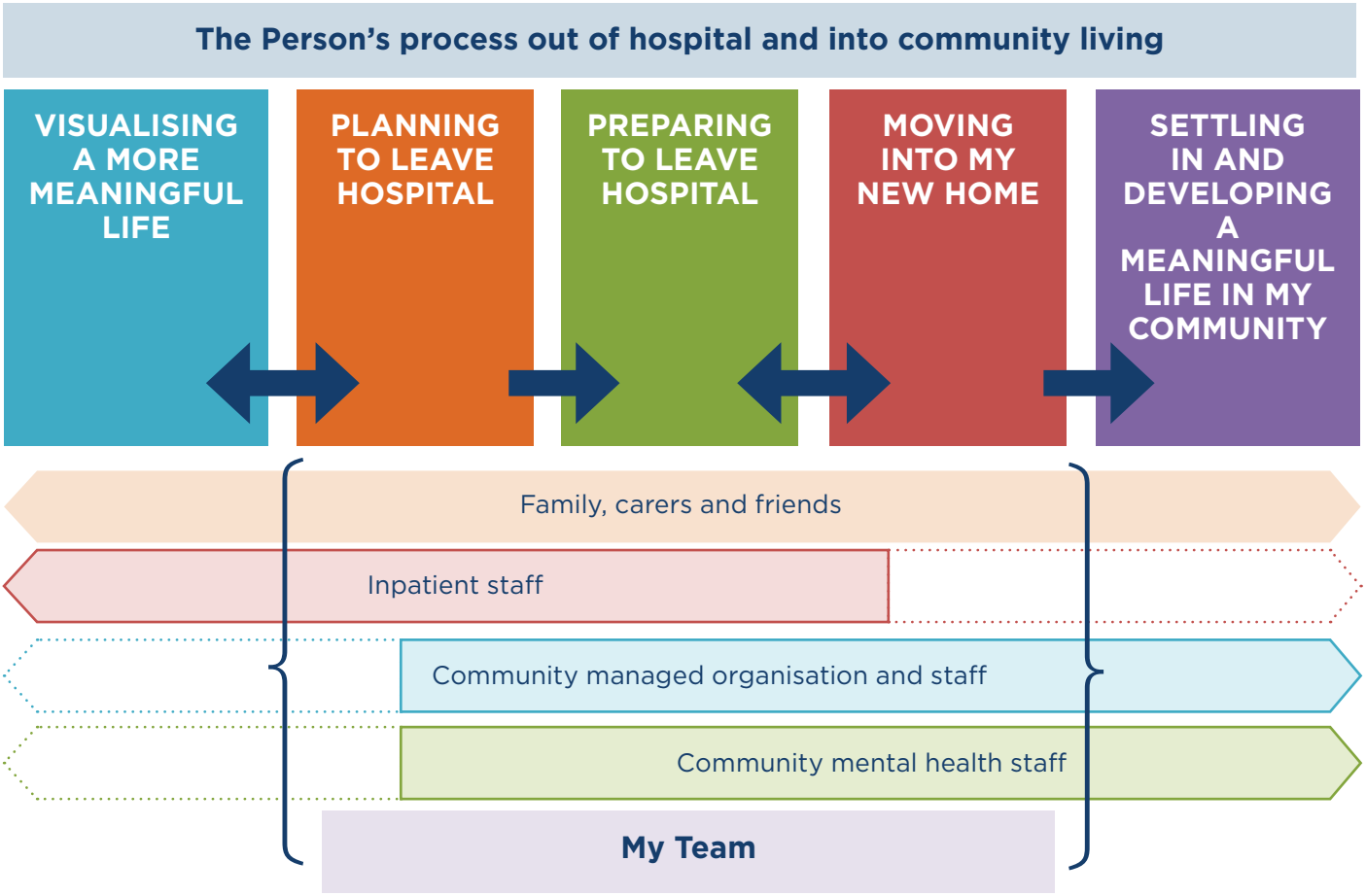
Figure 7 LHD Assessment Process



Source: NSW Health (2015b) My Choice: Pathways to Community Living Initiative, Getting to Know You, Planning and Assessment Booklet, April 2015.

The PCLI Assessment Task Group advised that the journey for each person who is moving out of hospital into the community is referred to as the 'person's process'. It is a five-phase journey and each person will experience the journey differently, with different amounts of time spent in each phase and with differing outcomes (NSW Health 2015b).

Figure 8 The Person's Assessment Process



Source: NSW Health (2015b) My Choice: Pathways to Community Living Initiative, Getting to Know You, Planning and Assessment Booklet, April 2015.

3.2.2 Pre and post transition

The assessment timeframe includes three initial time points:

- A baseline measure for existing long-stay consumers (Baseline T0)
- Pre-transfer from hospital (up to six months prior to hospital discharge), and
- Post-transfer at set intervals of every 26 weeks (6 months) over a period of two years' monitoring

Assessment can be completed over a number of days or weeks, depending on the needs of the consumer. The *Planning and Assessment Booklet* notes that the sequence of processes and assessments is to be decided by the clinical team, the consumer and their supports (NSW Health 2016f).

As noted previously, the first version of the assessment process was developed in 2015. The broader PCLI planning and assessment processes were developed by the expert group, in consultation with mental health services and the PCLI Steering Committee. A Fact Sheet, developed in collaboration with the Aged Care Unit in the Ministry and in consultation with LHD mental health and aged health services, was supplied to help LHDs address barriers between Aged Care Assessment Teams and mental health services relating to referral and assessment for long-stay mental health patients. The intent was to speed up the referral and assessment process for older patients in the PCLI cohort. There was also significant consultation and communication with LHD aged health/Aged Care Assessment Team (ACAT) managers by the Ministry

PCLI team to smooth the way for LHD mental health collaboration with ACAT around assessment for long-stay consumers with ageing issues. This was particularly crucial for those consumers under 65 years requiring transitions to residential aged care facilities (due to NDIS interface issues and impediments). In addition there was the need to trouble-shoot issues arising with ACATs, both at the local level and, if necessary, through escalation to and intervention by the Ministry. This was a significant area of work in the initial planning and implementation phases of the program.

Within LHDs, the assessment data will inform individual healthcare and rehabilitation needs, and facilitate care coordination. At the Ministry level, the data will be used for project monitoring and reporting. The Ministry PCLI team, in collaboration with LHDs and InforMH, developed a secure database for the electronic collection, storage and reporting of assessment data.

The NSW Mental Health Reform Monitoring Framework KPIs for the PCLI, which are integral to the NSW Business Case submitted to NSW Treasury (refer to 1.5.4), provided a strong imperative to roll-out the pre-transition assessments across the long-stay patient cohort in a relatively short timeframe.

3.2.3 Transitions to community living

The PCLI became operational in the key LHDs in mid-2015, with early efforts invested in consumer assessment and pre-transition planning. By October 2016, more than 200 long-stay consumers had been assessed (Hoban, Escott, McCaul & Rawson 2016).

The analysis presented in this section draws on data from the Health Information Exchange collated centrally by InforMH (Table 7). Only data for the period from mid-2015 to December 2016 is included. The earliest data in this table reports the size of the PCLI cohort 'as at census date' on 30 June 2015. The original PCLI cohort of 380 was based on 2014 data.

Table 7 Number of PCLI consumers by site, June 2015 to December 2016

	30/6/2015	31/12/2015	30/6/2016	31/12/2016	% change 2015-2016
Bloomfield	35	36	31	33	-6%
Concord	21	20	22	21	0
Cumberland	90	88	92	90	0
Liverpool	11	15	15	17	+55%
Macquarie	117	113	111	105	-10%
Morisset	60	63	60	57	-5%
Other	26	29	34	27	+4%
Total	**360**	**364**	**365**	**350**	**-3%**

Note. Information in the table was supplied by InforMH (2018) and provides a snapshot of activity at a point in time. The original PCLI cohort of 380 was based on 2014 data. Analysis is based on the consumers not discharged at the end of each period and a length of stay of greater than 365 days.

Interruptions in a stay (due to transfer or discharge) will result in length of stay counter being reset to zero. Consumers with more than 365 days' leave in the previous year are excluded.

According to the data from InforMH, the size of the PCLI cohort decreased by 3% between the commencement of PCLI in July 2015 and December 2016. There was an increase in the cohort at Liverpool Hospital from a low base, which may reflect local factors. The small increase at 'other' sites may have a similar explanation.

It should be noted that the size of the cohort is a snapshot on a particular day. It includes consumers not in the original cohort whose stays have since exceeded 365 days (i.e., 'second wave' consumers). Thus, although there may appear to be no change in the size of the cohort at a given site, consumers at that site have transitioned out of (and into) the cohort during the reporting period. Separate data for transitions during this period are not available. More comprehensive reporting on transitions to community living will be included in Evaluation Report 2 (up to June 2018) and Evaluation Report 3 (up to December 2018).

3.3 Service development

The quantum of effort and input to the service development process has been extraordinary. This work and the associated modelling has already extended from 2015 to the present and is likely to be ongoing due to the dynamic environment of health care. Significant energy has been invested in building the evidence base, understanding the patient cohort, assessments, market sounding and costing and stakeholder consultation. Additional modelling has been required following on from the indicative modelling to NSW Treasury and the Ministry in 2014/15, culminating in a complex procurement process. Against this background has been the ever-present need for communication, with presentations and briefings about proposed service developments provided to mental health and aged care audiences.

An analysis of data arising from routine data collection and the assessment process has helped segment the PCLI cohort which comprises two broad sub-cohorts:

- People with issues of ageing, which may include those as young as 50 years of age.
- People who do not have issues of ageing, which may include people over the age of 65.

This has been an important step as it reinforces the view of the Ministry PCLI team and LHDs that 'one size does not fit all'. Armed with this information and an understanding of the service delivery context (refer to Section 1.6.2 and Section 2.4) the decision was made to structure service development efforts across two stages.

Stage One service development, for the ageing cohort, was initiated and undertaken over 2016/17 (although work continues). Stage Two service development, for people without issues of ageing, is currently under development. As well as community-based PCLI partnership service options, inpatient solutions are planned. Some people will move to existing community-based services such as the NSW HASI and NDIS options.

The service development work has been underpinned by the initial evidence check (refer to Section 2.2) and a second evidence review commissioned in 2016. The second review focused on models of care for people with severe and enduring mental illness. It built on the earlier review and identified the critical importance of 'effective care coordination by a case manager or a case management team' and the role of peer-support workers (Kakuma et al. 2017).

3.3.1 Modelling

The Stage One service developments included:

- Clinical supplementations to LHDs for the PCLI
- Modelling and procurement for Mental Health-Residential Aged Care Partnership Services

Much of the previous work to plan for and establish SMHSOP provided a platform for this work. The first (and revised) SMHSOP plans for NSW give a policy and program development context and governance for the sub-speciality of older people's mental health. The most recent plan reflects a change in terminology:

- NSW Service Plan for SMHSOP 2005-2015
- NSW Older People's Mental Health Services Service Plan 2017-2027

Background documents developed earlier by the Ministry (Mental Health Branch Older People's Mental Health Unit) were used in the modelling. In particular, two evaluation reports provided good evidence for the models of care developed for Stage One services:

- Evaluation of the Mental Health Aged Care Partnership Initiative (MHACPI), 2011, Health Outcomes International
- Economic evaluation of the Mental Health Aged-Care Partnership Initiative (MHACPI), 2013, Health Policy Analysis.

Stage Two modelling and business case development is addressed in Evaluation Report 2.

3.3.2 Enhancements and tenders

The funding of the initial PCLI project manager positions has already been referenced. These positions are crucial to implementation of the initiative as they provide a major link between each LHD and the Ministry PCLI team. In late 2015 correspondence was sent from the Secretary, NSW Health to the LHD Chief Executives about funding advice for establishment of PCLI Stage One Clinical positions in Hunter New England, Northern Sydney, Western NSW and Western Sydney LHDs. The original correspondence went to Chief Executives in LHDs where partnership services were to be

established. Further correspondence was sent to Western Sydney LHD and Nepean Blue Mountains LHD arising from the results of the tender process for the MHACPI unit, which was located within the Nepean Blue Mountains LHD.

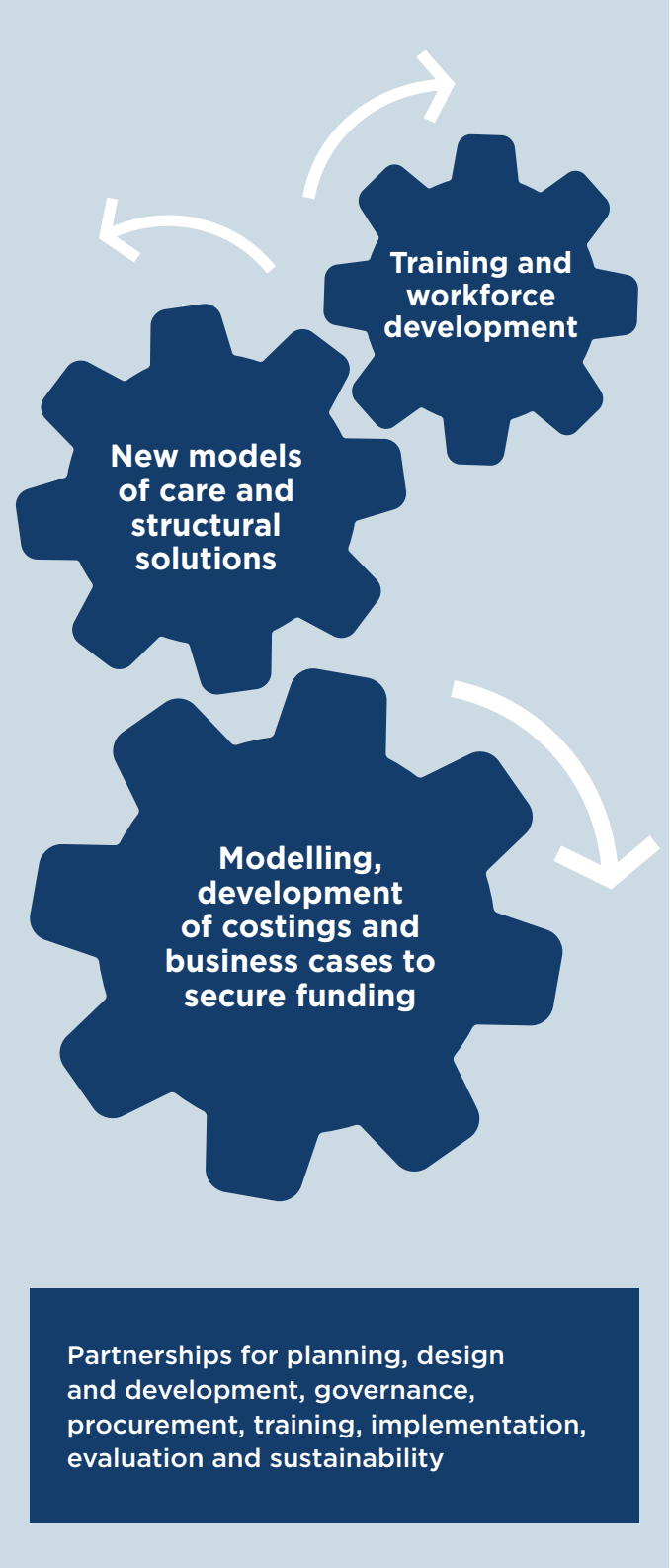
In 2015 the procurement plan and tender documents for Specialist Mental Health - Residential Aged Care Partnership Services (an expansion under the PCLI) was finalised and a tender, closing in March 2016, was released for MHACPI and Specialist Residential Aged Care Facilities. This process was informed by a costing study of mental health residential aged care services that provided a summary of financial outcomes for potential NGO service providers. Letters were again sent to Chief Executives about the PCLI service development plans for mental health residential aged care services. A procurement steering group was established with documented terms of reference, to assist with the complex and time consuming process of tender evaluation. Authorisation of the Stage One service development contracts was received. In 2015/16 additional funding to enhance SMHSOP community teams was also secured.

3.3.3 Partnerships

The range of partnerships required to establish and implement the PCLI should now be obvious from descriptions in previous sections of this report. Partnerships permeate every aspect of the initiative and function at multiple levels. Several of the major implementation strategies where partnerships are fundamental are depicted in Figure 9.

The Stage One service development process is a particular example of how the role of new external partnerships with NGOs and other aged care service providers are integral to the models of care developed for older age long-stay patient transitioning to the community. These partnerships have been facilitated through running a SMHSOP PCLI workshop in September 2016 and a MHACPI establishment workshop in November 2016. Further information about the development of Memoranda of Understanding with service partners, funding agreements and reporting requirements will be included in subsequent reports.

Figure 9 Example of PCLI Partnership Drivers



3.4 Information and evaluation

3.4.1 PCLI Program Logic

The PCLI program logic was finalised in May 2016. It sets out the strategic objectives, performance activities and outputs and intended outcomes of the PCLI. It was developed within the Ministry and tabled for discussion at the PCLI Steering Committee, ultimately being endorsed by the Deputy Secretary, Strategy & Resources in June 2016. The five strategic objectives of the PCLI include:

- Program management
- Governance, partnerships and communication
- Change management and workforce development
- Individual engagement and planning
- New service models – recovery based care in the community.

These objectives have been slightly re-framed into the quadrant framework that has become familiar to those involved in the PCLI (refer to Figure 3).

Figure 10 provides a summary of the PCLI Program Logic, with the full version included in Appendix 1.

The aim of the PCLI is essentially two-fold:

- To transition the current cohort of long-stay patients to community living.
- To change practices within mental health services so that the number of long-stay hospital admissions decreases.

An implicit assumption underlying the program logic is that working to transition the current cohort of long-stay consumers into the community is the means by which practices can be changed and sustained. For example, by moving towards a recovery-based model of care, using individualised assessment and collaborative care planning to meet the needs of each consumer, providing an adequate supply of suitable housing options in the community, and ensuring that individually-tailored services are available to support community living.

Figure 10 Summary of the PCLI Program Logic

Strategic objectives	Outcomes (1-2 years)	Outcomes (3-5 years)	Long-term ambition
Program management. Governance, partnerships and communication. Change management and workforce development. Individual engagement and planning. New service models – recovery-based care in the community	Consumer outcomes		Community living for people who experience complex and enduring mental illness. Recovery-based care pathways. Appropriate individualised high-support housing. Appropriate individualised high mental health services and support.
	Improved experience (engagement, choice and control).	Improved wellbeing, quality of life, physical health, mental health and social participation.	
	Family / carer outcomes		
	Improved experience (engagement, choice and control).	Engagement with care/cared persons. Satisfaction with quality, security and safety of care.	
	Providers / partners / staff outcomes		
	Improved expertise and skills.	Functional partnerships established. Improved availability of relevant expertise and skills.	
	System / service outcomes		
	Improved collaboration. Culture of recovery. Contemporary models of care established. Improved information sharing	Improved collaboration. Culture of recovery. Sustainable continuous improvement of service.	

3.4.2 Data collecting and reporting

The PCLI incorporates a considerable volume of data collection using a suite of assessment tools. A feature of the PCLI is that these data are not only intended for use in planning the care for individual consumers but also to plan services for groups of consumers (e.g. planning investments in new services).

Efficient and effective data collection processes are essential in an initiative that relies on periodic assessments to monitor patient experience and outcomes. A State-wide advisory group was established to review the aims and objectives of PCLI and identify suitable tools for outcome measurement. The primary aim of the suite of PCLI tools was to "get to know the person' who was long-stay. The other key aim was that they were intended for use in establishing an evaluation data set across all long-stay mental health facilities in NSW, complementing the existing (mandatory) measures and introducing a standardised approach to ongoing, regular assessment for this group of consumers.

Instruments considered for the PCLI tools reflected the core outcomes or issues for the program and – where possible – captured the consumer voice. They included standardised tools for assessing cognition and snapshots of daily living skills and function. Other criteria included easy access, low cost, psychometric properties and availability of manuals. Details of these tools and assessment procedures were documented in the *PCLI Planning and Assessment Guide*.

To provide a repository for information collected using these tools, a database was developed, first in Excel and later in Access. When the tools were introduced, each LHD had a stand-alone database with limited reporting capabilities. There were issues with the PCLI database as it was rolled out to LHDs and these are discussed in Evaluation Report 2. In mid-2017, consultants ARTD were engaged to work through functional and stability issues with the database and extend its reporting capabilities. This work has continued through 2018.

The *PCLI Database Management and Governance* document was released in 2016. It was developed for the PCLI Collaborative Group and designed to address emerging implementation issues. In the ensuing period correspondence has been sent from the Ministry to LHD Chief Executives outlining data management arrangements for the PCLI, including privacy and patient confidentiality processes.

PCLI data and reporting templates have been developed in an effort to streamline reporting from LHDs to the Ministry (Mental Health Branch) as part of the overall Mental Health Reform reporting. This is necessary as the Ministry must report to the NSW Cabinet Office about progress with the Mental Health Reform agenda on an annual basis. An important development to strengthen implementation monitoring of the PCLI is the inclusion of a Key Performance Indicator (KPI) for the PCLI in the annual LHD Performance Agreements developed between the Ministry and Chief Executives.

The six-monthly reporting template for LHDs is an important mechanism for data collection and aggregation to support monitoring of the KPIs and understand progress of the initiative. This is a spreadsheet completed by project managers and submitted to the Ministry in June and December each year. Reporting is cumulative, and indicates how many of the 'original' cohort of 380 consumers transitioned to date, where they went (in terms of accommodation type), average length of stay and other relevant information that provides accountability against budget and funding enhancements. In addition, it tracks new consumers who pass the 365-day length of stay criterion for entry into the 'second wave' PCLI cohort.

A further source of information is regular extraction of data from the HIE database, carried out by InforMH, on consumers who have been in hospital for more than 365 days. This includes scores on the mandatory outcome tools and thus provides a snapshot of the cohort and some insight into their needs.

The PCLI Data and Information Management Group has an ongoing role in ensuring that data is collected and available for health planning purposes, reporting and evaluation of the PCLI program. It assists with resolving issues that arise relevant to data collection.

3.4.3 Evaluation

The Ministry of Health issued a single stage open tender for a suitably qualified organisation to undertake an evaluation of the PCLI in September 2016. This was awarded to the Centre for Health Service Development with contracts finalised in January 2017. The evaluation involves a combination of formative, process and summative evaluation underpinned by the PCLI Program Logic (Appendix 1) and utilising the Evaluation Framework Model (Appendix 2).

The PCLI meets the three characteristics of what can be described as 'major system change':

- Participation of multiple stakeholders, both within and outside mental health services.
- The intended changes are system-wide.
- The changes require extensive coordination, with mechanisms in place to engage and align stakeholders during the planning and implementation of the program.

Programs involving major system change present many challenges for evaluators, with changes occurring at multiple levels across multiple settings, with outcomes only partially reliant on the program itself. It is difficult to separate these types of programs from the context within which implementation takes place (Turner, Goulding et al. 2016). The evaluation will take into account the contextual factors which are likely to impact on the implementation of the program.

The design of the evaluation is based on a two-year follow-up period for consumers and family/carers/guardians. However, according to the PCLI Program Logic, longer-term consumer outcomes such as improved wellbeing, quality of life, physical health, mental health and social participation are not expected to occur until 3-5 years after transition to community living. Therefore, these longer-term consumer outcomes fall outside the follow-up period.

The evaluation has the capacity to detect changes for individual consumers, especially for those who transitioned to the community in the early stages of the program. Changes, if they occur, will be seen both in scores on the PCLI tools and in the qualitative components of the evaluation, particularly the interviews conducted around consumer and carer experiences. However, significant change at an aggregate level (i.e., scores on the PCLI tools) may not occur within the two-year timeframe of the evaluation.

There may be some merit in considering some form of longer-term follow-up of consumer outcomes to build on the findings of this evaluation. This issue highlights the importance of fostering a consultative and iterative approach to the evaluation. The implementation of the evaluation framework and progress in conducting the evaluation is a focus of Evaluation Report 2.

3.5 Summary of key achievements

The process of program implementation has been highly effective to date, through:

- implementing effective underpinning project or program processes including governance and leadership of the PCLI, communication, change and innovation management and workforce development;
- working collaboratively to build a distributed model of leadership with clear roles for the Ministry PCLI team and LHD partners;
- initiating pre-transition assessments across the primary implementation sites and transitioning 3% of the long-stay patient cohort to appropriate community living;
- completing the procurement plan and releasing tender documents for Mental Health - Residential Aged Care Partnership Services (an expansion under the PCLI) and Specialist Residential Aged Care Facilities. This process was informed by a costing study of mental health residential aged care services that provided a summary of financial outcomes for potential NGO service providers;
- planning for the second stage of service development for people who are younger without issues of ageing;
- facilitating partnerships with diverse stakeholders to speed implementation, for example partnerships with NGOs and aged care providers;
- finalising the PCLI program logic which sets out the strategic objectives, performance activities and outputs and intended outcomes of the PCLI;
- building the initial data repository for PCLI specific data items and subsequently transferring this to an Access database to improve usability;
- establishing the Data and Information Management Group to ensure that data is collected and available for health planning purposes, reporting and evaluation of the PCLI program; and
- developing the Evaluation Framework Model and engaging an external and independent evaluation team.

4 Challenges moving forward

In the opening section of this report we identified the five 'simple rules' that can enhance success in large-system transformation in health care, and our framing concepts in relation to each rule. The rules are used to structure this discussion of the issues emerging through the evaluation process, particularly the challenges moving forward and associated recommendations to strengthen program implementation and evaluation.

This first evaluation report (Evaluation Report 1) provides a history of program development and early implementation efforts and how those engaged in the PCLI have set about 'building the foundation for transformational change'. Subsequent evaluation reports, in accordance with the PCLI Evaluation Plan (Masso, Coombs et al. 2017), will use qualitative and quantitative data sources and provide both formative and summative findings. Evaluation Report 2 will focus on 'demonstrating progress and learning as we go' and will cover the period from January 2017 to June 2018, while Evaluation Report 3 concentrates on the months between July and December 2018.

4.1 Leadership

Simple Rule 1: Engage individuals at all levels in leading the change

The Ministry PCLI team from the outset desired a model of distributed leadership that engaged LHDs and other partners in the planning, development and implementation of the PCLI. The pressures to generate 'quick wins' and demonstrate progress to secure further funding as well as the need to initially have a central point of coordination and facilitate state-wide engagement may have appeared to stakeholders to be more of a command and control model. This style of leadership was arguably appropriate for the scale and stage of this initiative and to generate momentum for truly transformational change. However as Minas (2005, p.38) wisely states:

It is clear that in thinking of mental health systems as complex adaptive systems, and of leadership for change in such systems, command and control styles of leadership are dead.

As the PCLI has progressed the pendulum has swung back to this original intent of distributed leadership and this has been demonstrated by communicating widely the aims, vision and strategies at the core of the PCLI and the focus on developing shared leadership of program processes. It should also be remembered that distributed leadership emerges and evolves dynamically in a way that cannot be planned in advance (Chreim et al. 2010 quoted in Best and Greenhalgh 2012, p.434). What is clear is that, in a distributed leadership model, the change still needs to be managed actively. The Ministry continues to do so, through supporting implementation sites and working hard to influence the wider NSW mental health service delivery system.

4.1.1 Recommendations

1. **Continue to foster the distributed leadership model throughout implementation of the PCLI.**

4.2 Collaborative monitoring and measurement

Simple Rule 2: Establish feedback loops

There should be feedback to those involved in the change using an agreed set of measures which are well understood. Routine reporting and celebrating program successes provides fuel to sustain implementation. The PCLI is a complex intervention and ongoing monitoring and evaluation is essential to ensure that the program is feasible, appropriate and acceptable and that program activities are being implemented as intended.

The assessments, devised as an integral part of the PCLI and used to plan care for individual consumers, will strengthen understanding of the outcomes for consumers. Early communication of progress in achieving the program KPIs is important in motivating individuals and organisations to continue with implementation, particularly in relation to factors associated with successful (and unsuccessful) transitions. Those engaged in the PCLI and external stakeholders benefit from receiving information about intermediate outcomes,

for example completed assessments, training of LHD personnel or evidence of early changes in work practices to facilitate new and improved care pathways. The Ministry PCLI team has used the six-month reporting template to capture achievements and the Dialogue Days to celebrate successes; both are useful measures. The PCLI Collaborative Group weekly teleconference is another very important mechanism.

Richardson and Denton (1996, p.203) looked at empirical investigations of the effect of communication on acceptance of change, noting:

Many attempts at change end in failure, and m any times the failure is due primarily to poor communication and lack of acceptance of the change by employees.

The challenge ahead is to sustain implementation and keep LHD personnel and other stakeholders involved as the PCLI is a marathon and not a sprint and there is a real risk of 'change fatigue'. As time passes, inevitably personnel who have been engaged in the initiative will move on and new personnel will join the mental health facilities participating in the program. This creates an ongoing need for training and continued vigilance in communicating the aims, purpose and processes of the PCLI.

Providing feedback to mental health personnel about the PCLI evaluation is also imperative as their continued participation in interviews, surveys and observational site visits is essential to the evaluation. If participants see no evidence that their views and voices have been heard, this can reduce their enthusiasm for ongoing input. As the experience of mental health personnel will evolve and potentially change over time it is important to capture perspectives at different time points.

4.2.1 Recommendations

2. **Review the PCLI Communication Plan to extend the reach to stakeholders within and external to NSW Health and ensure that messages reflect the stage of program development.**
3. **Assist those engaged in the PCLI to have realistic expectations about the trajectory of the evaluation and encourage their full participation.**

4.3 History and context

Simple Rule 3: Attend to history

Success depends on local history and a careful analysis of what has gone before. At the time of development the Ministry PCLI team demonstrated a sophisticated understanding of the prevailing mental health policy context and the role of the PCLI in meeting high level mental health reform objectives. The history of de-institutionalisation has been referred to previously in this report. The PCLI has set out to consciously learn from this history and to systematically address service gaps and develop robust processes to maximise the chances of successful transition.

Each implementation site has its own local history, culture and unique mix of challenges. The patient cohorts also differ significantly between the sites and this means that different resources will be needed to manage patients effectively in the community. The PCLI has successfully built on earlier collaborations with aged care providers, for example in the development of the Stage One service development models for MHACPI. One LHD has taken advantage of its pilot status in the NDIS rollout to successfully place several Stage Two consumers. However, the experience with the NDIS has been quite different at other sites.

4.3.1 Recommendations

4. **Influence entrenched cultures through consistent messaging, evidence of success and program adaptations in response to unforeseen challenges and stakeholder feedback.**

4.4 Clinical engagement and co-design

Simple Rule 4: Engage physicians

Doctors are of crucial importance to health system transformation because of their positional power and influence as opinion leaders. The identification of the NSW Chief Psychiatrist as the program sponsor reflected awareness of the need for medical leadership as did the prompt engagement of a clinical lead for the program. However, in an initiative of this scale, wide engagement with the full spectrum of mental health workers is essential. Most of those providing day-to-day care in the inpatient setting are nursing staff who have worked in mental health facilities for many years and have long-standing professional relationships with long-stay patients. Their engagement in implementation processes is fundamental to success, as they are the people who most frequently engage with the patient and their families. Allied health also have a very significant role in supporting transition processes. The PCLI advocates an iterative approach to the development of standardised processes and procedures that have consistency but also flexibility to accommodate local needs.

The rapidity of the roll-out of the assessment process has previously been discussed and was driven by NSW Treasury KPIs and the imperative to demonstrate progress and secure further funding. Care needs to be taken about balancing achievement of program objectives and targets with the need to maintain service delivery.

4.4.1 Recommendations

5. **Identify opportunities for further engagement of medical personnel as the program progresses.**
6. **Maintain existing mechanisms to share lessons about local implementation, including the development or adaptation of processes.**

4.5 Patient and family centred involvement

Simple Rule 5: Involve patients and families

Consumers and families should be involved in the change program on an ongoing basis. The PCLI appointed a Consumer and a Carer Lead early in the life-cycle of the program. Both leads sit on the PCLI Steering Committee. The PCLI documentation reviewed in the preparation of this report consistently reflects a commitment to a person-centred and recovery focused approach.

The authentic engagement with consumers and carers in all aspects of the PCLI is one of its most important achievements. While there is strong leadership for a recovery focused approach, this will take time to filter through to front-line staff and become apparent in day-to-day practice.

4.5.1 Recommendations

7. **Sustain current approaches to consumer and carer engagement.**
8. **Build ownership amongst front-line staff for recovery focused practice.**

4.6 Reflections on large-system transformational change

Best, Greenhalgh and colleagues (2012, pp.444-445) acknowledge that, although the five simple rules are necessary, they alone are probably not sufficient to drive large-system transformational change; for example, there does need to be a 'burning platform' or compelling motivation for change. The NSW policy context and PCLI vision provide this impetus.

The very nature of formative evaluation is about providing critical information about implementation.

Formative evaluation enables researchers to explicitly study the complexity of implementation projects and suggests ways to answer questions about context, adaptations, and response to change (Stetler et al. 2006, p.S1).

This evaluation is about learning about what works, for whom and in what context. Inevitably not everything works for everyone, everywhere, and such findings can be confronting when so much investment has been made in such a promising initiative. A consultative and iterative approach is essential, as is a willingness to reflect on and learn from challenges to program implementation.

4.7 Conclusion

The last entry in this report should be about the 380 people at the centre of the PCLI. It is worth noting that, in comparison to the overall annual volume of admissions to the six primary implementation sites, the original PCLI cohort of 380 long-stay patients represents a very small group of people. This cohort has experienced long periods of institutionalisation due to their enduring, severe mental illness and high support needs.

The PCLI has shone a spotlight on this group and their rights and desires for self-determination. This targeted reform initiative aims to establish sustainable, robust systems to allow those support needs to be addressed, enabling them to envisage and (in many cases) achieve a life outside hospital for the first time in many years.

The PCLI is building the foundation for transformational change but there is much still to be done that will require sustained energy, vision and commitment.

The essence of leadership is bringing about change in complex systems (Minas 2005, p.33).

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Appendix 1 PCLI Program Logic

STRATEGIC OBJECTIVES	ACTIVITIES AND OUTPUTS	OUTCOMES		THE LONG TERM AMBITION
What we invest in	What, to whom, by whom	Shorter Term: Years 1-2	Longer Term: Years 3-5	
PROGRAM MANAGEMENT	• Statewide steering committee • Service establishment (Stages 1 & 2) • Development of planning, engagement and assessment processes • Data capture/ analysis to determine the quantum and type of health services required (eg number of acute/ sub acute/ non acute beds to meet future need) • Delineation of future service spectrum • Monitoring, reporting and evaluation	INDIVIDUAL		COMMUNITY LIVING FOR PEOPLE WHO EXPERIENCE COMPLEX AND ENDURING MENTAL ILLNESS
		• Improved experience: engagment, choice and control	• Improved well-being and quality of life • Improved physical health • Improved mental health • Improved social participation	
		FAMILY/ CARER/ GUARDIAN		RECOVERY BASED CARE PATHWAYS
		• improved experience - engagement, choice, control	• Engagment with care/ cared persons • Satisfaction with quality of care • Satisfaction with security and safety of care	
GOVERNANCE, PARTNERSHIPS AND COMMUNICATION	• State support for LHDs • Co-ordination across jurisdictions, agencies and sectors • Effective operational and strategic partnerships across governement and non-government sectors • Communication strategies for families, staff and key agencies	PROVIDERS/ PARTNERS/ STAFF		APPROPRIATE INDIVIDUALISED HIGH SUPPORT HOUSING
		• Functional partnerships established for aged care service models • Improved availability of expertise and skills - clinical, non-clinical and disability • Culture of recovery • Provider/ Partner/ Staff experience • Improved collaboration	• Functional partnerships established for non-ageing service models • Improved availability of relevant expertise and skills - clinical, non-clinical and disability • Culture of recovery • Provider/ Partner/ Staff experience • Improved collaboration	
CHANGE MANAGEMENT AND WORKFORCE DEVELOPMENT	• Contemporary workforce design • Contemporary facilty/ home design • Workforce cultural change - to a preventative focus • Training needs assesment and training implementation			
INDIVIDUAL ENGAGEMENT AND PLANNING	• Individualised pathway development (engagment, screening and assessment) • Transition design	SYSTEM/ SERVICE		APPROPRIATE INDIVIDUALISED HIGH MENTAL HEALTH SERVICES AND SUPPORT
NEW SERVICE MODELS - RECOVERY BASED CARE IN THE COMMUNITY	• Development of contempoprary model of care across inpatient and community to embed a recovery approach • Modal solutions for modal groups • Comprehensive engagement, screening and assessment - from hospital into an individual's home • Development of transition readiness - managed transition to permanent community accomodation options • Skilled clinical and care support in the community 24/7 - the right range and level of services in the community • Integrated clinical, aged care and disability support services • Enhanced LHD specialist MH clinical services • Partnerships • Service Agreements	• Long stay patient planning (screening, assessment, service need analysis) completed for current cohort (N=380) • Ageing, non-ageing and inpatient service models developed to reflect contemporary models of care • Recovery oriented services established for first tranche (ageing cohort) • long stay patient transition underway (N=100), commencing with the ageing cohort • implementation of reconfiguration of existing resources and or additional service pathways • Improved information sharing	• Long stay patient transition continues with non-ageing cohorts • Reduced build up of long stay admissions for people with complex enduring mental health conditions • Reduced time in hospital for people with complex enduring mental health conditions • Increasing community based sector • More appropriate resource allocation (cost-benefit analysis) • Sustainable continuous improvement of service	

Appendix 2 PCLI Evaluation Framework

PATHWAYS TO COMMUNITY LIVING INTITIATIVE (PCLI)
DETAILED MONITORING AND EVALUATION FRAMEWORK MODEL

Pathways to Community Living Initiative (PCLI) -DRAFT Monitoring Framework CABINET IN CONFIDENCE

What we do		What progress do we see				The long-term ambition	What do we report		Actual measures
STRATEGIC OBJECTIVES	ACTIVITIES	OUTPUTS - YRS 1-2	Outcome measurement questions	OUTCOMES - YRS 1-2	OUTCOMES - YRS 3-5		Current/ anticipated data source	Current frequency of collection	
What we invest in	What, to whom, by whom	PROCESS MEASURES, as per the implementation plan		OUTCOME MEASURES	OUTCOME MEASURES			(Baseline / Pre: 3-6 mths prior transition to community / Post: every 26 wks over 2 yrs living in community)	
PROGRAM MANAGEMENT	Establish a statewide steering committee	**INDIVIDUAL**							
	Service establishment (Stages 1&2)		* How successful was the PCLI program in transitioning people from hospital into the community? * What personal characteristics of the 380 cohort impact individual, family/carer, care provision and system/service outcomes?	Improved experience: engagement, choice and control	Improved wellbeing and quality of life Improved physical health Improved mental health Improved social participation	**COMMUNITY LIVING FOR PEOPLE WHO EXPERIENCE COMPLEX AND ENDURING MENTAL ILLNESS**	File audit	Baseline	RAS-DS; CAN-C / CANE Elderly; Risk screening assessment; HCR-20 v3; NPI-NH; 3MS; WASI-II; RBANS; Trails A and B; Modified DAD Clinical Screen; PASS; LACLS05; HONOS; HONOS 65+; K10; LSP-16; RUG ADL; Wellness plan; Life in the Community Questionnaire; DemQOL (for RACF); YES survey consumer version; Carer Experience of Service version
	Development of planning, engagement and assessment processes						Social Work Assessment	Baseline + updated with change in circumstances	
	Data capture / analysis to determine the quantum and type of health services required (e.g., number of acute / sub acute / non acute beds to meet future need)						PCLI Tranision Readiness Assessment	Baseline	
	Delineation of future service spectrum						Health Mandated Measures (.g., HONOS,K10, RUG, LCQ etc)	Baseline, pre & post discharge	
	Monitoring, reporting and evaluation						PCLI Core disipline-specific, standardised measures	Baseline, pre & post discharge	
GOVERNANCE, PARTNERSHIPS AND COMMUNICATION	Coordination across jurisdictions, agencies and sectors	**FAMILY / CARER / GUARDIAN**							
	Effective operational and strategic partnerships across government and non-government sectors		* How did family and carers' experience of engagement, personal choice and control change over time? * How satisfied were they with the transition of their loved-one from hospital to mainstream community-based care facilities?	Improved experience: engagement, choice and control	Engagement with care / cared persons Satisfaction with security and safety of care	**RECOVERY BASED CARE PATHWAYS**	Interviews with individuals, family & carers		To be developed in consultation with external evaluators
	Communication strategies for families, staff and key agencies						Questionnaires		To be developed in consultation with external evaluators
CHANGE MANAGEMENT AND WORKFORCE DEVELOPMENT	Contemporary workforce design	**PROVIDERS / PARTNERS / STAFF**							
	Contemporary facility / home design		* How have care pathways, practices and agreements been developed/established between mental health services and community managed organisations for the transition of people from hospital to the community, including the ability of individuals to move back and forth between facilities and services for treatment as required? * What clinical practice changes have occurred within mental health and community managed organisations to decrease future long admissions?	Functional partnerships established for aged care service models Improved availability of expertise and skills -clinical, non-clinical and disability Culture of recovery Provider / Partner / Staff experience Improved collaboration	Functional partnerships established for non-ageing service models Improved availability of relevant expertise and skills - clinical, non-clinical and disability Culture of recovery Provider / Partner / Staff experience Improved collaboration	**APPROPRIATE INDIVIDUALISED HIGH SUPPORT HOUSING**	Interviews with mental health clinicians and residential care workers		To be developed in consultation with external evaluators
	Workforce cultural change - to a preventative focus						Benchmarking against national and international services		To be developed in consultation with external evaluators
	Training needs assessment and trainingcimplementation						Questionnaires		To be developed in consultation with external evaluators
INDIVIDUAL ENGAGEMENT AND PLANNING	Individualised pathway development (engagement, screening and assessment)								
	Transition design								
NEW SERVICE MODELS - RECOVERY BASED CARE IN THE COMMUNITY	Development of contemporary model of care across inpatient and community to embed a recovery approach	**SYSTEM / SERVICE**							
	Modal solutions for modal groups		* What system and service based changes have occurred? * What were the components of a successful model of care? * What were the perceptions and expderiences of stakeholders in relation to the transition preparation phase, assessment administration, staff delivery of services, family (re)-engagement and readiness of long-stay individuals to transition to community living?	Long stay patient planning (screening, assessment, service need analysis) completed for current cohort (N=380) Ageing, non-ageing and inpatient service models developed to reflect contemporary models of care Recovery oriented services established for first tranche (ageing cohort) Long stay patient transition underway (N=100), commencing with the ageing cohort Implementation of reconfiguration of existing resources and/or additional service pathways Improved information sharing	Long stay patient transition continues with non-ageing cohorts Reduced build up of long stay admissions for people with complex enduring mental health conditions Reduced time in hospital for people with complex enduring mental health conditions Increasing community based sector More appropriate resource allocation (cost-benefit analysis) Sustainable continuous improvement of service	**APPROPRIATE INDIVIDUALISED HIGH MENTAL HEALTH SERVICES AND SUPPORT**	Benchmarking against national and international standards		Survey and qualitative questions (to be developed in consultation with external evaluators)
	Comprehensive engagement, screening and assessment - from hospital into an individual's home						Questionnaires		To be developed in consultation with external evaluators
	Skilled clinical and care support in the community 24/7 - the right range and level of services in the community						Interviews with mental health clinicians and residential care workers		To be developed in consultation with external evaluators
	Enhanced LHD specialist MH clinical services								
	Partnerships								
	Service Agreements								

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