Getting To Know You

UNEXPECTED OUTCOMES OF A MANDATED ASSESSMENT AND PLANNING PROCESS IN THE NSW HEALTH
“PATHWAYS TO COMMUNITY LIVING INITIATIVE” (PCLI)

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What is the PCLI?

❖ NSW Government sponsored initiative:
  • For “380” people in long term psychiatric hospital care to translocate into community based, recovery oriented, care options

❖ A key platform for the reform of NSW’s MHS
  • MH Commission’s Strategy for Mental Health Services in NSW “Living Well”

❖ Significant Government commitment:
  • Reporting at highest level ~ “Interagency Task Force to Cabinet”
  • Treasury recognition ~ $110M funding, including new money
  • Work is complex and multifaceted with residential and innovative community support options
  • Organised in 3 stages over 3-8 years
    • Stage 1: 100 people mainly elderly in very long term psychiatric hospital care ~ up to 30 years
    • Stage 2: 280 people in range of acute and non-acute care
  • Involves processes of detailed assessment and evaluation
Overview of prevalence of mental illness*

* National Mental Health Commission 2014
PCLI: Target Population

Current service provision for adults requiring (inpatient or community) bed-based services in NSW

Forensic/high-secure

PCLI Cohort: LOS >12 MNTHS

INPATIENT ALOS > 9 -12 MNTHS
Community Support: ongoing 24/7 accommodation support (e.g., HASI PLUS)

INPATIENT ALOS > 6 -9 MONTHS
Community Support on Discharge: ongoing inreach residential supported accommodation (e.g., HASI or CLS)

INPATIENT ALOS > 2 MONTHS
Community Support on Discharge: ongoing specialist MHS support and NGO services

INPATIENT ALOS >1 - 2 MONTHS
Community Support on Discharge: periodic specialist MHS support and NGO services

INPATIENT ALOS < 1 MONTH
Community Support on Discharge: independent with mainly private or MBS services (small number may also access NGO support services)

Planned service provision for PCLI cohort: all with Severe and Persistent Mental Illness and Complex Needs

Risk to Others: Medium secure hospitalisation initially, then PCLI joint service delivery options with expected periodic hospitalisations

Risk to Self with Atypical Features: individualised PCLI community options; expected frequent hospitalisations

Very Complex Needs: PCLI joint service delivery in the community with expected periodic hospitalisations

Age-related needs: often very long stay: PCLI Stage One aged care and mental health partnered services in the community

Note:
ALOS = Average Length of Stay
MHS = Mental Health Service (NSW Health)
HASI = Housing and Accommodation Support Initiative
CLS = Variant of HASI - Community Living Support
HASI Plus = High level HASI at 16 - 24/7 accommodation support
What have we got to?

Stage 1
Assessment
✓ Over 250 assessments
✓ Over 58 transitions
✓ 6 monthly post discharge assessments
✓ Data base rolled out

Evaluation:
4 years
University of Wollongong:
• Centre for Health Service Development
• Australian Health Services Research Institute

Stage II
✓ Sax literature review
✓ Steering Group established
Consultations and market soundings
✓ Service and financial modelling commenced
# Assessment database

- Recovery Assessment Scale – Domains and Stages (RAS-DS)
- Camberwell Assessment of Needs (CAN-C)
- Camberwell Assessment of Needs Elderly (CANE)
- HCR-20 v3
- Neuropsychiatric Inventory- Nursing Home Version (NPI – NH)
- Modified Mini Mental State (3MS)
- WASI-II
- RBANS Neuropsychological Functioning
- Trails A and B
- Modified DAD Clinician Screen
- Performance Assessment of Self-care Skills (PASS)
- Large Allen’s Cognitive Levels Screen 5 (LACLS-5)
- Health of Nations Outcome Scale /65+^®
- Kessler 10^®
- Life Skills Profile 16^®
- RUG ADL^®
- YES Consumer experience of service survey^®
- Wellness Plan
- Life in the Community Questionnaire
- Dem Qual
Evaluation framework

Strategic Objectives
- Program management
- Governance & partnerships
- Change management and workforce development
- Individual engagement and planning
- New Service Models – recovery based care in the community

Outcomes 1-2 years
- Consumers and Carers
  - Improved experience ~ engagement, choice and control
- Providers
  - Improved expertise and skills
- Systems
  - Improved collaboration
  - Culture of recovery
  - Contemporary models of care established
  - Improved information sharing and communication with partners

Outcomes 3-5 years
- Consumers
  - Improved wellbeing, mental and physical health, social participation
- Carers
  - Engagement with consumer family member
  - Satisfaction with quality and safety of care

Long term ambition
- Community living and high quality of life for people with SPMI
- Recovery based care Pathways
- Individualised high support housing
- Individualised high quality mental health services and support
Description of Setting

- Large rural mental health inpatient facility in Orange, NSW
- Four units that provide medium to long term rehabilitation
- Total of 72 beds of which 83% currently occupied
- Of these approximately 68% come under the PCLI
- One of these units – Canobolas
Hospital Grounds
Canobolas Unit
Demographics of the Canobolas Unit

- 20 bed unit – currently 18 are occupied
- Average age is 61 years
- Length of stay in an inpatient facility ranges from 2 years to 60 years – average 20 years
- Majority have a diagnosis of schizophrenia or schizo-affective disorder
- Only 4 call Orange their community of origin
Assumptions

• Mental health inpatient care is the only form of care available for these people that is able to meet their needs
• They will be here for life
• The inpatient facility is their “home”
• We know them well as they’ve been here so long
• This is as good as they’ll get
Assessment and planning across the hospital pre-PCLI

- Fragmented – not automatically from a multidisciplinary perspective, differed across the units
- On an “as needs” basis
  - observations of increasing frailty
  - deterioration in mental state
  - in response to a review such as the Mental Health Review Tribunal
  - in preparation for a referral or hearing, for example, for an aged care assessment or Guardianship hearing
- Limited use of assessment information – reports sat in files, not necessarily shared with the clinical team
- Involvement of families and consumer – incidental and inconsistent
Assessment Process - Guiding Principles

❖ Human rights based model – prioritising autonomy and supported decision making

❖ Consistent approach and set of assessments

❖ Minimal number of assessments to achieve outcomes – not to unreasonably burden individuals

❖ Assessment process has the potential to build capacity in the workforce through professional training and experience in use
Criterion for Assessment Choice

❖ Provide clinically meaningful information to assist care planning
❖ Must be standardised with a published manual available to all clinicians
❖ Demonstrated reliability and validity as evidenced by publications in peer reviewed journals
❖ Must have good clinical utility – portable, practical and applicable to setting
❖ Appropriate to Australian context and where appropriate culturally adapted
❖ Demonstrated acceptability to consumers
Planning and Assessment Process

More than assessment. “Planning” and “Process” involves

• having conversation with person about preferences
• inclusion of family
• working with community services
• communicating with workforce
• sharing findings and information within clinical case reviews
Objections

❖ Over riding clinical judgement
❖ Not all assessments suitable for all people
❖ Seen as ‘extra’ work taking away from usual duties
❖ Imposed and considered a checklist only
Shifts and Changes

- Case review formats have changed to accommodate assessment information from a MDT perspective
- Focus of case reviews is not just on present treatment/management but now has a focus on the future
- Assessment and planning process has provided legitimacy to work in a more recovery-focused way
- Ensures the inclusion of family
- Started discussions with consumer not previously addressed
- Accountability and transparency improved
- Good to know the information collected from assessments and planning process are being used to inform service development
An Example

Story from the Occupational Therapist

❖ George, 59 year old transferred to Canobolas Unit from another LHD in 2014.
❖ Diagnosis - treatment resistant schizophrenia
❖ Intrusive and persistent behaviours agitate those around him
❖ Vulnerable to aggression from others
❖ OT conducted LACLS somewhat reluctantly
❖ Outcome resulted in consideration of different plan
Assumptions Busted

- Mental health inpatient care is the only form of care available for these people that is able to meet their needs
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