MY CHOICE: PATHWAYS TO COMMUNITY LIVING INITIATIVE

Planning, Assessment and Follow-up Guide

A guide for clinicians facilitating planning, assessment and follow-up for people moving into the community after a long stay in a mental health inpatient unit.

NSW MENTAL HEALTH REFORM 2014-2024

NSW GOVERNMENT

NSW Ministry of Health

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Produced by: NSW Ministry of Health

SHPN (MH) 200509
ISBN is 978-1-76081-463-2 (print); 978-1-76081-464-9 (online)

Further copies of this document can be downloaded from the NSW Health webpage www.health.nsw.gov.au

September 2020

This Guide is consistent with the NSW Health clinical documentation, data collection reporting and discharge planning and transfer of care policies and guidelines. Compliance with policies and guidelines at the relevant points of planning, assessment and follow-up is essential.

All requests for additional information are to be directed to your LHD PCLI Program Manager.

PCLI information is available through the NSW Health website
https://www.health.nsw.gov.au/mentalhealth/Pages/services-pathways-community-living.aspx

Contents

Everyone has the right to live in their own home and have opportunities to engage meaningfully with their community. We know that people with enduring and complex mental illness experience better quality of life and improved social and health outcomes if they are living in the community.

Organisation of services for mental health, World Health Organization, 2003

1. Background
1.1 Introduction

Pathways to Community Living Initiative (PCLI)

The Pathways to Community Living Initiative (PCLI) is a coordinated state-wide approach to supporting people who have had a long stay in hospital to re-establish their lives in the community, and is underpinned by the following understandings:

- People want to live and be valued in the community.
- A hospital is not a home.
- Community living is enhanced through the provision of recovery focused supported accommodation.
- Recovery begins at home and opens opportunities for work, inclusion and citizenship.

Established in 2015, PCLI provides state-wide leadership by the Ministry of Health in collaboration with Local Health Districts with the aims of:

1. **Enabling people with extended hospital stays (or at risk of)** and severe and persistent mental illness (SPMI) to transition into the community, including developing new service models for appropriate care; and
2. **Creating practice change** in inpatient and community services in a strengths-based and person-centred approach to decrease the number and length of long stay admissions.

National and international evidence shows us that a key to successful transitions from hospital to community living is a tailored assessment process for each individual. The PCLI Assessment Task Group (ATG) was formed in 2015 to develop a comprehensive engagement, information collection and assessment process that collectively provide a holistic perspective of each individual's personal strengths, capacities, needs and preferences. This includes a core set of objective, evidence based clinical tools designed to support existing assessment measures.

PCLI consumers

The PCLI includes people who have had a long stay in hospital (over 365 days) or who are at risk of a long stay. Some people have significant ageing issues, most have multi-morbidities including trauma related issues, alcohol and drug use, intellectual disability and physical health problems, and most will have severe and persistent mental illness and complex needs.

Journey to Home Guide

The *PCLI Journey to Home Guide* is for people moving to the community after a long stay in a mental health facility, as well as their families, carers, workers and clinicians. It is a companion document to the Planning, Assessment and Follow-up Guide.

The purpose of the Journey to Home Guide is to:

- help people plan, prepare for and sustain the move to community living smoothly and in a way that makes them feel safe
- give people practical strategies for each phase of the move
- provide advice, practical strategies and resources to help staff support person centred decision making in the journey from hospital to home.

The evidence tells us that critical to success will be a tailored assessment process for each individual wishing to transition from hospital to community living.

Dr Martin Cohen, Clinical Lead, PCLI (until April 2016) and former director MH, HNELHD

1.2 The aims and principles that underpin the assessment process

- **For each person who has been in (or is at risk of being in a) hospital for over 365 days the assessment and follow up process aims to:** ascertain their strengths, needs, potential and goals in order to develop, review and facilitate an individual plan to enable them to live a meaningful life in the community where possible.
- **For the PCLI program the aggregrated data collected from the assessment and follow-up process aims to:** further inform the development of a variety of community living models for people with a mental illness and complex and enduring needs who are experiencing a long stay in hospital.

Five principles have been developed to support the intent of evidence-based, contemporary practice in mental health care and guide the assessment of each individual.

All people have the right to live in the community
This is a basic human right. Given the right understanding, services, supports and the right transition processes there are people who are currently experiencing long stays in hospitals who could live in the community.
Every person who has stayed in hospital for over one year (or is at risk of) will have the opportunity to participate in an assessment in order to plan to leave hospital and maximise a high quality of life in the community.
High quality community based care can lead to improved health outcomes for people with a mental illness
High quality community care is least restrictive, recovery oriented, person-centred, contemporary in workforce and in facility/home design, and offers integrated clinical and support services.
High quality, evidence based approaches will be adopted in the assessment processes used and in planning for/and transition to quality, safe, home like and recovery-oriented community options.
One person, one plan, one step at a time
People who have been in hospital a long time are not an homogenous group. They are all ages and have different wishes and abilities as well as different levels of risk.
Each consumer will participate in an individualised assessment and be actively involved in decision making and planning. This process will be collaborative and iterative and will rely on good communication.
Connected with families, carers and communities
The families, carers and communities of consumers are important in the process of supporting a person into community living.
Communities that consumers are or have been positively connected to will be identified in the process of assessment and planning. This will include current, former and future friendships.
An integrated approach to system wide services
Integration between government agencies and across sectors is key to enable the development of appropriate community options for individuals with complex needs.
The Mental Health Branch and Local Health Districts will collaborate to facilitate the assessment process. Mental health services, aged care services and the community managed sector will work collaboratively to determine effective and efficient assessment processes and quality, meaningful community options for people moving to and living in the community following a long hospital stay.

1.3 Purpose of this Guide

Overview of the Guide

This Guide is based on the principles that underpin the PCLI, recovery focused and person-centred care.

The Guide is presented in four key sections as follows:

1. Background.
2. Understanding the person's process.
3. The clinician's process.
4. Stories of success.

Two stories have been included to highlight the challenges, opportunities and successes associated with transitioning people with long hospital stays to community living.

A number of appendices have also been included and provide additional supporting information.

Why is the planning, assessment and follow-up process important?

The planning and assessment process:

- is an important part of "getting to know you"
- informs collaborative decision making
- forms the basis of rehabilitation and care planning for all services involved in transitions
- enables change and wellbeing to be objectively monitored
- builds capacity for information sharing between LHDs and the collective reporting of PCLI outcomes to the NSW Ministry of Health.

The follow up after transition process:

- is an important part of ensuring that appropriate, effective clinical care and other supports are in place to maximise a person's quality of life
- assists to inform review and further development of PCLI planning, assessment, transition and follow-up processes as well as service development.

Who should use this Guide?

This Guide should be used by PCLI Program Managers, PCLI clinicians and PCLI peer workers, older adult and general adult mental health staff and other clinicians, peer workers, and managers involved in the assessment, transition and follow-up of people to community living.

Alignment with NSW Health and national strategy and policy

This Guide is consistent with NSW Health and national strategy and policy. Compliance with the *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services PD2019_045* at the relevant points of planning, assessment and follow-up is essential.

2. Understanding the person's process

2.1 The person's process

There are three key phases in the person's move from hospital to home as described in the *Journey to Home Guide* and below in Figure 1.

Figure 1: Journey to home phases

Phase 1 Planning your move	Phase 2 Making your move	Phase 3 Your community life
		
The first phase focuses on planning and preparing your move, and it starts when you begin to consider moving home. These discussions could start early – even at admission.	The second phase is the practical move from hospital to home, with support and ongoing assessment. It begins when you confirm a home address and timeframe for the move.	The third phase is about finding the supports to help you exercise your right to a meaningful life as a valued member of the community.
In the first phase you may: • decide where home will be. This could be a private residence or a home where support is built in such as a residential aged care facility or a supported accommodation setting • imagine living there • plan for the actual move Your clinician will do a 'Getting to Know You' assessment – a standard process that will help you plan for the move by talking about your: • strengths • need for support – this includes support from community-managed organisations (CMOs), friends, familiy and clinicians • preferences.	During this phase, some of your key tasks include: • learning about your community and routines, finances, how to navigate public transport, and the location of leisure activities • some of these may be provided in your home/facility or you may travel to these in your community • spending time looking after yourself to offset the stress that comes with moving home • deciding what furniture you may want or need and for some, connecting essential services. You can get to know your daily community with the support of CMOs.	The third phase focuses on: • settling into home • establishing routines and supports that will make it easier for you to stay there • maintaining a quality life in the community and connecting with it meaningfully • identifying aspirations.

It is acknowledged that each person will experience this journey differently, with different amounts of time spent in each phase and with differing outcomes. This process is not entirely linear. The transition from one phase to another will often include forward and backward movement whilst the person and their supports reflect on their wishes and preferences. They may develop new understandings about themselves and the potential options available. The person needs to decide what will give them the best opportunity to realise their dreams.

Figure 2 depicts the person's process and how this intersects with the involvement of the mental health team (both inpatient and community). For a person moving out of hospital and into the community there are certain steps that need to be undertaken. This is demonstrated below as 'The person's process', a three phase, five step journey which includes:

1. Planning your move: visualising a more meaningful life; planning to leave hospital; preparing to leave hospital.
2. Making your move: moving into my new home.
3. Your community life: settling in and developing a meaningful life in my community.

Figure 2: The person's process out of hospital and into community living

I believe change is possible, as long as we never disregard the value of empathy for others, and as long as we hold onto a fundamental belief in human potential and a willingness to reach beyond the status quo to consider new possibilities.

Bec Davis, social worker & mental health consumer, PCLI Dialogue Day

2.2 The person's perspective

The first phase in a person's process is to think about where they might want to live when they leave hospital. This will mean thinking about what 'home' means to them.

- What reminds them of 'home'?
- Would I like to live alone or with other people?
- Where could the location be?
- Why would I want to move?

People will be at different stages of readiness for community living:

- Some people will be ready to live in the community and will start planning to leave hospital.
- Others will start to plan and then change their minds, and then may change back again.
- For others the time may not be right.

The person's family may be important in this phase, having the capacity to generate a lot of support for the person's decision, as well as fear and concern for the future.

Once the person is starting to think about planning to leave hospital, they will want to find out what options are available.

They will think about what they want to be able to do in their home. Perhaps they may want to contribute to cooking? Visit friends and/or family? Travel on public transport to places in the community that interest them?

Participation in assessments can help the person realise their skills as well as areas that they may need support with, and how much support they might need for now.

Refer to the *Journey to Home Guide* for details on how to guide these conversations.

Assessment should be used to help individual decision-making and consumers should not be made to feel like a 'lab rat'.

Sandra Morgan, Member of ATG, PCLI Consumer Lead, NSW Ministry of Health

2.3 How assessment supports the person's process

Participation in assessment can help both the clinician and the person realise their strengths, skills and areas in which they may need further support or development, either in preparation for or after their move. This informs ongoing rehabilitation, health care and transition planning processes as well as the selection of accommodation and supports. Figure 3 illustrates how the PCLI assessment tools support the person's process on their journey to home in the community.

The assessment process begins with the conversation between a consumer and their supports. This conversation is ongoing. It is supported with a number of tools to support readiness to transition and is interwoven with core assessment tools. Together this leads to a holistic reflection of a person's options and potential steps in their transition and recovery process.

Figure 3: How the assessment tools support the person's process

3. The clinician's process

3.1 The information gathering and assessment process

There are six key components to consider in relation to the clinician's process and each component is described in detail in this section of the Guide. These include:

- The information gathering and assessment process.
- Informing planning and review.
- The assessment timeline.
- PCLI assessment tool selection.
- PCLI assessment tool battery.
- Follow-up of people after transition.

3.1 The information gathering and assessment process

To inform the person's process, the multi-disciplinary team is required to facilitate a comprehensive information gathering and assessment process. This is an important part of engagement and 'Getting to Know You'. It incorporates a combination of informal/non-structured and standardised/structured processes as outlined in Figure 4.

Figure 4: The information gathering and assessment process

1. **Conversations** with the person, their carers and support workers*.
2. Review of the person's **clinical record** including current care plans and past reports.
3. Conducting and/or reviewing **regular discipline specific assessments.**
4. Conducting the NSW Health mandated **routine assessment modules and outcome measures.** This should include the Physical Examination, Metabolic Monitoring, Substance Use Assessment, Family Focused Assessment, Domestic Violence Screening and others as applicable**.
5. Implementing the **PCLI assessment tools.**

* Refer to *Journey to Home Guide* for details on how to guide these conversations

** Refer to *Mental Health Clinical Documentation Guidelines GL2014_002* and *Mental Health Outcomes & Assessment Tools (MH-OAT) Data Collection Reporting Requirement 1 July 2006 PD2005_202*

3.2 Informing planning and review

3.2 Informing planning and review

The information gathering process ensures that decision making and planning is underpinned by clinically informed knowledge. This is used to support the person in realising their dreams and aspirations. The comprehensive planning and review process incorporates discussion of the findings of the assessments and the implications of this information for service planning, transition planning and accommodation selection.This information can also be used to assist with referral processes to National Disability Insurance Scheme (NDIS), Aged Care Assessment Team (ACAT), Housing Accommodation Support Initiative (HASI) and other high support accommodation options.

Back to Basics

A multi-disciplinary team clinical review for each individual is facilitated and documented by the care coordinator, following an agenda that includes:

- ✓ Background and current issues.
- ✓ Outcomes of assessments and information gathering, highlighting current needs.
- ✓ The person's strengths and resources.
- ✓ Current goals, aspirations and person's view of their situation.
- ✓ Current planning strategies and interventions provided.
- ✓ Recommendations for rehabilitation and other interventions to build skills and readiness for community living.
- ✓ Transition/discharge plan and barriers to discharge.
- ✓ Summary of general progress and proposed changes to care plan.
- ✓ Responsibilities and timeframes for any actions.
- ✓ Plan for collaboration and shared decision making with the consumer and their support people*.

Some good practice examples

Hunter New England Local Health District (HNELHD) has developed a **PCLI Assessment Summary and Planning Tool** that provides an objective reference of consumer needs. It enables staff to compare results over time to see where improvements have been made.

"I thought I knew the client's needs, but the form allowed me to see that information in a new way that enabled our planning to be more holistic." HNELHD clinician. Refer **Appendix 1.**

South Eastern Sydney Local Health District (SESLHD) has evolved their traditional multi-disciplinary review through the development of a **Personal Planning and Review Process** in their inpatient rehabilitation unit. It is consumer led and follows the principles of recovery oriented practice and shared decision making. Refer **Appendix 2**.

*A recovery and strengths oriented review process is facilitated in close collaboration with the consumer and their support people, involving them in all aspects of planning and decision making.

3.3 The assessment timeline

3.3 Assessment timeline

Core PCLI assessments can be interwoven with usual clinical and assessment practices over several days, weeks or months, depending on the needs and capacity of the consumer. Some assessments or processes logically follow others. It is the decision of the clinical team, informed by the consumer and their supports to determine the sequence and timing of assessment, so that the most meaningful, respectful and appropriate process is followed.

Assessment information is collected across three key points in time:

Figure 5: Assessment timeline

1. Baseline
As soon as possible to commence planning

Baseline assessments should be administered as soon as a person is identified as having or at risk of having a long stay in hospital (>365 days). Timing should be appropriate to the needs of the individual. This forms part of the visualisation and planning conversation and can be used when more detailed clinical information is required to aid the transition process. If any of these specific assessments have been recently undertaken and remain current, the clinical team may decide to use those results.

2. Pre-transition
Pre-transition from hospital to inform transition

Pre-transfer assessments are administered before transition from hospital, up to 6 months prior to transition if it has been 12 months since the baseline assessments have been completed. This is to ensure that any progress or decline with rehabilitation goals has been understood and accounted for in transition planning. *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services PD2019_045* should be integrated into the planning for transition.

3. Follow-up at 6, 12, 18, 24 months
Post transfer from hospital every 26 weeks for 2 years

Follow-up assessments are completed six months after the person has been discharged from hospital and every 6 months after that for a period of two years (4 time points). Follow-up assessments inform ongoing service planning by providing information to service providers regarding gains made since the transition and areas of continuing need, as well as enabling outcomes to be monitored.

Record keeping

All clinical work carried out as part of the PCLI process must be recorded as part of routine processes in the **medical records**. In addition, the **PCLI database** has been developed to capture and report the results of each assessment time point, enabling local analysis for planning and evaluation as well as statewide outcomes reporting. Refer to your local LHD PCLI Program Manager or contact to understand your responsibilities (if any) with regard to the PCLI database.

3.4 PCLI assessment tool selection

3.4 PCLI assessment tool selection

It is important to objectively measure each individual's strengths, capacities, needs and abilities using standardised and evidence based assessments. This assists individuals and their care givers to visualise a more meaningful life to plan leaving hospital. A core battery of assessment tools has been identified that are designed to complement other measures collected as part of routine clinical care. They do not preclude additional tools being completed as clinically relevant. These tools also enable objective monitoring of individual change and wellbeing.

The PCLI assessment tools meet the following criteria:

- Provide clinically meaningful information to assist care planning.
- Standardised with a published manual available to all clinicians.
- Demonstrated reliability and validity as evidenced by publications in peer reviewed journals.
- Good clinical utility – that is, they are portable, practical and applicable to the setting; relatively inexpensive and do not require extensive training.
- Applicable to the Australian context and where appropriate culturally adapted.
- Demonstrate acceptability to consumers (as evidenced in manuals or publications or through consumer involvement in selection process etc.).
- Acceptable to receiving facilities such as community-managed organisations and specialist residential aged care facilities as evidenced by current use of the assessment or another indication of acceptability.

Any additional tools that are selected and used locally should also meet the above criteria.

3.5 PCLI assessment tool battery

3.5 PCLI assessment tool battery

The following table provides a summary of the recommended PCLI assessment tools. In addition to the core PCLI assessments, other assessment options may be selected to further inform the process. Clinicians administering assessments may need the assistance of carers of the same cultural background, elders or community leaders or interpreters. Other specialist services may also be consulted for particular needs, for example, LGBQTI. Culturally adapted and validated assessment tools may also be indicated, for example, the Westerman Aboriginal Symptom Checklist which has undergone psychometric validation and is now available for purchase. Following Table 1 is the PCLI assessment tools - quick reference guide (Table 2) which is a one page guide for quick, easy and portable reference.

Appendix 3 provides a summary table outlining the duration of administration of each assessment tool, the administration requirements and the training requirements.

Table 1: PCLI Assessment Tool Battery

Recovery Assessment Scale – Domains and Stages (RAS-DS)	The RAS-DS is an adapted version of the original RAS scale that has been developed through consumer, researcher and mental health service collaborations. It is rated by the consumer and has been designed to: • Help consumers to take a leading role in understanding their own recovery progress, and from that, make recovery plans and track their recovery over time. • Help mental health workers to work more collaboratively with consumers, enabling recovery planning to be based on consumers own reporting through the RAS-DS and from conversations that follow around what matters to the individual person. • Assist services to track recovery outcomes. The RAS-DS supports a conversation with the person to identify how they feel about themselves and their lives which may include what will be/ is important to them in the community and how they can work towards this. It also allows the person to see progress over time and to review what is important for them as they settle into community living.
Camberwell Assessment of Need (CAN-C) and CANE Elderly	The adult Camberwell Assessment of Need (CAN) is used to understand the health and social needs of adults who have severe mental health problems. A summary of met and unmet needs is then produced from the information gathered, which can lead directly to possible interventions and care plans. There are several versions of the adult CAN for use in clinical work and in research studies. PCLI uses: **1. CAN-C for ADULTS** This detailed assessment measures the need rating; help received from formal and informal sources, and records an action plan for 22 domains of an individual's life. **2. CANE – for OLDER ADULTS** This tool incorporates the special needs posed by the elderly, incorporating 24 areas of individual need as well as two questions assessing the needs of the person's carer. The CANE collects information about the older person's needs from various perspectives, such as, the individual themselves, a key staff member and carer. This tool is helpful in ensuring that a broad range of needs have been considered from a range of perspectives. There is no right or wrong but the conversation can lead to better understandings from both the person and the mental health worker and used to inform rehabilitation and care planning. As someone moves into the community, their needs are likely to change so care plans need to be reviewed accordingly. A number of Community Managed Organisations (CMOs) use the CAN so always check which service is best placed to complete the CAN and make sure the plan is collaborative and shared by all.

PCLI Risk of Future Violence Screening Assessment	People living with mental health conditions have vulnerabilities to self-harm, suicide and violence, requiring mental health clinicians to be aware of and manage these risks as part of safe care planning. Violence in this context is defined as the actual, attempted, or credibly threatened infliction of bodily harm of another person (HCR 20: Assessing Risk for Violence Version 3 (HCR-20 V3) Author(s): Kevin S. Douglas, Stephen D. Hart, Christopher D. Webster and Henrik Belfrage; 2013.). This definition of violence is restricted to aggression associated with *bodily harm*. It broadly includes sexual violence, violence emerging from stalking behaviour, domestic violence, homicidal threats and fire setting. Legally sanctioned acts of violence and violence against animals are not included as part of this definition. Often, the types of issues that make a person vulnerable to future violence are also impediments to their recovery. The Risk Screening Assessment has been designed for the PCLI with the purpose of identifying people who require a full HCR-20 assessment to determine risk of future violence.
HCR-20 v3 (only if screen positive in PCLI Risk Screening Assessment)	The HCR-20 v3 should be conducted if indicated by the Risk Screening Assessment (above). Violence risk may be defined as the likely severity, imminence, frequency or duration of harm to others. The HCR-20 is a well validated clinical tool intended to aid clinicians in the assessment of violence risk and can be conducted by any mental health practitioner trained in the tool. This tool can help identify factors that might make someone more vulnerable to violence and in turn compromise their recovery. It enables the clinician and the person to put strategies in place that will minimise this risk and support a successful transition into community living. The Community Forensic Mental Health Service is available for support and advice regarding the HCR-20 v3 and people with complex histories of violence.
Neuropsychiatric Inventory-Nursing Home Version (NPI-NH)	The NPI-NH is a screening instrument used to evaluate neuropsychiatric symptoms in patients in an institutional setting. It assesses 12 behavioural domains including hallucinations, delusions, agitation/aggression, dysphoria/depression, anxiety, irritability, disinhibition, euphoria, apathy, aberrant motor behaviour, sleep and night-time behaviour change and appetite and eating change. The tool has strong psychometric properties.
Modified Mini Mental State (3MS)	The Modified Mini-Mental State (3MS) test offers a brief assessment of the person's attention, concentration, orientation to time and place, long-term and short-term memory, language ability, constructional praxis, abstract thinking, and list-generating fluency. It provides an overall screening of cognitive ability and can be used to monitor changes in cognitive function over time. Results of the 3MS can indicate the person's capacity to undertake further cognitive assessments using the WASI-II and RBANS and can assist in identifying and understanding cognitive difficulties experienced by the person. This can inform rehabilitation and care planning and the development of community supports.

WASI-II	The WASI–II provides a brief, reliable measure of cognitive ability or intellectual functioning. It is a screen for non-verbal, verbal and general cognitive ability, and can indicate if an in-depth intellectual assessment is warranted for the individual. Psychologists can use this measure when screening for intellectual disabilities or to measure IQ scores. The results of the WASI-II can indicate strengths and weaknesses in a person's cognitive functioning and inform rehabilitation and support approaches to maximise individual outcomes.
RBANS Neuropsychological Functioning	The RBANS provides a brief, individually administered battery to measure cognitive decline or improvement across five domains: Immediate Memory, Visuospatial/Constructional, Language, Attention and Delayed Memory. Together with the results of the WASI-II, the outcomes of the RBANS can inform rehabilitation and support approaches to maximise individual outcomes as well as informing on how much supervision and care the consumer needs. The repeat administration of the RBANS can also indicate changes in cognition over time.
Trails A and B	The Trail Making Test is a neuropsychological test of visual attention and task switching. The test generally requires ability to sequence (Parts A and B), ability to shift cognitive set (Part B), and processing speed (Parts A and B). The test reflects a wide variety of cognitive processes including attention, visual search and scanning, sequencing and shifting, psychomotor speed, abstraction, flexibility, ability to execute and modify a plan of action, and ability to maintain two trains of thought simultaneously. Results can inform approaches to rehabilitation and support programs, and repeated administration can indicate changes over time.
Modified DAD Clinician Screen	The Modified DAD screen quantitatively estimates functional abilities in both instrumental and basic activities of daily living in individuals with cognitive impairments. It helps delineate cognitive strengths and abilities, and especially focuses on executive function, which may impair performance in these everyday activities. It is suggested that the M-DAD be used to screen for areas for further assessment by an occupational therapist and highlight areas for discussion with both consumers and potential care providers in terms of strategies to support optimal function.
Large Allen's Cognitive Levels Screen 5 (LACLS-5)	The LACLS-5 is an evidence-based, standardised screening assessment of functional cognition developed within the framework of the Allen's cognitive disabilities model. The results of the screening tool are further validated by observation of additional everyday task performance. The model identifies cognitive strengths and abilities as well as difficulties. It incorporates the task/task environment and the type of cues to facilitate performance. Information gained from the assessment can assist in care planning with specific guidance for staff and families regarding what can be helpful to the consumer.

Living in the Community Questionnaire (LCQ)	This is a consumer-rated measure that focuses on social inclusion and recovery. The LCQ is designed to explore aspects of a consumer's life in the community including social activities, participation in employment or study, living situation, physical health care, self-expression, overall happiness and hopefulness. It has undergone extensive consultation, field testing and psychometric testing. The LCQ can support a structured approach to assessment and promote discussion between the person and clinician providing an overall impression of their recovery. The tool can be used to examine specific areas of the person's life that may be important for recovery and has practical implications for supporting collaborative care planning to assist people in achieving their goals. Repeat administration can provide a measure of outcome and change.

The most important thing is the conversation that's occurring and us learning about the consumer … we will start to really use these assessments to guide MDT discussion and help us form decisions about where people will be best discharged to.

South Western Sydney Local Health District Clinician

Table 2: PCLI Assessment Tools – quick reference guide

	All of the below core PCLI assessments are to be included in our initial processes with the person	Why?	Which of these assessments do we repeat every 6 months for 2 years?
Person centred	RAS-DS	What does the person value? How do they feel they are tracking with their recovery?	RAS-DS
	LCQ or DemQOL	How much is the person participating in community life? How much have they achieved and what would they like to continue to change?	LCQ or DemQOL
	CAN-C or CANE	What is going well? What type of help and support does the person continue to need or no longer need?	CAN-C or CANE
Behaviour	NPI-NH	This helps the individual and staff understand how someone's home environment is influencing the impact of their neuropsychiatric symptoms on their daily life and need for support.	NPI-NH
Functional	M-DAD	How independent is the person in basic and instrumental activities of daily living? What are the barriers to independence?	M-DAD
	LACLS-5	What is the person's level of functional cognition?	No
Risk	Risk Screen	What risks need to be considered and what management strategies might be needed?	As indicated
	HCR-20 v3 if indicated		As indicated
Cognitive	3MS, WASI-II	What are the person's cognitive strengths and limitations?	No
	RBANS, Trails A & B		Recommended
Routine Outcome measures	Outcomes Measures LSP Honos/65+ K10 Rug-ADL (65+)	What is the person's ability with basic life skills? Measures behaviour, impairment, symptoms and social functioning of the person. Anxiety and depression checklist. Activities of daily living scale measures the motor function of a person for four activities of daily living.	LSP Honos/65+ K10 Rug-ADL (65+)
	YES Survey	How satisfied is the person and their carer/s with the service provided?	YES Survey
	CES Survey		CES Survey

3.6 Follow-up of people after transition

3.6 Follow-up of people after transition

Each person transitioned out of a mental health inpatient facility following a long stay will receive a formal review as close to six months after discharge as possible. This is in addition to, but incorporated with, usual transfer of care practices.

Figure 6: Follow-up after transition involves all people

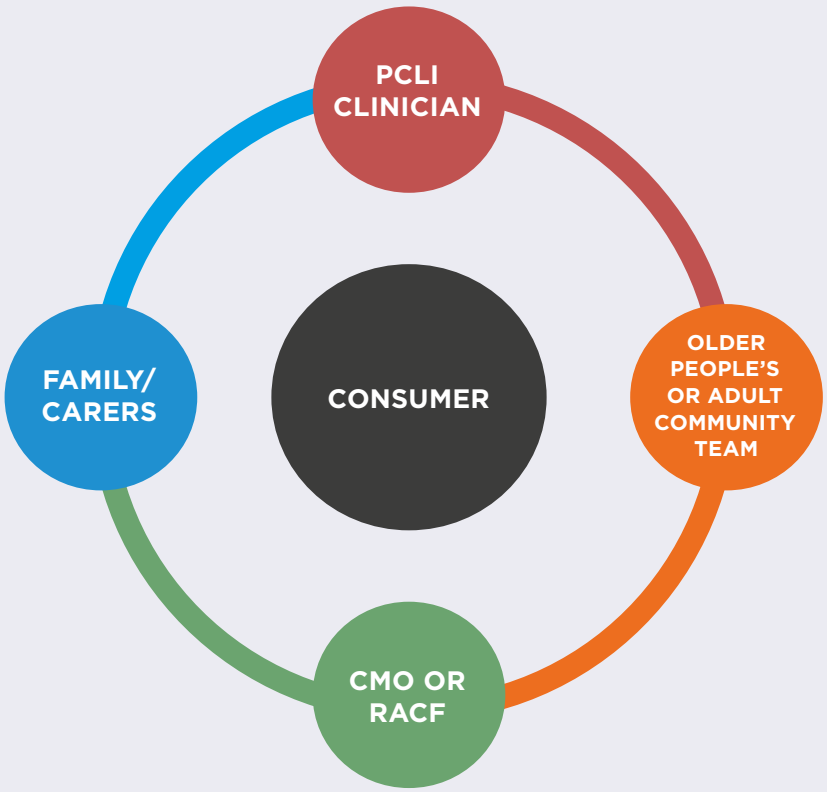
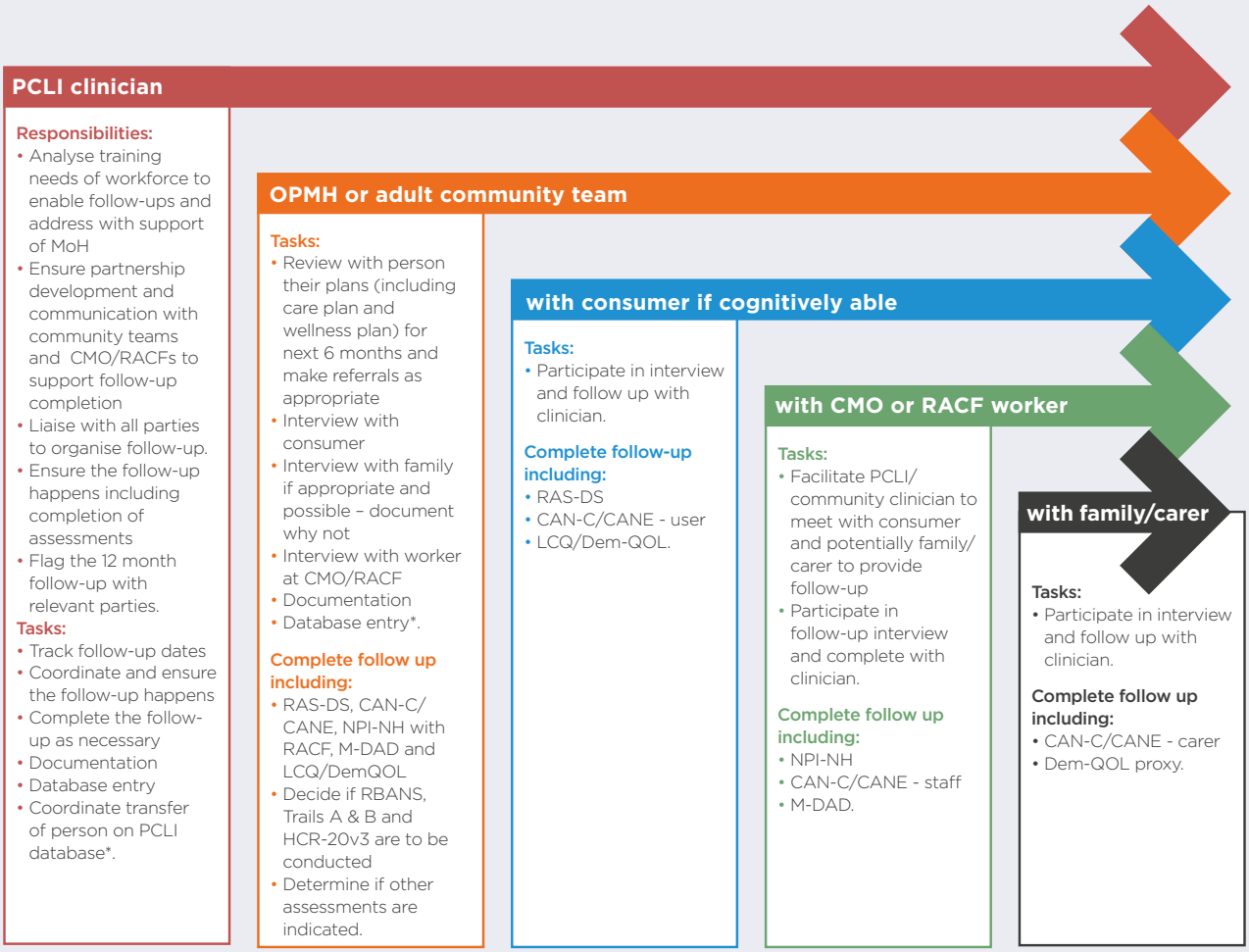


Figure 6 identifies the key people and organisations involved in the follow-up process. The follow-up review will involve engagement/interview with the person to gain their perspective on how life is for them now and the completion of five tools: three are completed with the person as clinically indicated, two are completed with the family/carer as appropriate, and three are completed with the community managed organisation (CMO) or residential aged care facility (RACF). Contact will be made with the person's GP and other significant providers/people as deemed relevant and agreed with the consumer. Figure 7 on the following page identifies the responsibilities and tasks for each person in the follow up process.

Figure 7: Follow-up after transition responsibilities and tasks



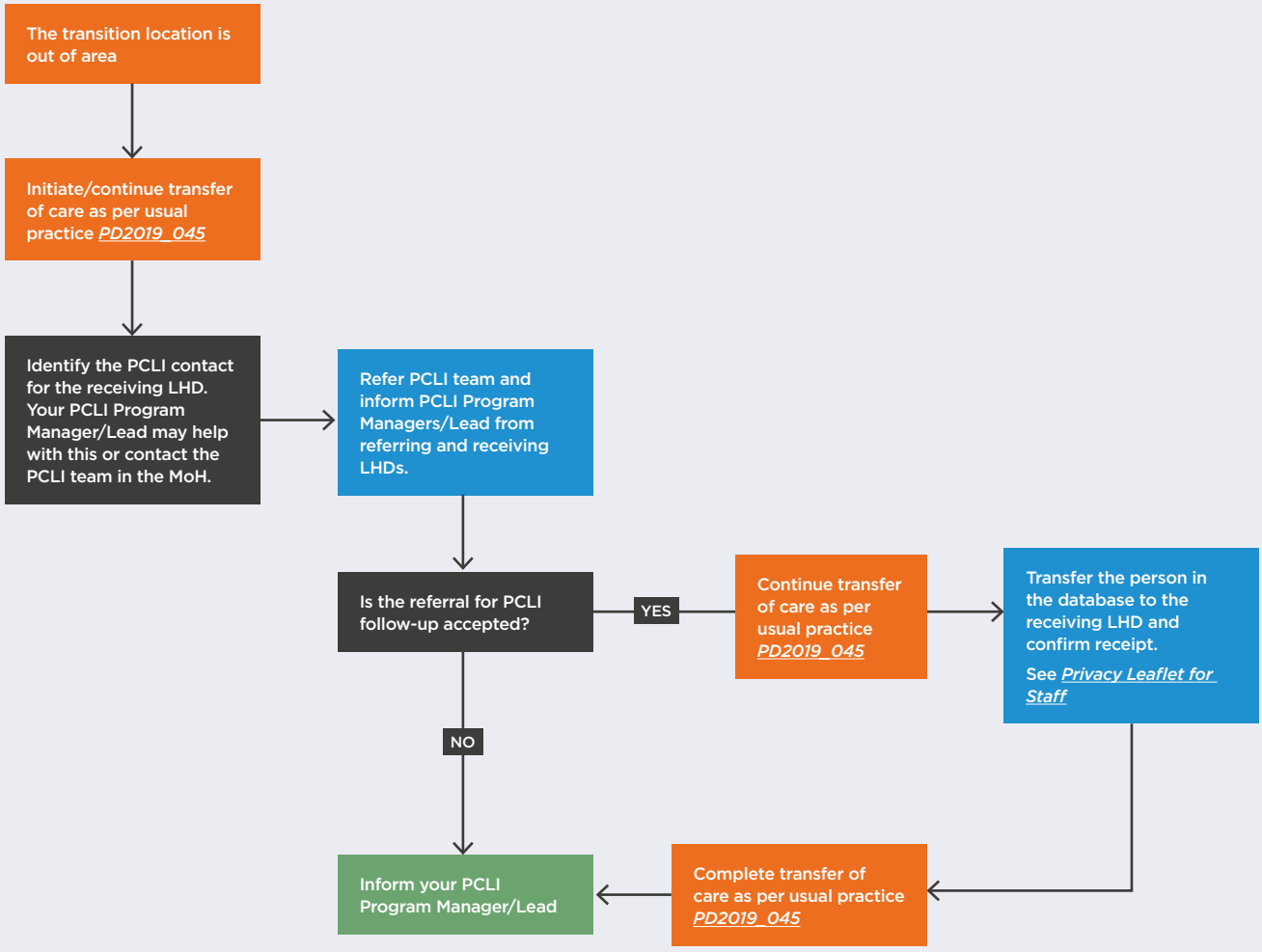
Note: RBANS and Trails A & B and other assessments may be selected informed by clinical judgement of the mental health team. Patient outcome assessment tools are also to be completed for every patient as per standard operating procedure for each LHD. This will include HONOS, HONOS 65+, K10, LSP-16 and RUG ADL.

The above diagram applies to consumers transitioning both within an LHD and to a different LHD. Where a consumer is transitioning to a different LHD relevant additional activities are marked with an asterisk *

When a person moves to a new local health district there will be a discussion and agreement during the referral and handover processes regarding which LHD is best placed to conduct the follow-up assessments. This will be informed by the current and ongoing needs of the person and the resources of both LHDs. There may be many reasons that a period of overlap is important for a person with such complex needs. Please talk to your LHD's PCLI contact to discuss your local arrangements for follow-up.

Figure 8 illustrates the process to be followed when a person is transitioning out of area.

Figure 8: Process for transition out of area



4. Stories of success

Visualising a more meaningful life: Nancy's story

Situation:

- Nancy is a 62-year old woman who has been living in hospital for 25 years, mostly in high-care, long-stay units. Nancy's diagnosis is schizoaffective disorder co-occurring with mild intellectual disability and marked behavioural disturbances. Behaviours include screaming often when needs are not met or as a response to voices, and aggression at times including kicking out at staff or other patients, and throwing food and crockery at meal times.
- Nancy told staff that she was unhappy in hospital because she missed her family and was lonely. A discussion followed to better understand her feelings and involve her family in her care. Nancy's father and sister became more involved and began to ask staff questions about the management of her behaviour, which was perceived as criticism of the care they were providing.

Visualising a more meaningful life:

- Discussions were prompted to consider alternatives to hospital and address the family's concerns.
- Initially, the family were suspicious about the motives behind the PCLI.
- A family case review confirmed that all parties had Nancy's best interests at heart and that there were aspects of her care that were difficult in hospital. Nancy's sister developed increasing trust in the process and both she and Nancy became meaningfully engaged in decision-making and planning for Nancy's future.
- Nancy's opinions varied over time but the consistent message was having somewhere where she could participate in more one-on-one social interactions and be closer to her sister.
- All agreed that Nancy would benefit from a smaller unit with more individualised attention and less disruption from other clients. The family were also keen that Nancy move to an area that would be closer to where the family would retire.

Planning to leave hospital:

- A set of assessments helped inform decisions about what kind of accommodation and supports would enable Nancy to live with a higher quality of life.
- An OT assessment revealed the need for shower equipment and physiotherapy assessment. Self-soothing activities were also recommended to assist with behavioural problems. A cognitive assessment completed by the psychologist indicated that Nancy suffers severe intellectual impairment requiring high levels of supervision and 24-hour care. Nancy's abilities and functioning were further informed by medical, physiotherapy and speech pathology assessments.
- In considering Nancy's strengths, it was identified that Nancy enjoys knitting and rug making.

Preparing to leave hospital:

- The treating team facilitated a visit with the family to a new PCLI MHACPI (Mental Health Aged Care Partnership Initiative) unit opening close to the family.
- The family were impressed with the enthusiasm of staff, the environmental features of the facility and the mental health support offered during transition.
- The family agreed to "take a risk" by submitting a referral which included the results of Nancy's assessment suite along with a comprehensive package of supporting documents. This allowed the MHACPI team to begin to understand Nancy's current presentation, functional abilities, behaviours of concern, and co-morbid medical issues.
- As the MHACPI sat outside of the LHD in which Nancy resided, there were multiple stakeholders involved and the process took some time to coordinate.
- Extensive communication with the family by both the referring and receiving mental health teams was essential.
- A close working relationship between the two LHDs and a willingness to provide a transition period in which both teams worked together was critical to a smooth journey.

Moving into my new home:

- Considerable preparation was needed by the MHACPI clinical and community transitions teams for Nancy's move. This involved adapting behaviour support plans for the MHACPI environment and aged care model, for example the approach to mealtimes.
- Given that Nancy was travelling out of area, the teams negotiated for an extended trial leave period of 28 days. This was to give sufficient time to settle in, allow greater communication between teams and enable transfer back to a familiar setting and support team if required.

Settling in and developing a more meaningful life:

- Almost immediately there were obvious signs that the level of stimulation and the approach of staff at MHACPI was supportive for Nancy. Since moving to the MHACPI, she has eaten all her meals in the communal area.
- There have been episodes of vocally disruptive behaviours however this has not affected Nancy's ability to engage in a number of previously enjoyed activities.
- Through the diversional therapy program she is being assisted to identify new interests and expand her social network within the facility.

Developing a meaningful life in the community: a clinician's experience

Situation:

- Ben was aged 49 when he moved to supported community living after a 4 year stay in hospital with a diagnosis of schizophrenia and acquired brain injury secondary to encephalitis. Ben, whilst in hospital walked with a slow, unsteady gait. He was often seen leaning and would require staff to rush to his assistance to prevent him falling. He wore the same clothing most days and his speech was so mumbled and illogical he was often hard to understand.

Meeting Ben in his new home:

- When we first spotted Ben I was somewhat convinced we had identified the wrong person. He looked at least 10 years younger and his posture showed a new found confidence we had never seen whilst he was on the ward … no introductions were required as he knew exactly who we were.
- Today, he sat tall, wearing a brightly coloured T-shirt with a quirky print which reflected his humour. He told us proudly about his support and access to the community and spoke about movies he thought staff back at the hospital should definitely watch – all with complete clarity. He was smiling! The most I had seen him smile in more than 3 years and as he walked us out still smiling he waved us goodbye.

My experience:

- It was actually sad to leave as I could have easily stayed for hours to chat about his new home, adventures and aspirations. We practically high-fived each other out the door and could not stop smiling. As soon as we arrived back to the office it felt like we were in competition to tell as many people about how well Ben was doing and share the positivity. More staff should experience days like this. It keeps you going.

Collective staff impact:

- I had already noticed an increased sense of hope after seeing some of the long stay consumers transitioning off the wards. Arriving to meetings and during team discussions there is a clear shift in the morale. This is not only for consumers but also for long term staff working in these wards.
- If I could bottle that feeling I experienced after seeing Ben I would make it mandatory for everyone to take a sip from that bottle and remember…this is why we do what we do.

5. Appendix 1

Example tool: Hunter New England Local Health District*

Figure 9: HNELHD has developed a PCLI assessment summary and planning tool

Type	PCLI assessment tool	Date completed/scores	Discussion
Person centred	Recovery Assessment Scale **(RAS-DS)** What were the key outcomes of completing this tool?		
	Camberwell Assessment of Needs Elderly **(CANE)** What needs does the client have? What needs does the carer have? Are these needs addressed?		
	Dementia Quality of Life **(Dem QOL)** How does the person/carer rate their quality of life? What factors currently have the greatest impact on this person's quality of life? What can be done to improve this person's quality of life?		
Risk	Other Risks – Falls, P.I., etc.		
	Historical Clinical Risk – 20 **(HCR-20 v3)** • Has a risk Ax been undertaken? • What is the overall risk of violence? • What triggers/protective factors exist? • What strategies are needed to manage these risks e.g. restrictive practices?		

* Permission has been granted for LHDs wishing to use or modify the HNELHD template with acknowledgement of the source.

Type	PCLI assessment tool	Date completed/ scores	Discussion
Cognitive assessment	Neuropsychiatric Inventory – Nursing Home Version **(NPI-NH)** • What are the main behavioural issues? • How often do these occur? • Are there effective strategies to manage such behaviours? • Less than 20 = mild behavioural problem. • 20-50 = moderate behavioural disturbance. • 50+ = severe behavioural disturbance. • NPI domains 3,7,8,9,10 will cluster under **"Hyperactivity".** • NPI domains 4,5,11,12 will cluster under **"Affective".** • NPI domains 6,11,12,10 will cluster under **"Apathy".**		
	Modified Mini Mental State **(3 MS).** Wechsler Abbreviated Scale of Intelligence II **(WASI–II).** Repeatable Battery for the Assessment of Neuropsychological Status **(RBANS).** **Trails** A and B. What did these assessments tell us about this client's cognitive capacity?		
Functional Assessment	Modified Disability Assessment for Dementia **(MDAD)** Clinician Screen. What executive functions are shown to have the greatest effect on functional performance? i.e initiation, planning/organisation, performance?		
	Large Allen's Cognitive Levels Screen 5 **(LACLS-5).** What level did the client achieve during assessment? What are the key patterns of behaviour at this level? What does this tell us about the person's best ability to function?		

- Was any new information found?
- Was there anything unexpected that was found?
- Is there any further assessment required before discharge planning can commence?
- Based on these results, what accommodation model does the team recommend (MHACPI, RACF, other Community based living)?
- Identify barriers to sustainable placement and assist in developing intervention plans targeting these issues.

6. Appendix 2

Example tool: South Eastern Sydney Local Health District*

Figure 10: MHRU personal planning and review format

Health
South Eastern Sydney
Local Health District

MHRU Personal Planning and Review Format

A brief guide to the MHRU client review meetings which are intended to follow principles of recovery oriented practice/shared decision making.

The process

Extend an invitation to people to participate in their personal planning process.

Communicate that it is about their plan and goals and how others can support them in attaining it.

Ensure that people wish to participate in a personal planning process.

Ensure that people are aware of the personal planning process.

Ensure that people have an opportunity to identify and invite others that wish to be involved in their planning.

Ensure the person is agreeable to the date and time well in advance of the meeting.

Unpacking Practices That Support Personal Efforts of "Recovery" (Glover 2009)

Timing and frequency

- Allow up to 30 minutes per meeting.
- Meetings take place every 3-4 weeks.
- Set date for meetings 1 week following admission or since the last PP&R.

Mental Health Rehabilitation Unit, The Euroa Centre, Prince of Wales Hospital, Barker Street, Randwick NSW 2031

Figure 11: Personal planning and review meetings - a guide for MHRU clients

Health
South Eastern Sydney
Local Health District

Personal Planning and Review Meetings (a guide for MHRU clients)

- You are invited to participate in a meeting with staff about your recovery plan and goals.
- You can pick and invite staff that you want to be involved (such as case managers etc.).
- You should know the date and time in advance (on the yellow sheet near the nurse's office).
- Lasts about 30 minutes and happens every 3 weeks.
- Your care coordinator meets with you to discuss your recovery plan before the meeting which will be used in the meeting.
- You are encouraged to lead the discussion if you are able, by telling staff how we can support your recovery (your care coordinator can support you with this).
- Feel free to change recovery plan to meet your current needs.
- You can ask which staff will assist with specific tasks on your plan.
- Feel free to ask any other questions to talk about anything which is important to you.
- The staff should ask you if there is anything you want written in notes about how the meeting went. Your Care coordinator should meet with you after the meeting to ask you what you thought of the meeting. You will be given a copy of everything discussed in the meeting.

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Figure 12: PP&R Facilitation Guide

Health
South Eastern Sydney
Local Health District

PP&R Facilitation Guide

1. Thank participants for coming.
2. Is everyone known to each other?
3. Set up the meeting e.g. "We are here today to discuss your recovery goals and agree how we can best support you in working towards these goals."
4. Ask client if they have had time to meet with CC and prepare for this meeting.
5. Recovery plan/strengths assessment brought into meeting (copies handed out is even better).
6. If client able to begin discussion around recovery plan this is ideal. If not, then CC to begin this part of the process.
7. Clarify if current recovery plan meet their needs.
8. If not, what needs to be changed?
9. Is there clarity about who is responsible for what? Are there target dates set?
10. Ask the client if there are other things they wish to bring up/stuck points.
11. Discuss openly any met or unmet needs – any risk issues or difficult behaviour? Interventions to address, how this may or may not fit into the person's goals.
12. Ask client how they would like the discussion reflected in the progress notes: "What would you like me to write in your file about today's meeting/how can I best reflect our discussion in writing up your notes today?"
13. Next date for PP&R set following meeting and written in relevant places.
14. Written copy of PP&R summary given to client *and pasted in eMR under the care plan section.*
15. Document that client was given copy in progress notes (this provides good evidence of partnering with consumers).
16. 'Debrief' session with participants to ask them how they thought the meeting went.

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7. Appendix 3

Summary guide for assessment tools

Table 3: Quick reference guide for PCLI assessment tools

Table 3 provides a summary guide for all PCLI assessment tools listed. Contact the PCLI Lead in your LHD for more information on how to access these tools.

Standardised Evidence-based Assessments	**Domain**	**Duration Minutes**	**Administration**	**Baseline**	**Pre** 3-6 mths prior to transition	**Post** Every 26 wks for 2 yrs post transition	**Cost** Yes or No	**Mandated Training required**
Recovery Assessment Scale – Domains and Stages (RAS-DS)	Personal Recovery	15	Nominated staff members from MDT/Peer workers recommended Consumer rated	✓	✓	✓	No	No
Camberwell Assessment of Needs (CAN-C) OR CANE Elderly	Needs + support actions	30	Nominated staff members from MDT	✓	✓	✓	Yes	No
Risk Screening Assessment	Need for full violence risk screen	10	In Case review/Clinician rated	✓	As indicated by change in circum-stances	As indicated by change in circum-stances	No	No
HCR-20 v3 (only if screen positive in PCLI Risk Screen)	Violence Risk	60	Trained team/Clinician rated	As indicated by screen and clinical indication	As indicated by change in circumsta-nces	As indicated by change in circumsta-nces	Yes	Yes (provided by Justice Health)
Neuropsychiatric Inventory- Nursing Home Version NPI-NH	Neuro-psychiatric symptoms	10	Nominated staff members from MDT/Clinician rated	✓	✓	✓	No	No
Modified Mini Mental State (3MS)	Cognitive Screen Mental State	10	Nominated staff members from MDT	✓			Yes	No
WASI-II	Current IQ	30	Level C Registered Psychologist required for administration	✓			Yes	No
RBANS Neuropsychological Functioning	Neuro-psychological Status	30	Level B - Allied Health or Special Education Professional	✓	✓	Reco-mmended	Yes	No Webinar available, group training available by Pearsons

Standardised Evidence-based Assessments	**Domain**	**Duration Minutes**	**Administration**	**Baseline**	**Pre** 3-6 mths prior to transition	**Post** Every 26 wks for 2 yrs post transition	**Cost** Yes or No	**Mandated Training required**
Trails A and B	Executive Attention	20	Level B - Allied Health or Special Education Professional	✓	✓	Reco-mmended	No	No
Modified DAD Clinician Screen	Independence in ADL & IADL	10	Nominated staff members from MDT/ Clinician rated	✓	✓	✓	No	No
Large Allen's Cognitive Levels Screen 5 (LACLS-5)	Functional Cognition	15-25	Occupational therapist	✓			Yes	Reco-mmended
Living in the Community Questionnaire or **DemQOL for people planning to go to RACF**	Social inclusion and recovery	15	Nominated staff members from MDT Consumer answered	✓	✓	✓	No	No
	Quality of life for people with demen tia	15-30 consumers 5-10 informants	Nominated staff members from MDT Consumer answered OR Carer rated	✓	✓	✓	No	No

8. Appendix 4

Routine outcome measures and experience surveys

Table 4 and Table 5 below provide a list of Outcome and Experience Measures routinely collected in NSW Health Mental Health Services. These measures will continue to be collected as part of routine clinical assessment for all consumers, as well as routine assessments.

This information will form part of the clinical data collection for the PCLI and inform people's process out of hospital and any follow-up clinical care.

Table 4: Outcome Measures routinely collected in NSW Health Mental Health Services

Mandated Assessments (formerly MHOAT)		**Duration (Minutes)**	**Administration**	**Baseline as due**	**Pre** 3-6 mths prior transition to community Every 13 weeks	**Post** Every 13 weeks over 2 yrs living in the community
Adult	**Older peoples alternative if indicated**					
HONOS	**HONOS 65+**	10	Nominated staff member from MDT	✓	✓	✓
K10		10	Nominated staff member from MDT	✓	✓	✓
LSP-16		10	Nominated staff member from MDT	✓	✓	✓
	RUG ADL	10	Screener of needs (receiving facility)	✓	✓	✓

Table 5: Experience Measures routinely collected in NSW Health Mental Health Services

Your experience of service (YES) surveys	**Duration (Minutes)**	**Administration**	**Baseline as due**	**Pre** As due, offered every quarter	**Post** As due, offered every quarter
YES Consumer Version	5	Consumer Perspectives – consumer rated	✓	✓	✓
Carer Experience of Service version	5	Carer perspective – carer rated	✓	✓	✓

9. Appendix 5

Frequently asked questions

Assessment

What do I do if someone can't complete the RAS-DS due to poor cognition?

If someone is not able to complete an assessment meaningfully due to poor cognition then the assessment should not be completed and the reason should be noted.

Why do I need to do an HCR-20v3 on someone who hasn't engaged in violence for many years or for someone with dementia?

The majority of people with mental illness do not engage in violence. However, if someone has previously engaged in violence, they are at greater risk of engaging in future violence, regardless of the period of time that has lapsed. Having dementia would not preclude a person from having their risk assessed using the HCR-20v3.

How long do we keep trying to offer assessments if the person declines?

This is a clinical decision for the multi-disciplinary team with the person and their family. Understanding why the person is declining the assessments will help inform this decision. You can help by explaining what the person may gain from the assessments and timing the assessment so it links to the person's goals and is meaningful.

What do I do if I think an assessment is not clinically appropriate for this person at this time?

This is an important and valid discussion to have with the MDT. This may apply to assessments requiring completion with the consumer and can be determined via the MDT review process. Any assessments rated by clinicians only should always be completed.

Follow-up

What do we do if the person is reluctant to complete follow-up assessments?

Planting the seed of follow-up assessments at the time of initial assessments can be helpful to assist the person to understand what they might gain from follow-up and to expect them and look forward to the follow-up assessments.

What do I do if the consumer may not wish to be followed up, especially if they are not receiving ongoing mental health care?

Discuss follow-up with the consumer prior to discharge and include in transition plan with agreement from consumer, family/carer as appropriate and RACF.

The existing Older Peoples Mental Health team does not know about PCLI; or they are not skilled in the assessments required; or they feel they are too busy. What should I do?

In the short term, make use of skilled PCLI resources. Discuss with MoH as necessary.
In the long term, build OPMH skill base and orient to PCLI requirements.

The receiving facility does not want to be involved. What should I do?

Facilities that have been procured by MoH will have indicated their willingness to be involved in the follow-up process. Other facilities may require explanation and training. If difficulties arise discuss with MoH.

If a person does not receive assessments whilst in hospital do I still offer them at follow-up?

Yes. The assessments provide valuable information to the person, their family and carers, other supports and the treating team at appropriate times and to compare over time. Being able to compare and discuss progress or a lack of progress is also helpful for the clinicians, peer workers and support workers to review how they are supporting someone and what therapeutic interventions are offered. Whilst it is ideal if the assessments can happen at the beginning of a person's planning they will still prove useful at later time periods.

Notes

We would like to acknowledge and thank the many contributors to this Guide.

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