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NSW Ministry of Health



Pathways to Community Living Initiative

Stage One
Summary Report



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

The authors of this report would like to acknowledge the people with complex mental health conditions who have lived in a hospital setting, sometimes for decades, who are making the brave transition back to living in the community. We would also like to acknowledge the dedicated carers, family, friends and staff who have and will continue to walk beside them on their journey.

Acknowledgement is made to the University of Wollongong, Australian Health Services Research Institute (AHSRI) for their evaluation of the PCLI which has helped inform this report.

LANGUAGE

Using agreed terms from the NSW consumer group (Being) and others, this document talks of people/individuals and person with a lived experience of mental illness rather than 'consumers' and uses resident and patient where definite clarification is required.

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Preface

Transforming systems to deliver value-based healthcare is a strategic priority for NSW Health. The Pathways to Community Living Initiative (PCLI) is a ‘major system change’ involving a paradigm shift in the approach to care with people who have severe and persistent mental illness (SPMI) and experience long hospital stays, or who are at risk of long or recurrent hospitalisations due to their complex care needs.

The PCLI, established in 2015 and led by the NSW Ministry of Health in collaboration with Local Health Districts, has addressed many of the system barriers for these individuals to enable them to achieve successful lives in the community.

This report focuses on the group of patients who also have significant ageing-related issues, many of whom have been in hospital for over 10 years. It summarises evaluation findings and NSW Health data, and describes the implementation of local partnerships across hospital and community-based settings that are delivering sustainable, co-designed and value-based care to meet the current and future needs of people with very complex mental illness.

While the Ministry has provided state level leadership for the PCLI across NSW, its local development has been achieved via the collective effort and distributed leadership of Local Health District program managers, mental health executives, clinicians and peer workers, with community-based partners.

This distributed leadership^{*} model is a key strategy of the PCLI. It is an approach that is creating a large-system transformational change across the domains of leadership, clinical engagement and co-design, person-centred care, inter-sectoral partnerships, and collaborative monitoring and measurement. It has facilitated change by engaging with the history and context of the mental health system in NSW, and developing new partnerships with the community managed sector.

I extend my appreciation to all staff across public and community managed sectors for your leadership and commitment to ensuring people who experience the impacts of major mental illness are supported to live well both in hospital and in the community.

Elizabeth Koff
Secretary, NSW Health

* Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S and Bitz J (2012) *Large-system transformation in health care: a realist review*. *Milbank Quarterly*, 90(3), 421-456 discussed in Williams K, Westera A, Kobel C, O’Shea P, Coombs T and Thompson C (2021) *Pathways to Community Living Initiative – Evaluation Report 5: Stage One implementation and outcomes*. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong, Wollongong.

PCLI Stage One at a glance



1. Where did we start?

A burning need

NSW Mental Health Commission's report 'Living Well, Putting People at the Centre of Mental Health Reform in NSW' (2014) highlighted:



**380 long stay
MH patients
in NSW**



**Existing services have
not been able to meet
the complex needs
of this population**

The evidence was strong

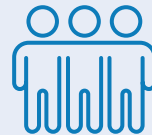
People with severe and persistent mental illness (SPMI) experience better quality of life and improved health and social outcomes if they are well supported in the community by structured clinical, support and wraparound services in appropriate environments.

We had strong foundations on which to build

In NSW we had 'pockets of excellence' (service providers and models) and strong policy foundations, including the Older People's Mental Health (OPMH) program and the NSW Mental Health Reform.

Pathways to Community Living

PCLI was designed to support people who have had a long stay in hospital (>12 months) to re-establish their lives in the community. It is underpinned by two key tenets:



People want to live and be valued in the community



A hospital is not a home

The PCLI represents a 'major system change' that seeks to: Transition long-stay patients into appropriate settings in the community.

Change practice to improve care pathways for people with SPMI who are long-stay or at risk of long-stay, to decrease number (and length) of admissions across NSW.

Stage One of PCLI

Stage One of PCLI focuses on people with significant ageing related needs and assessed as eligible for Commonwealth aged care funding support and/or is receiving services from the Older People's Mental Health Services.

Many people had very long lengths of stay (LOS), some over 15-30 years.



2. What have we achieved with Stage One?

Durable, effective and sustainable partnerships with aged care providers operating across NSW

Three service models for PCLI Stage One:

- Mental Health Aged Care Partnership Initiative (MHACPI) units
- Specialist Residential Aged Care Facilities (SRACFs)
- Generalist or mainstream aged care facilities

Improved experiences for people and carers

- Positive health outcomes for people following hospital discharge, including reduced psychological distress and improved life skills (particularly self-care, compliance, and anti-social behaviours)
- Low requirement for unplanned acute care following transition indicated people are doing well in the community
- Improved engagement, choice and control in people's daily lives following transition to the community
- Carers were very happy and could see the positive difference community living has made for their person, including the opportunity to live a more meaningful life and engage in a variety of interesting activities

Improved experiences for clinicians and service providers

- Improving attitudes to the PCLI program among treating teams are evident and represent a cultural change towards a 'culture of recovery' and a stronger focus on coordinated complex care
- Effective engagement of stakeholders across all settings - LHD inpatient mental health, community mental health and aged care providers

We have successfully transitioned 113 people to community living in Stage One

Total people transitioned

113



Destinations

57

Generalist RACF

34

MHACPI

22

SRACF

Stage One transitions to community living (at Dec 2019, initial and 2nd wave cohorts)

Improved efficiency and effectiveness of the system

- The PCLI provides a prototype of contemporary health system reform: delivering value for the system, delivering better outcomes for people and establishing the feasibility of a new funding approach
- Existing funding mechanisms across State and Commonwealth have been used to establish and resource local partnerships that operate as a system across the spectrum of care
- Early economic analysis estimates that transition to community living led to a large reduction in average costs regardless of discharge destination and age, ranging between \$12M and \$18M annually.



3. What's next for PCLI?

Continue to embed Stage One

- Continue to transition the Stage One model from a 'PCLI initiative' to Business As Usual (BAU) for LHDs, aged care and community organisations and the OPMH program

Stage Two is gathering momentum and success

- Stage Two is successfully operating and transitioning people to a range of community living options
- Stage Two specialist community services will be in place in 2023
- PCLI will continue to focus on the sustainable delivery of the Stage One and Stage Two models

Lasting system and cultural change

- Building on the PCLI, NSW Health will continue to pursue lasting systemic and cultural change to prevent a renewed build-up of long-stay patients with SPMI, improve support and opportunities for people and release capacity in hospital care

Executive Summary

Value-based healthcare for people with severe and persistent mental illness: Pathways to Community Living Initiative (PCLI)

A relatively small¹ but significant group of people with very severe and persistent mental illness^{2,3,4} and high levels of clinical symptoms require very high levels of 24/7 clinical and disability support that were previously only available in inpatient settings in NSW. International and national evidence shows that people with severe and persistent mental illness (SPMI) and complex needs can have greater quality of life, better health outcomes and fewer hospital bed days if they are well supported in the community by structured clinical, support and wraparound services within purpose designed, built environments.

A key recommendation of the NSW Mental Health Commission's report 'Living Well, Putting People at the Centre of Mental Health Reform in NSW' (2014) was for Government to transition around 380 long stay (inpatients with a length of stay >365 days) mental health patients, all with SPMI, to appropriate services in the community. The NSW Government recognised that existing services have not been able to meet the complex needs of this population and committed to address this recommendation.

Led by the Ministry of Health (Ministry) with Local Health Districts (LHDs), the PCLI, established in 2015 is the key driver for this major reform process. The PCLI seeks to develop and implement excellence in models of care, health programs and health services and provide efficient, effective and sustainable financial operations. To achieve this, a systemic approach encompassing the continuum of care across hospital and community sectors has been essential.

The PCLI has been designed to overcome many of the current system barriers to integration of mental healthcare across the community and acute sectors. It is founded on establishment of formal local partnerships across care settings that deliver sustainable, co-designed and value-based care to meet the current and future needs of people with SPMI.

Objectives

The PCLI aims to:

1. **Transition long-stay patients** into appropriate settings in the community including the development of additional contemporary, recovery-oriented community-based services, and
2. **Change practice to improve care pathways** for people with SPMI who are long-stay or at risk of long-stay, to decrease number (and length) of admissions across NSW.

¹ The Fifth National Mental Health and Suicide Prevention Plan. 2017; Available from: <https://www1.health.gov.au/>

² Productivity Commission, Mental Health Draft Report. 2019: Canberra

³ Fuller, J.D., et al., Building effective service linkages in primary mental healthcare: a narrative review part 2. BMC Health Services Research, 2011. 11(1): p. 66

⁴ Whiteford, H., et al., System-level intersectoral linkages between the mental health and non-clinical support sectors: a qualitative systematic review. Aust N Z J Psychiatry, 2014. 48(10): p. 895-906

Designing and implementing the PCLI

The PCLI is a 'major system change' involving practice change with integration of inpatient and community services through funded partnership-based service models between LHD specialist mental health clinical services and aged care providers. The overarching vision of PCLI is systemic, aiming to embed a contemporary approach to supporting people with SPMI to live well in the community. Successfully operationalising the vision has relied on a phased roll out, in which the PCLI has focused on two distinct cohorts. The Stage One PCLI cohort comprises people with significant ageing related needs (which includes people over 65 years and people under 65 years with early ageing issues) and assessed as eligible for Commonwealth aged care funding support and/or receiving services from NSW Health Older People's Mental Health Services. The Stage Two PCLI cohort comprises people aged 18 and over without significant issues of ageing who are receiving services from the youth/adult mental health services. While PCLI has been rolling out across both cohorts this report focuses on the Stage One cohort.

Successful implementation of Stage One of the PCLI has been supported through six key components:

- **An overarching program approach** to system change incorporating the key system enablers of governance and leadership, change management and innovation, engagement and communication and workforce development.
- **The person's journey** guided by a recovery focused and person-centred pathway tailored to each individual person's move from hospital to home in the community.
- **The mental health team's journey** supported through guidance and tools to implement and sustain comprehensive PCLI assessments and contemporary, strengths-based and recovery-oriented practice in hospitals and the community-based partnerships.
- **The partnership journey** supported through collaboration between LHDs, the Ministry and community managed organisations, including aged care facilities, to integrate care to meet the needs of people with SPMI in the community.
- **Budget and inputs** comprising a mix of current funding sources and dedicated funding for program management, 'top-up' funding for new community service development and operation, and funding for additional specialist clinical mental health services for community-based clinical in-reach services.
- **Monitoring and evaluation** including the PCLI assessment tools supported by key performance indicators (KPIs) in routine health data reporting and an external evaluation of the program.

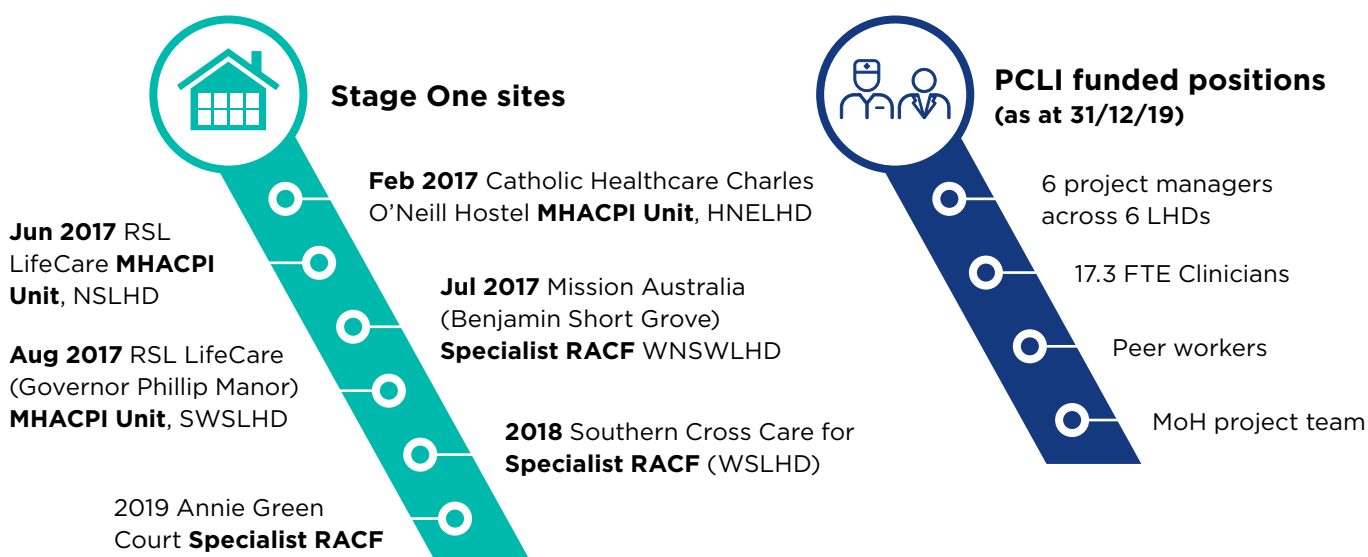
Stage One community-based services are embedded

PCLI Stage One provides three service models for supported accommodation and care in the community for long-stay patients with significant ageing-related issues. Two of these – the Mental Health Aged Care Partnership Initiative (MHACPI) transitional units and the Specialist Residential Aged Care Facilities (SRACFs) are provided by partner organisations. Generalist or mainstream aged care facilities are an option for many of the PCLI Stage One people.

Additionally, services are supported through a range of new PCLI-funded positions including PCLI project managers, OPMH complex care clinicians, peer workers and the MoH project team, as well as through existing OPMH policy staff and LHD OPMH service managers and teams. The service models and processes are now embedded for sustainability in the [NSW Health Older People’s Mental Health Program](#).

Figure 1 provides a snapshot of the Stage One MHACPI and SRACF service sites and the PCLI funded positions as at 31 December 2019.

Figure 1: Overview of establishment of Stage One sites and funded positions⁵



⁵ MHACPI unit dates indicate date of establishment of the unit; SRACF dates indicate when MH clinical and partnership support commenced.

Guide to this report

This report seeks to present a succinct summary of the progress and outcomes of the Stage One PCLI as aligned to the overarching strategy of NSW Health of value-based healthcare.⁶ The report is presented in line with the Quadruple Aim.^{7,8} The Quadruple Aim is the contemporary framework underpinning best practice health service planning, implementation and outcomes. The fundamental premise of the framework is that value is harnessed through simultaneously improving population health, improving the experience of receiving and providing care, and of reducing per capita cost.

The information contained in this document is not exhaustive and is intended to distil the key findings from other documents including the evaluation reports produced by the University of Wollongong, Australian Health Services Research Institute (AHSRI), guidelines and resources produced by the NSW Ministry of Health and available quantitative data (refer page 20 for details).



Improved health outcomes and experiences for people with SPMI

Improved experiences for families and carers



Improved population health



Improved experiences for service providers and clinicians



Improved efficiency and effectiveness of the system



⁶ Koff, Elizabeth and Lyons, Nigel. (2020). Implementing value-based healthcare at scale: the NSW experience. *Med J Aust* 2020; 212 (3). doi: 10.5694/mja2.50470. Published online: 17 February 2020.

⁷ Sikka R, Morath JM, Leape L. (2015). The Quadruple Aim: care, health, cost and meaning in work. *BMJ Qual Saf* 2015;24:608-610. <https://qualitysafety.bmj.com/content/qhc/24/10/608.full.pdf>

⁸ Bodemheimer, Thomas and Sinsky, Christine. (2014). From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. Nov-Dec 2014;12(6):573-6. doi: 10.1370/afm.1713.

The key findings are presented in the following sections:

Heading	Description
Introduction	Outlines the case for change, the aims of the PCLI, the characteristics of the Stage One cohort and summarises the person's process and the clinicians' process
Stage One implementation	Presents the key elements of the PCLI including: <ul style="list-style-type: none"> • the development and implementation of community-based aged care partnerships and service models, • a fit-for purpose workforce, and • system enablers to support practice change and sustainability.
Evaluation approach	Describes the qualitative and quantitative data referenced in this report
Improved health outcomes and experiences for people with SPMI	Presents the key findings for Stage One persons transitioned to the community
Improved experiences for families and carers	Presents the key findings based on the experiences of families and carers whose person was transitioned to the community
Improved experiences for service providers and clinicians	Presents the key findings based on the establishment of cross sector partnerships, the engagement of key stakeholders and the overarching cultural change
Improved efficiency and effectiveness of the system	Presents the key findings related to new models of care, overarching system change and future sustainability

Introduction

NSW Health has a strategic goal to transition the health system towards a system driven by value, focusing on the Quadruple Aim outcomes. The PCLI is a flagship program for value-based mental healthcare in the community. PCLI seeks to deliver a paradigm shift for long-stay hospital patients to transition to value-based healthcare in the community by:

- taking a whole-of-system approach to the transition of long-stay patients to community living
- investing in partnerships between NSW Health and aged care providers and community managed organisations
- creating practice change in inpatient and community settings to support a person-centred, recovery focused approach to decrease the number and length of long-stay patients.

The case for change

Societal values and expectations about the rights of people with a mental illness, including the right to live a meaningful life in the community, have changed dramatically over the last decades and is set to accelerate further over the coming years.

Mental illness and in particular severe and persistent mental illness, requires person-centred, integrated care across multiple services, providers and settings. It is well recognised that good quality community-based care reduces the need for hospitalisation, results in higher self-reported quality of life and improves community participation and both physical and mental health; it is seen as more

cost effective than inpatient services and has a high-cost benefit. Since the early 2000s, NSW has increased the quantum of community supported places through programs such as the Housing and Accommodation Support Initiative (HASI). The recent development of the National Disability Insurance Scheme (NDIS) has also increased these options. However, while many people transition successfully back into the community, NSW has retained a high number of long-stay patients.

At any one time according to benchmarked data in Australia, approximately three per cent of the population have a severe mental illness and their needs are never homogenous.⁹

People with severe and complex mental illness often require access to and coordinated support from various health services and professionals. Literature highlights a fractured mental health system, hindering the effective coordination of treatment and supports for people with severe and complex mental illness.^{10,11,12}

⁹ Commonwealth of Australia. The Fifth National Mental Health and Suicide Prevention Plan. 2017; Available from: <https://www1.health.gov.au/>

¹⁰ Productivity Commission, Mental Health Draft Report. 2019: Canberra.

¹¹ Fuller, J.D., et al., Building effective service linkages in primary mental healthcare: a narrative review part 2. BMC Health Services Research, 2011. 11(1): p. 66.

¹² Whiteford, H., et al., System-level intersectoral linkages between the mental health and non-clinical support sectors: a qualitative systematic review. Aust N Z J Psychiatry, 2014. 48(10): p. 895-906.

New contemporary models of care, that are evidence-based, are now a priority to ensure we meet the individual needs of people living with a mental illness and support the long-term sustainability of our health system.

In 2014, the Mental Health Commission (MHC) of NSW detailed a ten-year roadmap for strengthening mental healthcare in NSW *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*. *Living Well* articulates the vision that “the people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms.”

A key recommendation of the MHC was for the Government to transition long-stay mental health patients (over 12 months length of stay (LOS), in both acute and non-acute units) into appropriate services in the community.

Health data in 2011 going back to 2000 indicated that very long-stay (over 500 days) patient numbers had been increasing at a rate of 126 admissions per year compared to discharges of 108.¹³ Numbers were accumulating, not decreasing. Unless a ‘circuit breaker’ was instituted more beds would be required.

In response, the NSW Ministry of Health is funding the PCLI. The PCLI commenced in 2015, arising from the imperative to move the existing cohort of long-stay mental health patients to the community.

Pathways to Community Living Initiative: a new way of doing business

The PCLI is a major system change. It involves practice change with integration of inpatient and community services through funded partnership-based service models between LHD specialist mental health clinical services and aged care providers, for the Stage One cohort. Systems of non-acute care are being further improved to build more contemporary, strengths-based, rehabilitation and recovery-reoriented practice in hospitals and the community-based partnerships.

The PCLI provides statewide leadership by the Ministry of Health in collaboration with LHDs and after five years of development aims to:

1. Enable people with extended hospital stays (or at risk of) and severe and persistent mental illness (SPMI) to transition into the community, including developing new service models for appropriate care; and
2. Continue to create 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.

The purpose of PCLI is to support people who have had a long stay in hospital to re-establish their lives in the community. It is underpinned by two key tenets:

- People want to live and be valued in the community.
- A hospital is not a home.

¹³ NSW Health internal data sources.

Implementation activities for both Stages of the PCLI have proceeded simultaneously. The PCLI cohorts

The PCLI is focused on two distinct long-stay cohorts, based on identified needs and the approach to development of appropriate community living options – these are referred to as the Stage One and Stage Two cohorts.

- **Stage One cohort:** a person has significant ageing related needs (which includes people over 65 years and people under 65 years with early ageing issues) and is assessed as eligible for commonwealth aged care funded support and/or is receiving services from the Older People's Mental Health Service/Clinician
- **Stage Two cohort:** a person is aged 18 and above without significant issues of ageing who is receiving services from the Youth/Adult Mental Health Service.

At June 2015, the number of long stay patients was around 380¹⁴ with two major cohorts identified, all with SPMI, including:

- 100 people with significant ageing-related issues with an average LOS at 15 years.
- 280 people 18 years and above without ageing-related issues with an average LOS at 5 years.

While the initial focus and reporting of the PCLI is on the cohort of 380 people ('the initial wave'), it is acknowledged that long-stay patients are not a static group and that some people will become 'long stay' during the life of the program ('second wave'). Ensuring these people are in scope is consistent with the aims of the PCLI.

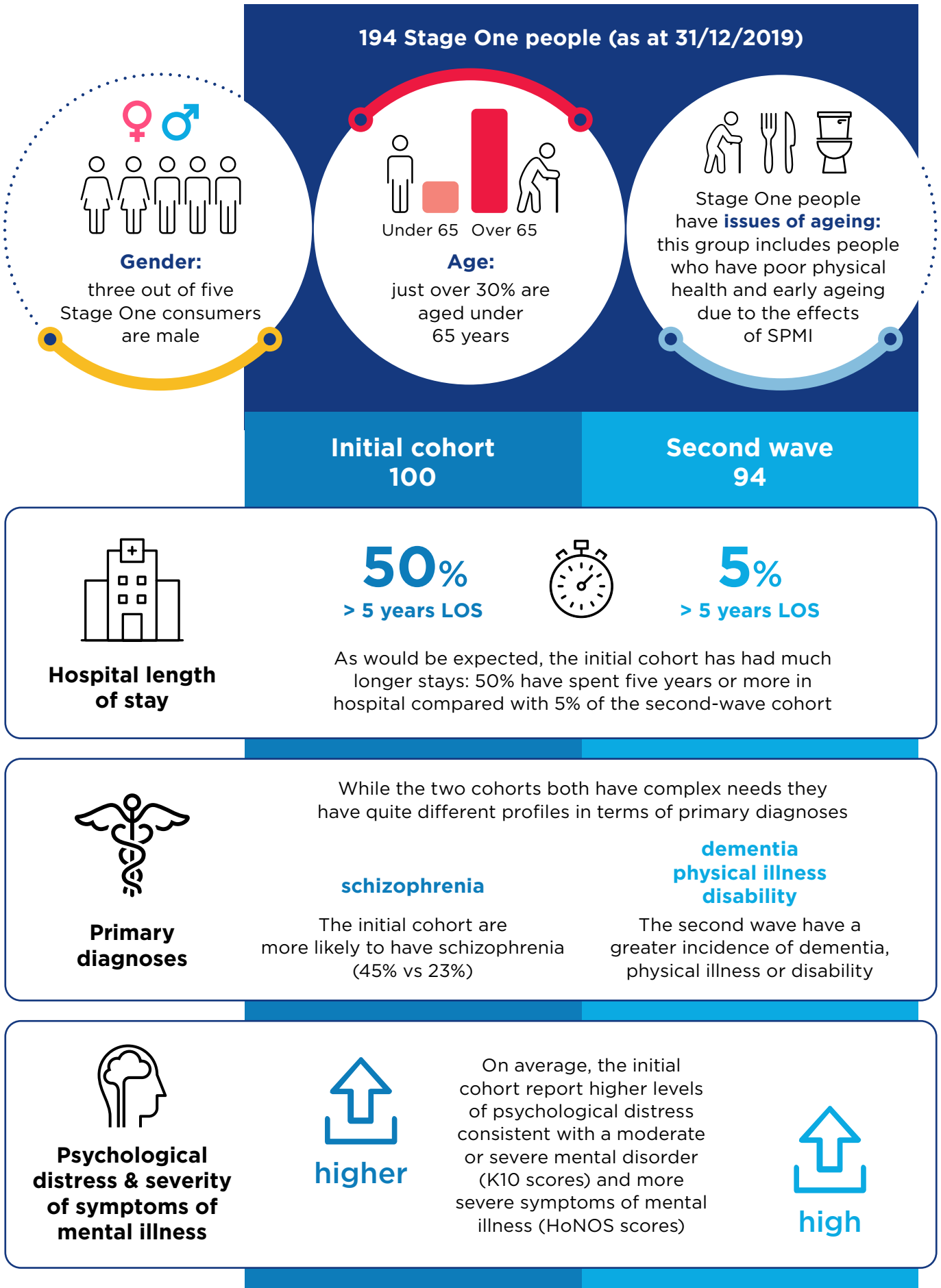
As of 31 December 2019, the Stage One cohort comprised 194 people, including those experiencing long stays at that time, as well as those who had transitioned into the community (or died) since commencement of PCLI.

PCLI Stage One cohort characteristics

Figure 2 presents a snapshot of patient characteristics and health status drawn from routinely collected data stored in the Health Information Exchange (HIE) as of 6 August 2020.

¹⁴ NSW Health internal data sources.

Figure 2: Stage One cohort characteristics



The person's process

A central component of the PCLI is understanding and supporting people in their transition from hospital to community living. The PCLI Journey to Home Guide¹⁵ outlines the recovery focused and person-centred pathway for a person's move from hospital to home across three key phases as illustrated in Figure 3.

It is acknowledged that each person will experience this journey differently, with different amounts of time spent in each phase and with differing outcomes. This process is not entirely linear and 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, develop new understandings about themselves and the potential options available, and decide what will give them the best opportunities to realise their dreams.

The clinician's process

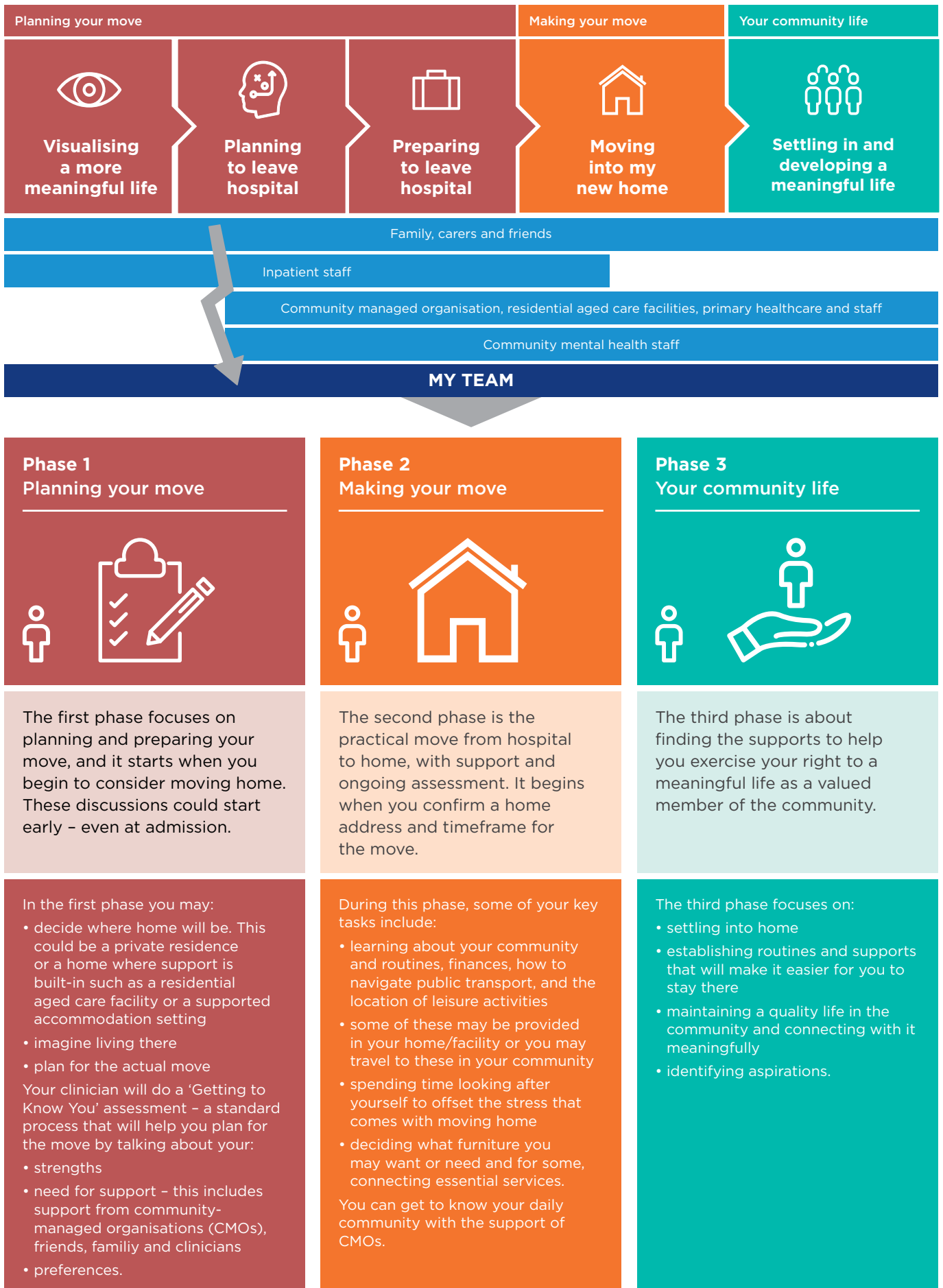
Supporting the person's journey home are the teams of clinicians and staff across both inpatient and community services. The PCLI Planning, Assessment and Follow-Up Guide¹⁶ outlines the clinician's process. There are six key components to consider in relation to the clinician's process and each component is described in detail in this section of the Guide. These include:

- the information gathering and assessment process
- informing planning and review
- the assessment timeline
- PCLI assessment tool selection
- PCLI assessment tool battery
- follow-up of people after transition.

¹⁵ <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/pcli-journey-to-home-guide.pdf>

¹⁶ <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/pcli-planning-assessment-and-follow-up-guide.pdf>

Figure 3: the person's journey to support Stage One transitions to the community



Part 1. Stage One overview

Case study 1



Olive's story

Olive is 76 years old and of Italian descent. She speaks Italian and at times can be difficult to understand, even with interpreters.

Olive has had multiple admissions to hospital since the age of 30 when she was diagnosed with schizophrenia.

Her last admission was for 23 years.

Olive had spent some time living in the community being supported by her family, but when she was last admitted to hospital in 1994 (aged 53), her mental state had deteriorated and she required inpatient care.

Her chronic delusions about her age, other people in her family and orientation to place meant she was not able to be supported at home with her family.

She has chronic delusions but this fluctuates – and as she has aged Olive's mental state has settled.

There was nowhere else for Olive to live – until now.



Planning your move

- Visualising a more meaningful life
- Planning to leave hospital
- Preparing to leave hospital

Olive has family close by, including her husband and daughter who were supportive but reluctant to move Olive because of their previous experience of chaos and trauma.

Olive's family required time and support from the PCLI and OPMH staff to consider and explore the possibility of the move. They were particularly concerned about the skill of care staff in managing a mental health condition and that Olive would refuse to eat in the new setting.



Your community life

- Settling in and developing a meaningful life

Olive is now living in 'generalist' RACF, with additional clinical support provided by the local OPMH team.

Olive has gained weight as she eats the food – Olive was quite thin as she didn't eat the hospital food and the family had to bring her food for years. Olive has now asked them to stop bringing it.

Olive is visited by her grandson who did not previously visit.

Olive has engaged well with the staff and her daughter has said she wished she made the move for Olive sooner.

Olive states she will not go back (to hospital).



Generalist RACF

Stage One implementation overview

The delivery of value-based healthcare for people with SPMI in Stage One of the PCLI required:

- the development and implementation of community-based aged care partnerships and service models,
- a fit-for-purpose workforce, and
- robust system enablers to support practice change and sustainability.

PCLI Stage One: community-based aged care partnerships and service models

Implementation focused on developing mental health partnership services with residential aged care facilities, to create community-based options for the Stage One cohort who have been inpatients for greater than 365 days and who can't find a pathway home. The services include two specialist models (the MHACPI unit and SRACF) supported through "top-up" funding provided by NSW Health through a statewide procurement process for a quantum of 80 beds, as well as generalist aged care facilities. Funding is also provided to LHDs for specialist Stage One PCLI staff.

The model of care is one in which the funded aged care services provide high level 24/7 support through skilled aged care staff and the additional specialist staff working in partnership with the LHDs and with in-reach from the LHD PCLI-funded older people's mental health clinicians. These models are now embedded in the NSW Health OPMH Program and its services.

The PCLI Stage One service development activities built on previous statewide efforts, particularly modelling and evaluation of mental health aged care partnerships and accommodation options. The development of the OPMH Program and clinical services by NSW Health over the past 10-15 years provided a strong platform^{17,18} as did the establishment of two pilot services within RACFs in NSW.¹⁹ Service development also reflected the innovative work and commitment of some key aged care providers in NSW in developing services and facilities to meet the needs of people with complex mental health needs, including people who were homeless or at risk of homelessness.

An independent evaluation²⁰ and economic evaluation²¹ of the MHACPI pilot services demonstrated that this model can be an effective and cost effective service for the target population, delivering better health outcomes than alternative options. In addition, it delivers high family, carer and staff satisfaction and has the potential to relieve pressure on acute hospitals and mental health inpatient services.

¹⁷ NSW Health. NSW Service Plan for SMHSOP 2005-2015. 2006.

¹⁸ NSW Health. NSW Older People's Mental Health Services Service Plan 2017-2027. 2017.

¹⁹ NSW Health. Summary Report: The management and accommodation of older people with severely and persistently challenging behaviours. 2006.

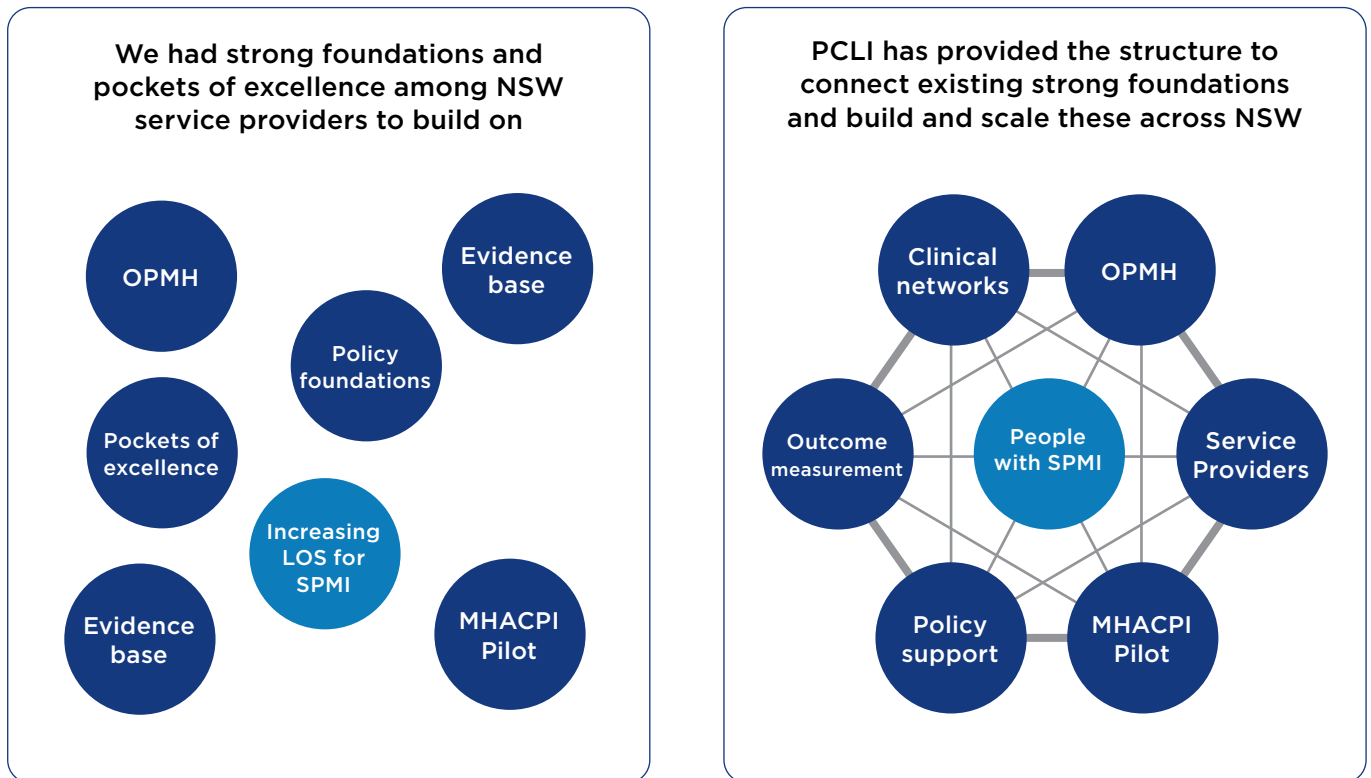
²⁰ NSW Health. Evaluation of The Mental Health Aged Care Partnership Initiative (MHACPI). Health Outcomes International. 2011.

²¹ NSW Health. Economic evaluation of the Mental Health Aged-Care Partnership Initiative (MHACPI). Health Policy Analysis. 2013.

Cross-sector partnerships between health and aged care are central to the PCLI Stage One service models, known as the Mental Health-Residential Aged Care (MH-RAC) partnership services. They were established through a series of steps including a costing study summarising financial outcomes for potential service providers, a procurement plan, and a series of tender processes. All partner organisations are not-for-profit, and most are existing mission-based services with supportive

governance arrangements with the capacity to draw on existing expertise and resources (such as specialist mental health staff, training and leadership) across a broader network of services. As illustrated in Figure 4 the PCLI aimed to harness the existing strong foundations and pockets of excellence among NSW service providers in order to connect, build and scale the approach to care in the community for people with SPMI.

Figure 4: PCLI has used existing foundations and pockets of excellence to build upon



Stage One aged care service models have been funded and progressively rolled out since 2015-16. The full quantum of 80 beds are now commissioned with the selected aged care providers in six LHDs. Contracts are at state level with operational agreements between the LHDs and the RACFs. There are state level/ LHD/MH-RAC benchmarking processes in place and clear reporting and KPI processes.

The “top-up” funding provided by NSW Health is for specialist clinical care within the selected Commonwealth funded RACF. This translates to employment of nurses, occupational therapists and other allied health professionals within the facility to provide additional clinical support to people transitioning to these services. It also supports the attendance at the weekly joint LHD and RACF clinical advisory committee and other key partnership activities described within the operational agreements. The additional PCLI funding to the LHDs supports these RACFs and the generalist RACFs with specialist in-reach clinical support and partnership activities.

These Stage One service models will be sustained through the NSW Health Older People’s Mental Health Program. As noted, PCLI Stage One provides three service models for supported accommodation and care for long-stay patients with issues of ageing. Two of these – the MHACPI transitional units and the SRACFs are provided by the funded aged care partner organisations. Generalist or mainstream aged care facilities are an option for many of the PCLI Stage One people. Figure 5 presents an overview of the Stage One accommodation sites and PCLI workforce. Table 1 presents a summary of the Stage One accommodation types, funding mechanism, target population and key features for each of the three community service models.

Figure 5: Stage One accommodation sites and funded support positions

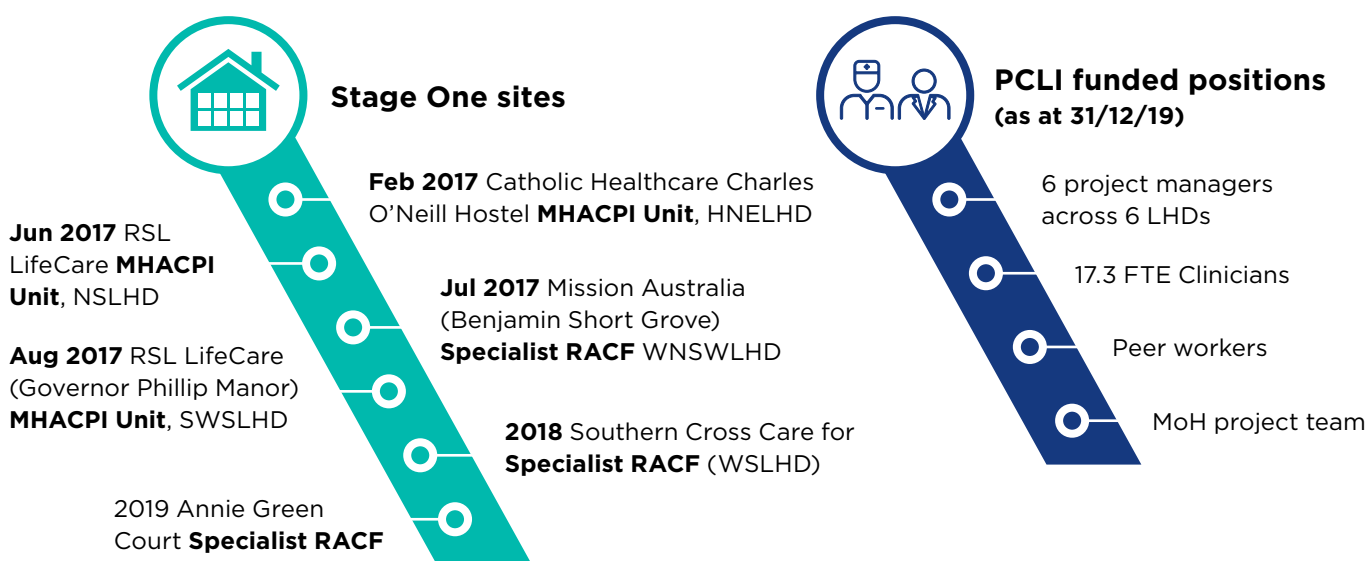


Table 1: Overview of Stage One accommodation types, target population and key features

Accommodation type and funding	Target population	Key features
<p>MHACPI transitional units - 10 beds</p> <ul style="list-style-type: none"> Feb 2017 Catholic Healthcare Charles O'Neill Hostel, HNELHD June 2017 RSL LifeCare, NSLHD Aug 2017 RSL LifeCare (Governor Phillip Manor), SWSLHD Commonwealth funding available for aged care residents. State recurrent funding to support higher staff-resident ratio; LHD specialist clinical and partnership services; and some capital funding to support appropriate physical environments 	<ul style="list-style-type: none"> People with complex mental health needs, including severe behavioural and psychological symptoms of dementia (BPSD), as well as aged care needs 	<ul style="list-style-type: none"> Purpose-designed 10 bed transition units within RACFs, operated by residential aged care providers Specialist consultation-liaison and mental health clinical input/support from the LHD OPMH service Supported transition for patients from the transition unit into other places in the aged care facility, when appropriate
<p>SRACF</p> <ul style="list-style-type: none"> July 2017 Mission Australia (Benjamin Short Grove), WNSWLHD - 10 beds 2018 Southern Cross Care for (WSLHD) 5 beds operational, a further 25 planned Annie Green Court, SLHD - 10 beds Commonwealth funding available for aged care residents. State recurrent funding; to support higher staff-resident ratio; LHD specialist clinical and partnership services; and some capital funding to support appropriate physical environments 	<ul style="list-style-type: none"> People with SPMI, high behavioural needs, aged care needs Includes complex needs including early ageing, disability and/or co-occurring complex health conditions eg. alcohol and other drug dependency 	<ul style="list-style-type: none"> Aged care facilities with environmental design features supporting function, a contemporary, flexible model of care that includes additional clinical management, appropriate supported daily living and social activities, and strong community linkages Specialist consultation-liaison and mental health clinical input/support from the additional PCLI clinicians attached to the LHD OPMH service
<p>Generalist RACF</p> <ul style="list-style-type: none"> General residential aged care facility with enhanced clinical support for episodic illness Commonwealth funding available for aged care residents. State recurrent funding supports LHD specialist clinical services 	<ul style="list-style-type: none"> Older people with mental illness (including moderate-severe BPSD) whose care needs can be met in this environment 	<ul style="list-style-type: none"> Specialist mental health referral and transition support for people with ageing issues and complex mental health needs; and, Ongoing specialist OPMH community consultation-liaison (clinical outreach to generalist RACFs) and mental health clinical input/support as required

PCLI Stage One: a fit-for-purpose workforce

The NSW Ministry of Health has funded PCLI program managers in six Local Health Districts (LHDs), where the majority of long-stay mental health patients reside in NSW public hospitals: Hunter New England (HNE); Northern Sydney (NS); South-Western Sydney (SWS); Sydney; Western New South Wales (WNSW); and Western Sydney (WS). These positions, supported by LHD executive leads formed a statewide team to support the initial implementation of the PCLI. Funding now supports senior PCLI coordinating positions in ten LHDs and St Vincent's Hospital Network; a rural project is developing.

Funding has been provided to employ 17.3 FTE²² senior clinicians in dedicated PCLI Stage One roles. The PCLI-funded OPMH clinicians work within existing LHD OPMH services and are effectively part of OPMH community teams, supporting LHD OPMH service managers. These clinicians assist existing staff and the patients and their families to engage in the suite of PCLI assessments, ensuring improved understanding of a person's wishes, needs and strengths and assisting them to transition to the community. PCLI clinicians also provide in-reach to community services and ensure post-transition assessments are undertaken for two years.

The PCLI clinicians and peer workers have proved highly successful in their role, crossing the paradigm of care between inpatient and community and across both public and community managed sector services. They form a community of practice and contribute to statewide PCLI dialogue days and workshops. The PCLI clinicians and peer workers cross the 'silos' of LHDs and work together, with other expert LHD staff in the best interests of the person with a mental illness who is long-stay or is at risk of long-stay.

The Ministry PCLI team provides strategic direction and resources to support LHDs with implementation. In turn, representatives from implementation sites contribute to statewide task groups such as the PCLI Steering Committee, PCLI Collaborative Group, PCLI Practice Network and MH-RAC Network. The OPMH Services Advisory Group is a mainstay of the PCLI policy environment. It provides advice to the Ministry Mental Health Branch on older people's mental health, facilitating the implementation of the NSW Service Plan for OPMH Services 2017-2027 and statewide OPMH policy directions, and promoting collaboration to support service improvement and service development in OPMH services across NSW. The group has been well placed to support the expansion of MH-RAC services under PCLI and, in particular, their integration within the OPMH Program and OPMH services.

²² As at 31 December 2019.

PCLI Stage One: system enablers to support practice change and sustainability

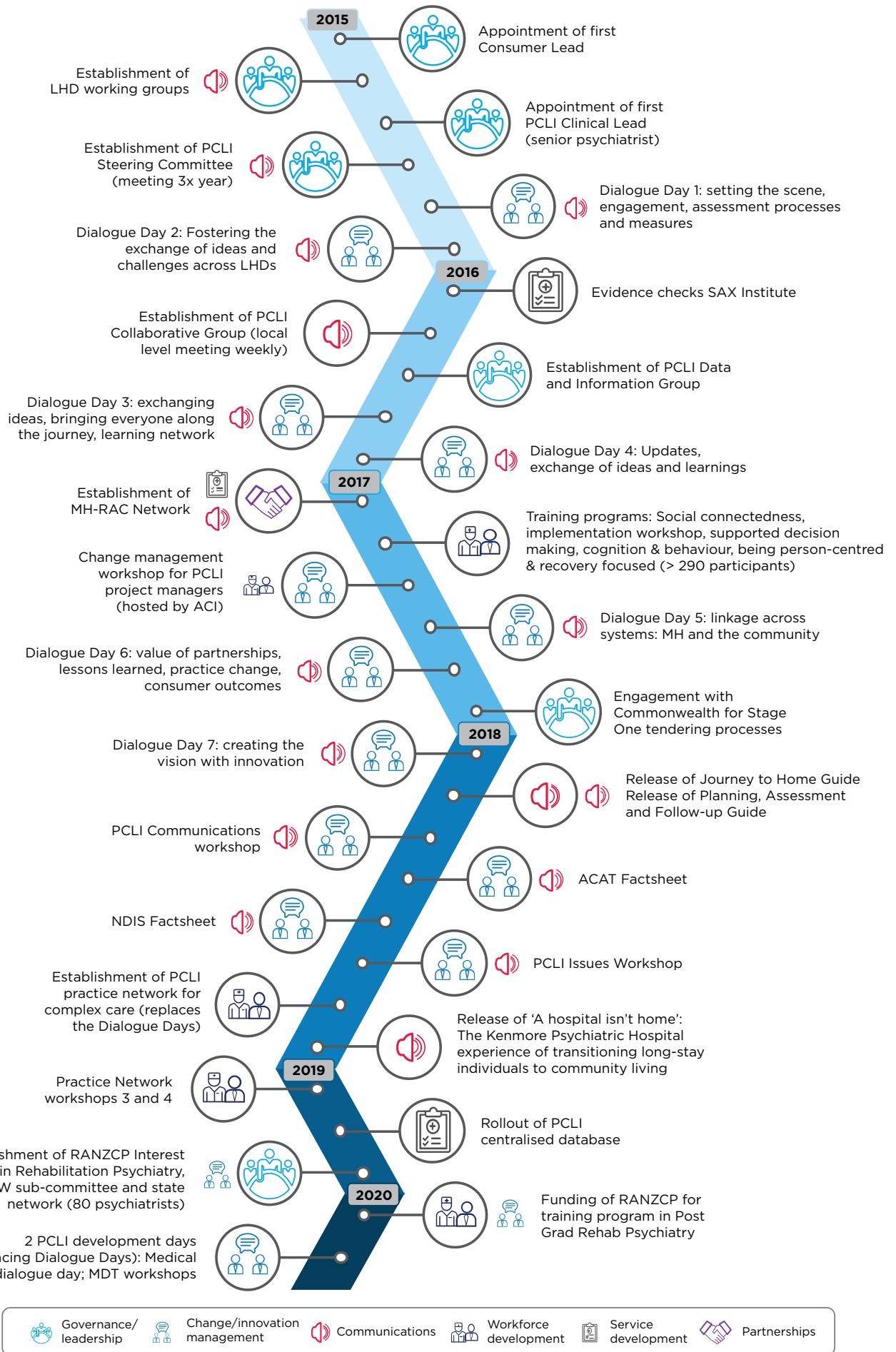
A structured change management and implementation approach has provided the foundation for Stage One service development and practice change. The foundation for PCLI Stage One has been provided by existing OPMH policy, program and services. These foundations have provided a platform for several key enablers to guide activities to support practice change and the ongoing sustainability of the Stage One PCLI program:

- **Governance and leadership:** establishment of governance structures and leadership roles at the State, partnership and local level to guide program development and implementation.
- **Change and innovation management:** support for change and innovation is a feature across all program components. Ongoing identification and opportunities for discussion about issues and risks support collective development of innovative solutions to address problems. It is important to note that change management is a constant and an essential element in supporting partnerships to deliver high quality care in a continually challenging and evolving environment.
- **Engagement and communication:** ongoing engagement and collaboration with key stakeholders, including clinicians, is crucial to successful program implementation, as is articulating the new service models and their place within the OPMH policy and planning documents. Mechanisms to support this engagement include workshops, dialogue days and regular meetings. PCLI and MH-RAC service models have been deliberately promoted and communicated to aged health and aged care services across NSW through annual Aged Health Collaborative Forums hosted by NSW Health. Additionally, a range of communication tools and processes have been developed to help support statewide dialogue. The PCLI website²³ includes updates, patient story films, clinician, person and family resources and documents. The development of guidelines for clinical and transition processes provides a foundation for consistent practice.
- **Workforce development:** the MoH PCLI team together with LHD PCLI staff continue to monitor training needs of staff and provide support as required. A complex care PCLI Practice Network has been established to support workforce development and improve practice and innovation, as do the MH-RAC Network meetings and collaboration. Workshops, dialogue days, presentations and local training opportunities are designed to support workforce development.

Figure 6 provides a snapshot of the key system enablers 2015 – 2020 supporting the PCLI approach to practice change and sustainability.

²³ <https://www.health.nsw.gov.au/mentalhealth/Pages/services-pathways-community-living.aspx>

Figure 6: Stage One system enablers 2015 to 2020



Stage One evaluation approach

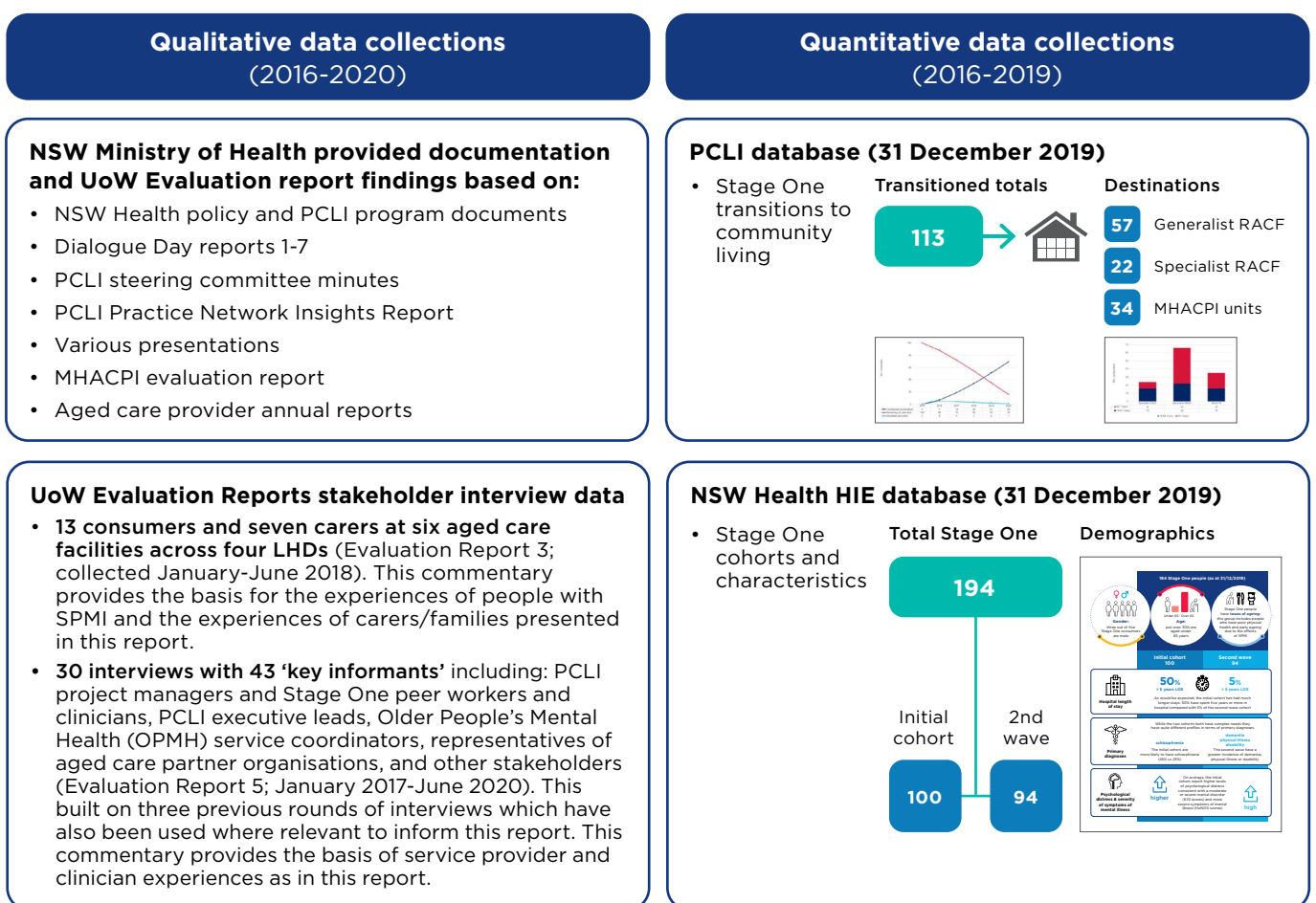
In January 2017, the Centre for Health Service Development (CHSD), University of Wollongong (UoW),²⁴ was engaged to evaluate the PCLI, with the following goals:

- To help consumers, carers, clinicians, managers and policy makers assess the impact of the PCLI and the extent to which it is meeting its objectives;
- To identify opportunities to refine the PCLI, and
- To inform future investment and practice.

The design of the evaluation was largely driven by the PCLI Program Logic Framework developed by the NSW Ministry of Health and endorsed by the PCLI Steering Committee.

The quantitative and qualitative data sources cited in this Summary Report are primarily derived from the NSW Health: Health Information Exchange (HIE), the PCLI database, interviews conducted by the evaluation partner (UoW) and PCLI program documentation. These are summarised in Figure 7.

Figure 7: Evaluation data sources



NB: Cost data for the economic evaluation was provided by the NSW Ministry of Health and MH-RAC partner organisations. All data analysed for the purposes of this report was de-identified and case studies presented in this report have used pseudonyms.

²⁴ For the purpose of this report the Centre for Health Service Development (CHSD), University of Wollongong is referred to as the 'evaluation partner'.

Part 2. Evaluation findings

Case study 2



Nancy's story



Planning your move

- Visualising a more meaningful life
- Planning to leave hospital
- Preparing to leave hospital



Making your move



Your community life

- Settling in and developing a meaningful life



MHACPI then
Generalist RACF

Nancy is a 62 year old woman with a diagnosis of schizoaffective disorder co-occurring with mild intellectual disability, chronic physical illnesses including ageing-related issues with constant anxiety and marked behavioural disturbances. When Nancy is upset or anxious she can become aggressive, for example by throwing food and crockery at meal-times.

She has been living in hospital for 25 years, mostly in high-care, long-stay units.

Nancy told staff that she was unhappy in hospital because she missed her family and was lonely. Subsequent discussions have helped to better understand her feelings and involve her family in her care.

With the PCLI staff a family case review confirmed that all parties had Nancy's best interests at heart and that there were aspects of her care that were difficult in hospital.

Nancy's sister developed increasing trust in the process and both she and Nancy became meaningfully engaged in decision-making and planning for Nancy's future.

The set of PCLI assessments helped inform decisions about what kind of accommodation and supports would enable Nancy to live with a higher quality of life.

The MHACPI clinical and community transitions teams prepared individual plans to support Nancy in her new environment including a behavioural management plan.

Given that Nancy was travelling out of area, the teams negotiated for an extended trial leave period of 28 days. This was to give sufficient time to settle in, allow greater communication between teams and enable transfer back to a familiar setting and support team if required.

Almost immediately there were obvious signs that the level of stimulation and the approach of staff at MHACPI was supportive for Nancy. Since moving to the MHACPI, she has eaten all her meals in the communal area.

There have been episodes of vocally disruptive behaviours however this has not affected Nancy's ability to engage in a number of previously enjoyed activities.

Through the diversional therapy program she is being assisted to identify new interests and expand her social network within the facility.

In late 2020 Nancy transitioned to a generalist RACF. Nancy no longer needs any care coordination from the MH service. She is well supported by her GP, NDIS, the RACF and her amazing family!

Improved health outcomes and experiences for people with SPMI

Community living is the long-term ambition for people who experience complex and enduring mental illness.

It is well recognised that people with severe and persistent mental illness experience better quality of life and improved health and social outcomes if they can maintain living in the community.

Mental illness and in particular severe mental illness, requires person-centred, integrated care across multiple services, providers and setting.



Summary of key findings

- As at 31 December 2019, 113 Stage One long-stay patients were living in the community.²⁵
- Just over 50% of people were transferred to generalist residential aged care facilities.
- While the PCLI has seen the discharge of people with very long stays and complex needs, statistical analysis suggests that those long-stay patients with a shorter LOS and higher self-care needs were more likely to be discharged. This finding provides powerful evidence to support the ultimate ambition of the PCLI to prevent the build-up of long stay patients in the future.
- Health outcomes for people following discharge were generally positive.
 - Psychological distress following transition to the community improved slightly and significantly improved life skills, particularly self-care, compliance, and anti-social behaviours.
 - Functional declines in activities of daily living and increased impairment over time in relation to cognition, physical illness, or disability in people aged over 65 years was evident. These findings may be as a result of the normal process of ageing.
- Most people were regularly followed up in the community after discharge by the older person's community mental health teams with support of the PCLI teams.
- The requirement for unplanned acute care facilities indicated that this group of people are doing well in the community. Hospital readmissions and presentations to the emergency department were uncommon. Twenty patients (16.9%) had short admissions to specialist mental health units as required (e.g., to stabilise medication) and 36 (30.5%) had an admission to a general hospital for physical healthcare needs. There were only 16 presentations (by seven people) to the emergency department.
- Experiences of people interviewed highlighted improved engagement, choice and control in their daily lives following their transition to the community.
- Most people interviewed identified that they were better able to engage in community activities, and live fuller and more meaningful lives in less restrictive environments in the community.

²⁵ Health data from 2020 shows that this number continues to grow.

Key findings discussion

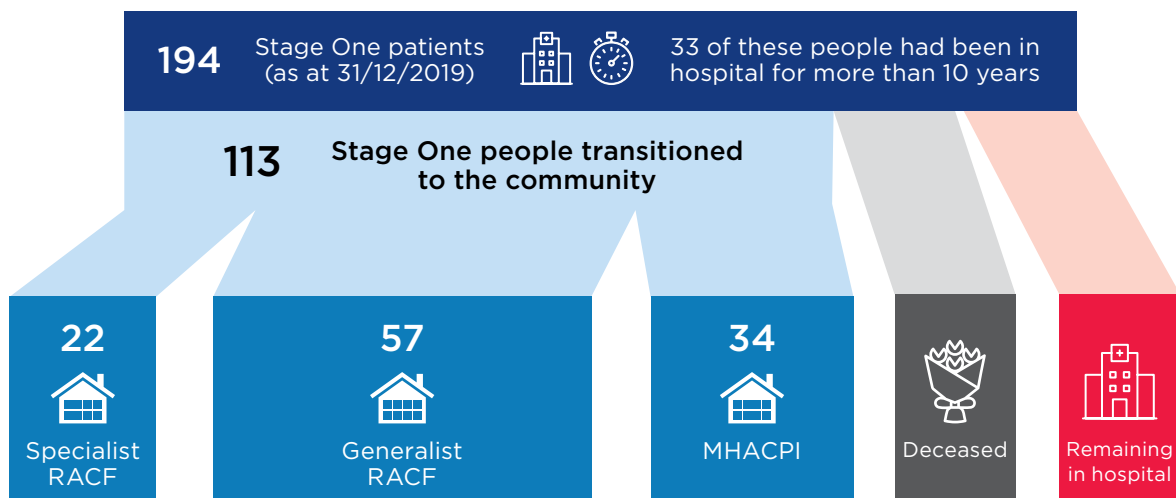
Transitions to community living

Given the right understanding, services, supports, and the right transition processes, people with SPMI who have experienced long stays in hospitals can live successfully in the community.

The Stage One PCLI cohort at December 2019²⁶ comprised 194 people with SPMI. Figure 8 shows that of this cohort, 113 people had transitioned to community living. Community living destinations consist of a range of places. Fifty-six people have transitioned to specialist accommodation offered by MH-RAC partners (22 people to specialist residential aged care facilities and 34 people to MHACPI units) and 57 people have transitioned to generalist residential aged care facilities.

Accommodation offered by MHACPI units are intended as transitional accommodation facilities to support people in their rehabilitation before final transition to a less specialist aged care community facility (usually in the same aged care facility). The UoW evaluation indicates that eight of the people who initially transitioned to MHACPI facilities have moved through to generalist aged care facilities or to other suitable accommodation. There is no designated length of time that a person can spend in a MHACPI unit, but the model is designed to include an active focus on transition out, and to monitor length of stay. For people who had transitioned to MHACPI accommodation the average length of stay was between one year and one year and three months. This includes PCLI Stage One people who have been discharged from the MHACPI and those whose stay continues (as of 31 December 2019). In SRACFs the average length of stay since transition from hospital was one year (367 days, SD 316 days). It is worth noting that transitions to SRACFs (to December 2019) have been slower to progress due to the requirement for redevelopment into a purpose-built facility.

Figure 8: Stage One community living destinations on discharge



²⁶ July-Dec 2019 NSW Health PCLI Outcomes Report.

Key factors predicting discharge

Two factors were found to significantly contribute to discharge from hospital for the Stage One cohort:

- **Length of stay:** As Figure 8 indicates, PCLI has successfully discharged people with very long stays and very complex issues. This achievement is important to recognise in light of analysis of the total transitioned cohort who had transitioned by the end 2019. The UoW statistical analysis indicated that the longer the stay in hospital, the lower the chance of eventual transition to the community: for every additional six months in hospital the likelihood of discharge decreased by 7.5%.
- **Self-care capacity (as measured by the LSP-16)²⁷:** was also an independent predictor of discharge status. People with the most severe self-care problems on the LSP-16 (including cognitive problems, physical illness or disability problems) were the most likely to be discharged to the community. It was suggested that this has been made possible through the establishment of partnerships between PCLI and the aged care providers and reflects the specialist nature of care now available to people with high self-care needs.

Hospital readmissions and presentations

Following transition to the community, 20 people (16.9%) had short admissions to specialist mental health units (e.g., to stabilise medication) and 36 people (30.5%) had an admission to a general hospital for physical healthcare needs. There were only 16 presentations to hospital emergency departments, involving seven patients. Together, these data indicate that health crises were rare and in general people were faring well in the community, despite their complex needs and history of institutionalisation.

Key informants also reported that there had been fewer readmissions to hospital than expected and less reason for people to require health intervention. When readmissions did occur, the person was usually discharged much faster than they had been in the past. Several key informants observed that people were less likely to need PRN medication²⁸ than they had previously, which they attributed to a “more calming, relaxing environment” in aged care compared with hospital.

Studies evaluating supported accommodation have reported reduced inpatient service use for people with more complex and longer-term mental health problems. One study using the Danish national health register to investigate inpatient days for people before and after a move to supported accommodation found a large reduction in inpatient days, with the average number of inpatient days being 167 days in the year prior to move vs. 27 days in the year after.²⁹

²⁷ All assessment tools and measures noted in the report are standardised and validated tools. For further detail see page 20 of The PCLI Planning, Assessment and Follow-Up Guide on the PCLI website.

²⁸ This is defined as ‘pro re nata’ medication – where medication is not scheduled but taken as needed.

²⁹ Nordentoft M, Pedersen MG, Pedersen CB, Blinkenberg S, Mortensen PB. The new asylums in the community: severely ill psychiatric patients living in psychiatric supported housing facilities. A Danish register-based study of prognostic factors, use of psychiatric services, and mortality. *Soc Psychiatry Psychiatr Epidemiol.* (2012) 47:1251-61. doi: 10.1007/s00127-011-0432-2.

Follow-up after transition

Continuity of care following transition is an important component of successful community living for individuals and one of the key PCLI enablers³⁰ is the emphasis on at least two year follow-up. Each person transitioned out of a mental health inpatient facility following a long stay is expected to receive follow-up visits at six monthly intervals for a period of two years to monitor physical and mental health and prevent further readmissions. This is in addition to, but incorporated with, usual transfer of care practices.

The UoW reported that the HIE data showed that most PCLI Stage One people were visited regularly by the older people's mental health community team following discharge, on average every 25 days. However, 12% of the PCLI Stage One people in the initial cohort and 17% of PCLI Stage One people in the second-wave cohort did not receive any community mental health follow-up.

Health outcomes

Most people did not have high levels of psychological distress in hospital or in the community, indicated by K10 scores at baseline and first follow-up. There was a slight improvement at follow-up, which was not statistically significant.

On average, there were statistically significant improvements on the LSP-16 overall and for the self-care, compliance, and anti-social behaviour sub-scales, meaning that PCLI Stage One people had fewer problems with these life skills once they had moved into the community than they had experienced while they were in hospital.

However, people did become more dependent on others for assistance with activities of daily living, with an increase in their average total scores on the RUG-ADL and the 'bed mobility' sub-scale.

After discharge, PCLI Stage One cohort scores for the 'impairment' sub-scale of the HoNOS 65+ increased significantly. This tool would have been used with the oldest Stage One people, and the finding indicates increased impairment over time in relation to cognition, physical illness, or disability possibly due to the ageing process. The overall potential for physical improvement for people in the Stage One cohort is limited by normal ageing as well as early onset ageing issues and the consequences of mental illness and treatments.

Deinstitutionalisation studies, in the main, report positive outcomes. Most individuals are successfully discharged from long hospital stays to community settings without any clinical deterioration.³¹ Evidence demonstrated that transition to community living is beneficial with findings across various studies showing that most patients were clinically stable in the community with improvement in positive symptoms of psychosis, social functioning, and challenging behaviours at final follow-up.

³⁰ PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services – this policy directive refers to processes and procedures relating to patients under the PCLI.

³¹ Dalton-Locke C, Marston L, McPherson P and Killaspy H (2021). The Effectiveness of Mental Health Rehabilitation Services: A Systematic Review and Narrative Synthesis. *Front. Psychiatry* 11:607933. doi: 10.3389/fpsy.2020.607933.

Experiences of people with SPMI

It is important to acknowledge that each person will experience the journey to community living differently. People who have been in the same facility for a long time are not a homogenous group. They are all ages and have different wishes and abilities as well as different levels of risk.

Interviews undertaken by the UoW in 2018 highlighted improved mental health and wellbeing for people who had transitioned to the community. Many of the PCLI Stage One people and their families who were interviewed for the evaluation had experienced long periods of illness and institutionalisation. Some had been engaged with the mental health system for more than 30 years; in one case, a person (whose carer was interviewed) had been in and out of institutions for almost 60 years.

The experiences of Stage One people interviewed has been summarised below under four key themes:

- Engagement, choice and control
- Physical and mental health
- Social participation
- Wellbeing and quality of life



Engagement, choice and control

When asked about whether they had a choice about their involvement in the PCLI and where they might be placed, most people and carers thought they may have had a choice, but they were not sure.

Following transition to the community, many people expressed an ability to have greater choice and control of their life, being able to make decisions about their day-to-day activities and interests. It was noted that those with greater impairments due to ageing and disability had relatively little personal capacity to make choices. Many people had some type of guardianship orders either with carers or with the state. There was evidence, however, that following transition some effort was being made to assist people to make decisions within their capacity.

Completing the PCLI assessments did not seem to be a burden for people. Most of the people the evaluation partner spoke to did not recall doing assessments. Some had a vague recollection but did not really know what the assessments were for.

People who had transitioned to community living were more likely than carers to say that the community setting was probably safer than the hospital. People especially appreciated feeling safe around other people in their home and in their neighbourhood.

A lot of people were introduced to their new community living service in a stepped or staged way, with a number of short visits before moving in which helped alleviate much of the anxiety for people with SPMI and carers.

Many people and their carers spoke about how they, or their loved one, liked having their own space and their own things. A few also spoke



I was slightly nervous, but really looking forward to moving forward and getting out of hospital.

about the improvement in comfort in having their own bathroom and the freedom to add their own furniture. Most had not had such facilities and opportunities to personalise their spaces while in the hospital setting.

Two Australian studies^{32,33} found that patients were more satisfied with their living arrangement in the community when compared to hospital.

People with SPMI and their carers highlighted increased family engagement and the availability of spaces to spend time together in the community.

When asked whether the PCLI people were treated with dignity and respect, interviewees overwhelmingly agreed. They had considerable praise for the skills and compassion of aged care and social care staff members. People who had transitioned to the community regarded this domain as one of the most important in terms of influencing their overall quality of life.

There is strong evidence that PCLI Stage One implementation sites are trying to facilitate people to have choice and participate in decision-making, consistent with mental health recovery orientation.

³² Hobbs C, Tennant C, Rosen A, Newton L, Lapsley HM, Tribe K, et al. Deinstitutionalisation for long-term mental illness: a 2-year clinical evaluation. *Aust N Z J Psychiatry.* (2000) 34:476–83. doi: 10.1080/j.1440-1614.2000.00734.x

³³ Chopra P, Herrman HE. The long-term outcomes and unmet needs of a cohort of former long-stay patients in Melbourne, Australia. *CommunityMentHealth J.* (2011) 47:531–41. doi: 10.1007/s10597-010-9351-z



Physical and mental health

People and their carers were asked about changes in their physical and mental health since transitioning to the community. For some people, the move had resulted in a dramatic improvement.

A couple of people found that with improved living and social environments they were able to work more effectively with their doctor to review their medications which they reported further improved their mental health.

For one person interviewed, their mental health had declined, and their carer attributed this to the progression of their illness.

Some people and their carers reported declined physical health since transition. This, however, was mostly due to the natural process of ageing rather than due to the changes in accommodation and support.



Social participation

Increased social engagement both in and outside community accommodation settings was highlighted including making new friends, enjoying going out for a coffee or to the shops and reengaging with favourite sporting pursuits.

People living in community settings reported that they had more meaningful things to do, felt that their life was more significant now than previously, and took pride in new achievements.

People who were living more independently also appreciated the practical help that was available, often through NDIS support packages.



Wellbeing and quality of life

People clearly enjoyed having their own private spaces that they could personalise and retreat to. Both they and their carers saw this as very important for their wellbeing. Some were able to talk about and show off their personal space with pride.

The move from hospital to the community had changed some people's perceptions of themselves and what they could achieve in life. Others were simply happy to be out of the hospital system.

Outings were also more prevalent in the more flexible community settings than they were in most hospital settings, and there was flexibility to use NDIS or other support funding to gain community access (as applicable). This extra support and freedom to go out and engage in activities could potentially help people rediscover things they were good at and/or enjoyed in the past.

A few people spoke about future goals and their personal strategies for keeping track of them.

Improved experiences for families and carers

The families, carers and communities of people with SPMI are important players in the transition to community living.

Carers and families are key partners in all aspects of treatment, care and recovery planning. Involving and providing them with key information is an important part of the decision making and transition process.



Summary of key findings

- Carers highlighted an improvement in the overall health and wellbeing of their person following transition.
- Prior to transition carers were more likely to be concerned about their person leaving hospital however any fears were generally alleviated once the person was settled in their new environment. Carers were very positive about the overall comfort and suitability of their person's new living environment.
- Carers spoke about improved relationships with their person and greater opportunities for family and community engagement.
- For carers, a number of issues remained unclear, including the financial implications of transition or implications if their loved one required periodic hospitalisation.
- Some carers were concerned about their own ageing and the potential additional caring role that may be required of them.
- Carers were very happy post transition and could see the positive difference that transition had made to their person including the opportunity to live a more meaningful life and engage in a variety of interesting activities.

Key findings discussion

This section of the report is based on the findings of the UoW evaluation partner from interviews undertaken with carers during July - December 2018.

Some carers spoke about how the system (prior to PCLI) had caused trauma for them and their loved one and/or exacerbated their 'burden of caring'. There were frustrations in regard to the side effects of treatments. Leaving their loved ones in long-stay wards of mental health facilities - some of which were old and rundown, with other very unwell people - had been difficult and traumatic for most carers.

Carers were much more likely to be apprehensive about the transition to community living. They worried that their person might become unsafe or unsettled or may not be cared for as well as they had been in hospital. After seeing the person's potential new home, carers became more supportive of the move. They were reassured by the environment and the professional support available.

The transition to community living had facilitated closer engagement of carers and, in some cases, improved family relationships. Staff of the aged care facilities had encouraged and supported family contact. In turn, carers appreciated that they now had fuller access to their loved one's home than they had previously.



Engagement, choice and control

Carers interviewed were unsure if their person had a choice about their involvement in the PCLI process and where they might transition to, however most thought they may have had a choice.

Carers generally reported that opportunities for their person to engage in meaningful activity had increased since transition to community living. Aged care providers had created a variety of innovative and engaging activities for their residents, including contact with animals, gardening and even odd jobs.

Many carers spoke about how they, or their loved one, liked having their own space and their own things. Carers appreciated having comfortable common or shared rooms they could use when visiting and compared the accommodation favourably with the much older hospital facilities. Carers felt it had been worth the effort to find a better home for their person.

For carers, an important criterion was proximity to their own homes. Most carers reported that their person was now living much closer than previously, which made it easier to visit regularly. However, for some distance remained a barrier.

Carers had hopes that their person would have a more fulfilled and happier life in future. They longed for a settled home for their person and felt that community living offered possibilities that had not been available in hospital.

Overall, people transitioned to the community and carers appeared to be very happy with the outcomes of the transitions they had achieved through the PCLI.

“

I think the best thing was having his own room... he's got photos on the wall and I bring him different things.

“

...the fact that she could transition for periods of hours and half-days and then days and then eventually a sleepover, I think was perfect. It means that it wasn't a jolt change for her.



Engagement with care/care persons

Most carers reported an increase in their level of involvement in their person's care post transition. Some appreciated this increased level of contact, and for others it was stressful.

Carers reported how aged care staff demonstrated caring approaches to reassure people and help them settle in to their new home.

Overall, carers tended to trust aged care staff to have the required expertise, to make the right decisions and to provide appropriate care for their person. There was also a level of ongoing anxiety for some carers, who felt they could never be sure how staff treat their person when they were not there.

Some carers felt there should be staff on the site with mental health qualifications, or that their person might benefit from the help of a psychologist. Others thought that the physical needs, mostly associated with ageing, were now more prevalent than the psychological needs of their person. Some carers indicated that they would like more information about their person's condition and what to expect in the future.

Although carers had greater peace of mind, knowing their person would be well looked after, most still chose to visit as often as they could. The caring role remained quite draining for some. Nevertheless, carers spoke about how they felt supported and included by the staff of aged care facilities when they visited.



Security and safety

Carers reported that they felt that the level of safety and security in the aged care setting was comparable to the hospital environment.

At the time of reporting, some carers were concerned about the 'temporary' status of the transition from hospital to the MHACPI facilities, while others welcomed this as a stepping stone to long term settlement in the community.

It was clear from talking to carers that previous transitions between hospitals or from hospital to unsuccessful community placements had caused them considerable stress in the past and had affected their own health and wellbeing. For some, the PCLI transition had initially increased their anxiety. However, this stress was alleviated now that they felt their person was in a stable, secure situation and was better off than they were in hospital.

In a few cases, the financial burden of caring appeared to have worsened since the transition to community living. The potential for negative impacts (e.g. burden of caring, financial stress; issues of ageing) on some carers requires further investigation to understand who may be vulnerable and identify the best ways to assist these carers.

The 2011 MHACPI evaluation reported, from the perspective of families and carers, the strength of community living facilities included:³⁴

- Improved quality of life for the person
- Good communication between staff and families/carers
- Person-centred approaches to care and high quality of care provided by staff.

³⁴ NSW Health. Mental Health Aged Care Partnership Initiative Evaluation Summary Report. June 2011.

Improved experiences for service providers and clinicians

Service providers and clinicians are critical players in achieving appropriate individualised high-level mental health services and support in the community for people with SPMI.

The PCLI aims to establish care pathways, practices and agreements between MH services and CMOs for the transition of people from hospital to the community, including the ability of individuals to move back and forth between facilities and services for treatment as required.

The overarching ambition of the PCLI is to embed cultural change that will drive sustainable practice changes among MH services and CMOs to decrease future long admissions. A designated and devolved

leadership approach has been actively pursued: shared, collective and extended leadership practice explicitly aimed to authorise ownership of reconfigured services to providers across the landscape and to build local capacity for change and improvement. Achieving the ambition of the Stage One of the PCLI has depended critically on cross-sector partnerships with aged care to deliver tailored service pathways, and on engagement and empowerment of providers across the landscape.



Summary of key findings

Durable, effective and sustainable partnerships with aged care providers are operating across NSW

- The PCLI has successfully brokered partnerships at the interface of mental health and aged care providers.
- Strong mechanisms and processes have been implemented to support, curate and sustain these partnerships in what has historically been a siloed environment.
- Successful development of sound working relationships between LHDs and the aged care services with which they are partnering has been a key driver of the success of Stage One transitions.
- The partnerships developed with aged care providers under Stage One of the PCLI provide important lessons for the ongoing partnership developments that are occurring within the program. Successful partnerships have occurred when the following elements are in place:
 - o A shared commitment to the overall program goals;
 - o Person-centred philosophy of care/support;
 - o Program infrastructure with appropriate staffing capacity;
 - o Agreed processes for oversight and ongoing support;
 - o Trust between individuals and organisations.
- A recurring theme in the stakeholder interviews has been the central role of trusting, respectful and responsive relationships that is required to sustain people in the community and prevent inappropriate readmissions to hospital.

Engaging and empowering stakeholders

- Early in implementation, stakeholders perceived the need for the PCLI, which reflected positively on the context for change. However, engagement was mixed: with allied health generally well engaged from the outset, and a more mixed picture evident for engagement of nursing and medical staff.
- Over time, PCLI engagement, change and support strategies have seen substantial momentum in nursing and medical staff engagement, and aged care staff reporting that they firmly believe that the PCLI has resulted in improved quality of life and outcomes for those who have been transitioned.

Cultural change

- One of the key goals of the PCLI at the system level is to establish a culture of recovery. The evaluation data reported improving attitudes to the PCLI program among treating teams over the course of implementation, indicating that culture change is occurring, building on existing practice, and that it is driving attitude and practice change.

Key findings discussion

Durable, effective and sustainable partnerships for aged care service models are operating across NSW

All sites appear to have experienced difficulties at the outset of the program, primarily due to limited understanding of the operational parameters, accompanied by cultural and even language differences between care settings.

The systems and processes of the PCLI and the MH-RAC service models (standardised assessments, clinical advisory committees, additional funding, specialist education and support, etc.) have provided a cohesive framework to guide the partnership arrangements. Partnerships between aged care services and health are fostered through formal and informal processes. These systemic enablers have underpinned the development of strong working partnerships between LHDs and aged care partners. The UoW evaluation indicates that partnerships have been facilitated by three key elements:

Leadership

- The evidence-based and collaborative approach to developing the MH-RAC services under the leadership of the Older People's Mental Health policy team has provided a robust program framework that articulates the various roles and responsibilities associated with implementing Stage One transitions.
- A partnership approach has been in evidence since the outset of the program.
- The MH-RAC Network (established in 2017 and convened by the Ministry) has provided cross-sector leadership through information sharing, capacity building and benchmarking for the wider Older People's Mental Health aged care service network.
- Local leadership in both the OPMH services and the aged care services, nurtured through a distributed and devolved approach by the PCLI, has emerged.

Resources and infrastructure

- The Ministry has worked closely with representatives of aged care partners in the development, funding and implementation of new and/or refurbished services to support Stage One people.
- At the service level, formal Memoranda of Understanding (MOUs) developed between LHDs and MH-RAC partners, set out the expectations and obligations of all parties, as well as the clinical and operational support that was to be provided.
- The structured processes/agreements, supported by joint clinical advisory committees, have provided a context within which issues can be discussed, challenges identified and collaborative responses developed. This has fostered a sense of trust and respect across sectors.
- In the main, aged care partners reported finding these processes to be highly valuable in terms of equipping staff with the skills and strategies to identify and address any emerging issues that have the potential to escalate and lead to readmission to hospital.

Responsive and receptive aged care context

- The aged care services have a person-centred care focus; their capacity to support clients to live with a sense of autonomy, taking a more holistic approach to care, has allowed them to address some important clinical and quality of life elements for people that were not available within hospital settings.
- Aged care organisations in formal partnerships with the PCLI have a history and familiarity in supporting people with mental illness, homelessness and/or behaviours associated with dementia.
- Their experience, organisational processes and tolerance for risk for individuals (and their acknowledgement of the ‘dignity of risk’) have enabled the transitions to be relatively streamlined. The providers’ willingness and confidence to work with risk and the dignity of risk in part reflects their own organisational mission and experience. It has likely also been bolstered by their partnerships and collaboration with local LHD MH services, providing the security of having specialist assistance available as needed.

A continued focus and investment in these three areas is essential to maintaining strong partnerships operating in an ever evolving environment and provides the structure to address challenges and issues in a timely manner.

Changes in practice to decrease future long admissions

A challenge for practice change has been and continues to be that it cannot be a “one size fits all”. There does not appear to be a standard way of transitioning a long-stay person to the community, either across sites or within a particular site. However, evaluation findings have noted that achieving appropriate accommodation has become less challenging as time evolves. In part this reflects that more recently there has been a greater emphasis on pre-matching the proposed accommodation with the person’s needs before they are invited to visit. PCLI has also provided structures and resources to accelerate change and improve discharge processes.

Improved availability of expertise and skills

The PCLI program managers are tasked with the vital role of program implementation and capacity building across LHD inpatient mental health, community mental health and aged care partnerships.

PCLI staff continue to build capacity of staff working in partner aged care facilities through training, mentoring and clinical review processes. Capacity building activities have been tailored to the needs and operational processes of individual care facilities. Capacity building activities support consistency in practices and address emerging issues and staffing changes. While aged care partners recognised the importance of consistency in staffing for PCLI people, they nevertheless acknowledged the need for a broader group of their staff to be skilled in mental health, particularly for purposes of staff relief, turnover and overall sustainability.

A commitment to local leadership has been articulated from the early days of the PCLI. The Ministry provides the necessary resources, strategy, and governance structures, the local LHD teams act as “champions” for the PCLI to drive change within mental health services. Evaluation findings identified that when the PCLI is across both inpatient and community it has brought teams together.

Culture of recovery

One of the key goals of the PCLI at the system level is to establish a culture of recovery.

Recovery-oriented practice³⁵ is defined as the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

Recovery-oriented service delivery is evidence-informed treatment, therapy, rehabilitation and psychosocial support that aim to achieve the best outcomes for people’s mental health, physical health and wellbeing.³⁶

Early in the implementation of PCLI, stakeholders regularly used the words ‘growth’ and ‘hope’ when talking about PCLI people, and also referred frequently to what people ‘want’. This language suggested that the PCLI was, from the outset, associated with a broad, humanistic definition of recovery orientation. Early success was able to foster the shift from ‘recovery’ of long-stay mental health people as a theoretical concept; it was being seen and heard in reports back from transitions. This is likely to reinforce and encourage further innovation and efforts to embed recovery orientation in usual practice.

The UoW evaluation reported improving attitudes to the PCLI program among treating teams over the course of implementation, suggesting that culture change is occurring and driving attitude and practice change:

- Inpatient staff were reported as being less likely to see hospital as a person’s long-term home, alongside a growing realisation that people can receive the care and support they require and lead a more fulfilled life out of hospital.
- There is strong evidence that PCLI Stage One implementation sites have been facilitating individual choice and participation in decision-making, consistent with mental health recovery orientation.
- At the LHD level, an appetite for change among some stakeholders is becoming more evident. Staff reported that it is increasingly common that, as staff identify people that are coming up to the 365-day length of stay, they start liaising with the PCLI clinician and initiate discussion about the current discharge barriers and consider accommodation models.

Improved Collaboration

PCLI teams in the LHDs are taking care to deal with inpatient staff members with great sensitivity, to demonstrate respect for their expertise and knowledge of the PCLI patients, and to consult them regularly as they work towards appropriate and sustainable transitions. In this way, the PCLI teams are establishing transitions to the community as a common goal, achievable through collaboration.

³⁵ Commonwealth of Australia, 2013. A national framework for recovery-oriented mental health services: Guide for practitioners and providers.

³⁶ Victorian Department of Health 2011, Framework for recovery-oriented practice, State Government of Victoria, Melbourne.

Provider/partners/staff experience

Effective engagement of stakeholders across all settings – LHD mental health inpatient, community mental health and aged care providers – has been an important foundational target of the PCLI change management strategy.

The UoW evaluation reported that, early in the implementation process, staff at the first six sites to participate in the PCLI suggested that LHD stakeholders understood and accepted the rationale for the PCLI. The vast majority agreed or strongly agreed with the statement that *People with complex mental illness can and should be supported to live in the community* and supported that:

- The PCLI will promote development of community services for people with complex mental illness.
- The PCLI is the logical next step in mental health reform.

These findings suggest that, early in implementation, stakeholders perceived the need for the PCLI, and reflected positively on the context for change.

Early engagement was, however, mixed. The general picture across LHD sites was that, within the inpatient settings, allied health (social workers, occupational therapists, psychologists) are well engaged with the PCLI, whereas the situation with regard to nursing staff was more varied, particularly regarding the strength of their recovery orientation. At the same time, it was reported that the clinicians with the least engagement with the PCLI appeared to be medical staff, despite examples of excellent medical leadership.

Successive evaluation reports to date document the considerable thought, resources and energy devoted to capacity building, workforce development, and facilitation of practice improvement and innovation to support implementation of the PCLI and promote sustainability (refer Figure 6 Stage One system enablers). The success of these engagement, change and support strategies has been evident in the evaluation findings:

- There are now signs that doctors' engagement in the PCLI is improving. This has been facilitated by stronger clinical leadership and by the increased, regular presence of PCLI clinicians (and, wherever possible, peer workers) in multi-disciplinary team meetings.
- Nurses are taking greater responsibility and getting more involved in transition planning with the support of the PCLI clinician.
- Allied health staff are seen as having a critical role in preparing people for community living; they remain commonly viewed as the inpatient staff members 'most on board' with PCLI.
- Aged care staff report that they firmly believe that the PCLI has resulted in improved quality of life and outcomes for those who have been transitioned.
- Provider perceptions now suggest reduced stigma, discrimination and misunderstandings about mental illness (in the aged care sector) and about ageing (in the mental health sector).

Improved efficiency and effectiveness of the system

The PCLI aims to deliver value-based healthcare through integration across settings, bringing together health, mental health and community-based services to support people with SPMI to live well in the community.

The PCLI Stage One has resulted in the establishment of contemporary and integrated models of care to meet the needs of people with SPMI and issues of ageing, substantially increasing the capacity and the capability of the community based sector, releasing and demonstrating a sustainable resourcing model.

Summary of key findings

PCLI Stage One has resulted in contemporary models of care that better meet the needs of people with SPMI and issues of ageing.

- Contemporary models of care, offering a range of accommodation options for people with SPMI with issues of ageing are operating across NSW.
- Models have been established across a range of options that are person-centred, focused on care in the community, have moved away from hospital focused care, prioritise recovery and wellness, not illness, and provide long term supported accommodation options.
- The PCLI models bring together specialist clinical MH services, MH support and accommodation and work across the health/aged care interface to support integrated, coordinated care, aligning with the policy directions articulated in NSW, nationally and by the Aged Care Royal Commission.

Systemic changes to practice have been key enablers of transition to community settings.

- Extensive practice change across process, engagement and professional support has been embedded.
- The experience of delivering outcomes that matter to people has supported embedding changes in practice.

Capacity of the community-based sector has been substantially increased.

- The PCLI target of commissioning 80 new specialist residential aged care places in MHACPI units and Specialist RACFs, has been achieved.
- Enabled by the PCLI, partnerships between LHDs and their local generalist residential aged care facilities have supported 57 people with needs for specialist mental healthcare to access and to transition to appropriate residential aged care facilities that meet their needs and preferences, with specialist mental health clinical support as required.



Summary of key findings

Consistent inclusive engagement of key stakeholders and a distributed leadership approach has enabled innovation in service models and their appropriate resourcing.

- The MH-RAC Network, has successfully supported the establishment and operation of the MHACPI and SRACFs.
- Clinical Advisory Committees (CACs) are jointly established between LHDs and their local specialist community mental health facilities to provide advice and support.
- Continuous engagement with the broader aged care sector, is promoting collaboration, innovation and practice improvement across the health system and partner services.
- LHDs are engaging with the broader aged care sector locally, to identify generalist providers/facilities to work with more closely, and aged care providers are benefiting from closer linkages with and support from LHD OPMH services.

Appropriate individualised high need mental health services and support have enabled successful transitions to community living

- A person-centred focus has enabled a range of tailored community options for people with SPMI, each with different supports available to meet individual needs: Of the 113 PCLI Stage One people who had transitioned to residential aged care as at Dec 2019, 56 had transitioned to specialist RACFs and 57 to generalist RACFs
- The pattern of transitions suggests the need for both specialised mental health-aged care partnership services and partnerships/pathways to generalist RACFs.



Summary of key findings

The PCLI provides a prototype of contemporary health system reform: delivering value for the system, delivering better outcomes for people and establishing the feasibility of a new funding approach.

The PCLI is delivering value to people and to the system.

- Early economic analysis estimates that transition to community living led to a large reduction in average costs regardless of discharge destination and age, ranging between \$12M and \$18M annually.
- As well as being associated with considerable cost savings, well-supported transitions of long-stay patients with issues of ageing from hospital to community living are associated with improved experience for people, their families and their carers, and no increase in mental illness symptoms or psychological distress.

Existing funding mechanisms across State and Commonwealth have been used to establish and resource local partnerships that operate as a system across the spectrum of care.

- The need to blend existing funding models and to pool payment streams across programs and providers, is well recognised in the NSW and National health reform agendas.^{37,38}
- The PCLI funding approach blends the Australian Government Aged Care Funding Instrument contribution, together with other Australian Government subsidies/supplements as appropriate, with top up funding from NSW Health per residential place and a modest capital incentive to providers.
- The service models are jointly planned, established and overseen by local providers, supported by cross-sectoral collaboration and continuity of care across settings and sectors, to address systemic barriers holistically, and to avoid introducing unintended perverse consequences with more narrowly targeted initiatives.
- By establishing and resourcing partnerships between government-funded health services and external, non-statutory bodies, the PCLI operates as a single system across the care spectrum.

³⁷ NHRA 2020- 2025

³⁸ NSW Health Strategic Plan

Key findings discussion

PCLI Stage One has resulted in contemporary models of care that better meet the needs of people with SPMI and issues of ageing.

The PCLI Stage One has been based on a substantial policy foundation which highlighted the need for sustainable systemic reform to address the needs of older people with high-level, complex and persistent mental illness for long-term residential and community care. The NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005 – 2015³⁹ had already expanded the ambitions for partnership models to support care in the community. Building on its predecessor, the NSW Older People's Mental Health (OPMH) Services Plan, 2017 – 2027⁴⁰ outlines a model for service delivery across the continuum of care for older people with mental illness, in partnership with a range of other key services and with families and carers.

Stage One has resulted in establishment and successful operation of contemporary models of care in the community that better meet the needs of people with SPMI and issues of ageing. The models are person-centred, they are focused on care in the community, they have moved away from hospital focused care, and they prioritise recovery and wellness, not illness.

These contemporary models of care offer a range of accommodation options for people with SPMI with issues of ageing across NSW:

- within discrete, secure, purpose-designed units within existing aged care homes (MHACPI transition units)
- within specifically designed aged care facilities targeted to older people with complex, chronic mental illness and high behavioural needs, as well as aged care needs (SRACFs)
- within mainstream aged care facilities supported by specialist clinical mental health transition and liaison support provided by LHDs.

Crucial components of a successful model of care include: inpatient readiness for transition training with continuity of care between inpatient and outpatient settings, services based on a recovery model, availability of suitable housing with up to 24-hour support and services for patients with complex needs, ongoing disability support, and clear communication with structured articulation of procedures and roles.⁴¹

³⁹ <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/nswsmhsop-serviceplan-2005-2015.pdf>

⁴⁰ https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2017_022.pdf

⁴¹ Matheson SL, Carr VJ. Transitioning long-stay psychiatric inpatients to the community: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2014.

Changes to practice have been key enablers of transition to community settings

Changes in practice have been embedded across process, engagement and professional support, including:

- individualised process ensuring optimal choice and control for people with SPMI
- availability of professional expertise e.g. PCLI/complex care clinicians working across inpatient and community settings, PCLI and OPMH Multi-Disciplinary Teams (MDTs), involvement of peer workers
- active engagement with people, their families and carers in exploring the options for transition
- creation of a supportive environment for staff in all settings to build knowledge, trusting partnerships and strong working relationships.

The experience of delivering outcomes that matter to people has supported embedding changes in practice.

The challenge of embedding recovery orientation into long-standing local systems should not be underestimated. It requires clear guidance on translating the concept of recovery into practice,⁴² support from managers and clinical leaders, and organisational commitment to taking 'positive risks'⁴³ scaffolded by clinical governance, mental health expertise, and practical support.

An increased community-based sector has been created and supported to flourish

The service developments and transitions of PCLI Stage One people are occurring within the context of an aged care sector facing considerable external pressures. The regulatory, policy and funding arrangements for aged care services have been the subject of increasing interrogation and refinement over the last decade. Despite these macro external pressures and influences, the capability of the community-based sector to meet the needs of people with SPMI and issues of ageing has been established and operates successfully across NSW.

The target for specialist aged care, 80 new residential places, has been achieved:

- Three new MHACPI transition units with capacity for 30 residents; and
- Three SRACFs with capacity for 50 residents in targeted places with additional specialist clinical mental health support.

These new/enhanced services build on three pre-existing MH-RAC services with NSW Health top-up funding and clinical support. In turn, these pre-existing services have benefited from being part of an expanded network of like services.

⁴² Waldemar, A. K., Arnfred, S. M., Petersen, L., & Korsbek, L. (2016). Recovery-oriented practice in mental health inpatient settings: a literature review. *Psychiatric Services*, 67, 596-602.

⁴³ Gee, M., Bhanbhro, S., Cook, S. and Killaspy, H. (2016). Rapid realist review of the evidence: achieving lasting change when mental health rehabilitation staff undertake recovery-oriented training. *Journal of Advanced Nursing*. 73, 1775-1791.

The PCLI has given further impetus for LHDs to engage with the broader aged care sector locally, and to identify generalist providers/facilities to work with more closely, and for aged care providers to benefit from closer linkages with and support from enhanced LHD OPMH services. Facilitated by the PCLI, partnerships between LHDs and their local generalist residential aged care facilities have also flourished. At December 2019, these partnerships have supported 56 people with needs for specialist mental healthcare to access/transition to appropriate residential aged care facilities that meet their needs and preferences, with specialist mental health clinical support as required.

The success of operationalising the new community-based models has been enabled through consistent inclusive engagement of key stakeholders. A supported distributed leadership approach has enabled innovation in service models. Key examples include:

- MH-RAC Network, a state-wide forum hosted by the MoH to support the establishment of the new MHACPI transition units and SRACFs. The Network aims to promote communication, collaboration, shared learning, benchmarking and quality improvement across new and existing specialist MH-RAC partnership services. An evaluation of the Network in 2019 found the majority of partners viewed the meetings very positively, providing an opportunity for ‘cross-pollination’ of ideas and building connections between partner sites. The welcoming and inclusive atmosphere of the meetings was seen as an extension of the partnership values of the Network.

- Clinical Advisory Committees (CAC)s are jointly established between LHDs and their local Specialist RACs and MHACPI units to advise on admission and discharge of residents, provide clinical review of residents, and to provide advice and support across the Specialist RACF and MHACPI transition unit.
- Engagement with the broader aged care sector as part of PCLI has built on investment in these relationships by the Ministry over recent years. For example, through the annual Aged Care Collaborative Forum which promote collaborative, innovation and practice improvement across the health system and partner services.

Individualised high need mental health services and support have enabled successful transitions to community living

The evolution of the expanded community-based sector has been purposefully supported to be person-centred in its focus. This focus has enabled a range of tailored community options for people with SPMI, each with different supports available to meet individual needs.

Deinstitutionalisation has been largely successful internationally. A focus on the number of people discharged can mask the reality of poor quality of life in the community for people with SPMI, who may face unemployment, poverty, homelessness, poor physical health, and substance misuse,⁴⁴ undermining community placements and ultimately leading to reinstitutionalisation.⁴⁵

⁴⁴ Novella, E J. (2010). Mental healthcare in the aftermath of deinstitutionalization: A retrospective and prospective view. *Healthcare Analysis*. 18, 222-238

⁴⁵ Fakhoury, W. and Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare. *Psychiatry*. 6:8, 313-316.

The pattern of transitions across the options made available to people through the PCLI clearly reflects its person-centred foundations, a driver of transition success. As at December 2019, approximately half of transitioned PCLI Stage One people transitioned to specialist aged care facilities, and the other half to generalist facilities. The pattern of transitions suggests the need for both specialised mental health-aged care partnership services and partnerships/pathways to generalist RACFs, with specialised services playing a particularly important role for very long LOS patients and patients under 65 years with early ageing issues; and, the generalist RACF sector providing support for many people who are over 65 years with complex mental illness, a group closer to the usual RACF population.

Systemic optimisation of the transition process, and of the community destination, to an individual's needs is also reflected in the acute service utilisation trends post transition. As already discussed, the readmissions of people who have transitioned to community settings have been rare and, when they do occur, tend to be brief. Moreover, the vast majority of the presentations and admissions have not been mental health related, and there have been only short admissions to specialist mental health wards recorded.

The low rate of readmission, and in particular mental health related readmission supports the findings that overall life skills and opportunities have been improved for the cohort of transitioned people without an increase in symptoms or distress.

Individualised pathways to living in the community have seen a profound and systemic cultural shift enabling the normalisation of transition to community living of people with SPMI

The PCLI has supported transition to community living for more than two thirds of the initial Stage One cohort.

The improving attitudes reported by the PCLI evaluation are a sign that culture change is occurring, and is being supported by stakeholders becoming aware of the considerable benefits of transition of PCLI people. Compared with earlier rounds of data collection, in the most recent interviews by UoW (August 2020) key informants were better able to provide positive examples of the cooperation and active involvement of treating teams in the long-stay units. Stakeholders were much more aware that following transition, people with SPMI were better able to engage in community activities, and live fuller and more meaningful lives in less restrictive environments. As well, benefits for families and carers have been observed by stakeholders, for example that visits can take place in a more home-like environment.

Key informants in mental health services also reported changes in how staff of their services think about long-term hospital stays and the idea of people with SPMI being able to live in the community. Inpatient staff are now less likely to see hospital as a person's long-term home and there is a growing realisation that people can receive the care and support they require and lead a more fulfilled life out of hospital.

The PCLI provides a prototype of contemporary health system reform: delivering value for the system, delivering better outcomes for people and establishing the feasibility of a new funding approach

Transition to community living leads to a large reduction in average costs of care

The main goal of the economic evaluation was to estimate costs associated with care during the patients' index stays (that is, the long stays identified in the HIE data) and compare them with costs of care incurred while living in the community.

Costs of care were estimated for the PCLI Stage One cohort in the initial cohort who had been discharged from hospital (n=66) at 31 December 2019. The analysis used a 'cost to government' approach based on the funding levels received by healthcare providers that provide services for the PCLI Stage One cohort. The following types of costs were included:⁴⁶

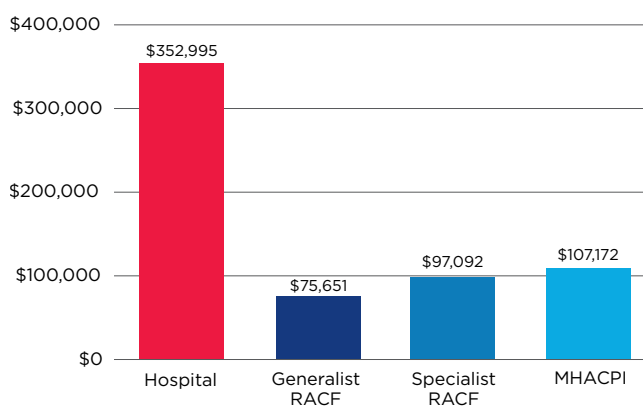
- Hospital-based care such as admitted care, ED presentations and community mental health services.
- Commonwealth funded residential aged care.
- Partnership agreements between NSW Health and MH-RAC providers.
- National Disability Insurance Scheme (NDIS) packages.

Transition to community living led to a large reduction in average costs of care, ranging between 52% and 79%, regardless of discharge destination and age (Figure 9). For the 66 PCLI Stage One initial cohort who had transitioned to residential aged care, this amounts to a reduction in cost for their combined care of between \$12.1M and \$18.3M annually.

Estimates of savings were highly robust to changes in input parameters (for example Aged Care Funding Instrument or ACFI, or NDIS funding) ($\pm 10\%$). None of the variations led to higher cost of care in the community compared with the cost of the index stay in a long-stay unit. If the cost of the index stay was increased, the cost reduction changed by up to five percentage points. Changes in all other parameters had very minor impact.

Taken together with the analysis of outcomes data for Stage One people on average, well-supported transitions of long-stay people with issues of ageing from hospital to community living are associated with considerable cost savings, with no increase in mental illness symptoms or psychological distress.

Figure 9: Annual costs for a Stage One participant in hospital care compared to community living options



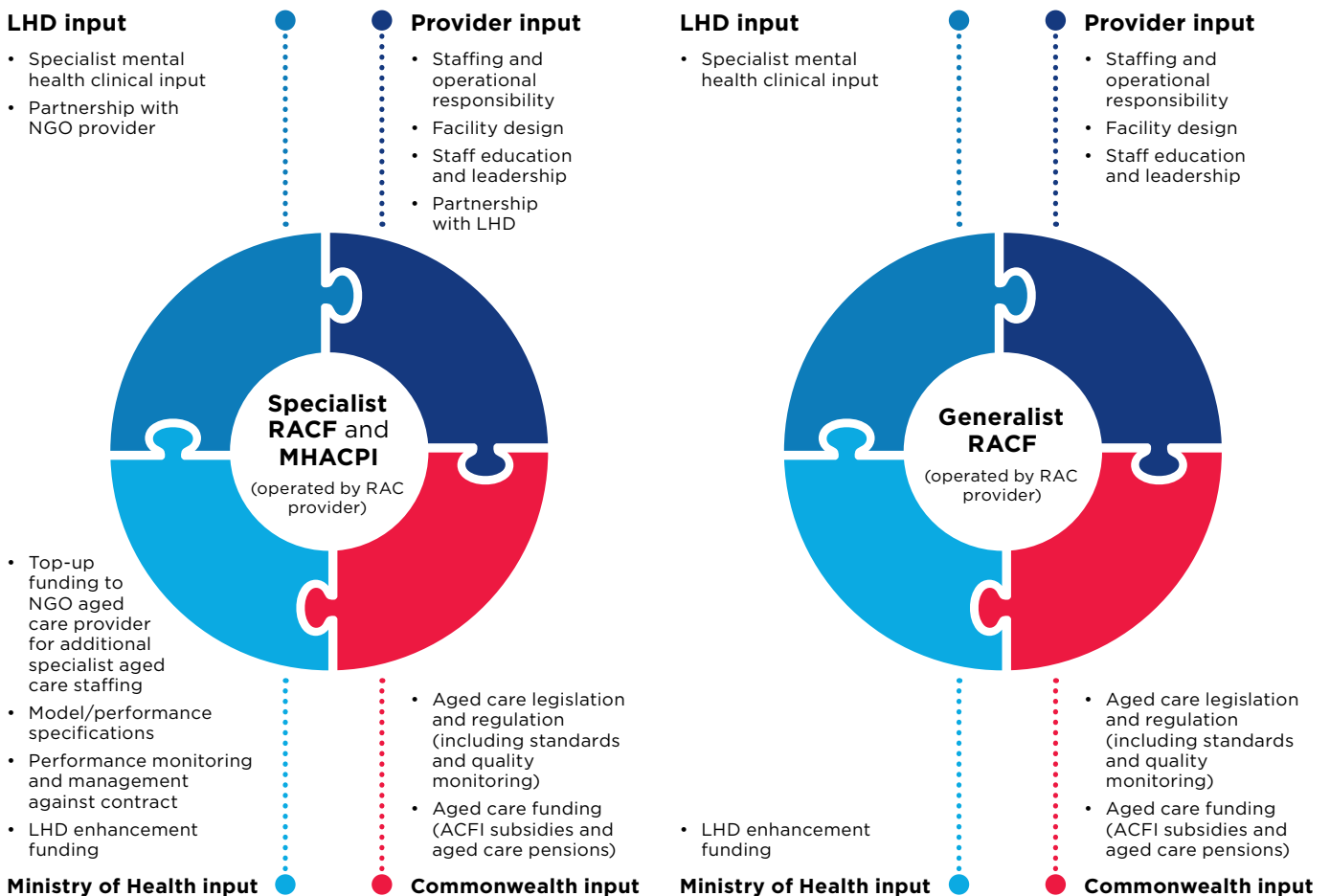
⁴⁶ Costs to providers have not been included in this economic analysis and requires further investigation.

Innovation in funding to achieve “one system of care”

Existing funding mechanisms across State and Commonwealth, as well as across government and non-government, have been used to establish and appropriately resource local partnerships that operate as one system across the spectrum of care for people with SPMI. The need to blend existing funding models and to pool payment streams across programs and providers, is well recognised in the NSW and national health reform agendas.^{47,48}

The PCLI funding and support approach is illustrated in Figure 10 below. The approach blends the ACFI contribution, together with other Australian Government subsidies/ supplements as appropriate. All models, specialist and general aged care, are supported by LHD input and clinical services, further ‘blending’ both financial and in-kind support from existing statewide mental health services into PCLI arrangements. For specialist accommodation, top-up funding from NSW Health per residential place and a modest capital incentive to providers are also provided, acknowledging the additional level of service to meet high needs.

Figure 10: Key inputs to Stage One accommodation partnership models



⁴⁷ Australian Government Department of Health. 2020–25 National Health Reform Agreement (NHRA). <https://www.health.gov.au/initiatives-and-programs/2020-25-national-health-reform-agreement-nhra>

⁴⁸ NSW Health Strategic Priorities 2019–20. <https://www.health.nsw.gov.au/priorities/Documents/strategic-priorities.pdf>

The service models are jointly planned, established and overseen by local providers to:

- support cross-sectoral collaboration and continuity of care across settings and sectors;
- address systemic barriers holistically; and,
- avoid introducing unintended perverse consequences with more narrowly targeted initiatives.

By establishing and resourcing partnerships between government-funded health services and external, non-statutory bodies, the PCLI Stage One has demonstrated operation as a single system across the care spectrum. Building on strong policy foundations and pockets of excellence to meet the needs of people with SPMI and issues of ageing across NSW service providers, PCLI Stage One has now provided the 'connecting tissue' to scale these foundations.

Cross-sectoral collaboration and integration of supports are essential, along with continuity of care across settings and sectors including specialised long-stay community residential care, backed by primary care, generalist and specialist mental health services (in inpatient, outpatient, and community settings), and work and occupation services, to support people at different stages of mental illness and respond to fluctuations and acute episodes.^{49,50,51}

⁴⁹ Kertesz, S., Johnson, G. (2017). Housing First: Lessons from the United States and challenges for Australia. *The Australian Economic Review*. <https://doi.org/10.1111/1467-8462.12217>.

⁵⁰ Thornicroft, G., and Tansella, M. (2013). The balanced care model: the case for both hospital-and community-based mental healthcare. *British Journal of Psychiatry*. 202, 246-248.

⁵¹ Davis, L., Fulginiti, A. and Kriegel, L. (2012). Deinstitutionalization? Where have all the people gone? *Current Psychiatry Reports*. 14, 259-269.

Beyond Stage One: improved population health

This report has focused on the outcomes of the PCLI Stage One. Stage One aimed to build mental health system capacity across settings, encompassing the mental health and aged care sectors, to ensure continuity of care and seamless support for people who have SPMI and issues of ageing, to enable them to transition to community living. The outcomes described here reflect a point in time in the PCLI and a focus on one of its target cohorts.

At a system change level, the overarching ambition of the PCLI aims to prevent a renewed build-up of long-stay patients through lasting cultural change that will see appropriate individualised high need mental health services and support for people, improving opportunities for people and releasing capacity in the acute sector.

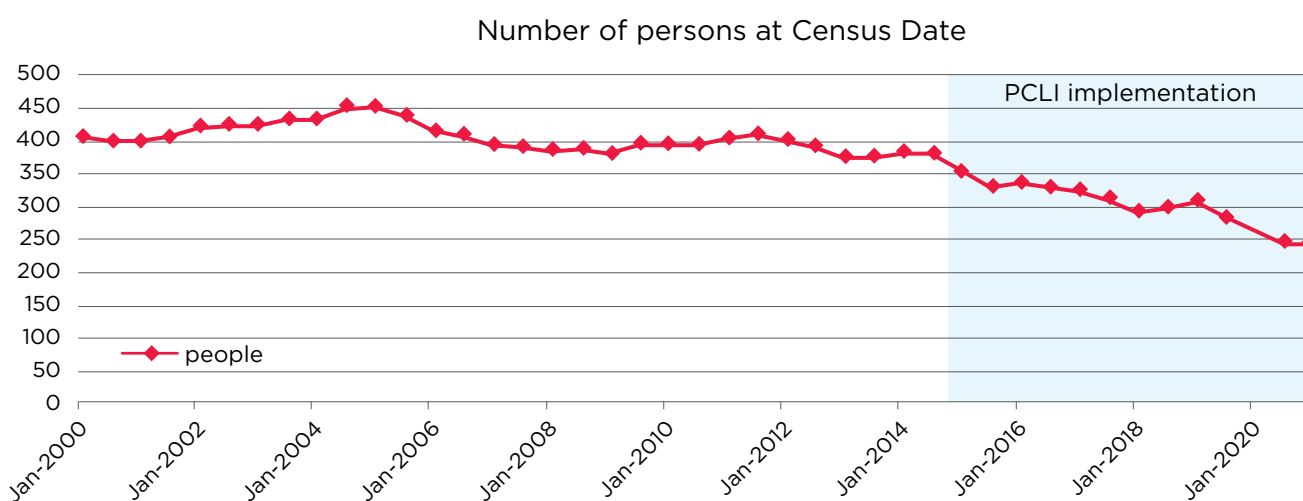
The evaluation of Stage One reported that mental health service providers have become less likely to see hospital as a person's long-term home, with a growing realisation that people can receive the care and support they require and lead a more fulfilled life out of hospital.

The impact of the cultural change revealed by the evaluation of Stage One is evident beyond the outcomes for the first cohort of the PCLI. The data indicate that there has been a reduced build-up of long stay admissions in NSW for people with complex enduring mental illness.

The PCLI Census monitors people over 18 years of age in all NSW hospitals on the census date with a stay greater than 365 days, i.e. an uninterrupted stay at the admitting hospital of more than 365 days since the day of admission. The PCLI Census data very clearly show the first sustained downward trajectory in two decades in both the number and LOS of patients with SPMI since the commencement of PCLI in 2015.⁵²

Figure 11 presents the number of long stay inpatients from January 2000 - December 2020. At the peak there were 452 long stay patients in January 2005. The data show a relatively stable number of long stay patients between January 2000 - July 2014. A marked and sustained declining trend in long stay patients is evident with the commencement of the PCLI. At 31 December 2020,⁵³ there were 244 long stay patients.

Figure 11: Number of long stay PCLI inpatients January 2000 - December 2020



⁵² The data analysis includes: 1. People still at hospital at census date, 2. People who had at least one stay at a MH ward, 3. Includes ECT people. The data excludes: 1. People under 18 years (at admission), 2. Designated forensic units in Justice Health, HNE, WNSW and WS LHDs. LHDs, 3. People who are admiratively admitted but have had over 365 days, 4. People who had leave days over 364 days in the stay.

⁵³ PCLI Census Report: 31 December 2020 (sourced by InforMH from HIE, May 2021).

Figure 12 shows a sustained declining trend in total length of stay in hospital for people with complex enduring mental health illness. As at July 2020 the total length of stay for all people in NSW hospitals with complex enduring mental health was 1,017 years, compared with 3,135 years

total LOS as at January 2000. The average LOS for these patients in January 2000 was 7.8 years, compared to 5 years in July 2020 (refer Figure 13). The maximum LOS recorded in 2011 was 74 years. The maximum LOS in January 2020 was 34 years.

Figure 12: Total LOS for all PCLI patients January 2000 - July 2020

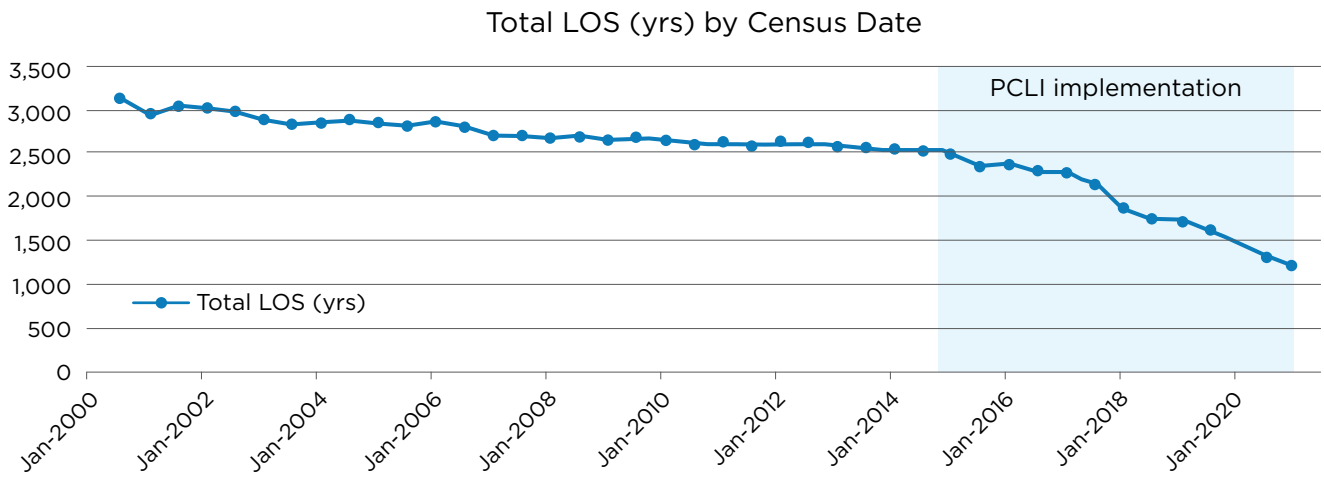
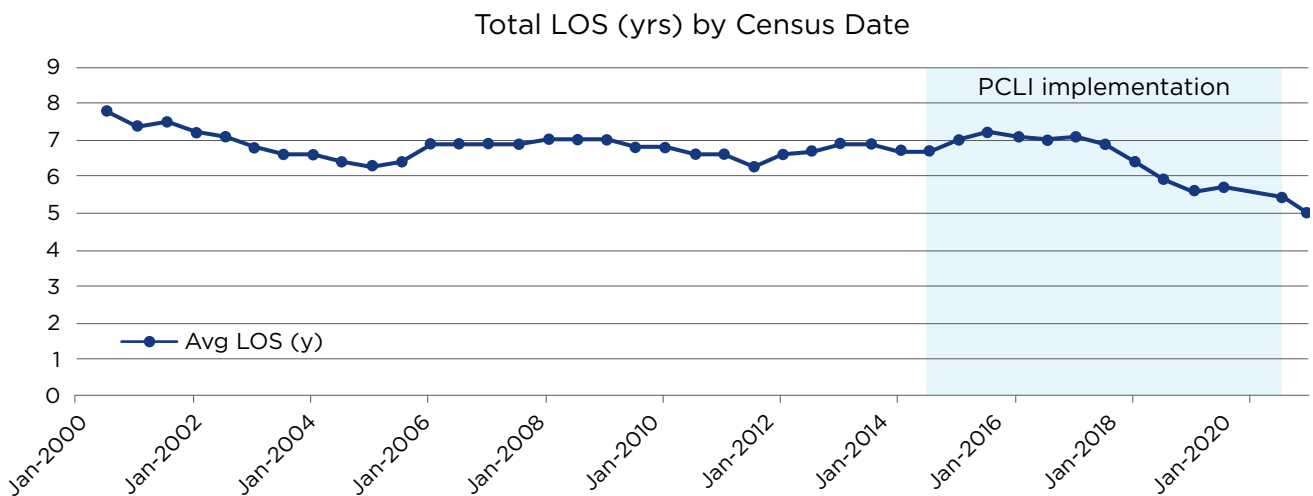


Figure 13: Average LOS for all PCLI patients January 2000 - July 2020



Case study 3



Glen's story



Planning your move

- Visualising a more meaningful life
- Planning to leave hospital
- Preparing to leave hospital



Making your move



Your community life

- Settling in and developing a meaningful life



Specialist RACF

Glen is 51 years old. He was diagnosed in 1985 with schizophrenia. Glen also had issues of ageing including a parkinsonised shuffling gait which increased Glen's risk of falls requiring increased care and assistance in showering and dressing.

Glen has had many admissions to Bloomfield hospital since he was 19 years old. Glen always said he felt 'tortured' and found it difficult to focus. His last admission was for 15 years.

Glen went to look at Annie Green Court in Sydney with another patient who was looking to move into the community, Glen wanted to go for the bus ride!

About 1 month after Glen visited AGC he asked if he could go and live at AGC. Glen didn't have any family living near Bloomfield hospital in Orange and his family found it hard to travel to visit him from Newcastle.

Annie Green Court staff worked closely with Glen to build trust. The staff took the time to get to 'know Glen' and understand his individual wants and needs.

Moving into Annie Green Court (AGC) was complex for Glen and his family, and the sort of supports provided by the PCLI SMHSOP team included:

- extra visits to the facility during the early stages of the transition, and
- keeping in touch with both Glen's family and the staff at the facility, to share what the mental health team knew about Glen and suggest strategies that might support him, especially in the early stages of settling in.

Glen now lives in AGC (a Specialist Residential Aged Care Facility) in Sydney and receives specialist follow-up support from the OPMH team as required.

In hospital Glen would have medication to help with his anxiety and issues. Glen has now had the opportunity to try other strategies to manage his anxiety including going to his room for a lie down, taking a shower or talking with staff.

Glen is a person at AGC, not a patient.

Glen has more control and freedom in his life: he goes for a walk, to the park or goes for a coffee or beer when he wants to. Glen is more social: he has made friends, enjoys playing bingo and he has broader conversations with others. Glen feels that he has a purpose and has developed a dry sense of humour. He loves Annie Green Court!

Glen's story can be found on the NSW Health website at:
<https://www.health.nsw.gov.au/mentalhealth/Pages/more-info-for-consumers-carers.aspx>

