Pathways to Community Living Initiative

Evaluation Report 6: Organisational case studies of practice change

NSW GOVERNMENT

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

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

We would also like to thank staff from the funding body, especially the Ministry PCLI team led by Robyn Murray and Kate Jackson, the wider Mental Health Branch, NSW Ministry of Health and the Local Health District PCLI program managers and executive leads, for their vision, energy and ongoing commitment to this evaluation.

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Foreword

I am delighted to introduce this evaluation report on the Pathways to Community Living Initiative (PCLI). PCLI represents a major initiative by NSW Health to improve the health and wellbeing of people living with protracted mental illness. PCLI was not just a time limited project. PCLI aims to fundamentally reform and improve how we care for and support people who have had long stays in NSW hospitals because of severe mental illness.

The Centre for Health Service Development at the University of Wollongong has been closely engaged with the NSW Ministry of Health since early 2017 in the evaluation of this important initiative.

The evaluation has been a huge undertaking, requiring extensive engagement with NSW mental health services and clinicians, consumers and carers. A series of evaluation reports have been released with findings on the impacts of the PCLI for consumers, providers and the system. This report presents a 'deep dive' into the processes of the PCLI.

The evaluation team has drawn on their comprehensive knowledge of the PCLI to examine, in detail, practice changes and service reforms as they unfolded at two participating local health districts. Their data sources included 47 interviews over a four-year period (2017-2020) plus site visits and analysis of program documents. They used a qualitative, organisational case study design, guided by protocols to ensure a rigorous approach to research and reporting. This type of case study is particularly suited to understanding implementation and change within a real-life context.

Since the advent of the PCLI, transition processes have become more structured and consistent, and are now more likely than previously to be driven by consumer perspectives and preferences. The PCLI has provided resources and tools plus the authority to encourage a problem-solving approach to these transitions, focusing on the consumers' support needs, capacities and goals.

At the two participating local health districts in this study, the PCLI teams were well supported by executive leadership, Older Persons Mental Health, and community teams. By sharing stories of success, providing assistance and mentoring with the transition processes, and building capacity in mental health aged care and disability services, the PCLI teams were effective change agents. Through these teams, the program has encouraged culture change to deliver more contemporary, recovery-oriented care for people with serious mental illness.

This study set out to demonstrate the contribution of the PCLI to practice change. It achieved this ambitious goal by carefully examining the program's causal assumptions, meticulously documenting the activities and processes of implementation, and comprehensively addressing – and rejecting – two rival hypotheses.

Previous research has identified key mechanisms for embedding recovery orientation in mental health services. The evaluation demonstrated that these mechanisms are present in the PCLI: collaborative planning with service users and families; multi-disciplinary approaches to care planning; organisational support and leadership; and a long-term, multi-modal approach. It identified the PCLI as 'the most likely and feasible *driver of change* in transition processes, clinical practices and service reform' at the case sites. In the words of one stakeholder,

We're asking our clinicians to have conversations with these consumers that they've never had before. That's a fundamental part of why PCLI is so important.

I commend this report.

Professor Kathy Eagar
Director
Australian Health Services Research Institute
University of Wollongong

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centre for health service development

Pathways to Community Living Initiative

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Glossary of terms and abbreviations

ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
Ax	Assessment (baseline)
CE	Chief Executive
CMO	Community-managed organisations
FTE	Full Time Equivalent
HASI	Housing and Accommodation Support Initiative - program to support people with a severe mental illness to live and participate in the community
HASI Plus	Additional support (16 - 24 hour/day) for people with severe or persistent mental illness
HI	Health Infrastructure
HNE LHD	Hunter New England Local Health District
HoNOS	Health of the Nation Outcome Scales
HoNOS 65+	Adaptation of HoNOS for use with older people with a mental illness
Initial Cohort	A group of around 380 mental health consumers who had been in hospital for over 365 days at the start of the PCLI. Information provided by the Ministry PCLI team shows that as at 31 December 2014 the estimated number of long-stay patients was 387. At the time of the first census in June 2015 there were 350 consumers in the initial cohort.
KPI	Key performance indicator
LHD	Local Health District
LOS	Length of Stay
MDT	Multi-disciplinary Team
MHACPI	Mental Health Aged Care Partnerships Initiative
MH-RAC	Mental Health – Residential Aged Care
MH-RAC Network	Network of Ministry and LHD PCLI staff, and representatives of participating Residential Aged Care Facilities
Ministry	Ministry of Health
Ministry PCLI team	Staff working in the Ministry of Health to provide strategic leadership for the PCLI
NDIS	National Disability Insurance Scheme

NGO	Non-Government Organisation
OPMH	Older People's Mental Health
PCA/PCW	Personal Care Attendant/Worker – supports those whose health status is stable
PCLI	Pathways to Community Living Initiative
PCLI Collaborative Group	PCLI governance group meeting weekly to focus on the practical aspects of implementation. Comprises Ministry PCLI team and representatives from LHDs, contractors, and others as required.
PCLI Practice Network	Network of Ministry and LHD PCLI program managers, clinicians and peer workers
PCLI program managers	Staff responsible for implementation of the PCLI within the LHDs that comprise the six primary implementation sites
PCLI Steering Committee	Governance group for PCLI program, meets three times annually and comprises representatives of the Ministry PCLI team, LHDs, Mental Health Discipline Leads and other content experts
RACF	Residential Aged Care Facility
RN	Registered Nurse – Degree level educated nurse, provides clinical leadership role in aged care
Routine Assessment Tools	K10, HoNOS, HoNOS 65+, LSP-16 and RUG-ADL. Every three months while admitted, every six-months post discharge.
SLS	Specialist Living Support. Stage Two clients only
SPMI	Severe and Persistent Mental Illness
SRACF	Specialist Residential Aged Care Facility
Stage One	Service development and clinical service enhancements targeted at those individuals in the PCLI cohort who experienced significant issues of ageing, approximately 100 individuals at July 2015.
Stage Two	Service development and clinical service enhancements targeted at individuals who are younger (18 years and upwards) without significant issues of ageing.
WS LHD	Western Sydney Local Health District

Executive Summary

The Pathways to Community Living Initiative (PCLI) is a major mental health reform program led by the NSW Ministry of Health ('the Ministry') in collaboration with NSW Local Health Districts (LHDs). It is a key component of the whole-of-government enhancement of mental health care under the *NSW Mental Health Reform 2014-2024*.

This is *PCLI Evaluation Report 6*, one output of the independent evaluation conducted by the Centre for Health Service Development, University of Wollongong, between January 2017 and October 2021. It presents the findings of a qualitative organisational case study of mental health service reform processes and resulting practice change at two primary implementation sites.

Background

PCLI clinical enhancements and service developments have focused on a relatively small group of people with severe and persistent mental illness (SPMI) and highly complex needs who have experienced, or are at risk of experiencing, stays in hospital exceeding 365 days ('long-stay patients'). For many years, this group had not benefited equitably from the reforms associated with previous deinstitutionalisation efforts and had limited options for community living. Planning began in 2014, with a pilot on the Bloomfield campus, Orange, for the first six months of 2015.

The PCLI was formally launched in mid-2015. It was focused initially on six LHDs with large mental health hospitals which house the majority of long-stay patients in NSW. The six primary implementation sites are: Hunter New England (HNE); Northern Sydney (NS); South-Western Sydney (SWS); Sydney; Western New South Wales (WNSW); and Western Sydney (WS). In its third year, the program expanded to include LHDs with smaller, co-located mental health units. Additional LHDs are: Nepean Blue Mountains (NBM), Central Coast (CC), Illawarra Shoalhaven (IS) and South-Eastern Sydney (SES) plus St Vincents Specialist Health Network. Recently, the program has extended again to include all the rural LHDs across NSW, with a senior clinician and rural program coordinator based at Murrumbidgee LHD. These LHDs work with the same cohort of patients with SPMI and complex needs, some having long stays in acute units and others experiencing recurrent hospitalisations.

Practice change and service reform are overarching goals of the PCLI. The program aims to embed a recovery approach in services through developing a contemporary model of care spanning non-acute inpatient and community mental health services. The PCLI processes, care pathways, partnerships and networks within and beyond the health sector have been designed to support people with SPMI and complex needs to move out of hospital and into the community, and reduce future long-stay admissions.

The evaluation team used a qualitative organisational case study approach to assess the extent to which the PCLI contributed to practice change and service reform in mental health services, and to understand how the observed changes unfolded over time. We had four hypotheses:

1. The PCLI contributed to the implementation of specific transition processes across the patient journey from hospital to community living.
2. The influence of the PCLI extended beyond the health system through cross-sector engagement, which is an integral part of the program.
3. The PCLI created favourable conditions for sustained practice change.

4. The PCLI contributed to service reform by positively influencing organisational culture and demonstrating how recovery orientation can be enacted in the care of people with severe and persistent mental illness (SPMI) and complex needs.

Our data collection was designed to elicit information relevant to these hypotheses and to allow us to test alternative explanations (Baškarada, 2014).

Methods

This is a qualitative study, drawing on program documents and interviews with key informants (KIs) and observations at the case sites between 2017 and 2020. Thirteen new interviews at the two sites were conducted for the case study. In addition, to facilitate analysis of change over time, four previous waves of interviews with the same participants (or other participants with similar roles) at the two sites going back to November 2017 were assembled into one longitudinal dataset, comprising 47 interviews in total.

Findings

The study described the PCLI processes of transition, the activities involved in each process, and how these were enacted. It also explored program mechanisms which facilitated transitions: purposeful engagement with the aged care and disability sectors, embedding the PCLI processes within routine practice in mental health services, and modelling and enhancing person-centred, recovery-oriented care for people with SPMI and complex needs. Relationships between the transition processes and facilitating mechanisms are summarised in Table 1 on page 28.

Transition processes

Chapter 3 describes *how* transitions now take place at the two case sites, and how the PCLI transition processes differ from usual practice before the advent of the PCLI. It focuses on the processes of initiating the transition, planning the transition, making the move to community living, and sustaining the transition.

The PCLI has provided a clear framework and timeframe for transition from hospital to community living. Consumers' readiness for transition is considered at regular meetings involving clinical leaders. These arrangements signal broad organisational commitment by mental health services to community transitions and to avoiding future long stays. Increasingly, the PCLI-specific processes are integrated into routine clinical review and management processes. They involve structured information gathering about the person's capacities and goals, and consideration of how their complex care needs can be met by accommodation and support providers. PCLI clinicians work with treating teams to plan the transition in detail, assess providers for suitability and fit, address administrative and funding issues (e.g., NDIS applications, guardian approvals), establish clinical pathways and behavioural support plans, and personalise the transition for the consumer. They work with family/carers, addressing personal concerns and practical issues, and involving them in transition planning and decision making. In addition, they offer support to aged care and disability care providers through both general, structured training and personalised mentoring around the care needs of individuals. Transitions are tailored, flexible, and led by the consumer whenever possible. Once transitioned, consumers have access to monitoring and clinical review through community mental health or Older People's Mental Health services.

Cross-sector engagement

The PCLI provides several mechanisms to facilitate successful and sustainable transitions to community living. One of these important mechanisms is engagement with stakeholders across the aged care and disability sectors (Chapter 4).

Regular and sustained engagement that extends beyond the health sector is crucial to achieving the program's strategic outcome of establishing person-centred care pathways. PCLI program managers, clinicians and peer workers play a bridging role to promote ongoing communication and ensure shared understandings and expectations.

The intensive in-reach to residential aged care facilities has helped build the confidence of managers and staff to accept and care for people from long-stay mental health facilities, and has helped build the capacity of facilities to meet the needs both of PCLI consumers and other residents with mental health issues. In the Mental Health-Residential Aged Care facilities, which receive PCLI top-up funding, PCLI clinicians provide a continuing consultation-liaison role.

In the disability support sector, PCLI staff often need to work across several providers to achieve a sustainable package of supports for individuals. Program managers and clinicians have developed systems to identify suitable prospective NDIS providers by asking targeted questions regarding their operating processes, governance arrangements, philosophies and values, and previous history of working with people with SPMI, captured in a format that can be shared with consumers and carers to help them make decisions. The capacity building role has focused on education and support around individual consumers' needs and facilitating relationships with community mental health teams.

Practice change

Another facilitating mechanism identified by the evaluation is the PCLI's activities in promoting practice change among staff of mental health services (Chapter 5). The PCLI has become embedded into mental health services by providing dedicated resources and establishing accountability around transitions and preventing future long stays in hospital. Leaders at LHD level – particularly the program managers and executive leads – have ensured that the program sits within existing clinical governance processes, and have helped to define the PCLI role, to meet local needs and enhance (but not replace) local expertise. The PCLI clinicians work with inpatient staff to draw on their knowledge, build their capacity and demonstrate the benefits of transition for patients. They also work with community mental health teams to build strong links with inpatient services and community providers so that there is seamless and informed support for people with SPMI and complex needs once they are living in the community.

Factors that may contribute to the sustainability of the PCLI were also identified. Ultimately, the goal of practice change is to make the PCLI become 'everyone's business': not associated with a particular group of people, a source of funding, or even the name 'Pathways to Community Living Initiative'. This goal has been front of mind for local leaders since the early days of the program and is supported by strategic leadership at Ministry level.

Service reform

The advent of the PCLI resulted in a fundamental shift in messaging and expectations around long hospital stays. Previously, for a small group of people with particularly severe and complex presentations and exceptionally high support needs, the hospital had been considered the person's home for life. The move towards more recovery-oriented, person-centred care required radical

changes in thinking and practice for some staff on the long-stay wards. Similarly, some families who had been told their person needed to stay in hospital were now told that they would be better off in suitably supported community accommodation.

The challenge of organisational culture change and service reform in this context should not be underestimated. Nevertheless, significant change has occurred, as documented by the evaluation over the past four years (Chapter 6). Among the inpatient staff, a problem-solving approach emerged, where the focus of discussion was on what was needed to make community living possible for the individual consumer. In almost all cases, families were happy with the outcomes of transition, even when they were initially reluctant to agree. Consumers themselves embraced the idea of transition to community, which became a powerful motivator for personal recovery.

The most obvious contribution of the PCLI to promoting service reform was the funding to employ PCLI program managers, clinicians and peer workers who acted as local change agents. The program attracted individuals who were passionate about deinstitutionalisation and mental health recovery, who acted as champions, either from within the PCLI or among the inpatient and community staff. The PCLI resources and processes, including the *Journey to Home Guide*, facilitated collaborative planning with service users and families. The presence of the PCLI teams made families more aware that the long-stay inpatient units were intended to be transitional. The PCLI toolkit was intended to foster the inclusion of allied health and nursing perspectives in transition planning through the selection of a variety of tools administered by different disciplines. There is evidence of multi-disciplinary collaboration within the inpatient units; the PCLI is likely to have contributed to strengthening multi-disciplinary practice and broadening the scope of discussions around long-stay consumers. The program's service reform agenda is consistent with NSW policy priorities and has endorsement at Ministry level and at the executive levels within participating LHDs, including the two case sites. Underpinning the PCLI is a focus on communication with all stakeholders, centred on the consumer's rights, needs, capacities, goals and preferences.

Discussion

The four hypotheses were confirmed (Chapter 7). The PCLI has instigated structured transition processes to complement and improve the discharge planning practices that existed previously. The program's influence has extended beyond the health sector to facilitate greater collaboration and integration with aged and disability care providers, building a more holistic system of supports around the consumer. Favourable conditions for practice change in mental health, particularly inpatient settings, have been established through governance, executive and local leadership, and systematic methods for gathering relevant information from consumers, carers, inpatient staff and aged care and disability support providers. There is progress towards service reform resulting, at least in part, from the activities of the program's key change agents, the PCLI program managers, peer workers and clinicians, who have modelled recovery orientation and upskilled other stakeholders to improve person-centred care across settings.

Conclusion

The current report presents evidence to support the assertion that the PCLI has contributed to the strategic outcome of establishing contemporary care pathways across settings and sectors, putting the principles of person-centred, recovery-oriented care into action.

First, the PCLI has built on existing discharge processes by introducing innovations and improvements that are explicitly designed to enable successful and sustainable transitions to community for people with SPMI and complex needs. Second, the PCLI transition processes have been enhanced through an additional set of facilitating processes, namely: cross-sector engagement with aged care, accommodation support and disability service providers; mechanisms to embed the processes within mental health services; and changing the culture of services by promoting and modelling recovery-oriented, person-centred care.

Two alternative explanations, derived from key informant accounts, were explored. These were:

1. The NDIS is the main mechanism supporting transitions to community, therefore Stage Two consumers would have moved out of hospital regardless of the PCLI.
2. The observed changes in practice and recovery orientation were already in train and would have continued without the intervention of the PCLI.

Although they contain elements of truth, the proposed alternative explanations cannot fully account for the changes observed over the timeframe of this evaluation. Consequently, the PCLI appears to be the most likely and feasible driver of change in transition processes, clinical practices, and organisational culture in relation to long-stay patients with SPMI and complex needs at the case sites. It is reasonable to conclude that, due to the contribution of the PCLI, long-stay mental health wards in NSW are increasingly seen as temporary stops on the recovery journey, rather than destinations.

1 Introduction

This report is the sixth in the evaluation of the Pathways to Community Living Initiative (PCLI), a coordinated state-wide mental health reform program led by the Ministry of Health (the Ministry) in collaboration with NSW Local Health Districts (LHDs). It presents the findings of a qualitative organisational case study of PCLI processes and resulting practice change at two of the six primary implementation sites. This study was commissioned as part of an extension to the PCLI evaluation, which began in January 2017 and continued to September 2021. A description of the purpose and scope of this study is provided below (with more information about the methodology in Chapter 2) followed by background information about the PCLI.

1.1 Purpose and scope of this study

From the start, the goals of the PCLI extended beyond transitioning people who had already been in hospital for long periods of time. There was also a stated intention to prevent future long stays, by changing practice and reforming services. This is shown by the second of the program's 'twin aims', as expressed in Evaluation Report 1 (Thompson, Williams & Masso, 2018, p.4):

Providing improved and sustainable care pathways that embed a recovery approach for people with enduring mental illness.

The current study focuses on this aim, using an organisational case study approach to allow a deeper focus on how the broad principles of this large-scale program of mental health care reform have been interpreted and operationalised at a local level. Qualitative organisational case studies examine the activities of a group of people (e.g., a business or government department) who are working with a particular purpose, and seek to understand that purposeful activity within its real-life context (Rodgers et al., 2016). In evaluation, organisational case studies can be applied to examine and explicate the links between program processes and outcomes (Yin, 1992). Case studies have been used for many years in evaluations of government-funded programs (United States General Accounting Office, 1990).

The case sites – Hunter New England LHD and Western Sydney LHD – were selected in consultation with the Ministry PCLI team and agreement was successfully sought from the LHD executive at each site. They were identified as 'typical' implementation sites for various reasons, which are explained in Chapter 2. This type of case study can be classified as 'instrumental' and 'collective', because of the purposive sampling of more than one site; multiple cases can provide greater understanding of the mechanisms of intervention and causation (Stake, 2000).

Based on the program's strategic objectives and our experience of the program since 2017, we proposed four hypotheses:

1. The PCLI contributed to the implementation of specific transition processes across the patient journey from hospital to community living.
2. The influence of the PCLI extended beyond the health system through cross-sector engagement, which is an integral part of the program.
3. The PCLI created favourable conditions for sustained practice change, and
4. The PCLI contributed to service reform by positively influencing organisational culture and demonstrating how recovery orientation can be enacted in the care of people with severe and persistent mental illness (SPMI) and complex needs.

Our data collection was designed to elicit information relevant to these hypotheses and to allow us to test alternative explanations (Baškarada, 2014).

1.1.1 Structure of this report

Chapter 2 describes the evaluation methods including the case study methodology and data sources. Chapter 3 describes the patient journey from hospital to home to illustrate how transitions to community have changed since the advent of the PCLI. The following chapters seek to explain *why* these changes occurred, examining the mechanisms by which the PCLI has contributed to change, namely: cross-sector engagement (Chapter 4), practice change (Chapter 5) and service reform (Chapter 6) respectively. In Chapter 7, findings are discussed and conclusions presented.

1.2 The Pathways to Community Living Initiative

This section of the introduction provides brief background information to provide essential context for the findings of this report. For details about the history and early development of the PCLI, see *Evaluation Report 1* (Thompson, Williams & Masso, 2018).

The PCLI is a component of the decade-long whole-of-government enhancement of mental health care under the NSW Mental Health Reform 2014-2024. The program aims to support people with SPMI who have been in hospital for more than 365 days, or who are at risk of a long stay (**'long-stay patients'**), and to reduce future long-stay admissions, by changing practice in inpatient and community mental health settings and providing care pathways and community-based support. Planning for the PCLI began in mid-2014 and the program was formally launched in mid-2015.

1.2.1 The target population

PCLI clinical enhancements and service developments have focused on a small group of long-stay patients with complex needs, who previously had limited options for community living. Within this group there are two distinct sub-groups, labelled Stage One and Stage Two.

Stage One consumers are long-stay patients with SPMI and significant issues of ageing and include some people aged younger than 65 years, because people with complex mental illness who have been hospitalised for extended periods tend to experience poorer physical health and earlier ageing than the general population. Because of their ageing issues, they are:

- Eligible for aged care funded support from the Australian Government for care in residential aged care facilities or in the community (accessed via the Aged Care Assessment Teams (ACAT) processes); and/or
- Receiving services from NSW Older People's Mental Health (OPMH) services or an OPMH clinician.

Stage Two consumers are long-stay patients with SPMI without significant issues of ageing. The PCLI assessments, literature reviews, and consultations with consumers, carers and clinicians have helped understand the specific needs of this cohort.

Two cohorts of consumers have been supported by the PCLI. The **initial cohort** consists of individuals who had been in hospital for more than 365 days at the census date of 30 June 2015. The **second-wave cohort** comprises individuals whose long hospital stay began after this date. Both cohorts include a mix of Stage One and Stage Two consumers.

1.2.2 Program design and delivery

The program is delivered using a distributed leadership approach which comprises:

- The **Ministry PCLI team** - the PCLI program manager, the Director of OPMH, senior project and policy officers, the clinical lead, the consumer lead, and the information lead (from InforMH, the Information for Mental Health unit in the System Information and Analytics Branch of the Ministry of Health). It provides strategic direction and resources to support LHDs with implementation and manages the contracts with the external service providers (aged care facilities, accommodation support services, disability service providers).
- LHD **executive leads**, and PCLI **program managers** funded by the Ministry to form part of a State-wide team supporting the program's implementation at the local level.

Primary implementation sites for the PCLI are six Local Health Districts (LHDs): Hunter New England (HNE); Northern Sydney (NS); South-Western Sydney (SWS); Sydney; Western New South Wales (WNSW); and Western Sydney (WS). The mental health services in these LHDs house most of the long-stay mental health consumers in NSW public hospitals. In its third year, the program expanded to include LHDs with smaller, co-located mental health units. Additional LHDs are: Nepean Blue Mountains (NBM), Central Coast (CC), Illawarra Shoalhaven (IS) and South-Eastern Sydney (SES) plus St Vincents Specialist Health Network. Recently, the program has extended again to include all the rural LHDs across NSW, with a senior clinician and rural program coordinator based at Murrumbidgee LHD. These LHDs work with the same cohort of patients with SPMI and complex needs, some having long stays in acute units and others experiencing recurrent hospitalisations.

Each LHD has been allocated funding for senior clinical positions to work with existing staff and support the implementation of the PCLI at the local level. Most of these LHDs now also employ PCLI-funded peer workers.

1.2.3 Community living options

Stage One consumers who require aged care have three options for community living, two of which are delivered via formal partnerships supported by contracts with the Ministry and service level agreements with LHDs. Participating services in the partnerships have been brought together for mutual support and quality improvement in collaboration with the Ministry, through the Mental Health-Residential Aged Care (MH-RAC) Network.

Mental Health Aged Care Partnership Initiative (MHACPI) units are discrete, secure, purpose-designed transitional units within residential aged care facilities. Under the partnership arrangement, the Ministry provides additional funding for staffing and the LHD provides regular clinical support from the PCLI Stage One team who are skilled OPMH clinicians and who work with the existing OPMH teams. Under the PCLI, three MHACPI units have been established within the Hunter New England, Northern Sydney and Nepean Blue Mountains LHDs, each with capacity for 10 people. The MHACPI units are regarded as transitional because once consumers have adapted to their new living arrangements, they are offered the opportunity to move to a less-intensive care setting within the existing facility or elsewhere. When this occurs, ongoing support is provided through OPMH services.

Specialist residential aged care facilities (SRACFs) are purpose-designed aged care facilities providing specialist models of care for people with complex, chronic mental illness. To provide supported places for PCLI Stage One consumers, the Ministry has partnered with three SRACFs within the Western NSW, Western Sydney and Sydney LHDs, providing 'embedded' funding to enhance clinical support within the facilities. Transition follow-up is also provided by the PCLI teams in the respective LHDs, with ongoing support through the OPMH services once the person is settled.

Generalist or mainstream residential aged care facilities (RACFs) are also accommodation and care options for Stage One consumers. Many, but not all, have pre-existing relationships with local OPMH services and inpatient long-stay units due to their history of supporting consumers with mental illness. Specialist clinical mental health transition and liaison support is provided by PCLI clinicians and OPMH services.

For Stage Two consumers at the highest levels of complexity and need, the Ministry will fund 230 24/7 places in **Specialist Living Support (SLS) services** across NSW, to be built by community housing providers and run by non-government organisations (NGOs) with suitable expertise. A Request for Procurement has recently been issued for these facilities (NSW Government, 2021). These services together with the PCLI clinicians and peer workers will form part of a state-wide complex care rehabilitation strategy.

Many Stage Two consumers have already transitioned to the community, utilising existing disability and accommodation and support providers such as through the Housing and Accommodation Support Initiative (HASI) or with funding through the National Disability Insurance Scheme (NDIS). Depending on the needs and preferences of the consumer and their family, they have access to a wide variety of community living options, including Supported Independent Living (SIL) group homes, public housing, private homes, and the accommodation provided through HASI Plus program run by NSW Health.

1.2.4 Strategic outcomes

The strategic outcomes (NSW Health 2016, pp.9-10) of the PCLI at completion will include :

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

This report focuses on the second of these strategic outcomes, namely the processes by which **improved care pathways** have been established at the case sites. It examines the extent to which the PCLI has contributed to the 'future service spectrum' via the development of cross-sector linkages to support community living, to reconfigured or additional service pathways through practice change in inpatient settings, and to service reform by embedding a recovery approach. It seeks to understand how changes unfolded over time. Outcomes of the PCLI in relation to long-stay patient transitions have been reported previously, and have been included in the final evaluation report delivered in December 2021.

1.3 The case study sites

This report uses a case study approach to examine processes of practice change resulting from implementation of the PCLI at two of the six primary implementation sites. It is recognised that each LHD participating in the PCLI will have its own unique service delivery context – a product of its population, geography, history, organisational culture, strategy, leadership, infrastructure and resources – and that this will shape the impacts and outcomes of the program at the local level. The rationale for selecting these two sites is explained in Section 2.1.1.

Quantitative information presented below (i.e., numbers of long-stay consumers, transitions to date) was sourced from the *PCLI Data Outcomes Report* (July-December 2020). Staffing data for WS LHD was taken from the report to the PCLI Steering Committee in March 2021. These numbers are provided to indicate (1) the scale of the task facing the case sites, and (2) the resources available in terms of staffing, and should not be regarded as a definitive presentation of program outcomes.

1.3.1 Hunter New England (HNE) LHD

Most of the HNE LHD PCLI consumers are or have been inpatients of Morisset Hospital in the following units: Ibis (for older people), Rosella (high support unit), Kestrel (medium-secure), and the Cottages, a series of open units of decreasing levels of support and increasing independent living that aims to prepare consumers to transition to the community. A few PCLI consumers had not been in Morisset but had spent time in acute units within the LHD. There were 72 long-stay consumers eligible for the PCLI at the first census in December 2014 (the initial cohort). Of these, 35 have transitioned to community, as have 91 second-wave consumers. Four of the initial cohort[1], and 55 second-wave consumers, were awaiting discharge at 31 December 2020.

Morisset was established in 1906 and was the second largest psychiatric hospital in NSW built outside Sydney. At its peak in the 1960s the site housed more than 1,400 people including people with mental illness and people with developmental and intellectual disabilities. Since then there has been a steady reduction in the overall population on the site, in line with policy (co-location of mental health inpatient services with general acute hospital services), practice changes and community expectations. The Ibis unit closed in late 2019.

To support transition of Stage One consumers, a purpose-built secure MHACPI unit was established at Charles O'Neill Court, operated by Catholic Healthcare, which has a history of supporting clients with long-term mental health concerns and homelessness. Between the advent of the PCLI and 31 December 2020, 13 people with SPMI and consumers with issues of ageing moved from the Ibis unit to the MHACPI, and 17 transitioned to mainstream aged care facilities across the LHD (PCLI Data Outcomes Report July-December 2020).

The region already has NSW Government funded accommodation support providers such as HASI. The region also was a pilot site for the NDIS and therefore has established processes and networks to provide enhanced community support to consumers in addition to those available through aged care and local mental health services. The LHD has established a Collaborative Care Arrangement that promotes partnerships between local public mental health services and community-managed organisations (CMOs). Between the advent of the PCLI and 31 December 2020, 96 Stage Two consumers had transitioned into community care settings.

At December 2020, supplementations under the PCLI have funded 9 staffing positions (7.2 FTE) at HNE LHD: 2.6 FTE for Stage One and 4.6 FTE for Stage Two, as well as the funded program manager position.

1. Some consumers have since died in hospital or were transitioned to 'other discharge locations', therefore the numbers do not add up to the total for the initial cohort. This is also the case for WS LHD.

1.3.2 Western Sydney (WS) LHD

The WS LHD PCLI consumers are or have been inpatients of two sub-acute and three rehabilitation units in Cumberland Hospital. There were 100 long-stay consumers eligible for the PCLI at the first census in December 2014. Of these, 52 have transitioned to community settings, as have 73 second-wave consumers. Twenty-four initial cohort consumers and 39 second-wave consumers were awaiting discharge at 31 December 2020.

Cumberland is a long-standing mental health hospital located at the site of the former Parramatta Female Factory, a residence for female convicts established by Governor Macquarie in 1817. The site has been in use continuously as a psychiatric facility since the mid nineteenth century and was renamed Cumberland Hospital in 1983.

PCLI funding was provided to support the development of a ten-place unit at RSL LifeCare Governor Philip Manor in the neighbouring Nepean Blue Mountains LHD. A 30-bed specialist residential aged care facility (SRACF) is under development in partnership with Southern Cross Care at the Marian facility, directly adjacent to the Cumberland hospital site, with the first five places operational in 2019.

Between the advent of the PCLI and 31 December 2020, 15 Stage One and 110 Stage Two consumers were transitioned into aged care or community care settings.

Supplementations under the PCLI have funded 9.8 FTE staffing positions in WS LHD to support transitions of PCLI clients: 5.8 FTE staff for Stage One and 4 FTE staff for Stage Two, as well as the funded program manager position.

2 Evaluation methods

This chapter describes the case study methodology, including the sampling, data collection and analysis, in the context of the broader evaluation of the PCLI. A project plan describing the proposed methods of the case study was submitted to the Ministry in September 2020.

2.1 Case study methodology

There are various protocols for case study research which have guided this study (Crowe et al., 2011; Miles, Huberman & Saldaña, 2020; Baškarada, 2014; Yazan, 2015; Yin, 2009). In addition, we have followed the *Consensus standards for reporting organisational case studies* produced by the University of York Centre for Reviews and Dissemination. Based on a rapid review and consensus process involving an expert group (Rodgers et al., 2016), this guideline aims to 'improve the consistency, rigour and reporting of organisational case study research, without constraining methodological freedom, thereby making it more accessible and useful to different audiences' and has been published by the Equator Network (2017). The reporting checklist is provided in Appendix 1.

The study has proceeded via the following basic steps (Yazan, 2015), each of which is described below:

- Defining the case;
- Deciding on the unit of analysis;
- Developing hypotheses, linked with broader theory and practice;
- Designing data collection materials;
- Data gathering through interviews with key informants, observations, documents;
- Data analysis and validation.

2.1.1 Defining the case and the unit of analysis

A case is a bounded system (Stake, 1995). Defining the case and specifying its boundaries clarifies the breadth and depth of the research (Baškarada, 2014). We have chosen to bind the case by time and place (Creswell, 2003) and by activity (Stake, 1995). The time boundaries are set by the first evaluation data collection (November 2017) and the most recent data collection (November-December 2020), a three-year period which covers the introduction of the Stage One and Stage Two clinical teams and the establishment and maturation of various local and State-level processes supporting the initiative.

Case selection was made on conceptual grounds (Crowe et al., 2011). The evaluation team discussed the options with representatives of the Ministry PCLI team. There was interest in ensuring each case included both Stage One and Stage Two consumers as each of these groups have unique care needs and it was therefore hypothesised that they would exhibit different patient journeys or care pathways. The cases had to be drawn from the group of six primary implementation sites as they have been engaged since the commencement of the PCLI so have the potential to illustrate the full spectrum of implementation processes and how these may have led to changes in practice over time.

Implementation within these two LHDs is assumed to be 'typical' as neither were pilot sites for the PCLI. A deliberate decision was made to include one regional LHD and one metropolitan as it is assumed that certain processes important in implementation will be influenced by the local service delivery context. This case selection is 'instrumental' in that the sites were chosen specifically to provide comprehensive insights into the implementation of the PCLI and the resulting practice changes. It is also 'collective' – that is, involves multiple cases – to allow us to compare and contrast aspects of implementation across different settings (Crowe et al., 2011).

Importantly the evaluation team has established productive relationships with the PCLI teams within each of these LHDs. This mutual trust and understanding provided an invaluable foundation for data collection. In case selection, access is a key consideration (Yin, 2009); studies are more likely to be informative and relevant if selected cases are 'not only interesting but also hospitable to the inquiry' (Crowe et al., 2011, p.6).

Thus, the **unit of analysis** is the implementation of the PCLI at these two LHDs during this time period, and the evaluative focus includes the processes that were implemented to facilitate transitions from hospital into the community and changes in practice that have occurred in the management of long-stay patients with SPMI and complex needs.

2.2 Evaluation questions, assumptions and hypotheses

Our starting point was the set of evaluation questions for the PCLI (Masso et al., 2017):

1. How successful was the PCLI program in transitioning people from hospital into the community?
2. What factors predicted success?
3. What was the consumer/family/carer experience?
4. Have high quality and responsive new services been established?
5. Has practice in existing services been reformed?
6. Was the model sustainable?
7. Did the PCLI result in value for the money spent?
8. How has the PCLI improved efficiency in systems/services/workforce? Includes consideration of benefits to individuals (e.g., quality of life, physical health, mental health and wellbeing).

This study was one part of the broader evaluation and could contribute towards addressing some, but not all, of these questions. In particular, the case study approach could shed light on Evaluation Question 1 by documenting in detail how transitions were initiated, planned, implemented and sustained at the two case sites; on Evaluation Question 4 by examining cross-sector working with aged care and disability care providers; and on Evaluation Question 5 by exploring efforts to embed the PCLI processes into service structures and to increase recovery-oriented, person-centred care.

Case studies are particularly suited to situations in which '*how* and *why* questions are posed, the investigator has little control over events, and the focus is on a contemporary phenomenon within a real-life context' (Yin, 2009, cited in Baškarada, 2014, p.3). We wished to understand *how* the PCLI had changed practice in the care of people with SPMI and complex needs in NSW non-acute mental health settings, and *why* (that is, the factors that facilitated or obstructed practice change). Based on the strategic objectives of the PCLI, and the evaluation team's experience with the program, we assumed that there would be some changes to document, that these would extend beyond the health sector, and that we could expect to see the kinds of barriers and enablers identified in many theories of organisational change. We proposed four hypotheses:

1. The PCLI has contributed to the implementation of specific transition processes throughout the patient journey from hospital to community living.
2. The influence of the PCLI has extended beyond the health system through cross-sector partnerships, which are an integral part of the program.
3. Activities of the PCLI have promoted favourable conditions for sustained practice change.

4. The PCLI has contributed to service reform through its positive influence on organisational culture and recovery-oriented care.

2.3 Data sources

This is primarily a qualitative study, drawing on program documents and interviews with key informants and observations at the case sites over a period of three years.

2.3.1 Data collection materials and methods

To capture information about the processes under investigation, we modified the key informant interview schedules that had been used for previous reports, prioritising certain questions and eliminating or de-emphasising others so that the interview was focused on the issues of greatest interest to the case study.

The evaluation team drafted an email providing a description of the proposed case study and methods, which the Ministry then sent to the relevant officers in each LHD seeking formal agreement to participate, which was subsequently granted.

We carried out purposive sampling of key informants at the two sites participating in the case study to include those involved directly and indirectly in the PCLI implementation. Sampling was driven by conceptual considerations (i.e., selecting those best placed to shed light on the evaluation questions) rather than by a concern for representativeness. Participants were:

- Program managers and executive leads;
- PCLI clinicians and peer workers (Stage One and Stage Two team members);
- OPMH managers/coordinators;
- Community mental health team members;
- Medical, nursing and allied health leadership within the two hospitals.

We liaised with the program managers at each site to set up interview appointments. Those invited were given a Participant Information Sheet and asked to provide written consent. Travel restrictions and physical distancing requirements were in place due to the COVID-19 pandemic, which affected data collection. We were able to conduct some interviews face-to-face during a site visit to the Hunter New England LHD site; the remainder (including all interviews at Western Sydney LHD) were conducted via videoconference or teleconference.

Thirteen new, in-depth interviews were conducted specifically for the case study (average length 61 minutes, total 799 minutes, range 30 to 112 minutes). Most interviews involved multiple participants; a total of 30 people took part. Interviews were recorded (with permission from participants) and professionally transcribed through a company that ensures security and confidentiality. Transcripts were entered into NVivo 12 Plus for data management.

We also used data from previous interviews that had recently been conducted for the Stage One report (Evaluation Report 5), to avoid overburdening participants by asking them to complete two interviews within a few months. In addition, to facilitate analysis of change over time, we assembled interviews with the same participants (or other participants with similar roles) at the two sites going back to November 2017, thus bringing together five waves of qualitative data collection in one longitudinal dataset, comprising 47 interviews in total.

Another source of data was the large quantity of written material collected during the course of the evaluation, including extensive notes from observations of various PCLI meetings, minutes and meeting documents, other program documents developed by the Ministry PCLI team and the participating LHDs, reflections written by individual evaluation team members, and notes from evaluation team discussions. The report also draws on the direct observations of evaluation team members during site visits each year from 2017 to 2020.

2.3.2 Data analysis and validation

Four team members worked together to code, index, analyse and write up the qualitative findings. Each has had extensive experience of qualitative analysis and lengthy exposure to the PCLI, creating deep understanding of the program and its context. All had visited and toured both case sites at least once, some multiple times.

A modified Framework Method of analysis was used, as this is highly suited to working with large datasets where the data are derived from semi-structured interviews, multiple researchers are working on the project, and the goal is a holistic descriptive overview (Gale et al., 2013). The Framework Method provides a systematic way to categorise and compare accounts and search for patterns in order to develop 'themes' which capture and express important concepts in the data. Themes are broad, abstract categories which recur in the data and illustrate relations, actions, beliefs, narratives or arguments (Maxwell & Chmiel, 2014).

Eight broad categories were pre-defined before coding began, based on the processes we wanted to explore: initiating the transition; planning the transition; making the move to community living; sustaining the transition; cross-sector working with aged care providers; cross-sector working with disability care providers; embedding the PCLI processes; and enhancing recovery-oriented, person-centred care.

Additional ideas which emerged during coding were developed into new codes within and outside of these eight process-related categories. Thus coding proceeded both deductively (around the pre-determined processes) and inductively (emerging from the data).

After coding was completed, parts of the dataset were allocated to team members for analysis and interpretation which then led into drafting sections of the report. The draft sections were edited and quality checked by KW, who was responsible for the overall delivery of the report. To support this process, and to ensure comprehensive and representative coverage of the issues raised by key informants, KW used 'iterative categorisation', a systematic and auditable method for moving from the coding stage through to thematic analysis and interpretation of qualitative data (Neale, 2016).

2.3.3 Ethical considerations

Case studies involving only one or two sites, each with a limited number of employees, increase the challenges of maintaining anonymity of interviewees. For this reason, the use of direct quotations in this report has been kept to a minimum. Quotes from interviews are indicated in blue italics, indented. Quotes from other sources such as journal articles are indicated by black italics, indented. We have not labelled quotes with key informant numbers but have indicated the site and date. No individuals are over-represented in the quotes selected.

For the purposes of ethical approval, the PCLI evaluation was divided initially into three components. This study is part of the Evaluation of Provider/System Change, which was approved by the University of Wollongong and Illawarra Shoalhaven LHD Health and Medical Human Research Ethics Committee in July 2017. An amendment application was submitted to cover the case study methods and the modified data collection materials; this was approved on 22 July 2020. On advice from the Ministry, site specific approvals were not required.

2.3.4 Reporting and quality control

Various authors have suggested standard approaches to reporting case studies (e.g., Stake, 1995; Merriam, 2009; Creswell, 2013). Our preferred approach to structuring the report most closely aligns with that proposed by Miles, Huberman and Saldana (2020). The main elements are listed below, along with sections of this report where the elements appear:

- The innovation (Pathways to Community Living Initiative) – Section 1.2
- The sites (target group, setting, governance structures) – Section 1.3
- The evaluation questions and research hypotheses – Section 2.2
- The processes of implementation – Chapter 3
- Variables affecting implementation – Chapters 4-6
- Discussion of causal network and ties to relevant conceptual work – Chapter 7
- Methodological limitations and confidence in results – Chapter 7

Strategies were adopted to ensure the rigour of this qualitative collective organisational case study, as recommended by Houghton and colleagues (2013). The evaluation team had prolonged engagement with the implementation sites over a period of three years, and also took advantage of regular opportunities to observe the program, for example, through attendance at PCLI Collaboration Group teleconferences, Practice Network meetings, MH-RAC Network meetings, and Steering Committee meetings. Multiple data sources were used to enable triangulation, increasing reliability of the findings. Team members kept their own notes and memos, and debriefed with each other throughout the data collection, analysis, and writing, thus documenting the process of individual and collective sense-making. We also engaged in reflective practice, considering how our involvement in the program may have influenced the findings of the evaluation. 'Thick description' of the findings is recommended to enhance the transferability of the study (Houghton et al., 2013). In this report, we have therefore aimed to provide sufficiently detailed description to allow the reader to make informed decisions about the extent to which the findings may apply to different contexts.

3 Transition processes

People moving from hospital to community living is aligned with contemporary, least-restrictive practice in mental health care and, as noted in other PCLI evaluation reports, provides positive outcomes and experiences for consumers who now have a life in the community.

This chapter describes how transitions now take place at the two case sites, and how the PCLI transition processes differ from usual practice before the advent of the PCLI. It breaks down the transition processes into four steps: initiating the transition, planning the transition, making the move to community living, and sustaining the transition. For each step, the associated activities are described. The goal of this chapter is to demonstrate how the approach to discharge has changed since the program was initiated at the two case sites.

The following three chapters describe *why* these changes have taken place. The key facilitating mechanisms have been cross-sector engagement with aged care and disability care providers (see Chapter 4), embedding PCLI processes within routine practice in mental health services (see Chapter 5), and enhancing recovery-oriented, person-centred care (see Chapter 6).

A summary of the transition processes and how they relate to the key facilitating mechanisms is shown in Table 1.

Table 1: Transition processes and facilitating PCLI mechanisms

Transition processes			Facilitating mechanisms	
Step	**Activity**	**Description**	**Cross-sector engagement**	**Practice change and service reform**
Initiating transition	Eligibility criteria	365+ day LOS or at risk of a long stay; patient is identified by MDT as potentially ready for transition	Maintaining up-to-date knowledge of available and appropriate accommodation and support options as well as the systems that govern eligibility and access to funding (e.g., NDIS, ACAT).	Establishment of clinical and corporate governance, including KPIs at LHD level, to prioritise, plan and facilitate transitions to community. Active engagement with inpatient units to model recovery orientation and socialise objectives of the PCLI. Education and training of inpatient staff. Identification and development of local leaders to act as champions, influencing staff attitudes and behaviours within inpatient units.
	Initial screening	Inpatient staff screen and report back to MDT	Relationship building with MH-RAC partners through regular communication and occasional delivery of general mental health education programs to aged care staff.	Participating in MDT meetings to discuss plans for possible discharges. Acknowledging/ validating the knowledge and expertise of inpatient staff, history/experience of caring for consumers.
Planning transition	Stakeholder engagement	Meetings with inpatient staff, consumer, family	Visiting and interviewing prospective service providers to ascertain capacity, service development requirements (staff training and support).	Participation of consumers and carers/ family embedded into protocols for clinical reviews and PCLI planning processes. PCLI participation in inpatient team meetings, providing education, mentoring, modelling behaviours.

Transition processes			Facilitating mechanisms	
Step	**Activity**	**Description**	**Cross-sector engagement**	**Practice change and service reform**
	Information gathering	PCLI assessment tools, *Journey to Home Guide*, consultation with family, investigation of community accommodation and support options	Assisting inpatient teams, consumers and families with identification, evaluation and selection of aged care, disability accommodation and support services.	Capacity building around processes of transition planning, including NDIS applications. Inter-LHD communications where necessary, regarding prospective accommodation and support providers and transfer to district community team. Education/support to complete the PCLI assessment tools (Ax).
	Detailed planning	Funding obtained (NDIS, ACAT), public guardian or family carer consent, selection of providers, personalisation of supports and requirements, behaviour support plan agreed	Working with inpatient staff to ensure relevant pre-conditions addressed e.g., NDIS package and plan, Aged Care Assessment Team (ACAT) approval if entering aged care, consent or guardianship approval, service agreements signed, financial arrangements established, and contemporary identification, Medicare, personal effects.	Encouraging the use of assessment tool findings to inform care planning and transition planning. Participating in MDT meetings to discuss plans for consumers who are in the process of transitioning.
	Capacity building	Educating providers and community mental health teams or OPMH teams about the specific needs of the consumer, working with the consumer and family on specific needs relating to the transition	Developing and delivering tailored education/mentor programs for aged care and/or disability care providers around individual consumers' care needs.	Communicating with community mental health services & OPMH around individual consumers' care needs. Practice Network meetings involving PCLI and community teams. MH-RAC Network meetings including PCLI clinicians, community teams and aged care partners. Benchmarking activities within MH-RAC Network.

Transition processes			Facilitating mechanisms	
Step	**Activity**	**Description**	**Cross-sector engagement**	**Practice change and service reform**
Making the move	Staged transition	Visiting for short periods, then longer periods; pace ideally determined by consumer	are processes and environment tailored to the needs of consumers. Individual preferences incorporated into program/care planning.	Inpatient bed remains available for the consumer until they are settled into the new home.
	Transition support	Consumer and aged care or community accommodation and disability support providers are supported by PCLI teams in collaboration with inpatient and OPMH/ community MH teams	Monthly Clinical Review Committees. Protocols established: out-of-hours support by PCLI, treating team, community team; readmission pathways including bypassing ED presentation with direct admission to inpatient unit; communication and streamlined discharge planning from inpatient to home.	LHD executive and management sign-off on protocols re provision of out-of-hours, readmission pathways including bypassing ED presentation with direct admission to inpatient unit.
Sustaining transition	Consultancy/ liaison	Consultancy and liaison role between inpatient and OPMH/community MH services and community providers	Feedback on six monthly PCLI reassessments to inform care planning. Routine reporting by MH-RAC providers to LHD and Ministry includes a standing item describing changes in staffing/organisational capacity/context that might affect ongoing care of transitioned individuals.	Regular clinical review meetings involving consumer, provider, community and PCLI representatives. Six monthly PCLI reassessments for two years.
	Ongoing support	Consumer and providers are supported by OPMH or community MH teams	Ongoing participation in clinical meetings (for MH-RAC transitions). Review of protocols between providers, inpatient and community teams, as required.	Continued explicit endorsement of recovery-oriented practice and prioritisation of transitions by Ministry and LHD executive. Regular data collection and reporting within LHD and to Ministry. Benchmarking activities. LHD and state-wide Communities of Practice.

3.1 Initiating the transition

Prior to the commencement of the PCLI, many long-stay patients had no clear sense of when their journey to community living would commence, let alone be completed. In the main, the key objective of long-stay mental health services was the stabilisation of symptoms; once this had been achieved, the focus shifted to remedial programs that had the potential to provide consumers with the life skills required to live in the community either independently or, as was most common, with ongoing support. For many, hospital was considered the only viable accommodation option and this became their 'home'. Initiating transition out of hospital was often a function of the availability of suitable accommodation options at that time (e.g., HASI, HASI Plus), clinical judgement regarding the capacity of the individual to 'cope' in a less structured environment, and assessment of risks to the individuals and the broader community.

The PCLI has provided a clear framework and timeframe for transition. In the first instance, for both LHDs this involved consumers who had been in hospital for longer than 365 days. The eligibility criteria have shifted somewhat for Stage One at HNE following the closure of the Ibis unit. However, WS has maintained 'real rigidity' around defining the target group for PCLI as those with stays longer than 365 days. According to key informants, this has been necessary because of the number of patients and also to avoid 'muddying the water' in measuring the impacts of the program, although the leadership at that site are happy for the PCLI clinicians to provide support and advice on consumers before that entry point to the program is reached.

Within this group of consumers, the initiation of discussions regarding transition has been subject to a number of individual and organisational attributes, including:

- The consumer's age, level of symptomatology or functioning, personal goals and preferences, needs as well as their strengths; and availability of families, carers and support networks;
- The availability of suitable accommodation services that have the organisational capabilities, culture, staffing skills and mix, and close linkages with mental health services;
- Health services which have inpatient staff who can see an individual's potential to live outside of hospital and have confidence that alternative service models will support them; skilled clinicians to interpret PCLI assessment tool results and navigate suitable options; and, community mental health teams that are appropriately resourced to provide ongoing support for consumers in their new homes.

Responsibility for initiating transition varies across sites, and over time. Prior to the commencement of the PCLI, the prospect of discharge was not considered until after a patient had been in hospital for 6-12 months during which time symptoms would be stabilised and they would have been involved in appropriate 'programs'. Length of stay included both time within the current inpatient setting, as well as cumulative lengths of stay across several sites.

In the main, consideration of consumers' readiness for a discussion regarding transition is considered within the context of LHD PCLI management and/or coordination meetings that involve clinical leaders as well as LHD management. These meetings have proved important in signalling a broader organisational commitment to the PCLI, embedding the narrative around transition and recovery within all aspects of mental health services within the district. During these meetings, barriers and enablers to transition are canvassed, and modelling of problem-solving occurs. As the

PCLI has developed, these considerations have increasingly been integrated within routine clinical review and management processes such as bed management, staff allocation and care coordination meetings, and long-stay pathway committees.

As the PCLI has progressed, and initial cohorts have been successfully relocated into community settings, the program has developed a more anticipatory approach to identifying prospective participants. PCLI assessment tools are now being implemented earlier in the stays of some consumers. While these tools provided services with a better understanding of the needs and strengths of consumers, they also provided a valuable marker for the treating team to consider transition initiation and raise awareness of the availability of PCLI teams (or individual PCLI clinicians) to support transition.

3.2 Planning the transition

The boundary between transition initiation and planning is not fixed; indeed, the act of initiation is in many cases the first step in planning.

3.2.1 Information gathering

In the pre-transition phase, consumers and carers meet with PCLI clinicians and treating team members to canvas the potential for moving out of hospital. Once the consumer and family have become familiarised with the idea of transitioning, a more focused process of information gathering begins. The PCLI has introduced a systematic way to determine the consumer's needs, strengths, and preferences using the suite of PCLI assessment tools including the national mandated mental health outcome assessment measures (Table 2). The assessments have been designed to place the consumer at the centre, and to encourage a multi-disciplinary approach to care planning. Use of the assessments by inpatient staff and PCLI clinicians is informed by the *PCLI Planning, Assessment and Follow-up Guide*. A companion volume for consumers and carers, the *Journey to Home Guide*, explains how the processes will unfold and provides information and encouragement for active involvement in transition planning. NSW Health Policy PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services directs LHDs to follow PCLI processes for long-stay patients.

Table 2: Outcome measures and assessment tools

Measure of health status/outcomes	Assessment tools (Mandated and PCLI-specific)
Consumer's level of satisfaction with social participation	Recovery Assessment Scale – Domains and Stages (RAS-DS) Living in the Community Questionnaire (LCQ)
Consumer's choice and control	Recovery Assessment Scale – Domains and Stages (RAS-DS) Living in the Community Questionnaire (LCQ)
Consumer's support needs for living in the community	Camberwell Assessment of Need (CAN-C or CANE)
Quality of life	Abbreviated Life Skills Profile (LSP-16) Living in the Community Questionnaire (LCQ) Dementia Quality of Life (Dem QOL)
Physical health	Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) Living in the Community Questionnaire (LCQ)
Mental health	Health of the Nation Outcome Scales (HoNOS or HoNOS 65+) Kessler Psychological Distress Scale (K10) Abbreviated Life Skills Profile (LSP-16)
Management of activities of daily living	Modified DAD (Disability Assessment for Dementia) Health of the Nation Outcome Scales (HoNOS or HoNOS 65+) Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) Abbreviated Life Skills Profile (LSP-16)
General wellbeing	Living in the Community Questionnaire (LCQ)

At this point or earlier, information is gathered about potential providers of aged care, accommodation support providers and/or disability services. The choice of providers may be guided by the PCLI program managers and teams who may have visited and interviewed providers to ascertain their capacities, limitations, and service development requirements. Because they are not tied to the inpatient setting, the PCLI clinicians are better able to keep up to date regarding service developments, new providers, and the systems that govern requirements for eligibility and access (e.g., NDIS, ACAT). They also have well-developed relationships with the MH-RAC partners at each of the case sites and have provided education and information to aged care staff to enhance their skills in caring for people with SPMI and complex needs. Through state-wide networks and meetings they can find out what options might be available in other LHDs. The location for transition is determined through consultation with the consumer (and family and carers, if available) and also depends on availability of appropriate support services in the chosen area.

3.2.2 Detailed planning

This stage of the transition involves a complex and dynamic series of activities, including:

- selection and engagement of preferred providers
- addressing associated administrative, regulatory and funding issues
- establishing clinical pathways and behavioural support plans, and
- personalising the transition process.

The planning process can extend over months, involving regular meetings between PCLI clinicians, treating teams, and prospective accommodation and support providers. Consumer and carer involvement in planning is central to recovery-oriented practice, which the PCLI aims to further help to embed in mental health services (see also Chapter 6).
The objective is to ensure every issue raised is appropriately addressed, including 'those small and unexpected things' that can impact on the sustainability of consumers' transitions.

There are regular meetings between stakeholders to ensure there is a shared understanding of the transition plan. As the assessments are completed and outcomes reviewed, potential accommodation and support providers are invited to participate in meetings. This provides an opportunity to deal with any concerns raised by service providers, and to identify gaps in service provider capacities which need to be addressed before or during the transition.

3.2.2.1 Provider selection

The assessment tools have provided a starting point for exploring potential accommodation and support options with consumers and carers, including preferred geographic location; proximity to family, friends, favourite past times; as well as preferred living arrangements. As described in Chapter 4, the PCLI has enabled an expansion of potential sites for relocation of Stage One consumers and has capitalised on the resources available through the NDIS for some Stage Two consumers, although there are still Stage Two consumers for whom the proposed Specialist Living Support (SLS) services will be the most suitable option.

Following the identification of potential accommodation and support providers, a considered process of selection occurs. For those expecting to transition into aged care, the selection is generally dependent on the availability of places within specialist services (MHACPI and SRACF) or, if looking to transition to a destination out of the LHD, consideration of generic/mainstream RACFs that have experience supporting residents with complex and chronic mental health issues. In such cases, the PCLI clinicians will confer with colleagues in relevant LHDs about the suitability of providers, and negotiate with OPMH services regarding the capacity to support the consumer. For consumers seeking to transition to CMOs, a similar process occurs, including engagement with the consumer, family and inpatient staff regarding suitable accommodation and support providers that meet the needs and preferences of consumers. The goal is to choose a location and provider according to the specific needs and preferences of the consumer; in reality, selection is often determined by availability, particularly with NDIS-funded group homes:

> *I can't see how the assessments actually affected where people would go and certainly, I don't think through NDIS there's been any tailor-made environments. I think it's been about opportunity... (HNE, 2017)*

Consumers generally have an opportunity to review their prospective living arrangements prior to a final decision being made. Potential options are presented to consumers for consideration, having been narrowed down by

the PCLI team on the basis of the assessment outcomes and availability of places. In practice, the options are generally limited to one site that meets the geographical and care needs identified. Consumers are supported to undertake site visits, along with the PCLI clinician and, if possible, their carers. For PCLI staff and treating teams, the visits provide an opportunity to become familiar with the environmental design and support capabilities of the service specific to the needs and preferences of the consumer. At the same time, the visits give service providers an opportunity to assess the 'fit' of the consumer to their existing staffing and client profiles.

3.2.2.2 Administrative, regulatory and funding considerations

Some early transitions resulted in consumers being transitioned without key documents, personal objects or legal processes having been completed, causing some distress to both the consumers and carers, as well as the service provider. Given the complexity of each consumer's life story, clinical and care needs, PCLI teams have since developed checklists comprising core domains (e.g., health, financial, legal, dietary, social) that are personalised for each individual. These are used to guide the planning process and make sure each issue is appropriately addressed.

Each provider of accommodation and support will have its own eligibility and approval processes which require completion prior to transition. These include:

- ACAT approvals for those transitioning to aged care services;
- NDIS assessment and funding plans for those aged under 65 years;
- Approvals from authorised entities, such as Office of the Public Guardian, and
- Consumer agreements regarding fees and charges as well as rights and responsibilities.

Alongside these processes, many consumers have also needed support liaising with Centrelink, Medicare and banks to ensure details are updated and automated payments that may be required are set up.

Obtaining consent to transition has not been without challenge, particularly in situations where families and carers had been 'traumatised' by previous unsuccessful attempts of the consumer living in the community. The high degree of clinical oversight developed and provided under the PCLI, and the structured and paced transition process provided a degree of reassurance, however it was often the experience of seeing their loved one engaging and thriving in their new home that appeared to make the most impact.

3.2.2.3 Clinical and behavioural support

Existing discharge processes within the LHDs have been enhanced through the development of more consolidated and contemporary clinical documentation that build on the PCLI assessments. Comprehensive behavioural support plans have also been developed that are contextualised to the consumers' new accommodation and support environment. Similarly, clinical oversight mechanisms are now tailored for the consumer, including membership, frequency of meetings, escalation protocols and development of pathways.

3.2.2.4 Personalising the transition

Having been in hospital for extended periods of time has resulted in many consumers having limited or no ownership of items other than what is required to maintain their basic hygiene and clothing needs. PCLI teams have worked with consumers and carers to provide a familiar and supportive environment within their new home and support their ability to engage in activities that are meaningful for them. This has included purchasing of new equipment (furnishings, clothing), familiarisation with technology (mobile phones, computers), and ensuring they have contemporary photo identification and, if appropriate, Opal cards for use on public transport.

The planning process also encompasses what consumers need to keep them physically healthy. For example, one transition involved arranging a sleep study for the consumer and the purchase of a continuous positive airways pressure machine to address sleep apnoea, and then training and encouraging the consumer to use the machine.

3.2.3 Capacity building

In recognition of the significant changes anticipated for consumers, PCLI clinicians have supported transitions through capacity building activities targeted at consumers, carers and providers. For consumers, the PCLI assessment and planning processes provide the main means to identify the functional, behavioural, social and vocational areas to target rehabilitation in the inpatient setting and beyond. Strategies implemented by PCLI clinicians are highly individualised. In addition to the formal clinical review meetings and MDT discussions regarding transition planning, PCLI peer workers and clinicians frequently meet with consumers and carers to ensure their needs, preferences and any concerns are addressed. This serves to help tailor the planning activities, as well as build confidence in the consumer of their ability to successfully undertake the transition.

Carers and families are supported, predominantly in terms of addressing concerns regarding accessing the new home environment, including practical issues such as assistance with public transport use. A significant focus of capacity building has been to build confidence of carers regarding the longer term support that will be available to their loved ones, particularly important for those who have been traumatised by previous unsuccessful attempts at transition. Carers are invited to participate in all aspects and decisions of the transition process, and provided with regular telephone contact by PCLI clinicians.

Capacity building activities with accommodation and supporters are provided to both specialist services and generalist aged care providers and CMOs. As the selection of provider is generally premised on their existing consumer profile and area of expertise, there should be a base level of knowledge about meeting the needs of mental health consumers within these services. PCLI clinicians have offered both structured education and training sessions as well as personalised mentoring with staff and management of provider organisations around the individual clinical and behavioural needs of consumers. Uptake of training has varied, depending on the expertise already available within the provider and frequency of staff turnover.

3.3 Making the move to community living

As with the initiating and planning stages of the PCLI, the process of transitioning from hospital to 'home' is a deliberative process that occurs in a way and pace that places the consumer at the centre. It involves staging the transition process and providing ongoing care and support during the settling in period.

3.3.1 Staged transitions

Transition processes are highly tailored and flexible and, wherever possible, led by the consumer. That is, consumer (and carer) choice and control underpin every stage of the transition process, with health services as well as providers in agreement of the need to work at their pace. In practice, this can involve a number of visits accompanied by the PCLI clinician or peer worker to enable the consumer to familiarise themselves with the different living arrangements, local environment, and people (other residents and staff). If progressing well, visits increase in frequency and duration, are at different times of the day and include overnight stays. This can take several weeks, or even months, and does not conclude until the consumer is confident to make the move to their new home.

During the transition and for a short time afterwards, protocols are in place at the case sites to ensure the consumer's inpatient 'bed' is maintained open for them. This buffer period is designed so that if a consumer feels the need to

return immediately, they do not need to be readmitted via the acute mental health service. It is an important source of reassurance for consumers and carers. Return is not seen as failure but as a learning experience and another step in the journey:

> *I say to the person, 'Well, it's just a hiccup. We're getting this ironed out so that this can actually be successful and hopefully you will stay out of hospital' (HNE, 2020)*

The staged transition approach is also helpful for clinicians, with several noting that if anything was likely to go wrong with the transition it would likely occur in the early stages. Using a deliberative, stepped approach therefore provided the opportunity to closely assess the consumer's adaptation to their new environment, and address emerging issues that may arise and, effectively, enhance likelihood of sustaining transition. Further, it provided the opportunity for 'testing out the systems and the support staff' for consumers, which was often important in gaining support from the Public Guardian and family for the transition. It also supports the consumer becoming familiar with new clinical supports, including the people associated with the community psychiatry and mental health team.

3.4 Sustaining community living

Once transitioned, consumers have access to ongoing monitoring and clinical review through OPMH or community mental health teams working with accommodation and support providers and, where possible, carers and family members. In the MH-RAC facilities, the PCLI Stage One teams continue to play a consultancy-liaison role, attending regular clinical review meetings and conducting follow-up assessments. Under the PCLI guidelines, all consumers should receive clinical oversight for two years after discharge and PCLI follow-up assessments should be conducted every six months. This has been mandated at HNE, whereas at the other primary implementation sites, the person may be discharged sooner and the follow-up period may be shorter than two years, unless the person is under a Community Treatment Order.

The success of the PCLI resulted in some unanticipated consequences for community mental health services. On the positive side, the potential benefits of this type of linkage and collaboration have become apparent and the model of teams working across settings is being applied more widely at one of the two case sites. On the negative side, the rapid increase in transitions of patients with SPMI and complex needs has added to workload pressures. Both case sites have had large numbers of Stage Two transitions that require follow-up clinical care. As the PCLI becomes embedded in routine practice, we would expect that patients with complex mental illness will continue to pass through non-acute services more quickly than pre-PCLI. There will therefore be a need to reconfigure the mental health workforce with a greater focus on the community so that workloads are sustainable and consumers continue to have access to the clinical care they need.

4 Cross-sector engagement

This chapter explores in depth one of the key facilitating mechanisms for transitions to community living: cross-sector engagement with aged care and NDIS-funded disability care providers. The design and implementation of the PCLI is very much premised on interaction, communication and collaboration between mental health services and relevant aged and disability support services. We expected that cross-sector working would be an important contributor to the success of transitions (Hypothesis 2) and this was confirmed. Regular and sustained engagement that extends beyond the health sector is crucial to achieving the strategic outcome of establishing care pathways centred on the individual needs of consumers.

4.1 Working with aged care providers

The partnerships with aged care services (OR aged care service providers) are operationalised at two levels within the PCLI. The Ministry maintains overall responsibility for contractual, funding and reporting arrangements for the MH-RAC specialist service models (MHACPI units and SRACFs). The role of LHDs is to support aged care services to meet the clinical, care and vocational needs of PCLI consumers regardless of whether they transition to a specialist or mainstream RACF. Creating relationships built on trust and transparency has been an important strategy in addressing concerns aged care providers have had accepting people with mental illness. This occurs through three key areas of activity: clinical support, capacity building, and service development.

4.1.1 Clinical support

The clinical support provided by LHD staff to participating RACFs has been critical, for a number of reasons. The legislative framework supporting aged care services emphasises a 'home-like' environment which, over time, has resulted in reduced levels of clinically trained staff, particularly registered nurses, and a greater reliance on relatively untrained personal care assistants to meet the day-to-day care needs of residents. Staffing levels have been shown to severely compromise quality and safety of residents, with nearly 60% of RACFs having 'unacceptable' staffing levels, and only 2% meeting international benchmarks for allied health staff (Eagar et al., 2019; Eagar, Westera & Kobel, 2020). Stakeholders also noted an increased risk aversion within care homes due to recent high profile abuse cases, changing regulations regarding restraint practices and use of antipsychotics, increased number of 'spot checks' by the Aged Care Quality and Safety Commission and public scrutiny associated with the Royal Commission into Aged Care Quality and Safety.

The PCLI has provided a structured approach to clinical oversight of consumers who have transitioned into these care homes. The requirements articulated in the contractual arrangements with the Ministry have been supported by local Memoranda of Understanding between the homes and the LHDs which detail the frequency, nature and composition of the Clinical Review Panels and associated clinical support arrangements. These have been facilitated through the interpersonal skills of PCLI clinicians in building relationships with key personnel, being available to provide advice and review consumers if and when issues arise. The success of these partnerships, however, has been heavily dependent on the individual personalities of the aged care clinical staff and the organisational support they receive. Both LHDs have experienced changes at the individual and organisational levels within their respective aged care partners, highlighting the need for ongoing investment in building and maintaining these relationships.

Both case study sites have worked closely with aged care providers that host and deliver the PCLI-funded aged care places. The HNE LHD was well placed from the outset in identifying a potential PCLI aged care partner due to Charles O'Neill Court's existing specialisation in supporting people who have SPMI and the facility's existing links with mental health services. The mission focus of Catholic Healthcare and its experience with the service delivery model[2] indicated an organisational culture and preparedness to undertake the internal design, staffing and local management changes needed to support PCLI clients.

The experience of WS LHD proved quite different. The closest aged care organisation to partner with was located in the neighbouring Nepean Blue Mountains LHD at RSL LifeCare's Governor Phillip Manor. This has presented challenges in relation to ongoing engagement between WS LHD and Governor Philip Manor, primarily due to its distance from Cumberland Hospital and governance issues between the two LHDs regarding consumers' ongoing clinical oversight and care management. The purpose-built SRACF at Southern Cross Care's Marian facility, which is immediately opposite the Cumberland campus, has proved to be a much smoother partnership arrangement for WS LHD, with a strong and trusting relationship between the clinical leads in the care home and the LHD.

Stakeholders at both sites attribute some early 'miss-starts' as being in part due to the LHD not passing on all the information about a client or downplaying issues or complexity to ensure intake. The lessons taken from this is that transparency is paramount to the success of placement and also to ongoing effective collaboration.

> *… we're very careful in not burning bridges. We're always trying to be very upfront and honest in the behaviours and things because they've got to know whether they've got the capacity to manage people. (HNE, 2019)*

4.1.2 Capacity building

Despite most participating care homes having had previous experience supporting consumers with mental illness, there are a number of factors that contribute to the relatively low level of understanding about mental illness among aged care workers. In part, this is due to the lack of clinical expertise (as noted above) and high turnover of staff within the sector. The negative reputation of some long-standing mental health hospitals and general assumptions about the severity and/or complexity of people who have resided there for long periods of time has made aged care staff wary and, in some cases, fearful of engaging with PCLI consumers.

The role of the PCLI clinician, therefore, extends beyond simply education and training, and includes reassuring staff of their capacity to meet the needs of residents, offering to be available for contact outside usual work hours for advice if needed. This has required constant support and input from the Stage One teams, the program managers, executive leads and Ministry PCLI team, to provide resources and adapt work practices to accommodate the needs of partner care homes. In addition to the scheduled review meetings or initial series of education sessions, PCLI clinicians have realised they need to be proactive in providing a regular presence at the care home, offering refresher training sessions and mentoring and modelling behaviours through working alongside staff in

2. Catholic Healthcare runs a MHACPI unit at St Joseph's in the Sydney LHD, which pre-dated the PCLI and was used as a model for the aged care service developments within the PCLI.

routine activities with consumers. Stakeholders from both LHDs and care homes have noted the extended process of collaboration has resulted in gaining a better understanding and appreciation of each other, and developing and implementing agreed processes that fit with both organisational cultures.

> *It was a real period of growth around understanding our partner a lot better, understanding their language, understanding too their commitment. (HNE, 2020)*

Both case sites also have transitioned people to other aged care services and they collaborate, support and build staff capacity in several different aged care services in their LHD.

4.1.3 Service development

PCLI clinicians across both study sites have undertaken a variety of service development activities to enhance the potential for and sustainability of transition at both the individual consumer and RACF level.

Accessing aged care is dependent on approval by joint Commonwealth/State funded ACATs, which have been under increasing pressure in recent years to prevent people aged under 65 years entering aged care. In recent years there has been one Royal Commission enquiring into aged care and another into disability services, both of which have raised concerns about younger people in aged care, creating additional uncertainty for those working in the ACAT program. Additionally, there has not been widespread understanding of the ageing related impacts of chronic mental health within ACATs. Despite the Ministry having negotiated an escalation flow-path for ACAT regarding PCLI clients, and providing LHDs with a fact sheet to guide applications, ongoing work has been required to ensure timely assessment and approvals are received to support transition.

The intensive in-reach service provided to RACFs throughout and following the transition process has been critical in building confidence of those homes to accept people from long-stay mental health facilities. It has also helped build capacity of the services in meeting the needs of residents with mental health needs across the RACF more generally.

PCLI teams have also implemented a number of initiatives designed to strengthen linkages between RACFs and the health service. Examples include the establishment of protocols regarding:

- access to clinical support out-of-hours;
- streamlined clinical review and readmission processes, including direct access to the local mental health unit, bypassing the need for emergency department presentation where possible;
- streamlined discharge planning through regular communication with facility management during a consumer's hospital admission, and coordination with PCLI and/or OPMH teams.

Another area of activity has focused on meeting the vocational and recreational needs of PCLI consumers, given the limited options available within RACFs. The availability of NDIS packages for those eligible has proven incredibly valuable for recipients to access additional care and recreational support. This has the added benefit of freeing up staff time which can be used to support those consumers who do not have NDIS packages. There is some evidence that the opportunities and activities engaged through NDIS funding have influenced activities more generally within the RACF, including the trialling of different craft activities, entertainment options and dining experiences (e.g., special afternoon teas, barbecue lunches).

4.2 Working with NDIS-funded disability providers

Partnership processes with disability service providers have evolved quite differently from aged care providers. In part, this is due to the changing landscape that has arisen following the introduction of the NDIS, including the emergence of many new providers within the sector and variability in their experience working with people with SPMI. Because NDIS packages are tailored to the needs of individuals, there is often no one provider that is able to meet all the needs; as such, PCLI clinicians generally need to work across multiple services in order to effect a sustainable package for each individual. The key activities of LHDs in working with disability providers are focused around facilitating individual choice, capacity building within services, and development of local processes and resources.

4.2.1 Facilitating consumer choice

The NDIS has been a major enabler for transitioning people aged under 65 years of age into the community settings. Stakeholders have highlighted the benefits of the increased range of providers that have now entered the sector, and the extended range of services available from these providers, which now provide consumers with more 'exit options' than previously available. In some cases, support for people with psychosocial disability through NDIS is being provided by established community managed mental health services which have a strong working relationship with LHDs through NSW Health programs like HASI, providing a foundation for partnership building within the PCLI. With the emergence of new disability providers, some offering supported accommodation options for people with psychosocial disability, mental health services within LHDs are now able to 'navigate' and build relationships with many more providers than previously.

However, with these new service arrangements have come some new concerns regarding the capacity of services to provide the level of support needed by some clients with SPMI. Stakeholders commented on the variability in the governance arrangements of some providers, and the risk this posed to consumers with high levels of ongoing clinical needs, particularly given the highly casualised nature of the sector's NDIS workforce. The prospect of having several different services being involved in supporting an individual also presents difficulties in ensuring a sense of coherence in terms of values, philosophies and processes so crucial for consumers with SPMI. Additionally, it was noted that skills required and time taken to navigate the range of potential providers effectively meant that it was not feasible to expect a consumer could do this without the support of a very well-informed advocate – in effect, the anathema of the choice and control philosophy that underpins the NDIS.

4.2.2 Capacity building

As with the aged care sector partnerships, capacity building has been an important element of the engagement process with NDIS disability providers, and similarly occurred at both the individual and organisational levels. Where partnerships have been established between disability providers with experience supporting people with mental illness, the capacity building role has focused on the education and support around the individual consumers' needs and facilitating relationships with local community mental health teams. For those new to supporting mental health clients, a more nuanced approach has developed. In these situations, capacity building and offering of clinical support is presented as a 'value-add' proposition to the provider, being mindful of the different approaches and philosophies that providers may have compared to the more established mental health services.

We would meet with every new service management and say, 'How do you want us to work in your team? What is your philosophy? What can we not disclose with your staff? How do you want this to run?' (HNE, 2020)

This approach has proved successful, with many PCLI clients now supported in community settings by providers with limited prior experience in mental health. Feedback from stakeholders, including carers and family members, include expressions such as 'thriving' when describing the changes that have taken place, readily citing examples of consumers engaging with others and participating in activities previously unavailable to them, or in which they were uninterested, prior to transitioning.

As with the aged care experience, the success of transitions has been very much driven by the personal interactions between PCLI clinicians and providers, including the commitment to providing ongoing support and facilitating networks and linkages with existing mental health teams. As one NDIS provider manager told a PCLI team member:

If your team wasn't involved he would have been back in hospital a year ago. But he's only out of hospital because your team is here. (HNE, 2018)

4.2.3 Resource development

The introduction of the PCLI within the shifting landscape of the NDIS and heightened scrutiny of the Disability Royal Commission has meant that many existing resources and processes within LHDs have required significant reconfiguring. Both case study sites have developed systems to identify suitable prospective NDIS providers by asking a series of targeted questions regarding their operating processes, governance arrangements, philosophies and values and previous history working with people with SPMI, ranging from formal interview style contexts to casual conversations. This information is captured, along with relevant brochures and service details, in a format that can be shared with consumers and carers in their consideration of potential providers. The information is also available for use by other members of the mental health teams in the LHD, as well as for other teams that may be seeking advice regarding transitioning a client to the LHD.

The time taken to establish eligibility and approval of an NDIS package can be quite lengthy, particularly given the complexity of care needs of PCLI consumers. Delays during this time inevitably impact on the timing of transition. Both LHDs have established effective working relationships with their local National Disability Insurance Agency staff, to assist in streamlining the NDIS application and referral processes. Each have also established their own internal processes to identify potential NDIS candidates and commence the referral and application process as early as possible. By 'flagging' those clients seeking an NDIS package, PCLI clinicians are able to start discussions with consumers and carers about their preferences, and commence reviewing potential provider options, even before the package has been approved.

Due to the absence of specialist PCLI accommodation for Stage Two, many stakeholders cite the NDIS as the single most important contributor to transitions for the consumers without issues of ageing. They do, however, contend that NDIS accommodation is not suitable for people with the most complex needs, who remain in hospital. Stakeholders are waiting for the PCLI Stage Two Specialist Living Support (SLS) services to provide suitable accommodation options for this cohort of people.

5 Practice change

Using the two case sites as exemplars, this chapter identifies and highlights the mechanisms through which the PCLI has operated to promote positive changes in mental health care practice and embed improvements so they become 'business as usual'. We hypothesised that the activities of the PCLI would promote favourable conditions for sustained practice change, and this has been confirmed. In addition, practice change has been one of the key facilitating mechanisms for the transition processes described in Chapter 3.

5.1 Embedding the PCLI in mental health services

Thematic analysis of the interview data identified five coherent sets of activities through which the PCLI has become embedded into mental health services: providing dedicated resources and establishing accountability; clinical governance processes; defining the PCLI role as distinct from that of the inpatient staff; working with inpatient staff to draw on their knowledge, build their capacity and demonstrate the potential benefits of transition for patients; and working with community mental health teams to build strong links with inpatient services and community providers so that there is seamless and informed support for people with SPMI and complex needs once they are living in the community. Factors that may contribute to the sustainability of the PCLI processes and outcomes were also identified.

5.1.1 Dedicated resources and accountability

The PCLI is the mechanism by which the NSW government is seeking to drive systemic change within mental health services and improve outcomes for consumers with SPMI. In order to shift the concept of the 'journey from hospital to home' to a reality, certain preconditions have needed to be in place at both a central (Ministry) and local (LHD) level. These include:

- Resources for additional staff, program management, MHACPIs, SRACFs
- Governance arrangements and agreements regarding KPIs, responsibilities and accountabilities such as:
  - Agreements between the Ministry and LHDs
  - Contracts between the Ministry and aged care and disability providers
  - Memoranda of Understanding between LHDs and providers
- Data collection and reporting systems
- Operational processes such as:
  - program guidelines and eligibility criteria
  - meeting and communication protocols
  - consumer assessment suite and review protocols
- Drivers of organisational culture to support implementation of change, including philosophy of recovery-oriented care, buy-in and commitment of clinical leads, identification and support of change agents.

State-wide processes are in place to facilitate communication and capacity building around the PCLI staff within LHDs and among the aged care providers participating in the MH-RAC Network. Regular meetings provide opportunities for stakeholders to meet, share experiences and problem solve implementation issues as they arise. They also strengthen links between the Ministry PCLI team and the LHDs, allowing rapid dissemination of information including implementation guidance, outcomes data and relevant, newly published evidence, and encouraging input from the LHDs into program development.

5.1.2 Clinical and corporate governance

One of the first tasks for the program managers at both case sites was establishing local governance and support structures for the PCLI. At HNE, there was a series of meetings to discuss how the new program would fit with existing clinical quality and patient care governance committees, and various working groups were set up to address particular issues (e.g., consumer and carer involvement). Champions – staff members who would promote the work of the PCLI – were identified for each of the long-stay units at Morisset that housed eligible consumers. The champion group fed information up to the working groups, which in turn fed information up to the executive level so that issues identified at the front-line could be addressed as quickly as possible.

Work was also underway at WS LHD to clarify how the PCLI would fit into local clinical and corporate governance and to develop governance structures to strengthen 'ownership' of the PCLI within front-line staff positions as well as at executive level. This task was regarded as essential in order to embed the PCLI within the mental health service and make it sustainable.

Thrice-yearly reports from the LHDs to the PCLI Steering Committee show the number and variety of formal working groups and other regular meetings established at the case sites to guide implementation and ongoing processes Table 3.

Table 3: Local governance for PCLI implementation at the case sites

Meetings	Frequency	Notes
HNE LHD		
PCLI Steering Committee	Bi-monthly	Chaired by General Manager MH, provides strategic and operational oversight of PCLI across the LHD
Stage One working group	Monthly	Chaired by Service Manager OPMH, focuses on all Stage 1 initiatives and reports up to steering committee
Stage Two inpatient working group	Monthly	Chaired by Nurse Manager Morisset, focuses on the ongoing rollout of planning and assessment work and PCLI education initiatives at Morisset Hospital and interface with Stage 2 clinical team
Stage Two community working group	Bi-monthly	Chaired by PCLI program manager, focuses on coordination of community follow-up assessments and interface with community teams
Clinical Advisory Committee for the MHACPI	Monthly	Chaired by Service Manager OPMH, the monthly interface meeting with Catholic Healthcare to examine ongoing referrals to the MHACPI unit
Long Stay Pathway Committee	Monthly	Chaired by PCLI Program Manager, an advisory group with a focus predominantly on long stay admissions and discharge delays in acute units
WS LHD		
MDT workforce meetings at long-stay wards	Regular (not specified)	PCLI program manager meets with MDT members to ensure PCLI remains a focus and to allow tailored support for each long-stay ward
Clinical coordination review meetings	Weekly	Stage One and Stage Two team members meet to ensure PCLI activities are occurring in a collaborative manner
Implementation review meetings	Monthly	Between PCLI program manager and executive lead
Clinical advisory committee meetings for the SRACF	Bi-monthly	Co-chaired by Director Community MH and Southern Cross Care General Manager for Care Service Operations
Clinical review meetings for Stage One consumers	Weekly	Participants include OPMH service manager, PCLI staff specialist, Marian Nursing Home senior staff
Rehabilitation and Recovery Services Patient Flow meetings (not PCLI-specific)	Weekly	PCLI program manager attends to ensure PCLI cohort is regularly discussed and transition plans updated

Source: LHD reports to PCLI Steering Committee, April 2021.

Establishing local governance in the MH-RAC partnerships was a precondition for implementation which took time to establish. For example, both sites experienced initial delays with Stage One due to the need to recruit, contract, support and develop relevant community care providers with whom to partner. During this time the PCLI Stage One teams were predominantly inwardly focused, working with hospital staff, community teams and clinical leads to identify, screen and support eligible consumers. These activities were also used to support staff in addressing their concerns around the program, helping build a receptive context for change. A similar process of relationship building will need to take place with the providers of community housing and support that will eventually deliver the Stage Two SLS services, as the service level agreements are negotiated, established and maintained.

By the time of the most recent interviews, the influence of the PCLI on local governance processes could be seen, for example in the way that transitions were initiated, in the division of labour between inpatient staff and PCLI clinicians, and in policies and procedures to support consumers and providers in the community. As one example, following careful work with clinicians over a number of years and leadership from the mental health executive, WS LHD was able to overcome a significant governance challenge which had previously prevented consumers who were having maintenance electro-convulsive therapy (ECT) from being discharged into the community.

5.1.3 Defining roles for the PCLI clinicians

At both case sites the Stage One clinicians operate as a standalone team within the structure of the OPMH service. Both teams struggled initially to find 'a place and a home' where they belonged. For a while they were not integrated either with the OPMH (community) service or with the inpatient settings, and it took time to work out how to add value to the pre-existing discharge processes rather than 'getting in the way'. Staff in the long-stay units also needed time to adjust their ways of working to the presence of the Stage One teams and to understand what they had to offer.

Over time, and with flexibility and 'creative thinking', the teams eventually became well accepted, although a few clinicians found it difficult to adapt and moved on to other roles. The liminal positioning of the team, although initially challenging, proved advantageous in the longer term. Ultimately, the role of the Stage One teams became very much about crossing thresholds and bridging gaps between settings and sectors.

> *The PCLI covers all of the team processes, from inpatient to community, and it links up the inpatient with community teams, and with the aged care facilities. And it's that continual link across those services, so you take that journey with the family and you're that constant person, or that constant team that they have contact with. (HNE, 2019)*

With the closure of the Ibis unit at Morisset, the role of the Stage One team at HNE is in the process of being redefined around consumers with significant issues of ageing who are at risk of long stays in hospital.

Both case sites learned from the experience of Stage One when deciding how to position the Stage Two clinicians within the respective mental health services; interestingly, they chose different approaches. Morisset is geographically isolated from the rest of the HNE mental health services, an hour's drive away from any community team, acute unit, or service hub, whereas Cumberland is a hub of mental health services for WS. These differences probably played into the LHD decisions as to where to position PCLI clinicians.

At HNE the Stage Two team is not attached to either inpatient or community but operates as a separate entity with a consultancy role in both settings. In an early interview, the team acknowledged that 'it has been a big job to learn where we sit and we cross over into many roles'. In the most recent interview, they acknowledged the complexity inherent in this way of working, but felt the challenges were outweighed by the benefits in terms of autonomy and mobility. The Stage Two clinicians and peer worker are able to join the consumer's MDT meetings as required.

WS has taken a contrasting approach of placing each of its three Stage Two clinicians in different community teams, but also assigning them to specific long-stay inpatient wards, so that they are considered part of both settings: 'they're not outsiders coming in'. The Stage Two clinicians are part of the MDTs, which is seen as a benefit. They also play an important role in educating providers of NDIS-funded disability support and accommodation.

There are advantages and disadvantages to both arrangements, which have been designed to fit within the context of the wider organisational and clinical governance structures of their respective LHDs. Stakeholders from WS attributed the embedding of positions within specific inpatient units and community teams as a way to engage fully with both settings, as an insider. Conversely, HNE sees the independence of the PCLI team, neither belonging to the inpatient nor community mental health team, as a unique advantage.

> *… really embedding [PCLI staff] as part of the inpatient team has meant that they have been able to develop that relationship with the nursing staff, with the NUMs, with the psychiatrists on the team, and they are just considered another part of that team. (WS, 2020)*
>
> *The [PCLI] team sit in a space where they can advocate to the inpatient facility and … they can also advocate to the community team about the way that those supports are expected to influence care and alleviate the concerns that might have been generated. (HNE, 2020)*

One important consequence of the separation of the PCLI clinicians into separate teams, within different governance structures, is that their work does not often overlap. Integration within teams and between teams and inpatient units occurs at the expense of fragmentation of the PCLI workforce at each site. This is not necessarily a problem while various local and state-wide mechanisms exist to promote mutual learning and program fidelity across the PCLI and to ensure that the goals of the PCLI remain a high priority. (These mechanisms include the presence of the PCLI program managers at each of the primary implementation sites and the continued participation of most clinicians in the PCLI Practice Network meetings.) It could be argued that any risks posed by this arrangement are outweighed by the evident advantages for implementation and the potential benefits for sustainability.

Collaboration between Stage One and Stage Two at each of the case sites appears to be marginal, mostly occurring in relation to particular consumers who might sit on the cusp of the two Stages or 'flip back and forth' depending on evolving needs (for example, a younger person who begins to develop ageing issues). They do not generally attend the same

local meetings, and each team draws on specialist expertise with their target populations. However, they do all have the opportunity to attend the twice-yearly PCLI Practice Network meetings and participate in the more informal PCLI clinicians' network.

Some key informants have expressed concerns about apparent resource inequities between Stage One and Stage Two, as the caseload for the former has declined while rapidly increasing for the latter. There have been some attempts to share resources across the teams with limited success due to different governance structures. Collaboration appears to work best when assistance with specific assessments (e.g., neuropsychology) is needed. The Ministry has now provided further LHD resources for Stage Two in January 2022.

5.1.4 Working with inpatient staff

Engaging staff working in non-acute units within inpatient mental health services has been crucial to the implementation of the PCLI. In early interviews, key informants told us that staff members were wary of the PCLI, and a small but influential minority of staff members were actively and vocally resistant. They attributed this behaviour to fear for 'their' patients, reflecting a culture of containment and protection within the long-stay units. Staff were also seen to be defensive about their role autonomy and being 'forced' into doing PCLI assessments within a short timespan when they were already busy. Despite reassurances to the contrary, the PCLI was perceived to be part of a larger agenda, which some staff suspected would involve the closure of units or hospitals and result in job losses.

Reflecting back, one key informant suggested that an explicit focus on change readiness and change management might have been helpful to get staff on board prior to the implementation of the PCLI. It may have been useful to acknowledge and deal with the distress, anger, suspicion and anxiety expressed by staff in order to avoid the early resistance which hindered progress in building collaborative working relationships between PCLI and inpatient teams. Nevertheless, this key informant felt that these relationships were, by 2020, 'now evolved and progressed so much'. For staff who had worked at the same hospital for much of their careers, the PCLI represented a radical change:

> *If we've had particular troubles [with staff], it's been out of a place of goodness and care and concern – and I think that's just a creation of our own culture and our own kind of environments. I mean, some of these staff have been working with patients for 20 years, 25 years, and we have [to do] a lot of work on how do you disengage? And how can you actually imagine this consumer … cared for, somewhere other than hospital? And that's actually been – that's what's been tricky. Because they don't know anything else. So, they don't know what the experience with the consumer will be like. (WS, 2017)*
>
> *… change of vision, and it's a real shift. A huge shift for them. So I think we're there now … but I think it's been a fairly rocky road for some. (WS, 2020)*

Recent interviews have documented numerous examples of inpatient staff being supportive and involved in PCLI processes. Ironically, this greater engagement has occurred despite some of the initial fears being realised; the Ibis unit at Morisset has closed, and some buildings at Cumberland will be demolished to make way for a transport link through the grounds.

To turn initial resistance around, a lot of work has been done to collaborate with staff and build their capacity around transition processes. Having experienced senior clinicians in the PCLI teams was necessary to build credibility and confidence around the transition processes. The PCLI program managers and teams have engaged with inpatient unit staff by:

- Demonstrating respect for, and drawing on, their knowledge of the long-stay patients;
- Fostering local leadership through education, mentoring and modelling;
- Ensuring that 'success stories' are communicated back to the units;
- Assisting with the use of the PCLI assessment tools.

5.1.4.1 Demonstrating respect and drawing on knowledge

Involving the front-line staff in transition planning was regarded by the PCLI teams as a 'game changer'. Rather than following 'the PCLI process' as closely as possible, the teams adapted to the needs of the inpatient teams and tried to add value to existing discharge processes and systems rather than replacing them. The result was a division of labour that appears to be satisfactory to all parties and achievable within the resources available. A practical example of this involvement was formalising clinical governance processes at WS to give the nursing staff on the units more responsibility for the initial screening and referral of people for discharge planning; this increased control and responsibility has led to greater engagement with the PCLI.

Another advantage to involving the inpatient team closely in transition planning is that they are familiar with the transition plans including provisions for management of symptoms and behaviours. This means that if staff from aged care or disability service providers in the community phone the hospital for help on weekends or out of hours, the inpatient staff can talk to them from the transition plan, 'they're handing over their knowledge of this person, they're involved with their input'. Their expertise is valued and they are invested in the success of the transition, contributing to its sustainability.

5.1.4.2 Building capacity and fostering local leadership

Early in the program, the Dialogue Days gave some inpatient staff an opportunity to travel to other LHDs and hear about their experiences in transitioning very complex long-stay patients to community living, where they were evidently thriving. The Dialogue Days thus provided a medium for disseminating not just information about the mechanisms of the program but also enthusiasm and hopefulness about the prospects of mental health recovery for these kinds of patients. These events were used strategically by the case sites to engage with inpatient staff. Rather than inviting the same people each time, a variety of staff had the opportunity to participate in the Dialogue Days. One key informant told the evaluation team that the Dialogue Days were a valuable chance to bring along influential nursing staff – who may have been somewhat cynical about deinstitutionalisation and the concept of the PCLI – and expose them to other ways of thinking.

Access to the PCLI-funded training opportunities in the early years of the program also helped build staff capacity and increase motivation for quality improvement. However, in some respects these courses were 'preaching to the converted'; those who volunteered were already motivated to improve their practice, whereas those who did not – for example, some senior staff on the long-stay wards – were perhaps those who needed the training most.

At the time, one key informant remarked that it was important for the middle managers to 'show leadership in this regard', rather than using negative language about the PCLI and its goals which could demotivate the front-line staff.

Once the PCLI clinical teams were in place, staff engagement became more natural and organic because it took place regularly in the workplace. Having the PCLI clinicians on the wards, talking to consumers and staff, offering hands-on help with assessments, and contributing to care planning created opportunities for incidental capacity building with inpatient staff. Their input in the wards has included practical help on navigating NDIS application processes for patients, and assistance with selecting suitable aged care and disability service providers, which not only takes some of the burden from inpatient staff but also encourages them to focus outwards and build community connections for the benefit of patients.

One example of capacity building occurred as part of a quality project at WS, which aimed to increase the completion and clinical utility of the PCLI person-centred assessments. The PCLI team had identified these tools as an opportunity for nurses to have an area of specialisation to give them a voice and a distinctive role in the MDTs around transition planning. Working with a member of the Ministry PCLI team, the program manager used Behavioural Insights principles to devise an approach which would engage and educate the nurses and ensure their efforts were reinforced, by encouraging the psychiatrists to initiate dialogue about the person-centred assessments during MDT discussions.

> *… we met with each ward individually, and we spoke to them, we gave them an update on PCLI. And then we spoke to them about the person-centred assessments, we went through the assessment tools. And we actually practised with them how they can be used to facilitate conversation, and how they can be used to assist with care planning. … We had a lot of 'Aha!' moments. And a lot of, 'Oh yeah, I can see how that would be a benefit'. (WS, 2020)*

At HNE, the approach to developing local leadership was taken a step further through a network of 'PCLI champions'. Early in the program, the PCLI Stage One Clinical Nurse Consultant began mentoring selected nursing staff who could take the lead in each unit. These staff were brought together as a group and consulted about what would be required and what it would mean for them to have a conversation with peers about why PCLI was important. In an early interview, the evaluation team was told that this strategy had only partial success because people moved on and went into different roles. Nevertheless, by the next round of interviews there were identified champions on each of the long-stay units at Morisset. One of these champions described the role as capacity building, mentoring, coaching staff in assessments and explaining the PCLI, mostly one-to-one coaching and training, and liaising with champions in other units. This individual had also developed a resource folder for the Morisset staff intranet site with all the PCLI documentation in one place along with policies, journal articles, videos, the *Journey to Home Guide*, and so on. By the final round of interviews, there were also champions or 'leads' within each of the three community teams working with the Stage Two team.

5.1.4.3 Success stories

Another very effective driver of increased inpatient staff support for the PCLI has been providing feedback about the successful transition of consumers. This has happened informally from the earliest days of the program. In the first round of interviews, one key informant observed the impact of an early success story on staff who had been opposed to the transition, 'out of a place of goodness and care and concern' that it would not work:

> *And by having that one successful transition to see how this can work, we've actually kind of got over some of those hurdles. (WS, 2017)*

The potential for using success stories both to reassure and motivate inpatient staff was grasped very quickly by the leadership at both sites, but some key informants were worried that these stories might somehow insult staff by suggesting that the previous work of the long-stay units was less than optimal. Nevertheless, as one put it:

> *I think you've just got to tell the truth. They're professional people, we can't be not sharing or not telling people because you're worried you'll offend someone. They'll have to deal with that … they'll have to come to terms with the fact that, wow, maybe, we have been a bit precious about who we're keeping and who we're sending on. (HNE, 2017)*

Rather than protecting the inpatient staff, leaders at both sites chose to validate their concerns and their professionalism and keep communication open. Importantly, the barriers to transition were acknowledged, as was the possibility that not all would be successful immediately.

Subsequently, both sites began regularly feeding information about transitioned patients back to the inpatient staff and seeing the positive effects the success stories had on the way those staff spoke and behaved in relation to long-stay patients. Methods for feeding back this information were both informal (such as a PCLI team member chatting on the ward about a person they have visited in the community) and formal (such as the 'postcards from home' initiative at one site). In the latter case, treating teams were worried that people who left hospital would be neglected, 'sat out in a chair and be forgotten about'. The Stage Two team helped people who had left hospital to write back to the wards to let staff know how they were doing. In the most recent round of interviews, the positive impacts of this systematic, structured feedback about the outcomes of transitions to community, facilitated by the PCLI teams, were reported:

> *[We show staff] a snapshot from the person of what they've done, what they look like and where they're at; and they absolutely love it. It helped us greatly with that culture change and us being accepted and our team - and we don't get that resistance now at all. (HNE, 2020)*

Teams have also taken opportunities to raise awareness of the PCLI and its achievements through other means, such as presenting at grand rounds and conferences. One of the case sites was recently honoured as a state finalist at the NSW Health awards.

Use of routine administrative data has also helped to promote the PCLI and engage inpatient staff in its success. For example, stakeholders from one LHD proudly cite the cumulative length of stay of successful transitions which highlights the impact of the program dramatically. These communication strategies serve the purpose of reducing the 'psychological cost' (Shortell, 2021) of the disruption brought about by the PCLI by reassuring inpatient staff that there are realistic and preferable options outside hospital for people with SPMI and complex needs.

5.1.4.4 Problem solving and promotion around the PCLI tools

Attitudes towards the PCLI assessments and data collection has shifted somewhat over the course of the program. Early in the implementation, there was a rush to complete assessments quickly to meet a deadline. LHD staff were also told the data were needed for Stage Two modelling around the planned SLS services. At the case sites, baseline assessments were administered to all long-stay patients over a period of about a month, mainly by inpatient staff, with LHD executive support and the imperative of a high-level KPI in the overall LHD Service Agreements between chief executives and the Ministry. (At some other sites, a small group of PCLI 'champions' accomplished this task.) The legacy was a level of resentment and suspicion, apparent in interviews with leaders and staff of the inpatient services; evaluation interviews over the following three years found that 'the PCLI' was synonymous with 'assessments' and with the 'bricks and mortar' that were expected to eventuate from the assessments.

Nevertheless, the first round of assessments did provide valuable data to guide service planning and a baseline against which consumer outcomes could be measured. The workload eased once the initial assessments were complete. According to key informants there now is an emerging acceptance that some of the tools may have a role in supporting clinical practice and transition. This is the result of persistent efforts dating back at least four years, as illustrated by the following example at one case site.

> In the first interview (last quarter, 2017), the PCLI team had been trying to move the language away from 'these are PCLI assessments' towards 'these are business-as-usual assessments', partly because the PCLI label was 'almost a dirty word' at that time, and implied that transitions were someone else's business and the treating teams did not need to initiate or plan them.
>
> By the second round of interviews (third quarter, 2018), senior managers in the service said they had developed a process to incorporate the PCLI assessments into care planning by creating a summary sheet and linking completion of the tools with clinical review schedules. The tools would feed information into a care plan, and key outcomes listed in the plan would be discussed at the clinical review meeting. These key informants were positive about the prospects, not just for completing the assessments, but for embedding them into routine care.
>
> By the third round of interviews (third quarter, 2019), the PCLI team reported that some inpatient staff were seeing benefits for consumers and had noticed that the effort to produce robust assessments had 'reinvigorated their care and how they look at things'.

Various strategies have been employed at both case sites to shift attitudes to the assessments, such as providing education about how and why to do the assessments, and developing methods to make practical use of the assessment data in case management and transition plans. At one site, the active involvement of senior managers signalled high-level support; this is likely to have shifted staff perceptions around the importance of the tools. At the other case site, it took a little longer. Eventually, with the assistance of the Ministry PCLI team, the PCLI program manager initiated a local quality improvement project informed by behaviour change principles. The project promoted the assessments to the medical officers, so that they in turn would ask for the data to be presented at MDT meetings and incorporated in care planning. By leveraging the positional power and influence of the medical staff they were able to generate some momentum towards embedding the PCLI tools within standard models of care.

5.1.5 Working with community mental health services

One of the features of the PCLI which distinguishes it from earlier deinstitutionalisation programs is the emphasis on continuity of care. This means staff of community mental health services and community-based OPMH services can (and must) make a substantial contribution to the success of transitions. Their input is especially important for Stage Two consumers who have moved into supported accommodation because clinical care is not part of the NDIS disability service model. Community mental health services fill this gap by working directly with consumers and accommodation service providers to provide clinical support to consumers.

PCLI engagement and capacity building with community teams appeared to occur later than with inpatient teams. In some ways, this emulated the actual consumer journey pre-PCLI, where the inpatient services worked with a consumer until discharge and then transferred care to the community team post discharge. Early focus on the inpatient teams may also have been a result of the need to concentrate first on assessment and identification of patients' needs so they could start planning for and working towards transitions.

However, by the second round of evaluation data collection, each of the case sites had Stage Two clinicians appointed and there was growing recognition of the importance of the community teams to sustaining transitions. At that time the Stage Two teams were small, with two clinicians at each of the case sites, and were establishing their roles as bridges between the inpatient and community teams. They had realised very quickly that community mental health clinicians should be included in the transition process much earlier, compared with standard practice before the advent of the PCLI:

> *... one of the most important things in our role is bridging the gap from inpatient to outpatient and transferring that care, which we really haven't had for these clients [in the past]. (HNE, 2018)*

Strategies to build closer links between inpatient and community services included:

- Involving community mental health staff in transition planning meetings;
- Inviting community mental health staff to PCLI training;
- Encouraging participation in information sessions about accommodation and disability support options;
- Linking community teams with disability service providers.

These strategies were necessary in order to manage workload, particularly for the Stage

Two teams, which are smaller and have a larger pool of potential consumers than Stage One. As one PCLI clinician put it, 'if I've got work at the hospital, there's only so much I can do in community'. This Stage Two team member explained that when they first started, it was expected that they would take on all transition-related tasks for the PCLI Stage Two consumers, including holding all the knowledge and providing all the support required. Other community mental health team members resisted getting involved with these consumers at first. Within the first year, the key informant had noted positive changes:

> *Increasingly, as the [community] team have come on board through education and, I suppose, through me spruiking it within the team itself, clinicians are now taking on PCLI consumers to support them, without too much issue. (WS, 2019)*

Even at that relatively early time in implementation, improved collaboration with community teams had decreased some of the burden for PCLI teams to follow-up and support consumers in the community. Importantly, knowing that clinical support was available for consumers had also allayed some of the fears inpatient staff had for consumers:

> *In the past … clinicians on the inpatients [units] were really the primary drivers of that journey until the point of transition within the discharge process. So there's much more integration across the services; in the past it was community and inpatient, whereas now the teams are actually working across those settings as well. (WS, 2019)*

This illustrates why it is vital that community teams are equipped and motivated to take on the challenges of supporting complex consumers. Not only does it share the burden of care, but it also helps embed this type of follow-up care into routine practice within community mental health services. This in turn supports culture change in the inpatient units, by allowing clinicians to feel more confident that transitions will be beneficial and worthwhile. In the long run, people with SPMI who leave hospital will be reliant on the quality of the clinical care and non-clinical supports available in community settings to assist them as needed during acute episodes and to help them maintain mental and physical health and quality of life.

5.1.6 Sustainability of the PCLI

Ultimately, the goal of practice change is to make the PCLI become 'everyone's business': not associated with a particular group of people, a source of funding, or even the name 'Pathways to Community Living Initiative'. This goal has been front of mind for the local leaders of the PCLI at both sites since the early days of the program. One strategy adopted quickly at HNE was to 're-brand' the PCLI clinician teams as 'community transition teams'. This was a response to the initial experiences of the Stage One team and the role confusion that had created some challenges in building relationships with inpatient and community mental health services.

Comments by one of the nurse unit managers explained the nature of the role confusion. This person had initially thought that the PCLI clinicians were there to work on the wards, but then they started working in the community as well. Eventually, it was apparent that they were there to 'coordinate and be there for the staff'. Using the name 'community transition team' immediately made the role clearer: the clinicians were there to help staff identify those suitable for the program and to assist with whatever pathway out of hospital was found to be most appropriate. Paradoxically, removing

the badge made the team's identity more obvious.

Nevertheless, key informants believe that if the community transition teams, the program manager and executive lead at HNE disappeared at this point, it is likely that the organisation would revert to older ways of thinking – perhaps not entirely, but largely. Some input of energy is still required to ensure entropy does not take its course. Similarly, at WS, key informants say there is still some way to go to 'break down the fence' around the PCLI and ensure it is truly embedded. Although the Stage One team at that site is well established and the LHD may be able to maintain the momentum of transitions for consumers with issues of ageing, the situation for Stage Two is different. There is a smaller team with less resources, serving a much bigger cohort; one key informant stated the program 'would fall over if they were to be removed today'. (The evaluation team understands that the resource will be annualised from the end of the initial four-year funding period.)

Designated positions in health services – particularly solo positions – tend to be lost when programs end, and staff time absorbed into other jobs. This highlights the importance of spreading the responsibility for transition planning across the workforce. In this respect, the PCLI champions could play a vital role in sustaining the work of the program. For instance, the champion on one unit conducted a survey of staff awareness of PCLI and found that the basic purpose and principles were not always well understood, and so, with the support of their manager, they introduced an educational program covering the history, purpose, processes, skills, and how the PCLI relates to the work of the unit.

As one key informant said in 2017, 'we don't want a sense of exclusivity around the PCLI or its processes'. Another, speaking in 2020, said other staff still saw the teams as special because of the separate funding source and because they were senior clinicians. However, this key informant firmly argued that there was a need to adopt the PCLI strategy for every consumer and to treat consumers equitably: 'It's part of our everyday business'.

Whether the PCLI as a program comes to an end, or morphs into a 'complex care rehabilitation strategy', the participating LHDs will at some point need to take stewardship of the program's mission and continue to resource and promote its goals and processes. There will be an ongoing need to manage the formal partnerships with MH-RAC services, which should assist in maintaining a focus on the Stage One cohort, and there will be a great deal of work to do to build partnerships with NGOs and community housing providers for the Stage Two SLS services. While the Ministry establishes and manages the contracts for both MH-RAC and SLS services, the LHDs will continue to be responsible for clinical governance through local service agreements. This arrangement should keep community transitions fairly high on the priority list for mental health service executive leadership and thus contribute to the sustainability of the PCLI goals and processes.

6 Service reform

Putting recovery orientation into practice is challenging for any mental health service (Hornik-Lurie et al., 2018; Waldemar et al., 2016) but perhaps more so in the context of long-stay wards for people with SPMI and complex needs. In this chapter, using the case sites as exemplars, we consider the ways in which the PCLI has contributed to service reform by fostering more recovery-oriented, person-centred approaches to transition planning for people with SPMI and complex needs. This chapter provides evidence to confirm the hypothesis that the PCLI has contributed to service reform through its positive influence on organisational culture and recovery-oriented care. In addition, service reform is one of the key facilitating mechanisms for the transition processes described in Chapter 3.

6.1 Enhancing recovery-oriented, person-centred care

The concepts of personal recovery and recovery-oriented mental health care arose in the late 1980s and early 1990s (e.g., Anthony, 1993) as a challenge to predominant biomedical models of mental illness. For individuals with SPMI, recovery means living a satisfying, hopeful and contributing life. Importantly, for the target group of the PCLI, recovery can occur even in the presence of symptoms (Anthony, 1993).

Recovery orientation is currently a dominant guiding concept for mental health policy and practice internationally (Lorien et al., 2020). For clinicians, recovery orientation refers to supporting individuals to achieve meaningful lives 'by promoting hope, attainment of personal goals, social inclusion, and supportive relationships' (Waldemar et al., 2016, p.596). Characteristics of recovery-oriented service provision include person-centredness and promotion of autonomy and strengths (Mental Health Information Strategy Standing Committee, 2015). According to the *National framework for recovery-oriented mental health services:*

Services play a key role in supporting the recovery process for people with mental health issues by helping them to access the internal resources they need in their recovery (for example, hope, resilience, coping skills, self-acceptance and physical health) and the external services and supports that support recovery and independence (for example, stable accommodation, education and vocational support). (Australian Health Ministers Advisory Council, 2013, p.25)

Despite fairly universal agreement that recovery orientation is desirable, it has proven difficult to implement in mental health care (Boardman & Shepherd, 2011; Slade et al., 2014; Waldemar et al., 2016). Acknowledged barriers to recovery orientation in mental health services include the entrenched biomedical model, staff attitudes (particularly risk aversion), and lack of consumer involvement in the implementation of recovery-oriented practice (Lorien et al., 2020; Tickle et al., 2014). There have been efforts to identify effective interventions to overcome these barriers (e.g., Gee et al., 2017; Shepherd et al., 2010; Slade et al., 2014) and also interest in measuring recovery orientation in services (e.g., Burgess et al., 2011; Mental Health Information Strategy Standing Committee, 2015).

The remainder of this chapter addresses the following questions:

- To what extent has recovery-oriented, person-centred care been observed at the case sites since the advent of the PCLI?
- What were the mechanisms through which the PCLI might have contributed to service reforms?

6.1.1 Observed changes in recovery orientation

In the early interviews with key informants at the two case sites, a concern for human rights and least-restrictive care was evident. The program attracted individuals who were passionate about deinstitutionalisation and committed to realising the 'promise long made but not delivered' of previous reform efforts, going back to the Richmond and Burdekin reports of the 1980s:

> *A lot of people have that human rights attitude but the models of care are still catching up and that's expressed by the fact that nationally in Australia there is no rehabilitation and recovery model of care. There are lots of acute ones but no non-acute sector models. (WS, 2018)*

When asked why this type of reform had not happened earlier, one key informant suggested that 'there wasn't the right driver at the top'; that is, it needed impetus and resources from the Ministry to support staff on the ground who were committed to a recovery approach:

> *It's something we can and should be doing, and we shouldn't shy away from it despite all the problems. I've also learned that a lot of people have been wanting to do this for a long time anyway, so it's not new and it's not ground breaking … [the PCLI] is giving us the mechanism and the tools to be able to do it … (HNE, 2017)*

6.1.1.1 Impacts on staff

The move towards more recovery-oriented, person-centred care requires radical changes in the 'mindset' of staff on the long-stay wards. It means a move away from considering the hospital as the person's home for life, as had been the case for the small group of individuals with severe and complex presentations who formed the initial PCLI cohort and who needed 24/7 support. For many years prior to the advent of the PCLI, staff of the long-stay wards 'took great pride in caring for very difficult people under quite difficult circumstances'. The hospital was seen as 'a place of compassionate caring to the end of that person's days'. To some extent this was understandable given the limitations in resources, non-acute inpatient and rehabilitation models of care, and community-based accommodation options for this cohort of patients.

The challenge of organisational culture change in this context should not be underestimated. The arrival of the PCLI disrupted the authority of senior staff who had worked within the existing culture, sometimes for many years. As one key informant explained, people who had spent most of their working lives in that environment had been 'inculcated that we don't discharge [these] patients'. The PCLI brought with it a fundamental shift in expectations for service providers and patients:

> *So it's a totally different attitude and mindset to think that everyone who comes to these services you should automatically think, where will they be, where will they go when they leave this hospital? (WS, 2018)*

During the 2018 round of interviews, key informants at both case sites noted that a very limited interpretation of recovery and rehabilitation had prevailed among the inpatient staff. According to one senior staff member, psychiatric rehabilitation had the reputation that 'nothing happens, nobody leaves the hospital, it's just … stagnant'. This comment reflects the traditional treatment paradigm in which recovery means absence of symptoms or stabilisation of illness. Recovery in this narrow sense is not easily attained for the cohort of patients targeted by the PCLI, which can lead to pessimism and risk aversion for staff, continuing dependency and social exclusion for consumers. Although some staff had already realised that change was needed, others were not ready to consider alternative ways of working:

> *I don't see a whole lot of rehab actually happening. It's custodial care. (HNE, 2018)*

One year later, some changes were being noticed. A problem-solving approach to transition was emerging; some inpatient staff were focusing 'on what the person deserves and wants and how to make that possible'. At the same site, a PCLI Stage Two clinician observed that some staff were thinking differently and seemed to be 'waking up' to the idea that things were changing for this group of patients. Change was also apparent in the use of recovery-oriented language. For example, a Stage One team member said the way staff reported behaviour had changed; whereas previously they would describe a patient as 'too behavioural … too unsettled to be placed' in the community, now conversations were taking place around how behavioural issues might be managed, and what could and could not be managed in aged care.

In recent interviews there is evidence that some inpatient staff are starting to see the situation from the patient's perspective. Such insights reinforce recovery orientation and promote reflective practice, but they can also be confronting as assumptions are exposed and challenged. PCLI peer workers spoke about their growing confidence in advocating for patients and challenging the dominant biomedical language. When the entrenched patterns of speaking and thinking are brought to the attention of inpatient staff members, some respond at first with shock or dismay, but eventually 'they get it and then they're happy with it'. Despite the discomfort in speaking up (or reflecting on their own practice), key informants report that the benefits are seen in terms of culture and practice change:

> *Changing the perception from patient to person, and it hasn't been a comfortable journey for some of it, as you can imagine, trying to change that practice. Sometimes even I've been pretty uncomfortable. (HNE, 2020)*

For example, one key informant related a story about a staff member who watched a former patient open the pantry door in their new home and stand there, staring inside. At first the staff member did not understand, and then they suddenly wondered how long it had been since that person had seen a pantry and had a choice about what they were going to eat. Another key informant spoke about a realisation that struck them when they heard how much enjoyment a former patient had in arranging the furniture in their new home and having their own television:

And that was a real take home message to me that we don't even allow a choice of which side the bed goes on in the room. Crazy. So that really stays with me about choice and control, and how little they have within our [service] – and I'm sad about that. (WS, 2020)

In the community, person-centred care can mean empowering people to express their views and to be assertive regarding the services they are receiving. It is important to understand the power dynamics inherent in the relationship between a person reliant on health care and other services, and the providers of those services. In the case of the PCLI, a former patient may be so grateful to be out of hospital that they are very compliant and accommodating, but they might not speak up about things that bother them. It takes awareness of this power dynamic and a conscious effort to elicit their opinions and feelings and to understand whether they really benefit from the help they are getting, or whether they 'just deal with it' because they do not wish to complain. As one PCLI team member explained:

I love that we have the opportunity, and I see this with my entire team, that we can model that kind of language and those sorts of questions in transition meetings with the consumer, 'What would you prefer?' (HNE, 2020)

6.1.1.2 Impacts on consumers and families

Personal recovery can begin when consumers still in hospital are encouraged to have hope for the future. The idea of transition to community was embraced fairly rapidly by patients; they started to ask for discharge planning and to connect the PCLI staff with the possibility of finding a place to live outside hospital. This occurred even among patients in secure units, some of whom had been there for decades. It is clear that the idea of 'going home' was a powerful impetus and motivator for recovery.

Once consumers were living in the community, their journeys towards personal recovery gained pace. This is apparent in numerous key informant accounts (and in the first-hand accounts of consumers and carers; see *Evaluation Report 3* and *Evaluation Report 4*). Indications of personal recovery were described by PCLI clinicians and program managers as well as by aged care managers and inpatient staff, and included:

- improved speech and communication
- better self-care (e.g., grooming and dress sense)
- greater attention to physical needs such as food and exercise
- taking more personal responsibility for physical and mental health (e.g., intention to reduce smoking, intention to adhere to medication treatment)
- greater social interaction and willingness to participate in group activities
- a sense of belonging and care for one's environment (e.g., having chores to do).

The facilitators of personal recovery, highlighted by key informants, seem to be things that most people take for granted: being consulted rather than coerced or directed, having options and access to information, doing meaningful activities, taking some responsibility for self and others. In community living

environments, rehabilitation can be more 'holistic' because people actually have to look after their own needs. Giving people jobs to do around the house helps to overcome the conditioning they have experienced in hospital, where they are accustomed to having things done for them. In short, 'their lives are fuller'. One anecdote summed up the impacts of recovery orientation for a long-stay patient:

> *So I think he's becoming alive within himself again. And whether that's medication, there could be a number of different factors here, but I think the environment also has enabled this person to feel more comfortable and to be more free within himself. So therefore, his speech and his wanting to communicate … he's talking in full sentences, smiling, participating in group activities. Things he wasn't doing [in hospital]. (WS, 2020)*

At both case sites, the advent of the PCLI resulted in a fundamental shift in messaging and expectations around long hospital stays. Families who had been told their person needed to stay in hospital were now told that they would be better off in suitably supported community accommodation. Naturally, this created some anxiety and concern within the families of people who had been in hospital 'for their safety and for their own good'. As described in Chapter 3, the PCLI teams work closely with families during transition planning (and often continue to do so for some time after the transition) and report that in almost all cases, family carers are happy with the outcome. They can see the benefits for the person, and in many cases it has enabled more comfortable and regular interactions with family:

> *They're not going to a mental health facility to visit their relative, and it's more normal, and I can't quantify it, but I would say it is a more pleasant experience for both the residents and the families when they visit in the community. (WS, 2020)*

6.1.2 Mechanisms for promoting change

Successful approaches to embedding recovery orientation in services are multi-modal, multi-year, and well supported by organisational leadership (Lorien et al., 2020). Effective mechanisms for promoting recovery-oriented practice include:

- Appointing a change agent or champion;
- Collaborative planning with service users and staff at all levels;
- Regular multi-disciplinary meetings;
- Explicit endorsement and prioritisation of the change by management;
- Supportive policies and organisational practices (Gee et al., 2017).

6.1.2.1 Change agents

The most obvious contribution of the PCLI to promoting recovery orientation has been the funding provided to employ the PCLI program managers and clinicians who are the local change agents. Their role development and their ways of working with inpatient and community mental health staff are described above (Chapter 5). The seniority of the PCLI clinicians and their connections across mental health settings place them in an influential position to promote recovery orientation. According to a medical leader at one of the case sites, the presence of PCLI teams 'changed the game for us' when they started bringing information to the inpatient staff about the availability of appropriate community options. They were able to bring new approaches and different ways of thinking to the table, shifting the discussions around discharge from 'Why?' to 'Why not?':

> *So there was an immediate shift in that mindset that we don't have to keep them forever. (WS, 2020)*

Another key informant suggested that the Stage One team's partnership style of working – influencing practice through clinical supervision, modelling, and mentoring – had 'infiltrated into the thinking of the broader older person service … So that's a culture change that probably the Stage One team has been a catalyst for.' The presence of the PCLI peer workers on these teams has certainly boosted their effectiveness. The peer workers bring a contrasting perspective to the work of transition planning and a deeper dimension to consumer and carer engagement in the process. They draw attention to inappropriate language and practices and prompt reflective practice, even within the PCLI teams. One peer worker said they were most effective when there were mechanisms in place which allowed them to bring back what they learned from consumers and carers and use it positively to influence the program.

6.1.2.2 Collaborative planning

Another mechanism for recovery orientation – collaborative planning with service users and families – has been provided by the PCLI resources and processes, including the peer workers and the *Journey to Home Guide*. The presence of the PCLI teams made families more aware that the long-stay inpatient units were intended to be transitional. Although labelling certain processes 'Getting to Know You' may have seemed odd at first – particularly when some had been in hospital for many years – they were designed to address the gaps in knowledge about patients' needs, capacities and goals that were uncovered in the earliest days of the program:

> *We're asking our clinicians to have conversations with these consumers that they've never had before. That's a fundamental part of why PCLI is so important. (HNE, 2018)*

These conversations did not happen automatically or easily at first. The complexity of the consumers, and the wide range of stakeholders involved, made detailed care coordination 'a struggle'. At one site, the program manager facilitated a learning process which involved getting all the PCLI clinicians together and running a session on how to have these conversations, how best to engage with carers, consumers, CMOs and so on, and how to use the information collected through the 'Getting to Know You' process to guide transition planning. Despite the challenging nature of the work, PCLI team members clearly were enthusiastic about the possibilities:

No clients ever would have [had this level of detailed planning] but especially these complex clients that really need this. It is so individualised in that way. We have got different clients, different CMOs, different community teams, different houses, different families. We can't just put them in a box. We are in a new age of mental health [care] which is really exciting. (HNE, 2018)

6.1.2.3 Multi-disciplinary meetings

A central element of the 'Getting to Know You' process was the use of the PCLI assessments. The selection of the PCLI toolkit was designed to inform collaborative, multi-disciplinary care planning, which is also an important mechanism for promoting recovery orientation. However, as described above (Section 5.1.4.4), an early rush to get the PCLI consumers assessed by a deadline has cast a long shadow on efforts to integrate the tools into routine practice. Although inpatient staff were convinced that assessment completion was 'a tick-box exercise', key informants were always clear on the purpose of the assessments, as shown by this comment from 2017 on the need to 'sell' the idea to inpatient staff:

This is about trying to get a picture of what these people look like, so that we can better build something for their future. (HNE, 2017)

There have been ongoing efforts at both case sites to try to get the inpatient staff to see the value of the tools to 'generate clinically useful conversations' and to inform transition planning, so far with fairly limited success (see Section 5.1.4.4). Quite apart from data gathering, the PCLI toolkit was intended to foster the inclusion of allied health and nursing perspectives in transition planning through the selection of a variety of tools administered by different disciplines. In this respect, it succeeded: there is evidence of multi-disciplinary collaboration within the inpatient units. No doubt this was already occurring, but the PCLI is likely to have made a contribution to broadening the scope of discussions within team meetings. With increased opportunities to work together to support successful transitions, some medical staff have gained a greater appreciation for the different roles in the MDT. For example, front-line clinicians now better understand and appreciate what allied health professionals can contribute to transition planning.

6.1.2.4 Leadership and organisational support

Among the key mechanisms for embedding recovery orientation are leadership, organisational support, and a multi-modal, long-term approach (Gee et al., 2017; Lorien et al., 2020). All these mechanisms are present and operating as intended in the PCLI. The program's service reform agenda is consistent with NSW policy priorities and has endorsement at Ministry level and at the executive levels within participating LHDs, including the two case sites. The program has been rolled out in partnership between the Ministry and the LHDs, the former providing the funds and strategic leadership and the latter providing the operational leadership and governance. A variety of resources, governance arrangements, systems, procedures and drivers have been available to the program to enable implementation and drive service reform.

6.1.2.5 Additional mechanisms specific to the PCLI

In addition to the mechanisms identified in previous studies, this evaluation has found that the bridging role of the PCLI clinicians is an essential element in its contribution to service reform. Cross-sector engagement by the PCLI teams builds links between health, aged care and disability providers, and provides opportunities to model and strengthen recovery orientation in the broader care system around consumers. Their roles include building capacity among the staff of these service providers, providing clinical support, and facilitating consumer choice in the transition process – these activities are described in Chapter 4.

The PCLI teams also act as a conduit for information throughout the transition process and often beyond. Underpinning the PCLI is a focus on communication with all stakeholders, centred on the consumer's rights, needs, capacities, goals and preferences.

For mental health staff working in inpatient units and community teams, communications have predominantly been framed as the PCLI providing systemic impetus to recovery-oriented practice. Communication channels have been formalised, including through internal directives, promulgation of guidelines and promotional materials, and the establishment of governance processes such as steering committees and executive meetings. PCLI clinicians proactively engage with inpatient staff around consumers' needs, during the information gathering stage at the outset and through the assessment processes, as well as through having a 'presence' on the units and participating in team meetings. Community teams have also participated in the development of clinical review meeting processes.

7 Discussion

This report has presented qualitative evidence from an in-depth examination of PCLI processes at two of the six primary implementation sites. It has demonstrated how PCLI transition processes have enabled successful and sustainable discharges to the community, and why these processes are effective, due to facilitating mechanisms that are integral to the program's design, namely cross-sector engagement, systems and activities to promote practice change, and embedding recovery orientation into mental health services.

7.1 The contribution of the PCLI

The study began with four hypotheses (Section 2.2), which have been confirmed. The PCLI has instigated structured transition processes to complement and improve the discharge planning practices that existed previously. The program's influence has extended beyond the health sector to facilitate greater collaboration and integration with aged and disability care providers, building a more holistic system of supports around the consumer. Favourable conditions for practice change in mental health, particularly inpatient settings, have been established through governance, executive and local leadership, and systematic methods for gathering relevant information from consumers, carers, inpatient staff and aged care and disability support providers. There is evidence of organisational change and service reform resulting, at least in part, from the activities of the program's key change agents, the PCLI program managers, peer workers and clinicians, who have modelled recovery orientation and upskilled other stakeholders to improve person-centred care across settings.

7.1.1 Hypothesis 1: Systematic, structured transition processes

Prior to the PCLI, discharge processes were driven primarily by clinician perspectives, historical practices and available options rather than patient preferences. The PCLI has delivered a structured approach to transitioning from hospital into the community, providing greater clarity and consistency for staff, consumers and families.

The PCLI program has provided the impetus and resourcing to motivate and facilitate discussions about transition to the community for patients with SPMI and complex needs, including some individuals who may not previously have been considered for discharge. In the first instance, it has put initiating transition from bed-based care clearly on the agenda, providing health staff with the tools (assessments, additional clinical resources), permission (KPIs) and processes (data collection systems, staff development programs, clinical panels etc.) to do so. The engagement of PCLI staff with treating teams has exposed a broader range of consumers for transition than would have previously been considered, and the introduction of evidence-based assessment tools has provided a greater transparency to the transition process. The continued presence of PCLI staff in team meetings kept transition discussions firmly on the treating team's agenda, and has changed the tone of discussions within the treating teams. There is greater focus on the identification of consumers who could be transitioned, and the services needed to support them, rather than the barriers that prevented transition.

7.1.2 Hypothesis 2: Promoting integration and collaboration across sectors

The absence of alternative suitable accommodation and support options has been a major contributor to the lengths of stay of PCLI consumers. The funding provided by the PCLI has helped remedy this, in terms of capital investments and clinical expertise employed by LHDs to build capacity within community services. The availability of the MHACPI and SRACF 'beds' has expanded the range of options for the Stage One cohort. In RACFs, PCLI staff have worked closely with management and staff in facility and workforce redesign processes, including provision of staff training, mentoring and modelling; development of referral pathways and communication protocols; and, familiarisation and consistency of key LHD staff involved in the care and management of residents.

Despite these investments, as the Royal Commission into Aged Care Quality and Safety highlighted, the ongoing workforce constraints within the aged care sector severely limit the sustainability of staff skills that have been developed. Several RACFs that support PCLI clients have experienced changes in management, leadership and operational processes that have impacted on staffing consistency and care outcomes for residents. As such, PCLI program managers and Stage One teams have a vital, ongoing role, not just in clinical review of residents who have transitioned, but also in capacity building and maintaining the relationships with the MH-RAC partners.

For those without significant issues of ageing, there has been an expansion of community based disability support services in recent years facilitated by the introduction of the NDIS. The regulatory framework surrounding service providers in this context is not as well developed as the aged care sector, and options are often limited to those providers which have a strong track record in supporting people with long term mental illness such as the state funded HASI program. The PCLI has played an important role in 'curating' the choices available to consumers and building capacity in community providers to ensure that people with complex needs have the best supports possible for successful, sustained experiences of community living. Consumers moving from inpatient services within the case sites have been able to access a range of services both within the case study LHDs and further afield.

7.1.3 Hypothesis 3: Establishing favourable conditions for practice change

Major system transformations do not occur without significant prior investment within organisations in securing the necessary resources and development of relevant governance, systems and operational processes needed to support and sustain the change being implemented. The case study sites have benefited from State-level resources, developments and activities that contribute to practice change and promote the transition of long-stay patients from hospital to more appropriate community settings.

Supportive leadership and ongoing efforts to embed the PCLI into local clinical and corporate governance structures have also facilitated practice change. In the early days of implementation, there were difficulties in defining the respective roles of the Stage One clinicians and the front-line nurses and allied health professionals on the long-stay wards who had previously been responsible for discharge referral and planning. The PCLI disrupted normal workflows and created tension; this is an example of the third law of health care integration, 'Your integration is my fragmentation' (Leutz, 1999). Shortell (2021, p.93) noted that:

The end goal is more coordinated, integrated care for the patient, but providers experience all of these changes as disruptive to their established routines, 'fragmenting' what they have customarily been trained to do. Thus, not only does integration have a financial cost … but it also has a psychological cost to the health professionals involved.

Therefore, one key to embedding the PCLI in mental health services was finding ways to minimise the psychological costs for inpatient staff. This was achieved by acknowledging and respecting their genuine concerns about the patients they had worked with, and drawing on their long-standing knowledge of the patients. With the help of leaders within the service, the program managers and clinicians have fostered local leaders and created networks of PCLI champions, alleviated concerns and fuelled enthusiasm for transitions by communicating 'success stories' back to long-stay units, and provided education and assistance for the use of the PCLI assessment tools.

It has been vital for the Stage Two teams to establish solid working relationships with community mental health teams, who take primary responsibility for following up consumers after transition. They have done so by involving community team members in transition planning and by encouraging the uptake of relevant training and information. They have also assisted in linking community mental health teams with disability care providers that are delivering services to PCLI consumers.

At one of the case sites, the PCLI adopted a consultation liaison model providing expert advice to the treating teams. At the other, the PCLI staff worked in a direct case management model, making decisions about the initiation of transition. As a result of this variability, some key informants made it clear that transition decisions were the responsibility of the treating team, while others indicated that it was firmly in the hands of the PCLI staff.

Regardless of where the PCLI clinicians are positioned within the organisational structure, they appear to be serving as a valuable resource to both inpatient and community mental health services and external providers. Across both Stages, the PCLI clinicians have established a vital bridging role across settings and sectors. It is reasonable to assume that their active participation in advocacy and care planning for long-stay patients has made a significant contribution to successful and sustained transitions to community living.

7.1.4 Hypothesis 4: Service reform via positive influence on recovery orientation

Key informants have always regarded the service reform component of the PCLI as central, something that had to be communicated to stakeholders and 'has to continue long after the project is gone'. From their accounts over the past three years it is possible to ascertain the progress that has been made towards that goal. In relation to the staff of inpatient mental health services, key informants have noted changes in 'mindset', which are especially evident in the use of language and problem-solving approaches. For consumers, indications of service reform can be seen in renewed hope for discharge and life outside hospital, and for carers the impacts of reform are shown in greater trust and willingness to consider community living options.

Consistent with research on the factors that facilitate greater recovery orientation in mental health services, the evaluation found that the PCLI program managers and clinicians were effective change agents. The PCLI teams and processes enhanced multi-disciplinary, collaborative transition planning. With organisational leadership, support and

accountability at the highest levels, the PCLI teams at both case sites have been well positioned to promote service reform at the grassroots level by encouraging and modelling recovery-oriented practice.

The bridging role of the PCLI clinicians was also identified as an essential element in the program's contribution to service reform. The PCLI has introduced new models of operating across settings and sectors which improve collaboration and communication between providers.

7.2 Alternative explanations

This organisational case study of two PCLI implementation sites has set out to demonstrate the contribution of the PCLI to practice change at the two case sites. When asking whether a program has made a difference, it is possible to talk about 'attribution' and 'contribution'. Both address the idea of causation. The former term is most useful when changes can be measured quantitatively and usually applies in experimental research. When examining changes that occur in complicated contexts, and those that involve quality rather than quantity (e.g., of service delivery and relationships) the concept of contribution is more useful (Almquist, 2011). Contribution analysis is also helpful when the program theory is relatively fixed with little scope to vary how it is implemented (Mayne, 2008), as is the case with the PCLI. Inferring causality through contribution analysis requires evidence that:

1. The program is based on plausible assumptions which are agreed upon by key players;
2. The activities of the program were implemented as intended;
3. The chain of expected events occurred;
4. Other factors influencing the program and its outcomes were considered and their relative contributions recognised (Mayne, 2008).

The first three of these conditions have been met, as set out above. This section addresses alternative explanations for the observed changes at the case sites. It is important to acknowledge and test rival hypotheses to establish the credibility of the case study and to minimise the potential bias that inevitably exists, as researchers tend to start with preconceived ideas (Baškarada, 2014). Consequently, two rival hypotheses were generated from the accounts of some key informants:

1. The NDIS is the main mechanism supporting transitions to community, therefore Stage Two consumers would have moved out of hospital regardless of the PCLI.
2. The observed changes in practice and recovery orientation were already in train and would have continued without the intervention of the PCLI.

In relation to the first rival hypothesis, it is true that the NDIS brought resources and opportunities that had not existed previously, including an influx of new disability service providers with a strong business imperative to build their client base. This was particularly the case at HNE, which had access to relatively plentiful NDIS support during the trial period:

> *The most revolutionary thing that's happened has been NDIS since we were part of the trial site because really, what we – I mean, our lengths of stays have halved over the last 10 years, and prior to that, people would just sit here because of external factors, there was just nowhere to put them. (HNE, 2018)*

However, the unregulated nature of the disability support market also introduced risks around providers taking on clients without fully understanding the extent and complexity of their needs. The NDIS is also not designed to provide the ongoing clinical support which people with SPMI generally need. Stage Two consumers may well have moved out of hospital regardless of the PCLI, but they would not necessarily have remained in the community in the long term. Stage One consumers who were under 65 years of age may also have benefitted from NDIS community access supports when they transitioned to aged care, but the market-based approach is not able to ensure that providers have adequate skills and knowledge for working with these extremely complex clients.

Further, the experience of HNE as a trial site was exceptional and has not been repeated at other PCLI implementation sites, including WS. Since the trial period, NDIS requirements (e.g., for eligibility and for regular review of support packages) have been continually refined, creating a system that has become notoriously difficult to navigate. In state-wide forums observed by the evaluation team, PCLI stakeholders have highlighted instances where provider efforts to improve the capacity and functioning of clients are 'punished' by a reduction in support levels when packages are reviewed. The unpredictability of funding for individual clients makes it difficult for providers to plan. The gaps in NDIS provision for psychosocial disability are well documented (Smith-Merry et al., 2018). Indeed, some have argued that the policy settings for the NDIS are incompatible with recovery-oriented mental health care (Rosenberg et al., 2019).

It is also true that opportunity – rather than consumer needs – determines transition timing and destination in many cases. This was seen in the early days of the MHACPI unit at Charles O'Neill when there was perceived pressure to fill the beds to ensure a flow of aged care funding (see *Evaluation Report 3* for details). It is also seen for Stage Two consumers who do not tend to move to 'tailor-made environments' based on their assessment results; rather, if a CMO has a SIL house with three bedrooms, the task is 'trying to find three people who might live together in a mutually comfortable way'. This is the reality of securing a place for a complex client with limited resources in a thin market. Despite the best intentions, and all the data derived from the PCLI assessments, a person who loves fishing is not necessarily going to end up living near a river. However, this is a shared human reality not specific to mental health or the PCLI.

The second rival hypothesis is illustrated by the following exchange which occurred during a discussion among inpatient staff in 2019:

A1: We hardly have discharges, so, to have one person be discharged out of our unit through the PCLI process, for many of the staff, this is a huge kind of thing, yeah, that someone can go out from our unit and not return back for the last, what, six months or so?

A2: Longer.

A1: It's longer. So, staff feel that if you put in the effort and systems are working well, chances are people can be discharged and perhaps not come back, which is what we've seen … It's still exciting to see that people can be transitioned out of our unit and not to be used as a place that you contained, until nothing works for you and if – that kind of thing is…

A3: This doesn't just happen because of PCLI.

A4: No, I was going to say the same thing.

A3: We've been discharging people effectively for years and they don't come back, and…

Certainly, developments were under way at both case sites to reform practice and support recovery orientation. There was already a movement towards involving consumers and families more in care planning. Over many years, there was rehabilitation work going on to prepare long-stay consumers for discharge to the community. However, it is also important to realise that there were consumers at those hospitals who had been there for decades and were unlikely to have transitioned to community without the resources, supports and impetus provided through the PCLI. This point was made by numerous key informants.

The PCLI has benefitted from and built on a considerable amount of earlier work. For example, at one case site there had been a review of seclusion and restraint with the goal of minimising use of containment, shifting the focus away from risk and considering more functional strategies for dealing with behaviours. At the other site, there was work under way to identify the expectations of clinicians, carers and consumers for sub-acute and non-acute mental health services and to use these insights for quality improvement. These efforts had already started to change thinking, perhaps creating a more receptive environment for the PCLI:

And so, all of these changes are starting to have an effect, where people are starting to go, oh, the way we used to contain people and nurse people around risk and around managing their behaviour, now they are starting to see behaviour as a way of exhibiting distress, not so much as a way of annoying the nurses. (HNE, 2019)

The PCLI has also prompted additional, new work that supports the goals of person-centred, recovery-oriented care. For example, a group of inpatient staff set up a 'transition preparedness group' for consumers getting ready for discharge. The PCLI approach is being introduced into other units, including acute care, in order to minimise unnecessary long stays. Staff are challenged to start thinking early in the admission about where the consumer is heading, to set an estimated date

of discharge and to document anticipated barriers to discharge, and benefits have been seen from these new procedures. Staff of the non-acute and sub-acute wards who felt that practice change was needed were given 'the blessing' to ask questions and to collaborate with like-minded colleagues and talk to others about different ways of working. As one key informant put it, because the PCLI was Ministry-led, it provided some authority and some urgency to empower individuals who were already motivated to create change in their workplaces. For others, who perhaps had not embraced the concept of recovery, it led to 'a more articulated intent' to follow contemporary principles and policy directions for care delivery.

In summary, it would be unrealistic to expect inpatient staff to be deeply familiar with NDIS procedures or the changing landscape of disability providers. Leading practice change in entrenched organisational cultures is a lot to ask from individuals without strategic leadership and additional resources. The NDIS and existing practice change efforts provided a foundation and a supportive context for the PCLI, and the PCLI in turn has added significant value, because the program managers and clinicians are focused on transitions as their area of speciality. However, the alternative explanations cannot fully account for the changes observed over the timeframe of this evaluation, and so the rival hypotheses are rejected.

7.3 Limitations

The analyses presented in this section are based on interviews with key stakeholders working in the two case study sites, including PCLI program managers, clinicians and associated team members (peer support workers), as well as clinical leads and staff working in inpatient units and community mental health settings. The majority of interviews were conducted within a group context, with the objective of encouraging members to reflect on developments taking into account different perspectives. Despite our attempts to ensure all participants contributed to the discussions, it is possible this format inhibited the participation of some members. While an invitation was issued for participants to follow-up with additional comments or feedback to the evaluation team members on a confidential basis, no further contact was received.

The case study approach has allowed the evaluation team to develop various working hypotheses about the processes and outcomes of the PCLI, which have been tested through the interview process. This has been an iterative exercise, with hypotheses refined and new ones developed as the interview process has progressed. While our data recording and analysis has been rigorous to give us confidence in our conclusions, ideally we would have preferred to discuss our findings with participants and incorporate their feedback prior to reporting. Due to time and resource constraints, however, this has not been possible.

7.4 Conclusion

Practice change and service reform have always been overarching goals of the PCLI, as shown by the strategic aims for the program, defined by the NSW Ministry of Health in 2016 (Section 1.2.4). The first aim can be measured quantitatively and qualitatively as it centres on the number and quality (i.e., success, sustainability) of long-stay patient transitions to community living. The second is best measured qualitatively. It refers to embedding a recovery approach in services through developing a contemporary model of care spanning non-acute inpatient and community mental health services. The current report presents evidence to support the assertion that the PCLI has contributed to this second strategic outcome.

First, the PCLI has built on existing discharge processes by introducing innovations and improvements that are explicitly designed to enable transitions to community for people with SPMI and complex needs. Second, the PCLI transition processes have been made effective

and sustainable through an additional set of facilitating processes, namely: cross-sector engagement with aged care and disability service providers; mechanisms to embed the processes within mental health services; and changing the culture of services by promoting and modelling recovery oriented, person-centred care.

Two alternative explanations, derived from key informant accounts, were explored. Both contain elements of truth, in that the PCLI has provided the imprimatur, resources and structured processes to take advantage of the opportunities presented by the NDIS and to build on the momentum of practice change efforts already under way. However, they do not fully account for the changes observed over the timeframe of this evaluation.

This 'deep dive' organisational case study has confirmed the role of the PCLI as the most likely and feasible *driver of change* in transition processes, clinical practices, and service reform in relation to long-stay patients with SPMI and complex needs at the case sites. It is reasonable to conclude that, due to the contribution of the PCLI, long-stay mental health wards in NSW are increasingly seen as temporary stops on the recovery journey, rather than destinations.

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Appendix 1: Case study reporting checklist

Reporting item		Reported on page no.	Justification for not reporting given on page no.
Describing the design			
1	Define the research as a case study	7	
2	State the broad aims of the study	8	
3	State the research questions/hypotheses	8, 9	
4	Identify the specific case(s) and justify the selection	7, 8	
Describing the data collection			
5	Describe how data were collected	9, 10	
6	Describe the sources of evidence used	10	
7	Describe any ethical considerations and obtainments of relevant approvals, access and permissions	10, 11	
Describing the data analysis			
8	Describe the analysis methods	9	
Interpreting the results			
9	Describe any inherent shortcomings in the design and analysis and how these might have influenced the findings	11	
10	Consider the appropriateness of methods used for the question and subject matter and why it was that qualitative methods were appropriate	11	
11	Discuss the data analysis	10	
12	Ensure that the assertions are sound, neither over- nor under-interpreting the data	10	
13	State any caveats about the study	49	

Source: Centre for Reviews and Dissemination, University of York. Downloaded from Equator Network, https://www.equator-network.org/reporting-guidelines/developing-a-methodological-framework-for-organisational-case-studies-a-rapid-review-and-consensus-development-process. Guidelines based on Rodgers et al., 2016