NSW Health

Journey to Home Guide

My Choice: Pathways to Community Living Initiative

A guide for people moving to the community after a long stay in a mental health facility, as well as their families, kinship, carers, workers and clinicians.

Program Management
Getting to Know you
Information and Evaluation
Service Development

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NSW Mental Health Reform

The authors of this guide would like to acknowledge all those people who have lived or are living with a complex mental illness, those who have had or are at risk of a long stay in hospital and those who are now living in the community.

Additionally we thank and acknowledge the dedicated carers, family, friends and staff who walk alongside.

The voice of those with a lived and living experience of mental illness, as well as their carers and loved ones was essential in the development and ongoing review process of this guide. Your voices are essential in the development of the work and we thank you.

The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We recognise the continuing connection to land and water and how culture is held, nurtured and shared. We acknowledge that we live and work on Aboriginal lands. We honour and pay our respect to the ancestors of yesterday, the custodians of today and those of tomorrow.

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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.

PCLI information is available through the NSW Health website.

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The *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services PD2019_045* recommends that consumers with long inpatient stays (or those at risk of long stays) who are being discharged should receive care that aligns with the Pathways to Community Living Initiative procedures and processes.

Acronyms/Definitions	
CMO	Community managed organisation
HASI/CLS	Housing and Accommodation Support Initiative and Community Living Supports
HASI Plus	Housing and Accommodation Support Initiative Plus
LHD	Local health district
MHOAT	Mental health outcomes assessment tools
NDIS	National Disability Insurance Scheme
PCLI	Pathways to Community Living Initiative
SVH	St Vincent's Hospital

Introduction

Background

The Journey to Home Guide is a resource within the Pathways to Community Living Initiative (PCLI). This initiative forms part of the mental health reform agenda, which supports a greater focus on community-based care by helping people to live in the community.

The PCLI approach to care adopts a rights-based, recovery-oriented approach that puts your quality of life and unique needs at the forefront. With this approach, we support your right to have your individual needs and values embedded into your care.

The PCLI approach to care advocates that:

- Aboriginal people have the right to access holistic and culturally safe services that provide the best opportunity for improved mental health and social and emotional wellbeing, and the significance of culture, family, community, and spirituality in the healing journey.
- all aspects of a person's health and wellbeing are equally important and should be met by health services working together for the best outcome.
- health services have a responsibility to work alongside people with lived experience of mental health issues to improve their physical health outcomes and quality of life.
- needs of children and families of people with mental illness should be acknowledged and supported.
- everyone has a right to live in the community — no matter how long they stayed in hospital.
- everyone should feel safe and comfortable to discuss all their needs free from judgement.

What is the purpose of this Guide?

The Journey to Home Guide is a guide for people moving to the community after a long stay in a mental health facility, as well as their families, kinship, carers, workers and clinicians. This may mean returning to the home you had before your hospital stay or moving to a new home in the community.

In this Guide, we offer practical suggestions and references that help put you at the centre of the decisions made in your journey from hospital to home. To take steps in this journey, you need hope, positivity and a strong support system. The purpose of this guide is to:

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

Who should use this Guide?

The Guide is for:

- people who have had long or multiple stays in a mental health facility and are ready to return home
- families, kinship and carers who will offer support during the move
- clinicians and health or support workers who are supporting the person through their move.

About your journey to home

There are three phases in your move from hospital to home, as described in Figure 1.

Figure 1: Journey to home phases

Phase 1
Planning your move

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.

In the first phase you may:

- decide where home will be. This could be the home you were living in before your hospital stay or a new home. It may be a private residence or a home where support is built-in such as supported accommodation or a Residential Aged Care Facility (RACF)
- imagine living there
- plan for the actual move.

Your clinician will work with you through a 'Getting to Know You' process that will help you plan for the move by talking about your:

- strengths
- need for support – this includes support from CMOs, friends, family and clinicians
- Wishes and preferences.

Phase 2
Making your move

The second phase may be the practical move from hospital to home, with support and ongoing review of your needs. It begins when you confirm a home address and timeframe for the move.

During this phase, some of your key tasks include:

- spending time looking after yourself to offset the stress that comes with moving home
- learning about or reacquainting yourself with 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
- 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.

Phase 3
Your community life

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.

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 hopes and wishes for the future.

How to use this guide

Information for family, kinship, carers

Throughout this Guide, and for the purpose of simplicity, we have used the term ‘carer’ to encompass family, kinship and carers.

Tips for carers are presented in each phase. These tips provide examples of things a carer can do, not things they have to do.

We recognise that circumstances will affect how much input a carer can have into your move home.

Information for clinicians and health and support workers

There is a separate section for clinicians and health and support workers at the end of each phase that will help them plan your move home with you. If you are interested, we encourage you to read this too. It will help you understand what you can expect and ask from your clinical team.

Language

In this guide, when we say:

- ‘we’, we mean ‘NSW Health’
- ‘you’, we usually mean the person — unless it is under a ‘Carers’ heading or in a section for clinicians
- ‘carer’, we mean families, kinship, friends and other non-professionals who are your support people
- ‘hospital’, we mean ‘mental health facility’
- ‘home’, we are talking about where you plan to live in the community where you can have quality of life. This could be the place you lived before your hospital stay, somewhere you have never lived before, a home that has staff available for support or a residential aged care facility
- ‘team’, your team will comprise different people at different times. The team may refer to the specialist mental health team, other health workers and support workers at either the hospital, in the community or at the community living facility that you are planning to move to
- We appreciate that the use of language is important and that the use of different language and terms may be appropriate for different people.

We encourage you to speak with your clinicians and let them know:

- How you like to be addressed
- If you require any communication aids e.g. a hearing loop, etc.
- The type of communication that is most helpful to you (face-to-face or digital).

Although we describe the three phases in a certain order, they are ongoing, changing and flexible — everyone’s experience of the transition is unique and there is no right or wrong way to do it.

Being flexible during the three phases

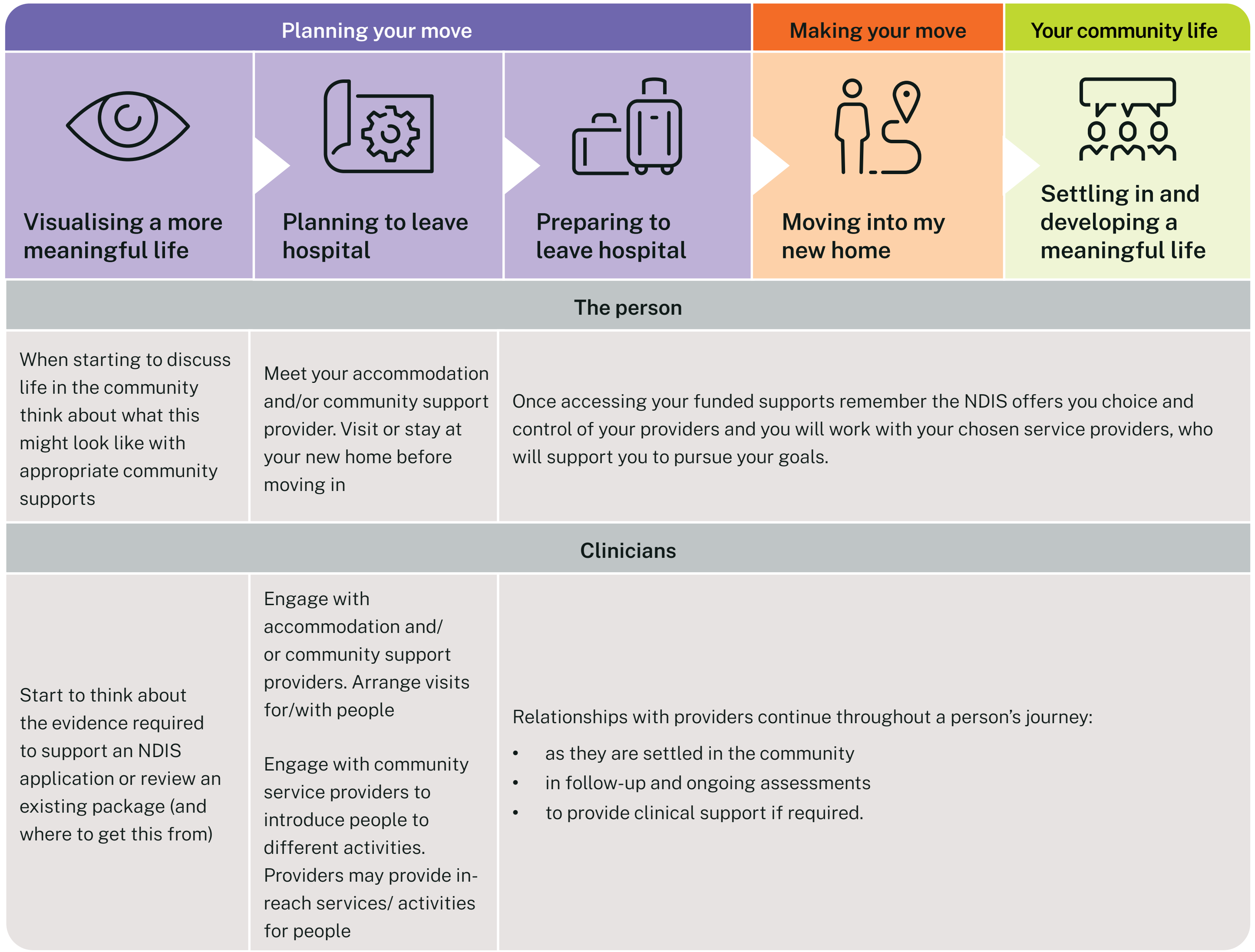
You might:

- pass through each phase more than once
- need a lot of time to work out what is best for you in a particular phase
- go back to an earlier phase and change your mind, and that's OK!
- need to return to hospital — sometimes for a short time, sometimes for longer.
- We recognise that we will need to help you, your carer and your new supporting team in planning for all these possibilities and make sure that you have access to the supports and services you need, when you need them.
- Revisiting an earlier step is not a backwards step — but rather an important step in the journey to a successful long-term move into the community. We should see these steps as trials of community living that need to be reconsidered and reshaped until you can access the support you need to be at home.

Engaging with community providers and your funded supports

For many people referral to community supports and providers will be an important part of their journey across all phases. Figure 2 below highlights the key considerations and linkages with community providers. Community providers may include services such as NDIS or NSW Mental Health Community Living Programs including Housing and Accommodation Support Initiative (HASI), Community Living Supports (CLS), HASI Plus and Mental Health Community Living Supports for Refugees (MH-CSLR).

Figure 2: Key considerations and linkages with Community providers



Planning your move			Making your move	Your community life
Visualising a more meaningful life	Planning to leave hospital	Preparing to leave hospital	Moving into my new home	Settling in and developing a meaningful life
The person				
When starting to discuss life in the community think about what this might look like with appropriate community supports	Meet your accommodation and/or community support provider. Visit or stay at your new home before moving in	Once accessing your funded supports remember the NDIS offers you choice and control of your providers and you will work with your chosen service providers, who will support you to pursue your goals.		
Clinicians				
Start to think about the evidence required to support an NDIS application or review an existing package (and where to get this from)	Engage with accommodation and/ or community support providers. Arrange visits for/with people Engage with community service providers to introduce people to different activities. Providers may provide in-reach services/ activities for people	Relationships with providers continue throughout a person's journey: • as they are settled in the community • in follow-up and ongoing assessments • to provide clinical support if required.		

How LHDs are using the Guide

WNSWLHD – Resources to support a successful transition to the community

The Western NSW Local Health District (WNSWLHD) peer support worker has created a Journey to Home ‘workbook’ to assist people in their transition to the community. A range of disciplines were consulted during the development providing an array of useful resources for the workbook; some of these include:

- simple exercises, grounding techniques, mindfulness and resources for coping with worry, budget checklist
- popular recipes.

Using the workbook with the person

The workbook is typically used in the last 2-3 months of a person’s hospital admission, in preparation for their discharge into the community. However, workbook activities can be adapted for use earlier in hospital admission or in the community.

Sharing the workbook with others

The workbook activities are typically worked through in a one-on-one scenario with the peer worker and the person. The peer worker types up the activities and shares with the person, the Mental Health unit and the relevant community teams.

Resources such as the Traffic Light Report, Wellness Plan, Introduction for my Support Team, My Strengths and Qualities, Sensory Preferences, Budget, List of Favourite Activities and Cleaning Checklist have been particularly useful for community teams in assisting them in getting to know the person and in prompting ideas for activities.

SESLHD and HNELHD – Support groups for people transitioning to home

In the South Eastern Sydney Local Health District (SESLHD), a support group facilitated by peer workers and Occupational Therapist (OT) students, has been piloted to support people on their journey to transition to home. The support group used the Journey to Home Guide as a basis for discussion. Weekly group meetings of 3-4 people were held over a period of 6 weeks. Feedback from participants about the support group has been very positive.

Hunter New England Local Health District (HNELHD) have also used the Journey to Home Guide in support groups. These groups were facilitated by the PCLI peer worker and the Morisset Hospital social worker, with the purpose of supporting people on their journey to transition to home. The Journey to Home Guide provided the framework for these groups. Groups of between 6-12 people (at any one time) were run for 6 consecutive weeks, with 2 weeks off and then another 6 consecutive weeks.

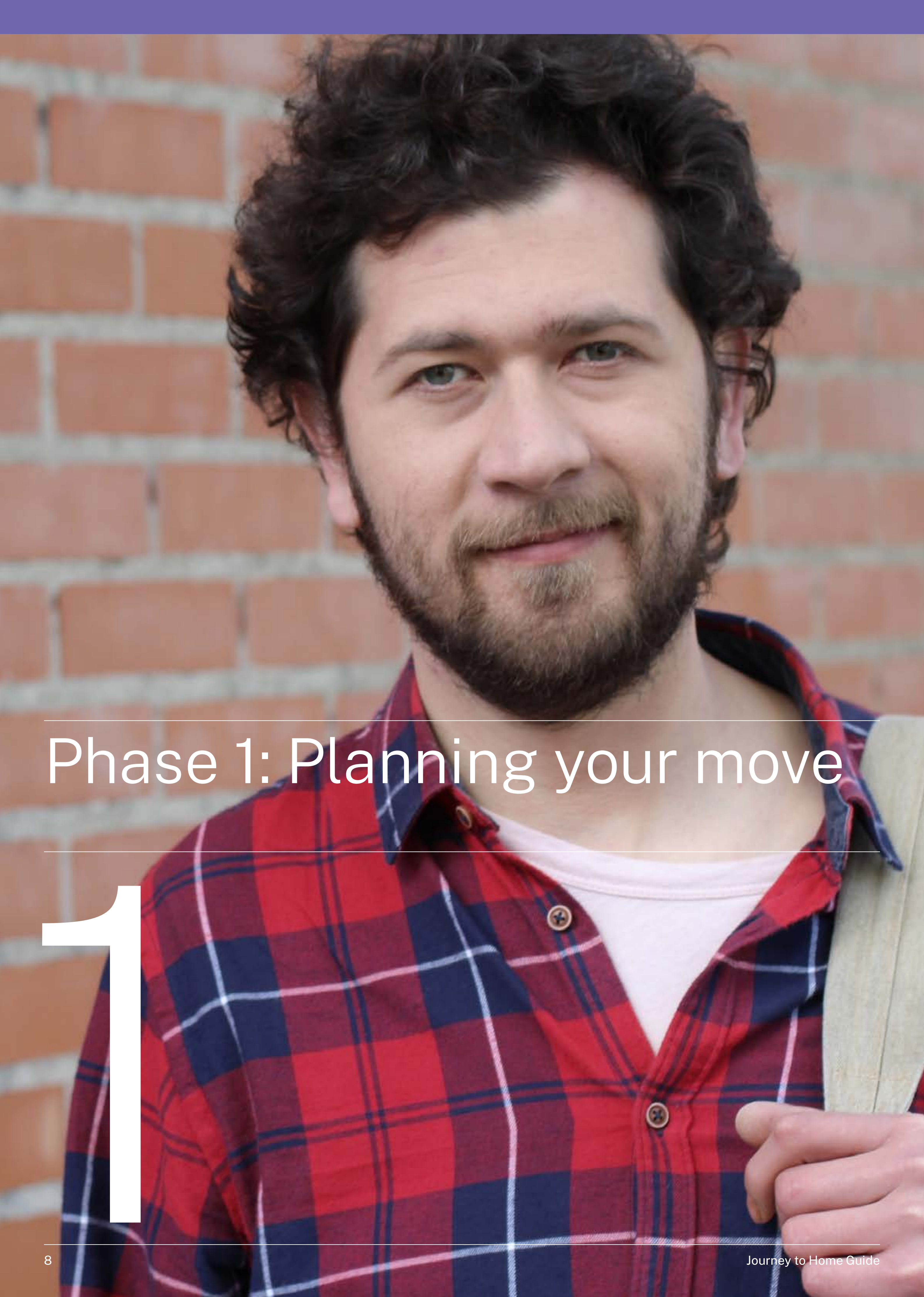
The Journey to Home Guide and support groups assisted people to navigate their own journey, become more autonomous and ask questions about their journey. Successes have included:

- **people more actively participating in transition meetings and taking ownership and driving their care pathway.**
- **engaging people prior to a transition plan on what is involved in the transition process, as often it is the unknown and long hospital admissions that can create anxiety for those people in not wanting to leave hospital.**

We wish you all the best on your journey.

From the person’s perspective, the workbook has assisted in fostering enthusiasm and excitement and has provided practical ideas to maintain a recovery focus.

Peer worker – Glenda Paton WNSWLHD



Phase 1: Planning your move

1

Introduction

In the first phase, we talk about planning and preparing for your move. For some this may be returning to your home before the hospital, for others it will be a new home.

Like every journey, moving from hospital to home begins with a vision. You might imagine what life will be like at home, recognise that change is possible (and positive) or express some hopes for the future.

Understandably, thinking about the move might make you doubt yourself, or feel confused or scared. Preparing to leave hospital involves:

- understanding and living with these feelings
- saying goodbye to the hospital environment
- letting go of the hospital's routine and support structures.

Goals and planning what you want to do

During this first phase, your goals may be to:

- work through your wishes and preferences for living in the community
- be able to tell others your wishes and preferences
- know your strengths
- identify areas where you would like support.

There are nine key considerations to discuss and think about when planning your move. These include:

- Your home
- Your skills
- Your interests and activities
- Your work and study
- Your routines
- Checking your supports
- Planning your move
- Making decisions
- Positive risk taking.

How you and your carers can plan your move

Use the prompts on the following pages to help you think about and discuss planning your move.

1. Think about your home

Things to think about and discuss

- What the future will be like and what you hope for.
- What 'home' means and where it could be and who you could live with.
- How you feel about leaving hospital.
- Whether there is anything you fear about living elsewhere.
- Previous moves and what they were like.
- The things that are important in a move like this — make a list of the top three.
- How to find out what options you have when you leave hospital.

Tips for carers:

Take the time to listen — home can be hard to imagine. You could also:

- encourage the person to move from imagining to planning
- tell them about their current home and changes or their new location and what it could offer — part of the journey is deciding on a destination.

2. Think about your skills

An OT is a member of the clinical team that can work with you and your carer on developing or maintaining skills as you prepare to leave hospital.

Things to think about and discuss

Talk about different skills, like:

- cooking
- cleaning
- shopping
- laundry
- managing money
- managing medication
- personal care
- making friends
- getting around in the community.

Talk about what you:

- can already do and skills you might like to learn
- might need help with — and what kind of help this might be.

What skills can you practise while you are still in hospital? Could you

- set up a budget now and try it out?
- learn to cook a meal you like to eat?

What skills are better to leave until you are in your home?

Tips for carers:

Can you support the person to engage with any activities now? How?

- cook some meals together
- do some cleaning tasks together
- have a self care session together, try face masks, a manicure, a new hairstyle.

3 . Think about interests and activities

Things to think about and discuss

Talk about:

- what you like doing now
- used to like doing but have not done in a while
- could do in the future
- can do by yourself — like going for a walk, or reading or drawing
- can do with other people — like joining a club or playing sport.

Tips for carers:

Can you support the person to engage with any activities now? How?

- download a fitness/walking app
- purchase some craft materials
- find the nearest street library.

4. Think about work and study

Things to think about and discuss

- Are you thinking about doing some work or study?
- What would you like to do?
- What work or training have you enjoyed in the past?
- What new things would you like to learn?
- Do you have concerns about work or study that you'd like to talk to someone about?

Tips for carers:

- go to an open day
- get local TAFE course list
- visit local mens shed.

5. Think about routines

Things to discuss

Talk about what:

- routines happen in hospital
- new routines you will do after moving
  - When do you like to wake up?
  - When do you like to have a shower?
  - What time do you prefer to take your medications?
  - Which main meal of the day do you like best?
  - What TV programs do you like to watch?
- things that will need to change in your routine when you move
- things you can start to change now.

Tips for carers:

Can you support the person to engage with any activities now? How?

- purchase a diary
- find a daily planner app
- create TV and music play lists.

6. Check your supports

Your 'circle of support' might include your:

- family
- carers
- spouse/partner
- friends
- pets
- CMO Staff
- General Practitioner (GP)
- mental health team
- housing and health professionals
- mental health or other peer support groups
- disability advocate
- community groups — including cultural or religious supports.

You might like to ask to speak to a Peer Worker. Peer Workers draw on their own personal experience of mental illness and recovery to provide information, support and hope that recovery is possible for everyone regardless of their situation, diagnosis or time spent in hospital. Peer workers are located in most mental health services.

Things to think about and discuss

- Draw your own circle of support. Who is in it?
- What other support people do you want or need?
- What would you like your circle of support to help you with during this move?
- What are the top three qualities you need in a support person?

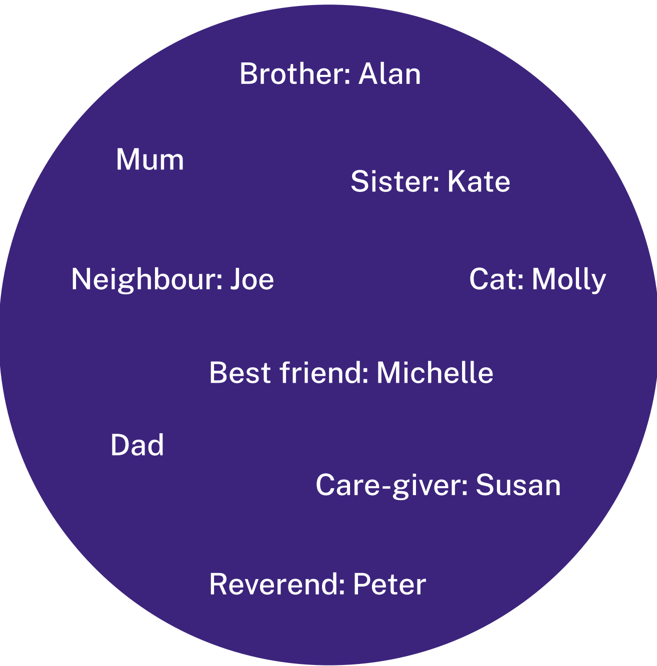
Tips for carers:

What top three things can you do to support the person in the way that works for them?

Who else in the circle of support could help the person and how?

- help get contacts list up to date in phone
- write numbers down in a note book.

Figure 3: An illustrated example of a circle of support



7. Planning your move

There are a lot of practical steps in the move home such as:

- developing plans
- talking to your team.

Your team will:

- facilitate the 'Getting to Know You' process, to help everybody understand more about your strengths, wishes and needs
- help you develop a transition or moving plan, which you can adjust depending on your changing needs, or write by yourself
- keep your family and carers informed about the plan and how they can support you.

Things to think about and discuss

- A move like this can be stressful, but you can be ready to deal with that stress. As part of your moving preparation, you can develop a wellness plan together with your health care provider where you think about and discuss the questions below. This can be shared with your support team.
- What is it like for you when things are going well?
- What daily routines can add to your wellness?
- When you are feeling unwell:
  - what are the early warning signs?
  - what will you do about them?
  - what is your plan for what to do?
  - how might you prevent a relapse?
  - what might help your recovery?
- You might like to practise some of the strategies in your wellness plan by:
  - building them into daily routines
  - finding hobbies or activities that are meaningful.

As part of your wellness planning you might like to develop a crisis plan that outlines the types of services and support you would like if you require crisis support.

Also, if you are currently under a community treatment order (CTO) by a Mental Health Tribunal, your team will need to check with the tribunal before you begin planning your move.

Tips for carers:

Think about what helps the person feel good and relax.

- do some relaxation together
- regularly talk through plans
- keep making time to do fun things together.

8. Talk about decisions

Let your support team know:

- where you would like to move to
- when you would like to move.

You may not be able to control these things — it may depend on when places are available — but your support team would like to know what you prefer.

You might need to make important decisions like:

- when would you like to visit your home first?
- would you like an overnight stay in your home before you move?
- who would you like to go with you?

Things to think about and discuss

- Do you know how the process will work?
- What decisions do you want to make for yourself and/or need help with?
- How do you feel about making decisions?
- Who would you like to help you with decisions?
- What your rights and responsibilities are.
- What legal things you should talk to a social worker about.
- Whether you should ask for an advocate or formal guardian for parts of your life.
- Whether you would like to speak to a peer worker.
- Who to ask (and when) if you are not sure of something.

Prepare an introduction about yourself for your new support team, which might be part of your care plan. You can tell them about:

- what you are like when you are at your best
- your top five: likes, dislikes, strengths, weaknesses, interests
- strategies for managing your wellbeing.

Tips for carers:

You can spend time with the person's:

- team to find out about
  - the process and what to expect
  - what support you might need
- social workers to find out about some of the legal aspects you might need to consider when preparing for the move.

9. Positive risk taking

Things to think about and discuss

Positive risk-taking relates to behaviours that involve you taking on challenges leading to personal growth and development. This includes developing new interests, trying something you're not sure you can achieve, deciding to act differently in a relationship, and taking on new roles. There is nearly always benefit from this; even if it all goes wrong resilience is developed through trying and failing. Positive risk-taking, risk for a reason will be needed to meet many of your recovery goals.

- What does positive risk taking look like for you?
- What opportunities does positive risk taking offer you?
- How can you be supported to take positive risks?
- What has helped in the past?
- What has not helped in the past?

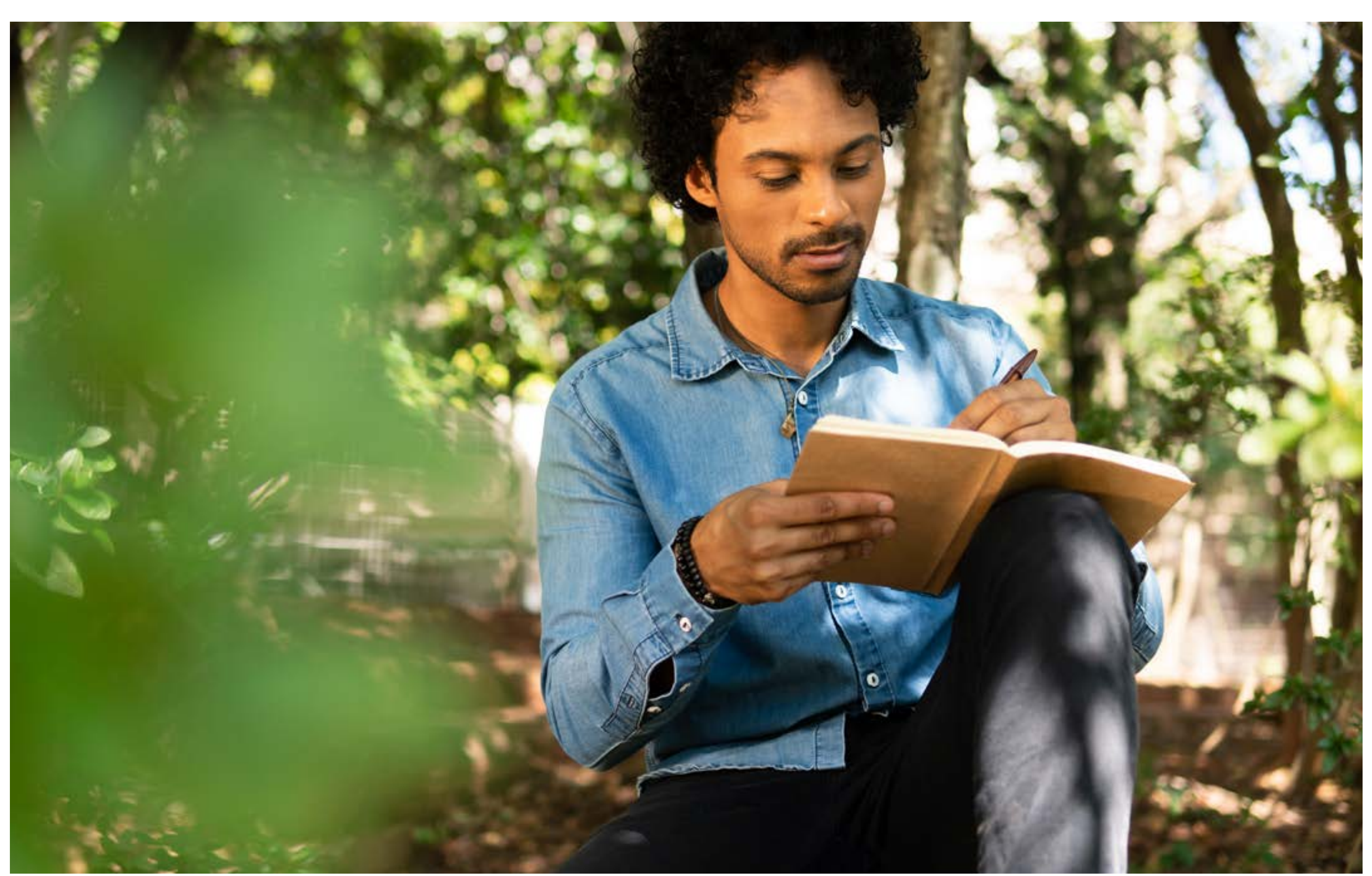
Tips for carers:

To work out what support you can give, you can:

- recall the person's experiences – including what worked and didn't work
- use the wellness plan.

If a person takes a positive risk and is unsuccessful, they can learn from the experience – but taking a risk can sometimes lead to harm. Think about how you can:

- avoid over-protecting them through the process of taking risks
- tell the difference between positive risk taking and harmful risks
- support the person to consider positive and negative consequences of their decisions.



Support for carers

Whether you can be actively involved in the move or not, it is important that you are included in communication about the person's plans and are given the chance to provide feedback. It is also important that you look after your own wellbeing and have your own support network.

Your feelings

- How do you feel about the person:
  - returning or moving to their new home?
  - making decisions for themselves that you might not agree with?
  - taking risks in their lives?
- What are you:
  - fearful about?
  - excited about?
  - curious about?
- What will you find:
  - easy about this process?
  - hard about this process?
- What support do you need during this process?

More information for carers:

Health care professionals are available to answer your questions along the journey. The links below provide additional information that you may also like to look at.

- You can also ask to speak to the Family and Carer consultant in your local mental health service.
- For information on rights and responsibilities see: https://nswmentalhealthcommission. com.au/news/commissionnews/ updated-guide-tomental-health-rights-in-nsw
- Information about the Pathways to Community Living Initiative can be found at: http://www.health.nsw.gov.au/mentalhealth/pcli/Pages/consumers-and-carers.aspx

For clinicians and teams

Phase 1: Checklist for clinicians and teams

- [ ] Identify a dedicated staff member/s to complete transition tasks with a clear completion date.
- [ ] Identify all members of the Multidisciplinary Team (MDT) and the person's circle of support and provide regular updates on progress.
- [ ] Consider what the person needs to support their decision making and what they already have.
- [ ] Coordinate the 'Getting to Know You' process (which includes explaining to the person what it is); refer to the Planning, Assessment and Follow-up Guide for more information.
- [ ] Develop a transition plan with the person, informed by the person's goals and clinical outcomes of the 'Getting to Know You' process.
- [ ] Provide all team members (including the person and support persons) with an up to date version of the person's transition plan.
- [ ] Develop a wellness plan with the person to support ongoing self-management (including a crisis plan that outlines their preferred treatment and support options in times of crisis).
- [ ] Review the person's existing care plan and any risk management strategies and consider new issues that may arise as part of the transition.
- [ ] Prepare a detailed handover plan for the receiving clinical and support service teams.
- [ ] Connect the person with the community and make a detailed list of services and resources.

Phase 1: For clinicians and health and support workers

There are five key considerations to discuss and plan for when supporting a person to transition to the community. These five considerations align with the nine steps that the person and their carer will discuss as identified at the beginning of this chapter. The five considerations include:

1. **Understanding your role and the circle of support.**
2. **The 'Getting to Know You' process.**
    a. **Talk about the person returning or moving home.**
    b. **Talk about skills and routines.**
    c. **Talk about interests, activities, work and study.**
    d. **Talk about decision making.**
3. **Connecting the person with the community.**
4. **Preparing a transition plan including a wellness plan.**
5. **Preparing for handover.**

Use the prompts on the following pages to guide discussion and activities to support a person in planning their move.

1. Understanding your role and the circle of support

Your team must ensure that:

- the process is as seamless as possible for the person
- tasks in the transition plan are assigned to a person, with a clear review or completion date
- all team members have an up-to-date version of the person's transition plan
- feedback is shared with the team and the person's circle of support about the process and the progress of the transition journey
- you look for ways to help the person engage with their community:
  - what is the person interested in?
  - what will the person need to link with?
  - what services and resources might help?

Communicating and collaborating

- How are you communicating with the person and their circle of support?
- Is the person's unique perspective at the core of your communication strategy?
- Are you 'doing to', 'doing for' or 'working with' the person?
- Are you supporting the person to take control and giving them as much choice as you can?
  - Have you thought about whether you are promising the person anything that is outside their or your control?
  - How and when are you going to have honest conversations with the person to be clear on the difference?
- What do you know about the person and their story which will help the planning and preparation process?
- Are there gaps in your knowledge about the person?
- What is your experience of transitions in the past?
  - How do you feel about this person's transition?
  - Does this positively or negatively influence your interactions with this person? How?
  - How can you ensure previous experiences don't interfere with your role now?
- Have you been trying to protect the person from any situation that might be risky?
  - What is the nature of the risk?
  - Is it the kind of positive, supported risk taking that will help the person to learn from the experience, even if it is unsuccessful?
  - Talk about these risks with the team.

Collaborating with other LHDs

A person may wish to live outside the LHD they are currently in. This may be because they:

- have family or friends there
- have fond memories of another place
- want to move back to where they grew up
- want to access what that community provides.
  - A person will be asked where they would like to live as part of talking about their transition plan. When a person wants to move, you must contact the new LHD as soon as possible.
  - Clinicians and other supports from the new location will be involved in collaborative care planning, and a shared care approach will support a flexible and responsive move to home. Refer to the PCLI Statewide Portal, if you are unable to access the site please contact your local PCLI representative for useful links and articles.

Things to do early

- Coordinate any community referrals that are needed and make sure someone will complete and follow them up.
- Encourage the person and their carers to attend events or services in the local community.
- Introduce the person to key people from the new team to support engagement and connection.

2. The ‘Getting to Know You’ process

Talk about leaving the hospital

Your role is to support the person through the pre-contemplation, contemplation and action journey.

Questions to ask yourself

You might already know the person you are working with, but as part of the ‘Getting to Know You’ process, there are some important questions to ask yourself to work out what you know and what you need to learn.

- Do you really know the person — have you spent time with them, listened to them and know their story?
- What don’t you know about them?
- What is the person’s perspective on their mental health history?
- How have they felt past transitions have gone?
- What has worked in past transitions?
- What has not worked?
- Who are their key support people?
- How far along the change process are they?

Ask the person

Start talking about what life in their home might look like. Invite the person to reflect on and tell their story by using techniques such as:

- motivational interviewing
- asking ‘magic wand’ questions
- journalling or working with the person and their carers to create a ‘My story’ book
- drawing a home and asking them to name items they couldn’t live without.

Ask the person if they would like to speak to a peer worker (if available). Peer workers know what it is like to experience mental illness and can share experiences of personal recovery with a person and represent hope that is often missing in people’s lives. Encouraging people to consult with peer workers during the planning and transition phase is an important element to providing contemporary, person-focused care.

Refer to the PCLI Statewide Portal for resources and references to assist you. If you are unable to access the site please contact your local PCLI representative.

Talk about skills and routine

Some things that the person will need and want to do in their home include:

- preparing meals
- shopping
- cleaning and laundry
- developing a weekly shopping list
- budgeting
- what skills they want to develop or enhance?

Questions to ask yourself

- What skills or routines can the person practise while still in hospital?
  - How will this happen?
  - When will this happen?
  - What other team members are needed to support this?
- What skills can they practise on day or overnight leave?
- What skills are best left until the person moves into their home?
- How the person can be supported to develop their skills without getting overwhelmed?
- How will the person manage their medication routine?
  - Have we done a full assessment of medication and explored the person's thoughts around this?
  - Have we provided information, education and strategies to develop self-management?
  - What supports will the person need to manage their medication at home?

Talk about decision making

- What is the person's status under mental health legislation?
- Who has the person identified as their main support (nominated carer)?
- Does the person need or want:
  - a substitute decision maker, like a public or private guardian (or any other decision-making support)?
  - an asset assessment with a social worker (e.g. if the person will move into a RACF)?
  - powers of attorney?
  - a disability advocate?
  - advice from a financial planner?
  - a community treatment order?
  - future care directives?
  - funeral plans?

Coordinate the 'Getting to Know You' process (which includes explaining to the person what it is). Refer to the Planning, Assessment and Follow-up Guide for more information.

3. Connect the person with their community

Make a list of:

- services or community resources that the person could engage with, for example:
  - The WayAhead Directory — a mental health support service directory for New South Wales
  - local councils
  - Disability Employment Services/Centrelink
  - churches
  - social and leisure groups and organisations that are of interest to the person, such as sporting groups/gym/walking groups/swimming pool
  - libraries and community colleges
  - volunteer organisations
  - community groups such as Rotary or the Country Women's Association.
- links you need to make with community organisations, such as:
  - CMOs
  - housing organisations.

Talking to mental health staff and others in the community is a good way to find new resources.

4. Preparing a transition plan and a wellness plan

The transition plan is your reference document. You will need to develop it with the person so their wishes are reflected in it, where practicable.

To develop the transition plan:

- work out with the person whether a gradual transition (e.g. increasing day and overnight leave) is better — or a single move date, with regular support from clinical staff that the person knows
- use the planning and assessment process alongside anecdotal strategies that offer insight into the person's abilities and needs
- review possible risks including current risk management plans and strategies to minimise any transition risks
- think about the date of the move and
  - what will happen
  - when it will happen
  - who is supporting the process and how.

When you talk to the person:

- ask them what they think about dates for:
  - initial visits to their home
  - starting the move
  - the full transition to the home environment
- manage their expectations and explain what things might be out of the team's control (e.g. If unexpected vacancies arise in new accommodation, a move may need to be at short notice)
- outline the steps to transition and who is responsible for each step
- develop a timetable with possible dates for each milestone in the transition, including:
  - visits to accommodation options
  - meetings with people in the person's circle of support
  - the move date
  - hospital farewell events
  - a housewarming
  - reviewing crisis management planning and risk management strategies
  - skill development
  - routines
  - discussing key decisions
  - general checking in
  - moving personal belongings
  - personalising the new space.

If you know the home or community where the person will live, you can also plan when:

- staff will visit the person in their home
- the person will visit new supports in the community.

Wellness plan

Encourage the person to develop a wellness plan. What — if anything — are you able to do to support this?

Ask the person:

- what it is like for them when things are going well
- what they think about their mental health history
- what things they do to manage their mental health and prevent relapse
- how they have dealt with change before
- what their triggers and early warning signs are
- what being unwell is like from their perspective
- whether they have a plan for what to do if things aren't going well.

The Mental Health Outcomes Assessment Tools (MHOAT) Consumer Wellness Plan module has been designed by NSW mental health consumers. All consumers are encouraged to complete it. Its completion can be assisted by the clinician and/or nominated carer. Other Wellness Plans may also be used. Refer to the PCLI Statewide Portal, if you are unable to access the site please contact your local PCLI representative for examples.

As part of wellness planning consider also developing a crisis plan that outlines the preferred treatment and support options identified by the person in times of crisis. Some wellness plans include sections on crisis planning.

5. Preparing for handover

Prepare a detailed handover with the person for the new support team outlining:

- details about the person, such as
  - likes, dislikes and preferences
  - strengths
  - interests
  - their strategies for managing distress
  - current and previous treatments
  - a summary of their wellness plan including crisis planning strategies
- when handovers will start
- a period of overlap
- when handovers are completed
- the roles of the current team and the new team — and how these will change during the phases of transition
- key times for warm handovers and formal written handovers
- details of any risk issues and risk management strategies including possible triggers for certain behaviours and what has and hasn't worked in the past.

Once you know the person's home address, you will need to coordinate links with the new mental health team to start overlap support.

Phase 2: Making your move

2

Introduction

The second phase starts with you moving home and beginning to spend time in it. In this phase, you will move home and settle in. We want you and your circle of support to control this process as much as possible including how we support you if your new team need to respond quickly because of unforeseen circumstances.

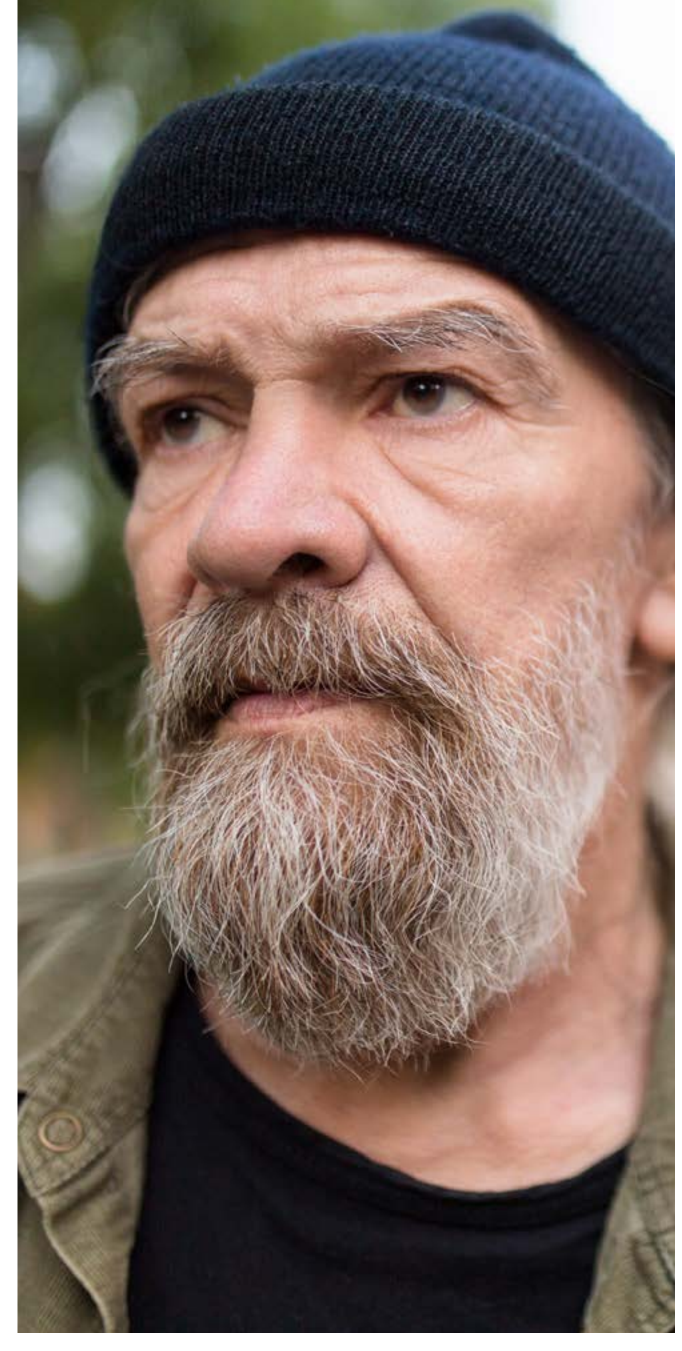
Your goals and vision for the future

Your goals and vision for the future is about what you would like to do. In phase 2 this may be to:

- Move into your home feeling supported and hopeful.
- Be involved in the decisions and activities relating to the move in any way you can (and wish).
- Have the things and support you need in your home and community.

There are eight key things to discuss, think about or do when making your move. These include:

- Saying goodbye.
- Spending time in the community.
- Visiting your new home or your home before hospital.
- The week before you move.
- Packing your bag.
- The day of the move.
- Your first weeks home.
- Your feelings.



What you and your carers can do to make your move

Use the prompts on the following pages to help you think about and discuss making your move.

1. Saying goodbye	
Things to think about and discuss • your time in hospital — it may have been a very important part of your life • how you might want to say goodbye • farewell events — if you would like one: – Who would you invite? – What food would you have? – Where would it be? – Who could help organise it? • housewarming events – Would you like to do something to mark moving into your new home or returning home? – What would the event look like? – Who would be there?	**Tips for carers:** The person might need extra support from you: • if hospital has been their home for a long time and they are finding it difficult to say goodbye — take time to listen to their concerns • in planning or having a formal goodbye to the inpatient setting.

2. Spending time in the community	
• Visit your new community while you are still in hospital. **You could go to places like the:** • GP (doctor) • local shop, or shops where you can buy furniture or household things • pharmacy • train or bus station — how long does it take to get to these from your home? • local park • local mental health service • local CMO providers • sporting facilities — there may be a gym, swimming pool, walking group or aerobics class • library • start going to a community group near your home, e.g., a shared reading group or a social group at the local church. **You could also:** • explore employment and education options in the community. • organise a visit to your local inpatient facility, so you know where it is and what it looks like — just in case you need to be admitted at some stage (if you'd like to do this, talk to your clinician)	**Tips for carers:** • go for a drive around to locate new places • support visits to new places • help the person make a plan for when and how they will visit new places.

3 . Visiting your new home or your home before hospital

Talk about your first visit:

- When do you want to go?
- What should happen? (e.g. Would you like to have lunch there?)
- Who should come with you?
- Would you like to stay overnight before moving?
- Do you need new furniture or other household goods (e.g. kitchen utensils) for your home?
- Who's going to hold your spare key?

4. The week before you move

In your first week, you may need to go to lots of appointments — including extra meetings, assessments and spend time working with the clinical team.

Discuss:

- appointments you might like to arrange yourself
- days and times that would work best for you based on your routines.

You and your carer could keep a note pad and write down:

- any questions as you think of them — so you both remember to ask when you see the right person
- things you need to remember to do.

Your team will:

- help you make a routine for your first week, including:
  - dates and times for things you need (or want) to do
  - when you will get up and go to bed
  - when you will eat your breakfast, lunch and dinner
  - other tasks you need to do and when you will do them.
- a schedule of your first week, which tells you when you have
  - meetings
  - visits with the mental health team
  - appointment with the GP
  - other activities or appointments.
- talk to you about practical aspects of the move, like:
  - shopping for household goods
  - setting up Centrepay for rent and utilities
  - setting up a bank account.
- help you with your medication routine, including:
  - working out how it might look
  - putting you in touch with your local pharmacy
  - discussing any requirements you may have under a CTO.

Tips for carers:

You may wish to:

- talk to your team about who will coordinate the practical aspects of the move
- get a copy of the key contact list.

- help with who to ask if things are unclear, so you can make a list of key contacts. These contacts might be the first person you need to call with any questions:
  - phone numbers of people in your circle of support
  - key contact in your new supporting mental health team
  - key contact in your referring mental health team
  - Mental Health Line (1800 011 511)
  - emergency contact — police, fire or ambulance (000)
  - your GP
  - local pharmacy.
- provide you with an up-to-date transition plan.

If you would like to, now is the time to finish your introduction to your new supports.

5. Packing your bag

Make a list of things you would like to pack in a bag to move home. These may include:

- mobile phone and charger
- clothes
- shoes and socks
- identification — like your passport, birth certificate or Medicare card
- money
- your wellness plan (including your crisis plan if you have one)
- medication for the first few days
- things that make you feel at home, like pictures or ornaments
- toiletries
- books or magazines
- your calendar or diary
- a list of key contacts.

Don't forget to ask your team whether you have anything being held in security!

6. The day of the move

Your transition plan will tell you:

- when things are taking place
- who is responsible.

Things to discuss

- What would make you feel at home on the day of the move?
- How supported do you feel?
  - Is anything missing?
  - Would anything else help?
  - Who could fill these gaps?

Tips for carers:

Think about things the person likes that can make this stressful time a little less stressful. For example, a small cake, flowers, a favourite movie or a good friend to come and welcome them might help.

7. Your first weeks

A checklist for the first week

- Carry out the routine you discussed with your team for every day of the first week.
- Put all your appointments for the week in your calendar so you know what is happening when.
- Identify who is available to support you with each appointment.
- Plan how you will get to all your appointments — by car, bus, train or walking.
- Pick a time to visit the pharmacy to collect your medication — if your medication routine is changing, you might need to book a time so that pharmacy staff can explain the changes to you.
- Pick two new things to visit in your first week — a shop, library, café or park — and work out who will help you visit these places.
- Pick one 'well done' activity to do in this first week to congratulate yourself on your move.

Things to discuss

- What things will help you through your move?
- What might make it harder?
- What are the most helpful things that family, friends or carers can do?
- What do your rights and responsibility documents say?

Tips for carers:

In the first weeks after the move, you can help by:

- using the person's daily and weekly schedule to help them structure their day — you may need to do a lot of prompting in the first few weeks
- practising skills that the person has scheduled to do in their first week with them — for example, finding bus or train timetables or topping up Opal cards
- celebrating wins and achievements genuinely and often
- exploring the local environment — such as cafés and shops — with the person
- accompanying the person to scheduled appointments using their regular mode of transport — you could go with them the first few times, then let them go on half the journey themselves until they can do the whole journey alone
- looking up community events in the area that the person might like and going with them to some.

Be aware that the person's mental health can sometimes take a step back after a move like this. You can support them by:

- knowing who in a mental health facility you can call if you are concerned
- keeping in touch
- encouraging them to use their wellness plan
- being an advocate for good communication with the person and other support people
- understand that steps-back can happen, talking to the person about what might help, and being supportive.

If you are not happy with the process, you have the right to provide feedback through the channels open to you.

8. Your feelings

It is important that you:

- are clear on the positives for moving to a new home/returning home — it can be really helpful to imagine, visualise, talk and write about them to remind yourself of what they are
- can talk about the pace of change — moving home can be stressful, with a lot of action going on and many things to do
- pace yourself and get support from people around you to get things done
- have excellent communication within the circle of support and know you have the right to it.

You might feel like your mental health takes a backward step after a move like this. This is because it can be very intense. Coming to terms with how you feel about the move may include:

- talking about anything that may not be positive or that you find stressful
- writing or thinking about these feelings
- doing some physical exercise to help yourself feel OK with your feelings, or about yourself
- having your wellness plan ready so you know what to do if you start to have doubts.

For clinicians and teams

Phase 2: Checklist for clinicians and teams

- [ ] Connect the person with local general practitioner, dentist, optometrist and other health professionals as required.
- [ ] Arrange for the completion of a physical health check including:
  - dental check
  - vision check
  - general physical health check – medication review.
- [ ] Ensure adequate clothing and personal toiletries are available.
- [ ] Ensure required documents/cards have been received including:
  - Medicare card
  - Pension
  - bank account established and cards
  - cash
  - transport card
  - scripts for medications and adequate supply of medications.
- [ ] Schedule follow-up appointments and/or meetings and communicate to the person.
- [ ] Prepare timetable for visits from clinical and support staff.
- [ ] Identify a 'go to' person (in the community or new facility and original facility) and provide contact details.
- [ ] Prepare new daily routine and schedule of tasks with the person.
- [ ] Provide copies of all documentation and plans to the person (and carer as appropriate) and new supporting team including wellness plan, crisis plan, transition plan, handover plan etc.
- [ ] Arrange a farewell function if desired.
- [ ] Consider the most appropriate time of discharge and arrange for a carer and/or staff member to accompany the person to their home.
- [ ] Conduct a comprehensive handover with the person's new support team.
- [ ] Provide support to the person during their first weeks in their home.

Phase 2: For clinicians and health and support workers

There are four key considerations to discuss and plan for when supporting a person to plan their move. These align with the nine steps that the person and their carer will discuss as identified at the beginning of this chapter. The four considerations include:

1. **The week before the move.**
2. **The handover.**
3. **The first week at home.**
4. **Questions to ask yourself.**

Use the prompts on the following pages to guide discussion and activities to support a person in making their move

1. The week before the move

With the person and carers

- Implement some of the plans you have made with the person about community engagement.
- Develop a timetable for visits, including:
  - the person's visits or overnight stays in the new home
  - staff visits to the person in their home
  - detailed information about who is responsible for each of these.
- Work with the person to create a daily routine, incorporating:
  - preferred times to get to bed and wake up
  - shower and self-care routines
  - times to shop and cook their own meals
  - cleaning and laundry
  - whether they need to manage their money and budget independently
  - their medication routine — and whether they feel confident enough to manage it independently
  - leisure activities they engage in or want to engage in
  - any work or study they would like to do.
- Revisit the schedule of tasks related to the move and help the person decide:
  - what they will do this week
  - what they will do the week they move into their home
  - how and when they can practise the skills they need in their home.
- Support the person to develop a budget or weekly shopping list.
- Encourage the person, family and friends to:
  - visit the person at their home
  - visit the local community and inpatient facilities — for some people, it can create a sense of security
  - start individualising their space with valued possessions or trinkets, new curtains or new bed sheets.

With other clinical staff

- Provide the new supporting team with a detailed handover, including:
  - the person's likes, dislikes, preferences, strengths, interests and strategies for managing distress (using the person's introduction and wellness plan)
  - current and previous treatment considerations
  - risk issues and management strategies if relevant.
- Visit the person's home and be introduced to new staff (if relevant) and participate in an activity or outing, if there is one.
- Consider a farewell function at the inpatient unit.
- Consider having pre-transition appointments with the GP and community mental health teams.

2. The handover

- Be sure that everything the person needs is with them or at their home — especially clothes, medication, money, etc.
- Ensure that support staff in the community are familiar with the handover plan and able to implement it.
- Use the ISBAR techniques each time the person moves between support teams.
- Consider implementing a warm handover, where staff from the inpatient unit provide support in the new facility/community service for the transition period.

3. First week at home

Be prepared for the fact that developing new habits and routines might take time — changes in routine can be very disruptive, especially if a person has cognitive challenges. Don't be too quick to determine that the transition has failed.

With the person and carers

- Help the person get to their home — either transporting them or helping them catch public transport.
- Consider what activities would help with the transition to their home — for example, a house-warming party, or cultural traditions might help.
- Revisit the schedule of tasks related to the move and help the person check what still needs to be done to settle in.
- Revisit the routine plan with the person and check the progress of the routines they have planned, including where they will have leisure activities and their budget plans.
- Practise some skills with the person in their new environment — or just be in the vicinity when they are doing some of these activities.
- Support the person to do practical things in the community, such as:
  - getting to know people in the local shop or cafés
  - developing confidence with public transport.

Visit friends in the hospital from which they came

- Keep talking to the person about what support they think they need and to make sure any small issues do not become big problems.
- Revisit wellness planning to make sure the person can manage their own wellness throughout the process.
- Contact the circle of support to find out their views on the person's progress.

With staff

- Remind community mental health staff not to change treatments too quickly — changes they observe in this period may be about the change in environment, rather than the treatment's ineffectiveness.
- Schedule regular team meetings with the person, staff from the inpatient unit and community supports to identify and solve issues before they get too big.
- Identify a 'go to' person in the:
  - person's new environment that the person can talk to if they are not sure about anything
  - original facility who can be contacted for further information or advice during the transition.

4. Questions to ask yourself

- Are you doing everything instead of delegating? If the answer is 'yes'
  - stop, think and plan what you can delegate to whom
  - work out how you can monitor and review outcomes.
- Are all the tasks informed by the 'getting to know you' process?
- Is your planning clear?
  - Have you clearly identified all the tasks that need to be done on the transition plan?
  - Do all members of the team know exactly what they must do on specific days?
  - Is this written down and updated regularly?
  - Do all team members have access to it?
- Are you:
  - getting the best out of the team around you to ensure care is well coordinated within the community-based teams and other community supports?
  - motivating the team around you to make everyone feel part of a community with a common goal?
- Is the transition plan up to date including wellness and crisis planning and risk management strategies?
- Who will the main support be?

Phase 3: Your community life

3

Introduction

The third phase involves you settling into your home and establishing a meaningful life in your community. This phase begins when you are living in your home, and you feel you are ready to embrace community living with greater autonomy. It involves a natural farewell to the hospital setting and engaging with the community support system.

Building a community life is a journey; it is deeply connected to your recovery and involves ongoing self-development. We need to understand that every person, at any age, wants to feel part of the community and contribute to where they live.

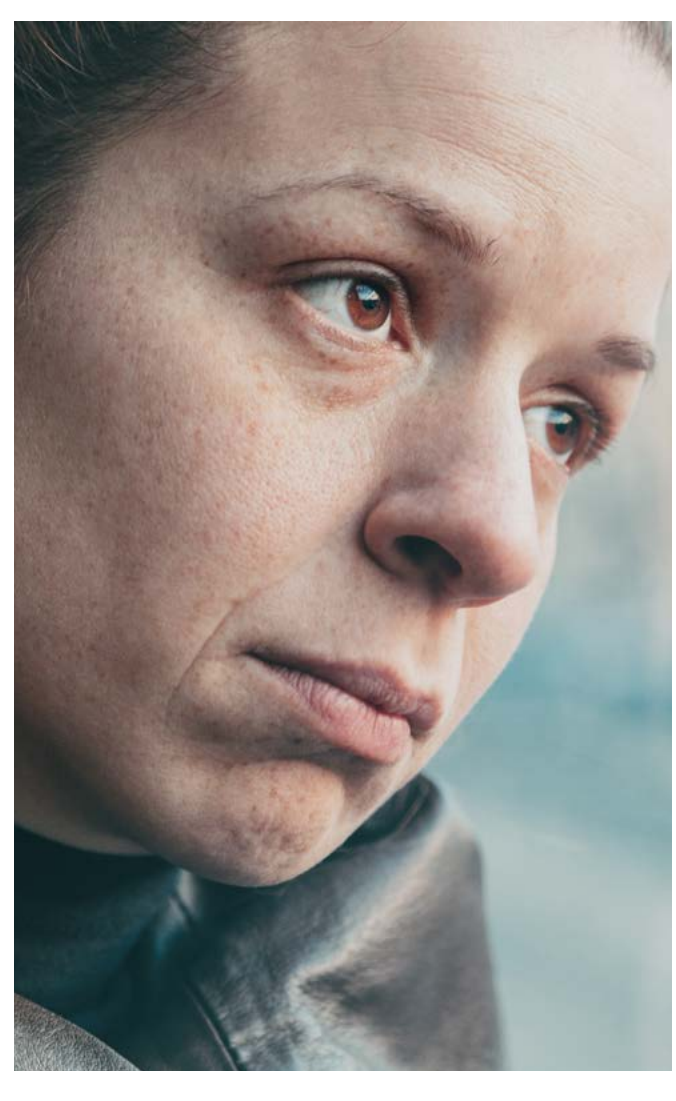
Your goals and things you want to do

Your goals for the third phase may be to:

- build meaningful personal, social and community connections
- live a full and happy life
- be able to stay living in the community.

Here are some key things to discuss, think about or do when making your move. These include:

- support with the move
- maintaining skills and routines
- setting goals
- reviewing health and support needs.



What you and your carers can do to build a meaningful life at home

Use the prompts on the following pages to help you build a meaningful life in your new community.

1. Support with your move	
• To ensure you are supported, you may have several teams working with you for some time after you move into your home. One of these teams will be from the hospital, the other in your community. • Your team will give: – you a clear end date to the support from the hospital. By this time, your connections with your support team in the community will be well established – you and your carer a copy of the support schedule for your move. **Things to remember** • The process of moving is not always in a straight line. It can involve taking steps forward as well as taking steps backwards. Learning happens moving forward and backwards. • Make sure you know who the inpatient contact is who ties up any loose ends. • Just because you have left the hospital, it does not mean that the doors are shut. Sometimes a visit from one of the hospital team can help you feel connected.	

2. Maintaining skills and routines

Things to discuss with your team and support workers

Ask your team:

- to help you refine your weekly routine if required
  - When will you get up and go to bed?
  - When will you eat your breakfast, lunch, and dinner?
  - What other tasks do you need to do and when?
- about developing skills you want to get better at.

Things to do

- Continue to put all your appointments in your calendar so you know what is happening when. Identify who can support you with each appointment. Think about:
  - how will you get to each appointment and how long it will take you to get there?
  - when will you see your mental health team?
  - when your support visits are?
  - when other people in your circle of support are helping?
- Pick one new place to regularly visit
  - Will this be a new shop, library, café or park?
  - What support will help you visit these places?
  - Is this something you would like to try yourself?
- Regularly acknowledge what you are doing well.
- Revisit your wellness plan
  - How did it work during the move?
  - Was there anything you learned about yourself?
  - How is it working?
  - What needs changing?

Things you could do with your carer

- Acknowledge and celebrate achievements in a way that is meaningful — talk about how you would like this to happen. Small symbols to say ‘well done’ can help.
- Implement key activities from your wellness plan where you confirm you need it.

Tips for carers:

- Listen. The person will have been through a lot during this move. They may need your help to process what has happened.
- Know the person’s wellness plan and refer to it to help the person keep themselves well.
- Know the person’s early warning signs and communicate openly with them about these.
- Be aware of the person’s main contact at the original facility who deals with solving problems.

Things to remember • It takes time to settle in and find routines for yourself. Talk to the people supporting you if you need help or are feeling overwhelmed. • Have confidence in your own strength and the resilience that you have built through learning to live with your mental health issues. • Remind yourself how far you have come, and of the positives your future holds. • You are the one who makes decisions about you. People around you are there to help, but any decision is yours to make. Many decisions involve trial and error — this is how we learn.	
3. Setting goals	
• Decide if you want to set some new goals. Sometimes your goal might be to maintain how well you are doing, rather than trying to change. Listen to what your intuition is telling you. • Think about things you would like to do that might involve taking some risks and getting outside your comfort zone. Could you get some support from your circle of support in taking some of these risks?	
4. Reviewing health and support needs	
• You will be asked to complete PCLI assessments every six months for two years after you move home. This will help with checking how you are going in the community, thinking about your next steps and ensuring that you are being supported in the areas that are important to you. • As well as these, think about some of the broader help you might need: – Do you think you would benefit from some therapy or training to build skills or knowledge? – Would you like to talk to a counsellor or someone else about how you are feeling or any difficulties you are having? – Do you need help with your physical health?	

For clinicians and teams

Phase 3: Checklist for clinicians and teams

- [ ] Maintain contact with the person to provide initial support and troubleshoot any problems.
- [ ] Develop a single collaborative care arrangement and care plan with the person's new support team including clearly delineated roles.
- [ ] Identify a date to formally conclude the transition support phase and a key liaison person to tie up loose ends.
- [ ] Review skills and routines with the person and continue to identify opportunities.
- [ ] Conduct six month (and ongoing) follow-ups in line with the PCLI Planning, Assessment and Follow-up Guide.

Phase 3: For clinicians and health and support services

Here are some key considerations to support a person in their new community life.

These align with the steps that the person and their carer will discuss as identified at the beginning of this chapter. The considerations include:

1. **Transitional support.**
2. **Reviewing skills and routines.**
3. **Coordinating services.**
4. **Conversations about setting goals.**
5. **Reviewing health and therapy needs.**
6. **Positive risk taking.**

Use the prompts on the following pages to guide discussion and activities to support a person in their new community life.

1. Transitional support

Things to do with the person

- Optimally, maintain contact with the person (visits, if possible) to troubleshoot any problems that may arise.
- Work out clear dates when the transition support will end. This may involve increasing support from the new support team.
- Formally conclude the transition support phase, ensuring that the person has a clear understanding of who to go to and how to seek help.
- Listen. The person will have been through a lot during this move. They may need your help to process what has happened.

Things to do with staff

- Ensure there is a key liaison person at the original facility to tie up unforeseen loose ends at the end of the formal transition process.
- Ensure links with key community organisations are established — identify any problems and strategies to address them.

2. Reviewing skills and routines

Things to discuss with the person

- Review routines regularly
  - What is the person finding easy?
  - What are they finding difficult?
  - Is the routine still meeting their needs?
  - How might their routine change to address any challenges?
- Explore unforeseen changes to routine or behaviour. These conversations help the person feel supported and can also help them to identify challenges or threats to the sustainability of their living arrangement — and make changes accordingly.
- Encourage community living skills and review them regularly
  - Acknowledge what skills the person does well
  - Investigate what they are having difficulty with
  - Explore new skills the person might like to engage in. Sometimes it is not about improving, or taking up new skills, but rather about maintaining existing skills
  - Let the person decide and work at their own pace.
- Continue to explore options for:
  - hobbies — not necessarily for starting new hobbies, it may be about re-establishing old ones
  - finding and maintaining paid employment — if it is their goal. Link with disability employment services if helpful
  - educational pursuits — if it is their goal. Link in with mainstream courses and consider if the person may require adjustments or accommodation to a mainstream course. A step by step approach may be needed to enable this.
- Encourage ongoing engagement with the wellness plan
  - Use the wellness plan as a platform for encouraging wellness behaviours.
  - Offer to help continually review the wellness plan once the person has settled in. What did they learn from the transition? What would they change in their wellness plan?
- Keep the person informed about local services and where expertise is available to help them.

Things to remember

- Be prepared that it might take the person time to develop new or different habits and routines in their new environment outside hospital. (Changes in routine can be very disruptive, especially for individuals with cognitive challenges — don't be too quick to determine that the transition has failed).
- When a person is settling into their home, it is common for them to need varying levels of support at different times. Having the flexibility to offer this can really help the person to keep living at home.

3. Coordinating services

- Adopt a collaborative care arrangement to support informal and formal service partnerships with clearly defined roles. Work together to provide the best support. Services involved should develop a single plan to facilitate a coordinated approach.
- If there are specific cultural needs, think about linking with cultural resources within the community.

4. Conversations about setting goals

Things to remember

- For some people, living in the community will bring a greater sense of freedom and they will feel positive. For others, this experience may feel challenging or even unsupported or unsafe.
- Recognise the person's capacity to make choices about lifestyle, time use and social contact they engage in.
- Recognise that goal setting may be challenging.
- It is important for clinicians and carers to have an ongoing conversation with the person about their choices and feelings about their new environment, to understand their motivations and behaviour.
- Let the person settle in at their own pace.

Things to do with the person

- Review short-term and long-term goals regularly.
- Six months after transitioning, use the tools listed in the PCLI Planning, Assessment and Follow-up Guide, including the Recovery Assessment Scale — Domains and Stages, and the Camberwell Assessment of Need, to assist with goal setting.
- Take the time to understand the reason for engaging in activities that might appear unproductive. For example, if someone chooses to spend a lot of time at home watching TV, does this indicate they are contentedly settling in to their new environment, or does it indicate they are feeling unsafe in the community and at risk of becoming isolated?
  - How are you going to have conversations about this to help differentiate between both? Ask questions and listen to the answers.
- Monitor the person's strengths and challenges. Acknowledge and encourage the strengths and identify what supports would help with the challenges.
- Celebrate wins genuinely and often. Know how to deal with 'I don't know' when you start to talk about goal setting. Try these tips:
  - Be mindful of the way you are asking the question. Are you asking a question that is too broad? ('What would you like to do today?')
  - Think about asking a closed question that gives choice. Limit it to two or three choices. ('Would you like to do something inside or outside?')
  - Start broadly with these closed questions and funnel downwards so you are more likely to end up with something they want to focus on. ('Would you like to do something active or not so active?')
  - Name it. ('It sounds like you find this hard. Do you want to tell me about that?') Use your active listening skills.
  - Encourage. Give praise genuinely, often and honestly.

5. Reviewing health and therapy needs

- Would the person benefit from social skills training and social cognition training to help with challenges and give them confidence to make friends?
- Would the person benefit from peer support?
- Does the person need ongoing therapy supports? This might include cognitive remediation, cognitive behavioural therapy, stress management training or education to promote self management and recovery?
- Address lifestyle factors and help the person to form pathways to manage their health condition. This may not involve clinical services.
- What support does the person need for physical health?
- Six months after transitioning, use the tools in the PCLI Planning, Assessment and Follow-up Guide to help with this review.

6. Positive risk taking

- The person is the director of their own care, which involves risk taking and trial and error. Positive risk taking is an opportunity for significant functional gains — at worst it is a learning experience.
- Positive risk taking at this phase may involve exploring unknown territory. To help, recognise the challenges that this may bring, and engage extra support from the person's circle of support.

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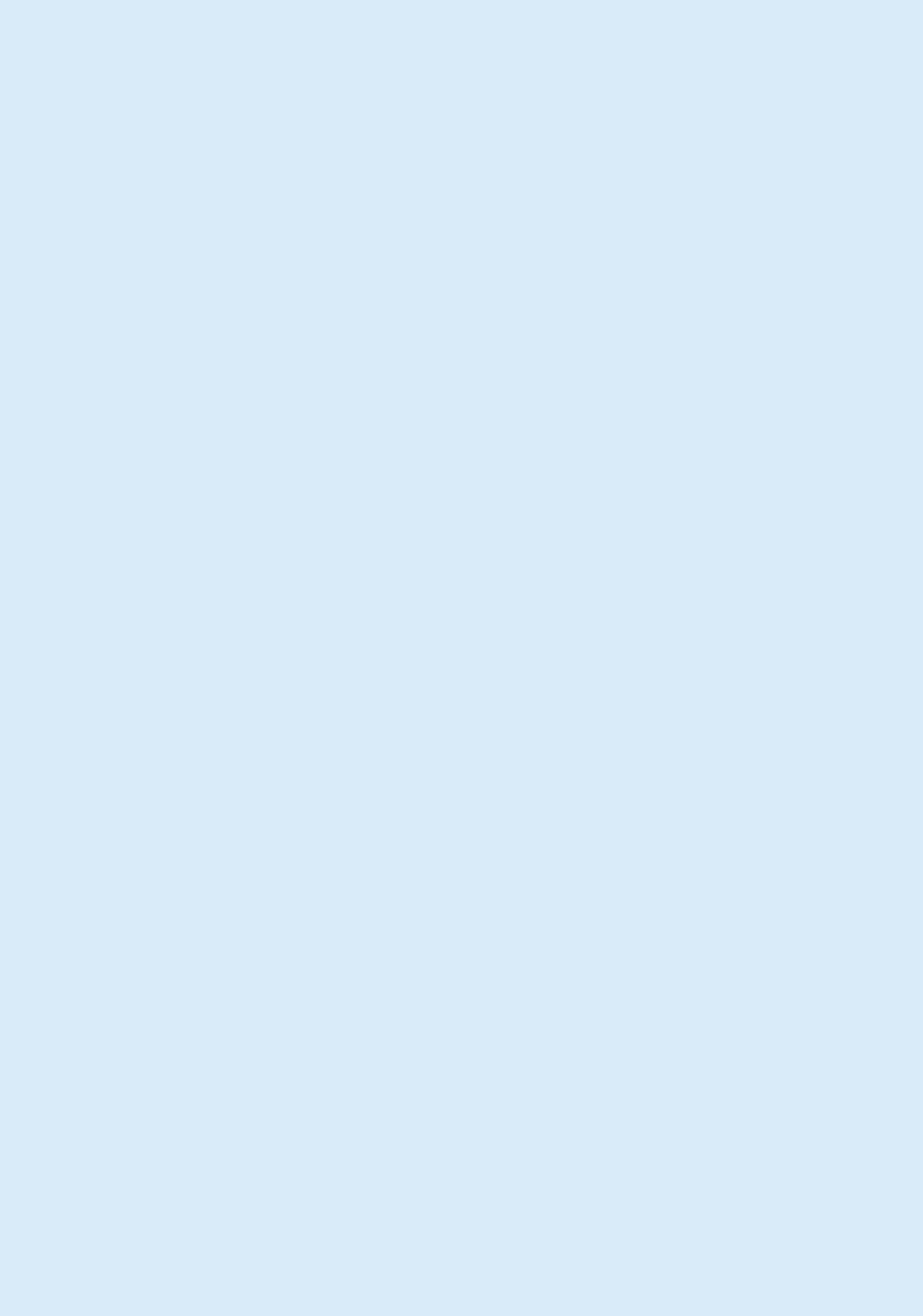

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