NSW Health

Planning, Assessment and Follow-up Guide

My Choice: Pathways to Community Living Initiative

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.

Version 4.0 Revised August 2023

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.

All requests for additional information are to be directed to your Local Health District (LHD) Pathways to Community Living Initiative (PCLI) Program Manager.

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

Contents

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

ACAT	Aged care assessment team
CMO	Community managed organisation
HASI/CLS	Housing and Accommodation Support Initiative and Community Living Supports
HASI Plus	Housing and Accommodation Support Initiative Plus
LGBTQIA	Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual
LHD	Local health district
MDT	Multidisciplinary team
MoH	Ministry of Health
NDIS	National Disability Insurance Scheme
PCLI	Pathways to Community Living Initiative
RACF	Residential aged care facility
SPMI	Severe and persistent mental illness
SVH	St Vincent's Hospital

This Guide at a glance

Where are we now?

The original purpose of the publication of the Planning, Assessment and Follow-up Guide (PAFU) (this Guide) (2018) was to initiate a 'call to action' for PCLI clinicians to rethink the planning and assessment process for a person with severe and persistent mental illness (SPMI) in the context of assisting the person to move from a long hospital stay to community living.

The key purpose of this Guide has evolved as the PCLI program has matured and the Guide has assisted to provide new and unique insights in understanding a person. Multidisciplinary teams (MDTs) are provided with a more holistic view of a person and use these insights to inform more patient-centred care and transition planning.

Value of this Guide

The value of this Guide is increasingly evident with LHDs using it to focus on a person's needs, preferences and goals. Recent assessment focus groups highlighted that the assessment suite:

- contributes to increasing the understanding of different aspects of the person
- guides interaction with a person and supports in-depth conversation that allows you to 'get to know a person' holistically
- provides opportunity to instigate evidence based clinical discussions that may change the trajectory of a person's care
- gives additional information for use and discussion with the whole MDT.

> 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**

Building relationships and understanding a person

- It is acknowledged that each person will experience their journey differently, with different amounts of time spent in each phase and with differing outcomes.
- When communicating with people from any group or diverse culture, whether a younger or an older person, using language they are comfortable with is important.
- When working with someone of Aboriginal origin ensure access to holistic and culturally safe services, that provide the best opportunity for improved mental health and social and emotional wellbeing.
- Working collaboratively with a person during assessments and throughout their journey in a manner suitable to them is important.
- Clinicians need to be responsive, coordinated and flexible to meet varying needs in different environments and with changes in need over time.

What do staff need to know?

- This Guide provides staff with a solid understanding of the individual assessments and the planning and follow-up processes.
- This Guide provides a framework to inform effective and coordinated person-centred care in collaboration with the MDT.
- Local training, education and resources will support clinicians to further understand the practical application and value of this Guide.
- That the mental health system is complex, and we must support a range of measures that seek to simplify care pathways for the consumers yet provide effective care.

Embedding the Guide into daily practice

Many LHDs have embedded the components of this Guide into daily practice. Current examples of how this is being achieved across different LHDs are presented throughout.

Background

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1.1 Introduction

PCLI

The 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:

- Hospital is not a home.
- Everyone has a right to live, be valued and flourish in the community.
- Our PCLI history is important and tells a story of success.
- Our focus is the individual and moving one step at a time, together.
- We have the resources and expertise to make this change happen.
- Our focus for the future is exciting.
- We are building a sustainable health system.

Established in 2015, PCLI provides statewide leadership by the Ministry of Health (MoH) in collaboration with LHDs and SVH with the aims of:

1. **Enabling people with extended hospital stays** (or at risk of) and 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 person's individual 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. Most people have SPMI together with other complex and diverse co-occurring conditions including trauma related issues, alcohol and drug use, cognitive or intellectual disability and physical health problems. Some people may also have significant ageing issues.

We know that PCLI consumers are more likely to have poorer health outcomes, and a decreased lifespan compared with the general population. This further supports the importance of a holistic assessment process and the provision of seamless, individualised, and integrated care to ensure better outcomes.

Effective communication is crucial to positive engagement. It is important that regardless of any group or diverse culture, whether a younger or an older person, we use language they are comfortable with.

A recovery approach should underpin all interactions and communications. Appropriate language is a vital component of communicating and establishing a sense of self-determination. If the wrong words are used, feelings of powerlessness can be overwhelming, especially when decisions about things important to a person seem to be or are in the hands of others.

Journey to Home Guide

The *PCLI Journey to Home Guide* is a companion document to the PAFU. It is for people moving to the community after a long stay in a mental health facility, as well as their families, kinship, carers, support workers and clinicians. It is a companion document to the PAFU. The purpose of the Journey to Home Guide is to:

- help people plan, prepare for and sustain the move to their home in the community 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)
Hunter New England Local Health District (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 aggregated 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.

A number of principles have been developed to support the delivery of evidence-based, contemporary practice in mental healthcare and guide the assessment process of each person.

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 process 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 person will participate in an individualised assessment process 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 the person are important in the process of supporting a person into community living.

Communities that a person is or has 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 (MHB) and LHD will collaborate to facilitate the assessment process. Mental health services, aged care services and the Community managed organisation (CMO) 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 links to the PCLI Statewide Portal have been included and provide additional supporting information. If you are unable to access the site please contact your local PCLI representative.

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 MoH.

The post transition follow-up 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 support future PCLI planning and service development.

Who should use this Guide?

This Guide should be used by PCLI Program managers /Co-ordinators, 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 transitioning 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.

Understanding the person's process

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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

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:

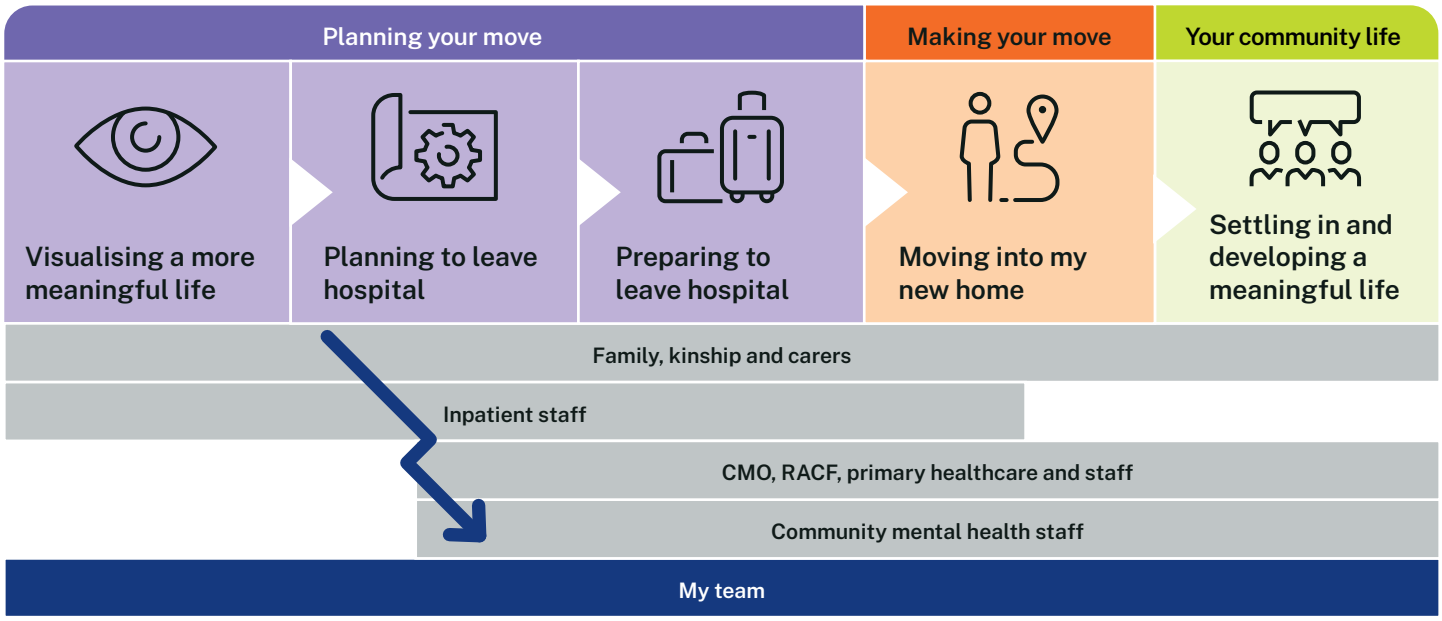
- settling into home
- establishing routines and supports that will make it easier for you to stay there
- maintaining a quality life in the community and connecting with it meaningfully
- identifying hopes and wishes for the future.

It is acknowledged that each person will experience their 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':

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, kinship or carer 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?

The assessment process 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.

2.3 How assessment supports the person's process

Engaging in the assessment process can help both the person and clinician realise their strengths, skills and areas in which they may need further support or development, either in preparation for or after their move. This allows informed ongoing rehabilitation, healthcare 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 person and their supports. This conversation is ongoing. It is supported with a number of tools to inform 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.

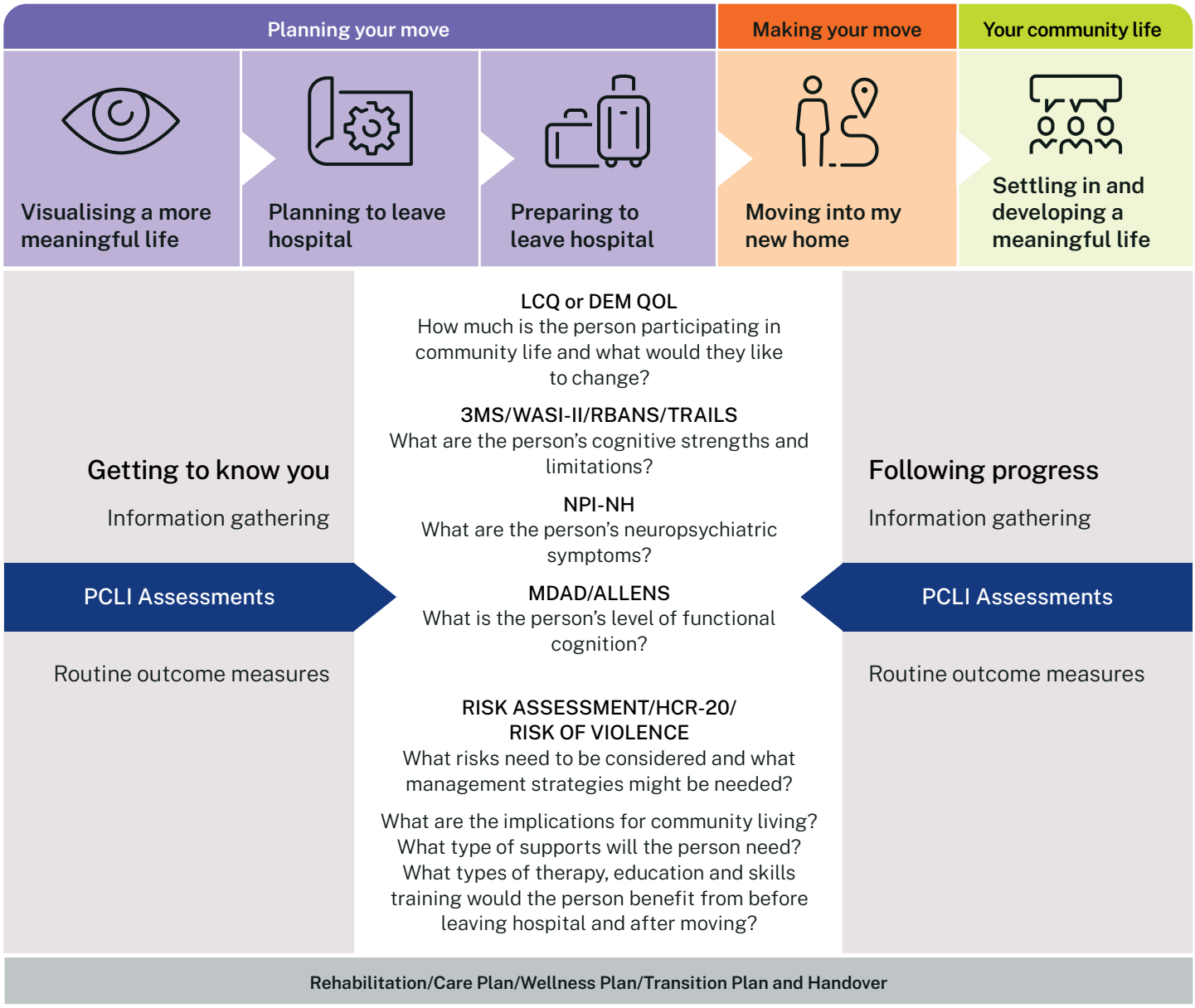
The assessment process may indicate the need to engage with a specialist clinician or team. The diversity of specialist PCLI Clinicians across the state is growing to include Exercise Physiologists, Aboriginal workers, Speech Pathologists, and Drug and Alcohol Clinicians.

There are a growing number of specialist teams available that can enhance the level of care a person receives when we work in collaboration. These services may include (but are not exhaustive) Tertiary Referral Service for Psychosis (TRSP), Intellectual Disability and Mental Health Services, and Specialist Eating Disorder Services.

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

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



*For description of tools see Page 20 Table 1 PCLI Assessment Tool Suite

LHD practical examples

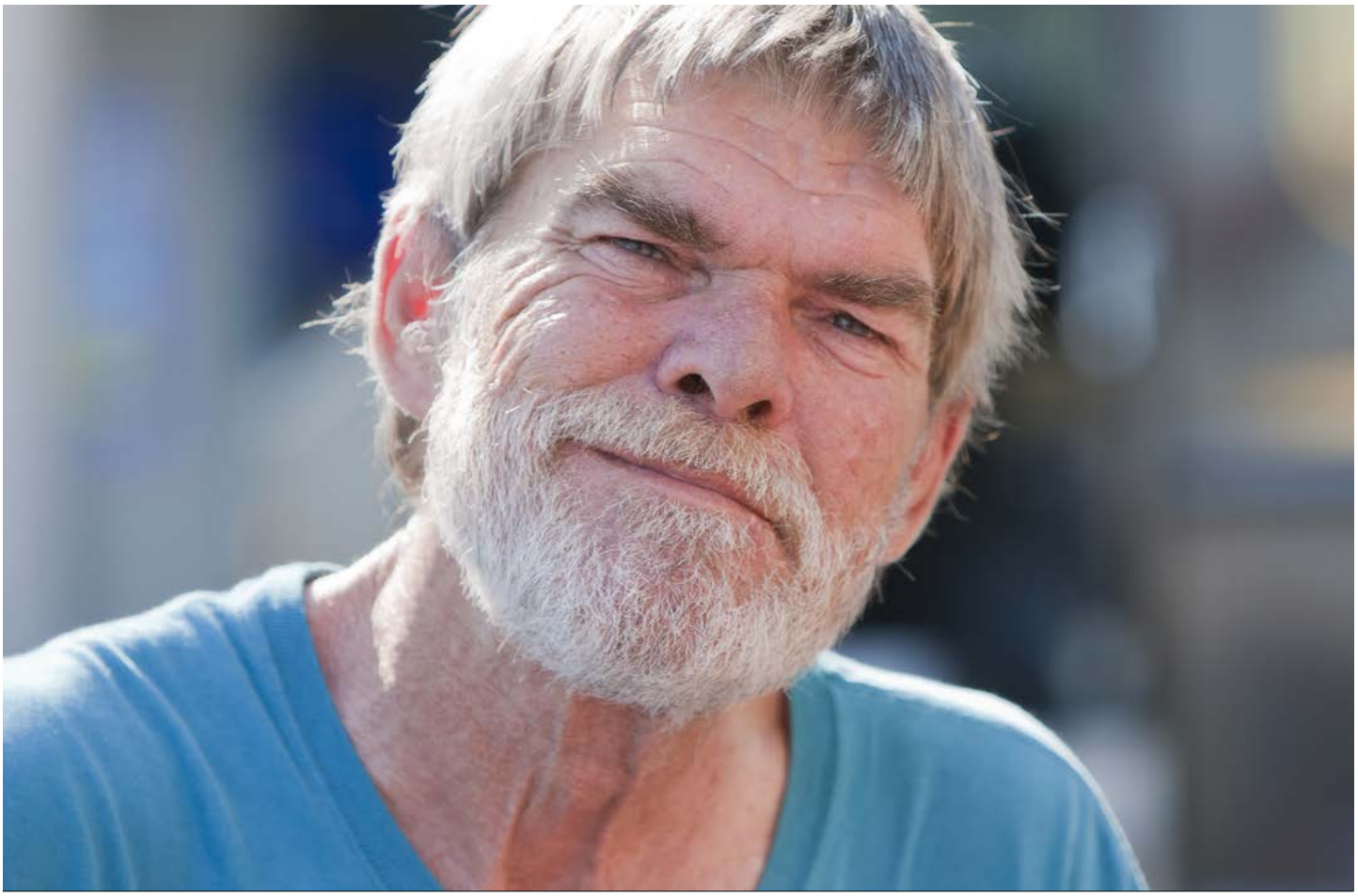
Hunter New England LHD: Innovative use of the Neuropsychiatric Inventory (NPI)

HNELHD have used the NPI tool to track a person's journey by comparing the person's baseline assessment results with their later results. This provides rich comparison information about the areas that still need support as well as celebrating the areas that have shown improvement. The tool is being administered initially in the ward with nursing staff and later in the community with care staff. This comparison has enabled different perspectives about a person's priority needs and behaviours and enabled a clearer direction for meeting the support needs of the person.

One specific example of use of the NPI is highlighted below:

The NPI was used to establish the accommodation model and level of support that would best suit the person when returning back into the community post a readmission. Readmission was due to increased behavioural responses and the Supported Independent Living (SIL) not being able to support the person's needs. The process followed:

- One LHD clinician completed the NPI with the person from the SIL (team leader) who knew them best to get a baseline. The same LHD clinician then completed the NPI again with the ward staff and compared the two assessments.
- The NPI results of the two assessments clearly showed minimal to no behavioural issues reported when the person was in a 24/7 structure (hospital) compared to when the person was living in a unit with one other person (unit complex with staff on site).
- The NPI results supported our clinical thinking and provided good evidence to both the Guardian and National Disability Insurance Scheme (NDIS) for the person to be accommodated within a 24/7 SIL model. The person has now been stable and well supported without our team for over 12 months.



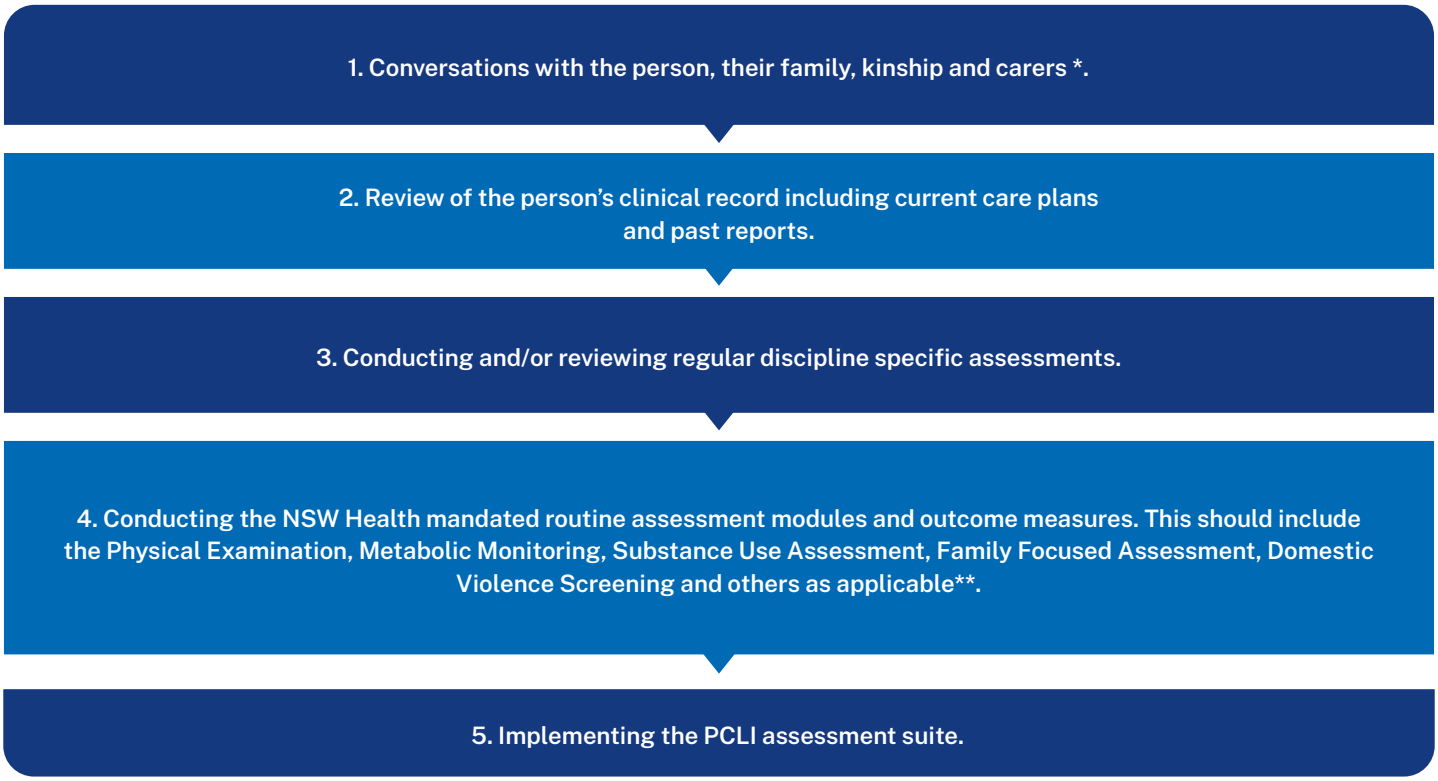
The clinician's process

3

3.1 The information gathering and assessment process

To inform the person's process, the MDT 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



Strategies to engage the MDT

MDTs play an essential role in the planning and assessment of mental health consumers. Strategies to involve MDTs in discussions about planning and assessment for all consumers may include:

- Regular meetings: scheduling regular meetings or time slots in meeting to discuss PCLI assessment and planning, for example, rotating PCLI team members through different MDTs and communicating common messages about assessments and value.
- Encourage participation: across all team members to actively participate in discussions about planning and assessment, including PCLI and non-PCLI clinicians.
- Clear communication: sharing assessment results in a timely manner, for example PCLI clinicians presence on the ward daily and interact with all clinicians.
- Leadership: using key leadership roles to influence engagement and practice change.
- Establish roles and responsibilities: to ensure everyone has a clear understanding of their role and can work collaboratively to achieve the desired outcomes.

* 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*

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 NDIS, Aged Care Assessment Team (ACAT), Housing and Accommodation Support Initiative (HASI), Community Living Supports (CLS), HASI Plus and other high support accommodation options.

Back to Basics

A MDT 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.

LHD practical examples

SESLHD has re-branded their traditional MDT review through the development of a My Meeting My Way process in their inpatient rehabilitation unit. It is consumer-led and follows the principles of recovery oriented practice and shared decision making.

HNELHD has developed a PCLI Assessment Summary and Planning Tool that provides an objective reference of a person's 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

LHD practical examples

Northern Sydney LHD: Using the Guide to change a person's discharge trajectory

The PAFU Guide is used in NSLHD as a powerful tool to change a person's discharge trajectory by providing evidence-based assessments of a person's needs, preferences and goals. The assessments are instrumental in informing discussion with both hesitant ward staff and families. The RAS-DS provides a focused direction to commence discussions and the evidence gathered across other assessments help to shape and prioritise the person's needs in the longer term.

A change in discharge trajectory has been noted on several occasions where it was initially thought a person would require a SIL pathway but the suite of PCLI and other assessments have highlighted that the person's overall needs require a RACF pathway. The RAS-DS allows for very personal discussions, which translate into specific care needs and help identify the appropriate pathway for longer term care.

South Eastern Sydney LHD: Using the Guide as a tool for transition planning

In SESLHD, the PAFU Guide is used as a tool to help prepare people for a successful move from hospital to home. The PAFU Guide assists in shaping a comprehensive and patient-centred approach to transition planning.

The SESLHD rehabilitation short stay inpatient settings invite the person to participate in their goal planning. They have a My Meeting My Way format that is used to guide a person's assessment process.

The PAFU assessments provide the MDT with supplementary information about a person's needs, preferences, goals and mental and physical health conditions.

The RAS-DS is a useful tool in informing the MDT, especially when a person is unable to be present at meetings, providing information about who a person is, their values and goals, and how they feel they are tracking with recovery.

Hunter New England LHD: Incorporating the Guide into daily practice

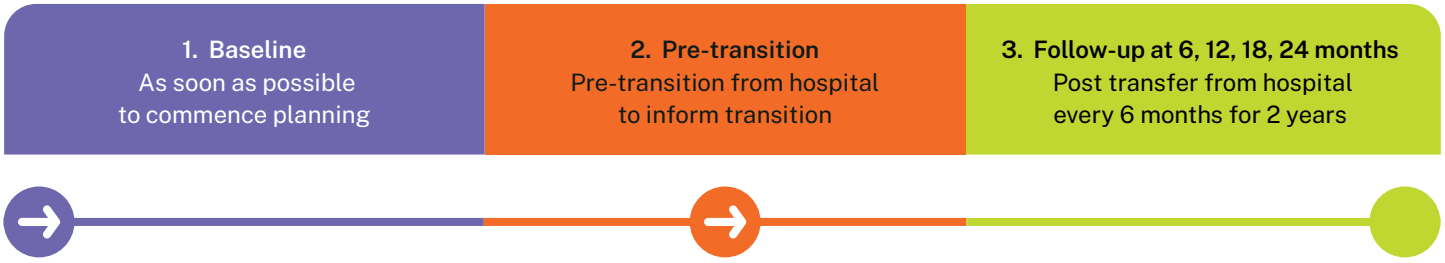
HNE are using the PAFU Guide to support multidisciplinary teams in weekly ward rounds. The PAFU Guide is helping to inform discussions about a person's assessments, treatment plans and any review requirements. By embedding the use of the Guide into business as usual HNE is ensuring a person's journey is a continual focus and the person is receiving high-quality, comprehensive assessment, and planning that meets their physical, emotional, and mental health needs.

3.3 The assessment timeline

The PCLI assessment suite can be interwoven with usual clinical and assessment practices over several days, weeks or months, depending on the needs and capacity of the person. Some assessments or processes logically follow others. It is the decision of the clinical team, informed by the person 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



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.

Pre-transfer assessments are administered prior to transition from hospital, 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 have 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.

Follow-up assessments are completed as close to 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.

Timely communication

Timely communication is an essential component of a person's journey.

- For consumers, it helps to ensure a person feels more supported and informed about their care, influencing their engagement and overall experience of care.
- For clinicians and other service providers, it can facilitate earlier intervention, treatment and planning leading to better and more timely outcomes for the person.

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 demographic, current and historical information relevant to the PCLI approach to care and the results of each assessment time point. The PCLI Database enables instant sharing of information within PCLI networks and across LHDs. Refer to your local LHD PCLI Program Manager or LHD contact to understand your responsibilities (if any) with regard to the PCLI database.

3.4 PCLI assessment tool selection

It is important to objectively measure each person's strengths, capacities, needs and abilities using standardised and evidence-based assessments. This assists a person and their care givers to visualise a more meaningful life to plan leaving hospital. A suite 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 a person's journey and wellbeing.

The PCLI assessment tools meet the following criteria:

- Provide clinically meaningful information to assist care planning.
- Provide a framework for clinicians to clinically underpin their recommendations for care plans.
- Support others to build capacity in their understanding of a person's presentation and what to look for.
- Support the use of a common language that can help a person and service providers better understand what is happening.
- Standardised with a published manual available to all clinicians.
- Demonstrated reliability and validity as evidenced by publications in peer reviewed journals.
- Good clinical utility - ensuring that, 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 a variety of people (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 suite

The following table provides a summary of the recommended PCLI assessments. In addition to these assessments, other assessment options may be selected to further inform the process.

Specialist knowledge, and awareness of specialist services is growing within PCLI. The collaborative nature of PCLI allows clinicians to seek support and guidance from across the network to bridge knowledge gaps in assessment, interventions, and potential service collaborations.

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; Lesbian, Gay, Bisexual, Trans, Queer, Intersex Asexual (LGBTQIA). Culturally adapted and validated assessments may also be indicated, for example, the Westerman Aboriginal Symptom Checklist, which has undergone psychometric validation and is now available for purchase. Table 1 presents the PCLI assessment tools. Table 2 presents a quick reference guide to the assessment tools.

The PCLI Statewide Portal provides a summary table outlining the duration of administration for each assessment tool, administration and training requirements.

If you are unable to access the Statewide Portal please contact your local PCLI representative.

Table 1: PCLI assessment tool suite

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 the person 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 the person, 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. PCLI Networks value the RAS-DS because it ***"helps people identify areas of their journey that are important to them."***
Camberwell Assessment of Need (CAN-C) and CAN-E Elderly	The adult 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. CAN-E for OLDER ADULTS This assessment 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 CAN-E collects information about the older person's needs from various perspectives, such as, the individual themselves, a key staff member and carer. This assessment 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 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 Networks value the CAN-C and CAN-E because it ***"ensures the sometimes difficult topic of relationships and intimacy are acknowledged."***
PCLI Risk of Future Violence Screening Assessment	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. Often, the types of issues that make a person vulnerable to future violence are also impediments to their recovery.

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. PCLI Networks value the HCR20 because it ***"not only manages risk for organisations but can help the person understand their own behaviours."***
Neuropsychiatric Inventory- Nursing Home Version (NPI-NH)	The NPI-NH is a screen used to evaluate neuropsychiatric symptoms in person when in a supported 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. PCLI Networks value the NPI-NH because it ***"supports staff to scaffold conversations regarding the impact of symptoms on behaviours. The breakdown of domains supports a very guided conversation."***
Modified Mini Mental State (3MS)	The 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 Intelligence Quotient (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 tool 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. PCLI Networks value the RBANS because it ***"gives a good breakdown of memory impairments."***
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. PCLI Networks value the Trails A and B because it ***"gives evidence to why a person might be behaving a specific way and what kind of day-to-day activities they may struggle with."***

Modified DAD Clinician Screen	The M-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 the person and potential care providers in terms of strategies to support optimal function. PCLI Networks value the M-DAD because it ***"breaks tasks down into areas of ability and aspects of support required within a task. Not a straightforward yes or no."***
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 screen 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 person. PCLI Networks value the LACLS-5 because it ***"helps to guide support needed by breaking down function and relating it to cognitive capacity."***
Living in the Community Questionnaire (LCQ)	This is a person-rated measure that focuses on social inclusion and recovery. The LCQ is designed to explore aspects of a person's life in the community including social activities, participation in employment or study, living situation, physical healthcare, 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. It 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 an indication of outcome and change. PCLI Networks value the LCQ because it is ***"excellent to use in the community to encourage thinking about next steps for engaging with community living and the lifestyle the person aspires to achieve."***

The most important thing is the conversation that's occurring and us learning about the person ... 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

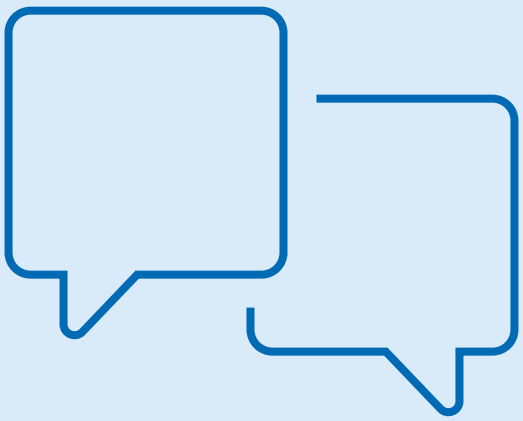


Table 2: PCLI Assessment Tools – quick reference guide

	All of the below 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 CAN-C or CAN-E	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
		What is going well? What type of help and support does the person continue to need or no longer need?	CAN-C or CAN-E
Behaviour	NPI-NH	This helps the person 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. As indicated.
Risk	Risk Screen	What risks need to be considered and what management strategies might be needed?	As indicated
	HCR-20 v3 if indicated		No
Cognitive	3MS, WASI-II	What are the person's cognitive strengths and limitations?	Recommended
	RBANS, Trails A & B		
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+)
Satisfaction surveys	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

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 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 the appropriate follow-up assessments. Contact will be made with the person's General Practitioner (GP) and other significant providers/people as deemed relevant and agreed with the person. Figure 7 on the following page identifies the responsibilities and tasks for each person in the follow up process.

Benefits of follow-up assessments

Follow up assessments will help with checking how a person is going in the community; benefits include

- ensuring that a person is being supported in the areas that are important to them
- understanding if a person would benefit from some therapy or training to build skills or knowledge
- understanding if a person needs help or is having difficulties with anything
- supporting a person to think about their next steps.

Figure 6: Follow-up after transition involves all people

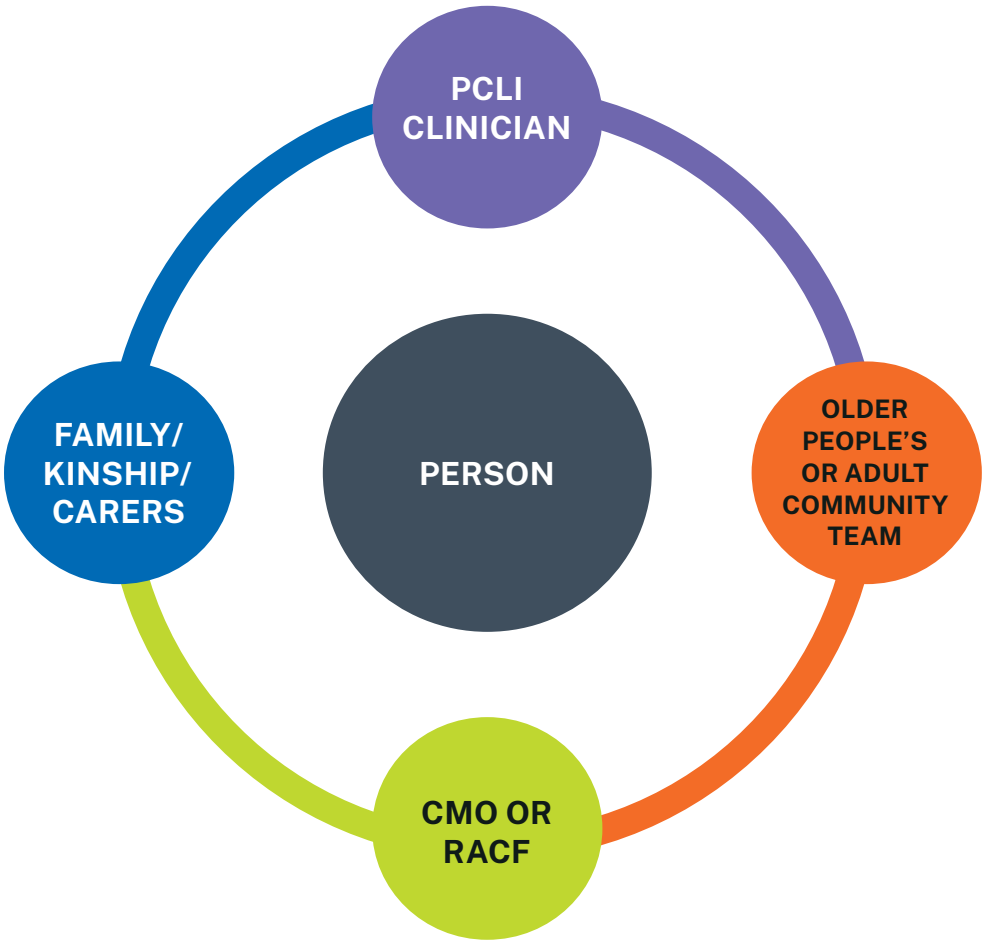
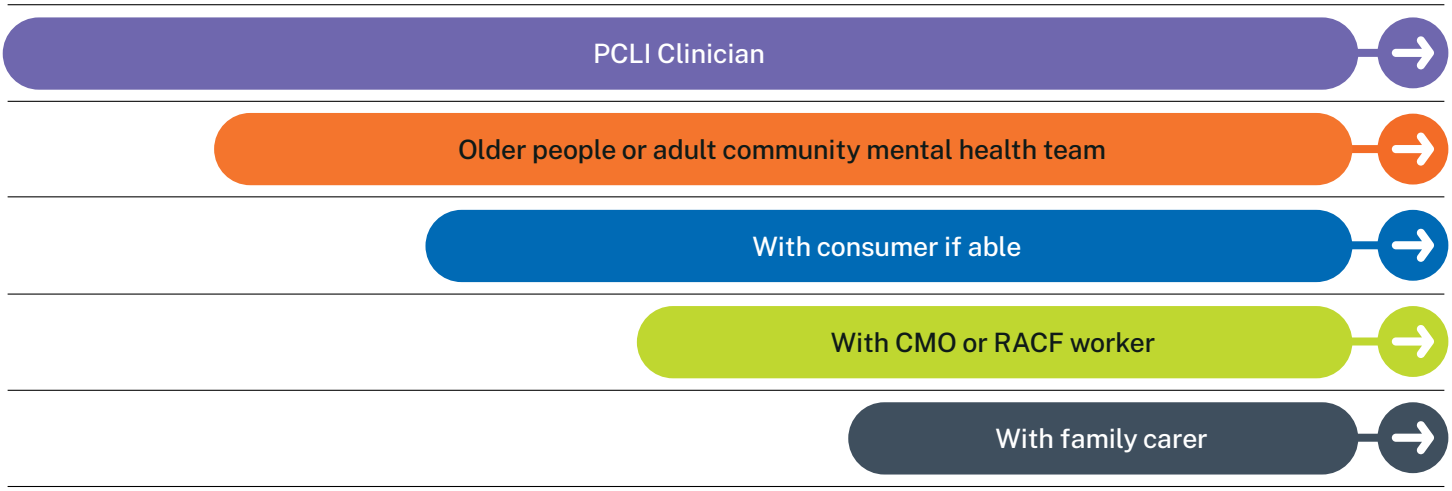


Figure 7: Follow-up after transition responsibilities and tasks



PCLI Clinician

Responsibilities

- Analyse training needs of workforce to enable follow-ups and address with support of MoH
- Ensure partnership development and communication with community teams and CMO/RACFs to support follow-up completion
- Liaise with all parties to organise follow-up
- Ensure the follow-up happens including completion of assessments
- Flag the 12 month follow-up with relevant parties

Tasks

- Track follow-up dates
- Coordinate and ensure the follow-up happens
- Complete the follow-up as necessary
- Documentation
- Database entry
- Coordinate transfer of person on PCLI database*

Older people or adult community mental health team

Tasks

- Review with person their plans (including care plan and wellness plan) for next 6 months and make referrals as appropriate
- Interview with the person
- Interview with family/kinship if appropriate and possible – document why not
- Interview with worker at CMO/ RACF
- Documentation
- Database entry*

Complete follow up including

- RAS-DS, CAN-C/ CAN-E, NPI-NH with RACF, M-DAD and LCQ/Dem-QOL
- Decide if RBANS, Trails A & B and HCR-20v3 are to be conducted
- Determine if other assessments are indicated

With consumer if able

Tasks

- Participate in interview and follow up with clinician

Complete follow-up including:

- RAS-DS
- CAN-C/C-CAN-E – user
- LCQ/Dem-QOL

With CMO or RACF worker

Tasks

- Facilitate PCLI/ community clinician to meet with the person and potentially family/ kinship/carer to provide follow-up
- Participate in follow-up interview and complete with clinician

Complete follow-up including:

- NPI-NH
- CAN-C/CAN-E – staff
- M-DAD

With family carer

Tasks

- Participate in interview and follow-up with clinician

Complete follow-up including:

- CAN-CE/CAN-E – carer
- Dem-QOL proxy

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 person 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 people transitioning both within an LHD and to a different LHD.

* Where a person is transitioning to a different LHD relevant additional activities are marked with an asterisk.

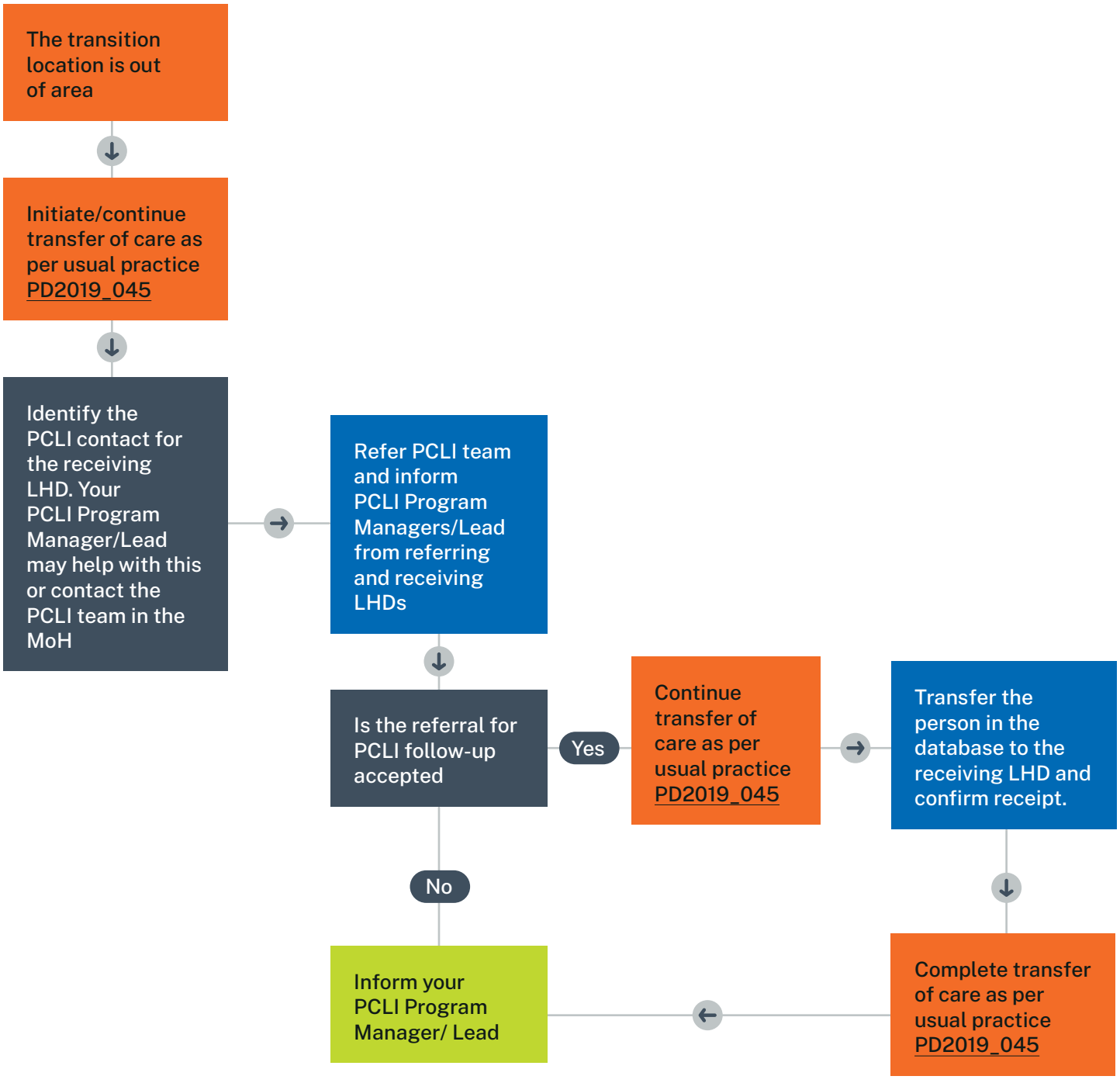
Transferring to another LHD

When a person moves to a new LHD there will be a discussion and agreement during the referral and handover processes regarding the best way to conduct the follow-up assessments. This will be informed by the current and ongoing needs of the person and the resources of the 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.

Providing feedback to the person regarding their progress throughout the follow up phases will help them to continue to be engaged and understand what is working well, what might need to change and what they want to work on next to help them embrace community living with greater autonomy. Remembering a transition to the community is only one stage in a person's journey and there are many more to come.

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

Figure 8: Process for transition out of area (Note: LHDs have varying transfer and follow-up processes)



Stories of success

4

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

What an experience it was to see a person I had worked with for many years be out in his own home in the community. I was an inpatient-only clinician and here's my story.

It felt like I was going to see an old friend and have a cuppa, and what a sweet cup of tea it was.

I worked with this person daily from Monday to Friday for what felt like an eternity. It was easy to lose hope when working with him; he has suffered long term schizophrenia for many years and was now impacted with early onset dementia. It felt like he had no options in life, just a daily choice around whether or not we played dominos when I was free, he never said no.

It was a lovely feeling to see him in his new home, that warm and fuzzy feeling you get on only very special occasions. He showed me his room, the card we had all made him on the wall above his desk-his backyard-his bathroom and introduced me to the others who lived with him, I could hear the pride in his voice and the excitement he had to share it, he made a very good friend in his new home and the staff said that they went everywhere together, he was able to speak to family overseas and eat whatever he desired. These things seem so normal to us, so simple but for someone who had spent not days, not months but years in hospital it was so exciting to see.

At the end this person told me he has not played a game of dominos since being in hospital and I was glad to know that. To me it meant his days were filled with so much joy that he could do as he pleased, he was fulfilled and not just playing dominos when I had time for a quick game.

Working with people for many years can be challenging, it can be exhausting and it can feel like there's no light at the end of the tunnel but this experience for me showed that persistence pays off. To see a person truly happy is the best experience a clinician can have. I am excited to see what PCLI and NDIS holds for those in our metal health service and deep down know that recovery can happen, even when it's a long and bumpy road!!

Ms R's story: life in the community

Situation

Ms R is a mid 40's aged lady who had been an inpatient on a mental health ward for 5 yrs. Prior to her admission Ms R had lived with her sister most of her adult life due to the stability of her mental health being influenced by her excessive drug and alcohol use. Her frequent relapses in mental state over many years had resulted in significant cognitive decline and Ms R requiring a significant level of support to live in the community. During this admission her sister became physically unwell herself and despite numerous attempts was no longer able to act as Ms R's carer. Sadly Ms R's sister passed during this admission.

Ms R was discharged to a SIL environment living with other females of a similar age in a locality that was familiar to her. The home provides 24 hour waking support.

Progress identified at the 6 month follow-up

When talking about her community life Ms R reported she feels safe and is happy with her life, she has no desire to return to hospital, despite missing a number of staff, whom she passed on messages to.

Ms R reported that she enjoys the choice of food and although she cannot cook she enjoys helping others where she can. Staff report that Ms R is encouraged to assist at meal times and that she enjoys the different cultural dishes that are cooked by different members of the household.

At the follow-up assessment the CAN assessment indicated a 40% reduction in areas of unmet needs, and Ms R was happy to engage in some other assessments that she had previously declined to engage in whilst in hospital.

Whilst in hospital Ms R regularly accessed Pro Re Nata (PRN) 'as needed' medication and family members often brought in extra benzodiazapine based medications for Ms R. Attempts to minimise use and implement alternative strategies were very difficult to implement. When discharged from hospital the supported living provider worked to develop their PRN process, being aware of this potentially being a challenging area. In a 10 month period Ms R has only accessed PRN 14 times, this is a huge achievement for Ms R considering her historical misuse of both prescribed and street drugs.

Ms R talked of dreams and desires to go on holiday and visit new places in her future. In a short time despite a significant loss in her life Ms R has made significant achievements and is embracing her freedom in the community.

Acknowledgements

This Guide has been developed and updated with the input of many people over several years. The most recent review of this Guide (2023) has been led by the PCLI team with an invitation extended to all LHDs and the statewide PCLI network to engage in this review process. We would like to acknowledge and thank those people that participated in the 2022/23 focus groups and contributed to this edition of the Guide. We also acknowledge all those that have been involved and are listed in previous editions of the Guide.

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