SESLHD GUIDELINE COVER SHEET

NAME OF DOCUMENT	Mental Health Service Rehabilitation Clinical Pathway and Process
TYPE OF DOCUMENT	GUIDELINE
DOCUMENT NUMBER	SESLHDGL/048
DATE OF PUBLICATION	December 2021
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standard 1.27 National Standards for Mental Health Services 2010: Standard 10. Delivery of Care (10.5.2)
REVIEW DATE	December 2024
FORMER REFERENCE(S)	SESLHD MHS Policy 'Rehabilitation Care Pathway' 2007/01V3 SESLHD MHS Guideline 'Rehabilitation Clinical Process' SESLHDGL/012
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	SESLHD Clinical Director, Mental Health Service
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FUNCTIONAL GROUP	Mental Health
KEY TERMS	Rehabilitation, recovery, strengths
SUMMARY	This guideline outlines the rehabilitation service pathway and applies a standardised rehabilitation process across the SESLHD Mental Health Service (MHS), ensuring clearly defined, evidence-based interventions are incorporated by clinicians into rehabilitation practice. This document combines the former SESLHD MHS Policy 'Rehabilitation Care Pathway' and SESLHD MHS Guideline 'Rehabilitation Clinical Process'.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

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Mental Health Service Rehabilitation Clinical Pathway and Process

Section 1 - Background

This document has been written to provide guidelines for specialist rehabilitation clinicians regarding the rehabilitation clinical pathway and process delivered by Inpatient, Community Rehabilitation Services, and the Adult Blended Virtual Rehabilitation program in South Eastern Sydney Local Health District (SESLHD). This Guideline is to be read in conjunction with SESLHD Mental Health Service (MHS) policy documents, and with special reference to the SESLHD Rehabilitation Model of Care 2016.

Rehabilitation services in SESLHD are provided by specialist rehabilitation professionals within three Community Mental Health services, two Inpatient Rehabilitation Units, and the Blended Adult Rehabilitation Virtual Care Program. Teams are multi-disciplinary and include occupational therapists, social workers, psychologists, nurses, doctors and peer support workers. They strive to provide a spectrum of interventions to meet the needs of consumers (and carers) residing in the LHD.

Section 2 - Principles

Rehabilitation clinicians work collaboratively with people to explore their strengths, skills, supports and resources to support successful and satisfying living, learning and working in the environments of their choice. A set of evidenced-based interventions is utilised, designed to facilitate change, increasing ability and role functioning and developing skills that are specific to individual needs. The focus is on strengths, self-determination, collaborative partnerships, hope, community participation and citizenship, family and social networks and inclusion, holistic care, cultural diversity and reflection and learning. Services are time limited and provided by working individually, in groups or by linking with Community Managed Organisations (CMOs) and other community services.

Rehabilitation service provision strives to be:

- Recovery Focused
- Values Based
- Strengths Focused
- Trauma Informed
- Individualised
- Integrated
- Targeted, Time Limited and Evidence-Based

Rehabilitation services seek to facilitate:

- Self-Directed Care
- Social Inclusion
- Partnerships and Collaboration

Section 3 - Definitions

Rehabilitation:

- Mental health rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed, and individualised. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice. *United States Psychiatric Rehabilitation Association 2009* .

Personal Recovery:

- Being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. *National Framework for Recovery Oriented Mental Health Services 2014.*

Recovery Oriented Practice:

- The application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. *National Framework for Recovery Oriented Mental Health Services 2014.*

Rehabilitation Care Pathway:

- Refers to the journey taken by the consumer through mental health rehabilitation, from the point of referral to the point of discharge.

Throughout this document, the terms patient, client and consumer may be used interchangeably to acknowledge the varying preferences of people who give and receive services in the SESLHD MHS.

Section 4 - Responsibilities

Multidisciplinary Mental Health Rehabilitation Workers are responsible for:

- Ensuring their clinical practice reflects the principles and philosophy of the Guideline.

Managers are responsible for:

- Monitoring staff compliance with the Guideline.

Rehabilitation Coordinators are responsible for:

- Providing staff with education regarding the implementation of this Guideline.
- Providing feedback to services regarding achievement of such via key performance indicators.
- Ensuring the Guideline continues to reflect NSW Ministry of Health policy directives, guidelines etc.

Section 5 – Referral and Access

The Rehabilitation Service Pathway is summarised in APPENDIX A.

5.1 COMMUNITY REHABILITATION

5.1.1 Service Access

Community rehabilitation may be provided as a one-off assessment, short-term (one to three months), medium term (three to 12 months) or longer term (over 12 months).

People entering the MHS for the first time access specialist community mental health services via a local, single entry point i.e. Intake/Triage.

People must meet the following **Entry Criteria**:

- Reside within the catchment area of the local site.
- Be aged 18-65 to access the Adult services OR
    - If under 18, meet the criteria for Early Intervention/Early Psychosis/Youth Mental Health (or other needs by negotiation) to access specialist rehabilitation for this population OR
    - If over 65, meet requirements for adult rehabilitation rather than Specialist Mental Health Services for Older People (SMHSOP).
- Have mental health issues impacting on their ability to function within their chosen community and a demonstrated need for and capacity to benefit from a rehabilitation program.
- Be willing to participate in rehabilitation programs or in engagement and readiness processes. Stable and non-violent behaviour is an additional requirement for some specialist rehabilitation interventions.
- Consumers accessing specialist community rehabilitation should preferably also have a separate, designated mental health worker who is able to coordinate other aspects of their mental health care, including physical health and acute needs. This may be a MHS case manager/care coordinator or doctor, a private psychiatrist, GP or other relevant community worker as negotiated with the rehabilitation service. Consumers who become acutely unwell will be guided to their designated mental health worker, care coordinator or other appropriate supports as required. Consumers with a private doctor must be regularly reviewed by a MHS doctor, in line with SESLHDPR/418 - Relationships with External Clinical Care Providers – Mental Health Services.

5.1.2 Referral and Allocation

The Community Rehabilitation Referral Process is summarised in APPENDIX B.

Referrals for community rehabilitation are collected, reviewed and allocated as appropriate to an individual rehabilitation clinician within an Adult Community Mental Health Team (ACMHT). The process of allocation includes consideration of the date received, the needs of the consumer, whether the consumer is known to the service, the particular skills of the workers and the programs available. In the situation where more referrals are received than can be

allocated immediately, a prioritisation process may apply, with each referral being assessed for urgency.

5.1.3 Prioritisation

The following steps will assist the service in making a decision regarding the order of priority for referrals and are summarised in APPENDIX C. It is noted, however, that each referral will be considered on an individual **basis** and allocated according to available resources.

High Priority: urgent need with considerable risk of deterioration.

- Pending or recent discharge from an inpatient facility or recent move to independent living requiring clinical interventions to assist with successful community living.
- Direct referrals to specialised rehabilitation programs such as: the Adult Blended Virtual Rehabilitation Virtual Care Service, Early Intervention/Youth Mental Health, or specific time limited groups/programs/interventions.
- New referral to the MHS, no current care coordination needs and has identified rehabilitation needs - delay in allocation may adversely affect rehabilitation readiness and engagement.
- Referrals for urgent Occupational Therapy Independent Living Assessments.

Medium Priority: delay in access to rehabilitation is perceived to have some impact on recovery.

- Re-referrals where a significant improvement in rehabilitation readiness can be demonstrated.
- When the person is engaged with another government or non-government clinician and is making some progress towards rehabilitation goals. Involvement of a rehabilitation clinician will assist in goal achievement, but delay in allocation will have minimal detrimental effects on progress.
- Referrals for non-urgent Occupational Therapy Independent Living Assessments.

Low Priority: delay in access is perceived to have minimal impact on recovery.

- Prior involvement has demonstrated that rehabilitation is unlikely to benefit the consumer further, and there is little change in readiness or circumstances.
- During times of limited rehabilitation resources, it may be necessary to give low priority to consumers who have been referred via private sources and who have external supports.

5.2 INPATIENT REHABILITATION

5.2.1 Service Access

- Inpatient rehabilitation is available for a stay of up to three months or longer as indicated. The Inpatient Rehabilitation Units provide a service to existing clients of the MHS. The Units are accessed via direct referral from either an Acute Inpatient Mental Health Unit or a Community MHS. External service providers wishing to make a referral to a Rehabilitation Unit must do so via the Intake/Triage system as per usual protocols for

new referrals to the MHS in accordance with SESLHDPR/418 - Relationships with External Clinical Care Providers – Mental Health Services.

In this instance the MHS will conduct a comprehensive assessment to determine what the consumer's needs are and whether or not referral to the Rehabilitation Unit is suitable. External referring agencies must agree to resume responsibility for mental health service provision to these consumers once rehabilitation is complete or deemed unsuitable for any reason. Consumers referred this way are expected to also engage with the local community MHS while they remain an inpatient, and after discharge.

5.2.2 Mental Health Rehabilitation Unit (MHRU) Referral Process

The referral stage represents the first part of the engagement and assessment process. This provides the opportunity for a face-to-face meeting with the consumer and the clinicians, as well as exploring the MHRU environment. The main purpose of this meeting is to clarify the reasons for the referral from the consumer's perspective, and to discuss what the MHRU has to offer. This enables all parties to gauge what the consumer is looking for in an admission to see if these are a 'good fit'. Discussions would include; unit programming, personal priorities and aspirations, values and shared understandings, length of stay, and any other topics which are relevant to the individual.

1. Opportunity given to consumer, family/supports and primary clinician to visit the MHRU prior to referral being made.
2. MHRU Referral Form sent to Nursing Unit Manager (NUM) via email and/or fax. Letters must include:
    a) Reason for referral
    b) Consumer's expectations of the admission
    c) Clinical handover, including relevant past and present information
    d) Most recent physical health assessment
    e) Any available cognitive, neurological, Occupational Therapy or Social Work assessments
    f) Current accommodation issues and legal status
    g) Any other information deemed relevant to the referral.
3. Follow-up meeting between the MHRU NUM and consumer, family/supports and primary clinician.
4. Discussion between medical teams and allied health teams as relevant.
5. Referral discussed at weekly referral meeting.

The following **Entry Criteria** must be met:

- The person has mental health issues impacting on their ability to function within their chosen community.
- The person has a demonstrated need for and capacity to benefit from an inpatient rehabilitation program and these needs cannot be met in the community.
- They have the ability (as assessed via cognition and mental state) to engage in a range of clinical hospital-based mental health rehabilitation assessments and treatment options.

- It is considered likely that a stay in the Rehabilitation Unit will be of positive benefit to the person, in the form of:
  - Improved self-management of their mental health issues and establishment of community connections to support this.
  - Development of skills necessary for living in the community.
- When concurrent issues are present such as alcohol and other drug use issues, developmental disability or personality disorders, suitability will be assessed depending on current rehabilitation needs and willingness to engage in the rehabilitation process.
- If the person is being transferred from an Acute Inpatient Unit, they will have had the opportunity to be given information on the program and are agreeable to transfer to the Mental Health Rehabilitation Unit. A rehabilitation assessment will then be conducted to ascertain their goals, hopes and personal recovery plans during an admission.
- Where the person enters the Unit under the NSW Mental Health Act (2007), they must have identified rehabilitation needs and the ability to participate in an engagement process. Involuntary referral to the Unit for a longer period of inpatient care may assist with assessment of treatment needs and engagement in a rehabilitation program.
- Where it is unclear if the above criteria can be met, a time limited trial of inpatient rehabilitation may be negotiated.

5.2.3 Allocation and Prioritisation of Referrals

All consumers referred to Rehabilitation Units require a safe, structured environment to identify a recovery vision and work on rehabilitation goals, above the capacity of community rehabilitation. The system for prioritising referrals and determining the most suitable unit for admission is based on the needs of the consumer, the phases of readiness described in the Motivational Interviewing framework and other demographic factors. These are outlined below and summarised in APPENDIX C.

High Priority

- People considered to have an urgent need are those with considerable risk of deterioration if given no access to inpatient rehabilitation. For these individuals, intensive rehabilitation is required in order to manage community living, which cannot be provided by community rehabilitation and other services. This may be either due to:
  - Pending discharge from an acute inpatient service OR
  - Deterioration in the community, with successful community living in jeopardy.

Medium Priority

- People considered to have a moderate need are those with some risk of deterioration if given no access to inpatient rehabilitation (as for High) OR it may be a consumer returning to inpatient rehabilitation following unsuccessful previous admission but demonstrating a shift in ‘readiness’ or circumstances.

Low Priority

- People considered to have a non-urgent need are those whereby current community supports are sufficient to maintain successful community living, however, a period of

inpatient rehabilitation would provide the opportunity to further build skills and independence.

5.3 Blended Adult Rehabilitation Program (Virtual Care)

The COVID-19 pandemic has rapidly necessitated innovative approaches to consumer treatment that integrates technology into service offerings. In response, SESLHD has been exploring contemporary approaches involving intensive community rehabilitation using predominantly online and telehealth means to deliver these services.

The Blended Adult Rehabilitation Program is for people who would benefit from a period of higher intensity support to assist in functional and psychosocial rehabilitation as part of their journey towards recovery and well-being. The focus of the Blended Adult Rehabilitation Program is on strengths, self-determination, collaborative partnerships, hope, community participation, family and social networks and inclusion, holistic care, cultural diversity and reflection and learning. Services are intensive and time-limited (12 weeks) and provided by working individually, in groups or by linking with Community Mental Health Services, Community Managed Organisations and other community services.

The Blended Adult Rehabilitation service will allow people in the community who may be at risk of a hospital stay or at risk of their community engagement breaking down, to participate in intensive and short-term psychosocial rehabilitation services to facilitate skill building towards well-being, sustaining mental health and community living.

The Blended Adult Rehabilitation service will allow people to step down from a stay in an inpatient facility and will provide additional support to a person who no longer requires inpatient care but does require assistance in re-establishing themselves in the community
Individuals accessing the program will be provided with an iPad and mobile data to engage for the duration of the rehabilitation program, with the device remaining the property of SESLHD MHS and being returned upon completion of the program.

Individuals looking to access the service need to be under the existing care of a SESLHD MHS community mental health team.

Section 6 - Engagement

It is good practice and evidence-based to attempt outreach to engage consumers who are at risk of disengagement at time of referral and throughout rehabilitation intervention. Examples of outreach include: explaining rehabilitation and the rehabilitation clinician role, talking to the case manager, phone call/text from computer paging to consumer, writing a letter to offer an appointment.

Engagement is recognised as a legitimate and essential component of the rehabilitation process. Strategies are employed to build a collaborative, therapeutic relationship (therapeutic alliance) and a true partnership. Engagement strategies may be employed as a starting point for rehabilitation, prior to or as part of the assessment process. Engagement is also a continuous process that occurs throughout the life of the rehabilitation process. As part of this process, rehabilitation workers may engage in strategies to assist a person in becoming ready for active participation in a rehabilitation program.

Engagement begins from the first contact with the consumer, be it face-to-face, phone or other forms such as in writing or via email. Often contact with the consumer begins with either phone or written contact. Clinicians should be mindful of the importance of incorporating a recovery focus into any form of contact with the person, which in turn will assist in the engagement and assessment process.

The referral stage represents the first part of the engagement and assessment process. This provides the opportunity for a face-to-face meeting with the consumer and clinicians, as well as exploring the MHRU environment. The main purpose of this meeting is to clarify the reasons for the referral from the consumer's perspective, and to discuss what the MHRU has to offer. This enables all parties to gauge what the consumer is looking for in an admission to see if these are a 'good fit'.

Discussions would include; unit programing, personal priorities and aspirations, values and shared understandings, length of stay, and any other topics which are relevant to the individual.

Section 7 - Assessment

Comprehensive assessment is an integral part of any recovery-oriented service system (Anthony, 2000).

In community settings, all referrals should be accepted for assessment unless clearly contraindicated i.e. out of catchment area. A comprehensive rehabilitation assessment is then carried out with the consumer, providing the basis for the development of an individual rehabilitation plan. The assessment process is individualised, strengths based, addresses both functional and quality of life issues, and should support the person's recovery goals. Rehabilitation Assessment takes the form of:

i) Rehabilitation Initial Assessment Tool

This tool serves as a prompt for the clinician to gather information about the person's situation, identifying their skills, strengths and needs and determining areas in which rehabilitation intervention and support can be provided. A copy of this tool should be placed in the person's file and recorded in the electronic Medical Record (eMR). This should include a summary of the assessment and the action plan. If the person does not wish to participate in rehabilitation, the reasons for this should be noted using language which reflects their self-determination. (NOTE: in circumstances where the rehabilitation clinician feels there may be some benefit to rehabilitation participation, it is important that strategies to engage with the person are assertively pursued before the decision is made not to proceed.)

ii) Strengths Assessment

It is an expectation that rehabilitation services in SESLHD utilise the Strengths Model to support individual recovery. Once trained in the model, clinicians should utilise both the Rehabilitation Assessment Tool and the Strengths Assessment Tool as part of the overall rehabilitation assessment process. Experienced Strengths practitioners who have completed their Strengths Model Competencies may choose to use the Strengths Assessment Tool in place of the Rehabilitation Assessment Tool.

iii) Mandatory Standardised Assessment Tools

These are completed by/for all consumers and form the basis of outcomes reporting. They are used to inform the assessment process with the following noted:

COMMUNITY: In situations when the rehabilitation worker is the primary clinician, he/she is responsible for completion of the Mental Health Outcomes and Assessment Tools (MH-OAT) assessments and measures.

INPATIENT: The most recent MH-OAT assessment should form part of the referral documentation sent by the referring service. If not, the primary nurse is responsible for completing the MH-OAT assessment. MH-OAT outcome tools are collected upon admission and completed by the primary nurse.

iv) Physical Health

In line with current SESLHD and broader health service directives, it is the responsibility of inpatient rehabilitation clinicians (care coordinators and doctors) and community rehabilitation primary clinicians to ensure routine physical health screening and assessment is conducted and appropriate interventions offered as necessary to address the consumer's comprehensive care needs.

v) Other Rehabilitation Assessments

This may include other assessments, including discipline specific and those to address specific issues and goals e.g. living skills, cognitive functioning, vocational needs, medication adherence.

Recovery Oriented Rehabilitation Assessment

The aim of a recovery oriented rehabilitation assessment is to:

- Engage with the person in their own unique recovery journey
- Develop a relationship with the person through getting to know them, above and beyond their illness
- Focus on the person's strengths and resources through utilising a strengths based approach to assessment
- Shift the focus of intervention from the treatment of the signs and symptoms of mental illness to the goals and aspirations of the individual
- Begin the process of assisting the person to identify their 'recovery vision'
- Facilitate the development of a person-focused, goal-orientated recovery plan that will guide the person and the rehabilitation clinician in the individual's recovery journey.

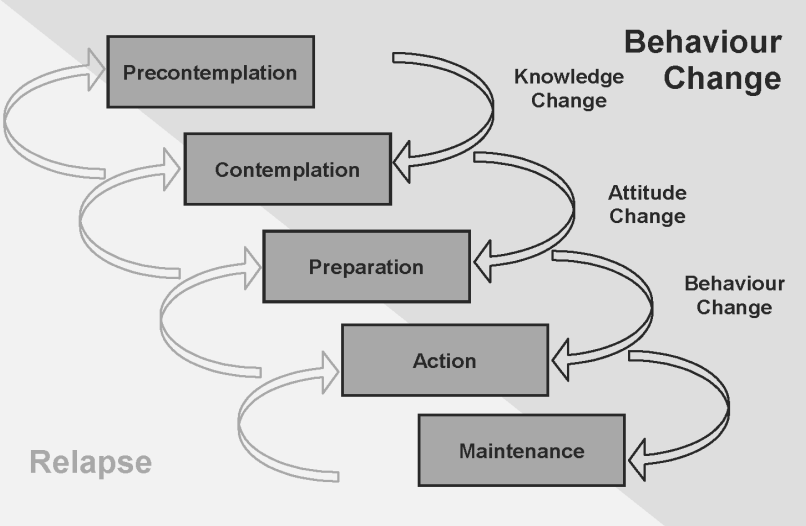
In order for assessment to meet these aims, of utmost importance is the approach that clinicians take to eliciting information within a recovery and strengths based paradigm. Clinicians are encouraged to develop their own language and way of asking questions that meets their own needs and facilitates active participation in the assessment process. Clinicians are encouraged to consider:

- Questions and actions that engage a person's **HOPE**
- Questions and actions that create **DISCOVERY**
- Questions and actions that encourage a person's **ABILITY TO RESPOND/ TAKE CONTROL**
- Questions and actions that invite an **ACTIVE SENSE OF SELF**
- Questions and actions that facilitate **CONNECTEDNESS**
  (Helen Glover, 2013)

While the assessment format provides the framework for the completion of a comprehensive rehabilitation assessment, all clinicians should be aware that methods of assessment encompassing recovery and strengths are the central component to engaging consumers in their own recovery. Staff are encouraged to utilise a Motivational Interviewing approach to their assessment. This approach is an interpersonal style designed to assist clients at pre-

contemplation stage to explore and resolve ambivalence, and to increase motivation for change. It is based on the broader Transtheoretical Model *(Prochaska and Di Clemente, 1982).*

Motivational Interviewing (MI) is grounded in a respectful stance with a focus on building rapport in the initial stages of the counselling relationship. A central concept of MI is the identification, examination and resolution of ambivalence about changing behaviour (motivationalinterviewing.org).



'Process of Change' Transtheoretical Model (Prochaska and DiClemente, 1982)

Section 8 - Values

Within the SESLHD Rehabilitation Service, the main tool for personal goal planning is the Strengths Assessment.

It may be of assistance to utilise a ***values clarification*** process to assist the client to establish meaningful goals. Values clarification allows consumers the opportunity to identify the leading principles that guide and motivate them through life. It will bring into focus the important values and strengths that the person processes and thus give guidance to the care planning process. Evidence suggests that by assisting people to recognise how well they are living in alignment with their values, it will assist them in setting more meaningful goals *(Oades, Andresen, Crowe, Malins, Marshall and Turner, 2008)*.

There are several ways to assist your clients in clarifying their values

A few values clarification tools are provided below:

- The Happiness Trap Values Questionnaire
- The Happiness Trap Brief Bull's Eye Worksheet
- The Happiness Trap Long Bull's Eye Worksheet

Section 9 – Rehabilitation Goal Setting and Service Planning

It is the responsibility of the allocated community rehabilitation clinician or the inpatient rehabilitation care coordinator/primary nurse to develop, implement, monitor and review the rehabilitation service plan.

An individual rehabilitation service plan is collaboratively developed and reviewed at a minimum of every 13 weeks in the community and every two to four weeks in inpatient units. Central to this process is the consumer's voice, upholding their right to be involved in their own care. A collaborative rehabilitation service plan may also engage carers, clinicians, community supports and other services who can assist the consumer with their plan. This may be documented on the Mental Health Clinical Documentation Care Plan in eMR or utilise an alternative format/tool such as the Strengths Personal Recovery Plan if this is considered more useful. If the latter option is used, the Personal Recovery Plan format can be used within eMR documented in the MH Care Plan.

Rehabilitation Plans should incorporate the following:

- Description of the person's personal recovery goals and detailing of strategies to address barriers to achieving this. Strategies should indicate who is responsible for each i.e. consumer, staff member
- Acknowledgement of strengths, abilities and resources the person is able to utilise in achieving their goals
- Input of family/carers, referrers and other relevant agencies as appropriate and available and with consent
- Maximum utilisation of community resources and promotion of social inclusion
- Written indicators of progress
- Signatures of consumer and clinician.

Copies of the Rehabilitation Plan should be made available to the consumer, family/carer (with consent) and clinician/s.

Recovery Oriented Rehabilitation Planning Principles

In rehabilitation services, the care planning process commences after the initial rehabilitation assessment and values clarification process (if utilised). Conversations should at all times be conducted within a recovery framework and encourage consumers to build personal control and be actively involved in the care planning process. Be curious and ask:

- What do you want?
- What do you hope the outcome will be?
- How would you like things to be different?
- What has worked for you in the past?
- What will you do to further your recovery, and how can I help you do this?
- Who else would you like to involve in this process? (friends, family members)

(Ashcraft and Anthony 2008; Glover 2005)

Helen Glover (2013) encourages staff to focus the rehabilitation care plan on assisting the person to overcome the obstacles that have got in the way of him/her having reached the goal previously (see diagram below).

Figure 2 Focus of Support : Focus on what is getting in the way and not the attainment of personal goals

'Unpacking Practices that Support Personal Efforts of Recovery Workbook' (Glover, 2010)

Goal Setting

Many people have learnt to develop goals according to the S.M.A.R.T. criteria.

Specific
Measurable
Achievable
Relevant
Time-framed

This form of goal setting focuses on the ***outcome*** as being of most value. Whilst this may be useful in some situations, in a recovery oriented service, it is often the ***process*** that is of greater significance.

Frequently Asked Questions:

"What happens if a person has a goal that is unrealistic?"

It does not matter whether a clinician thinks the goal is unrealistic or not. It is the process of working towards the goal with the consumer that is more important than the eventual outcome.

e.g. A consumer told his rehabilitation clinician that he had always wanted to be a pilot. The clinician suggested that they have their regular appointments at the local airport to support his aspirations. He became familiar with many of the staff at the airport and through visiting the airport regularly, was approached by an airline to work as a baggage handler. As part of his employment he was entitled to free flights. He had never actually flown before and discovered

that he was actually terrified of flying! Whilst he did not achieve his initial goal of becoming a pilot, he loved his job at the airport.

It is important that clinicians ensure when setting goals with consumers that they work with their aspirations (what they want), their confidence (the belief in themselves that they can achieve this) and their competence (skills).

- Aspirations (Do I want it?)
- Confidence (Can I do it?)
- Competence (Am I able to do it?)
- Environment (Am I supported to do it?)

At times consumers may be feeling overwhelmed and uncertain and may need assistance from staff to help them discover what they do want. Staff need to provide hope to consumers, assisting them to recover their identity and find meaning and purpose in their life. By utilising techniques such as motivational interviewing and incorporating a solution focused approach, consumers may be able to have greater involvement and responsibility in the care planning process.

"But the consumer I am working with has no goals"

People often find it difficult to see beyond their current life situation. Glover & Roennfeldt (2013) identify that for many people the process of driving their own planning is new and they may face barriers that make it difficult for them to engage in 'self-directed' support e.g. fear, self-stigma, negative experiences with the system, previous low expectations from professionals and lack of self-efficacy. It does not mean that the person is 'not ready' for rehabilitation. It is important that the service provider develops a therapeutic relationship, creates an expectation of self-determination and creates an environment to support the person to tackle these difficulties and promote individual choice. Goal-setting can therefore be a process and utilise strategies to explore what is meaningful to the person and clarify what changes or skills are needed to take steps forward with their recovery. The values-clarification exercises noted in the previous section, as well as the Strengths Model, can assist with this process.

When working with clients using the Strengths Model, the group supervision process can be utilised to engage with the person to find a goal that is passionate and meaningful to them (Rapp & Goscha, 2012).

Section 10 – Rehabilitation Intervention

Rehabilitation services provide specific, targeted, individually tailored interventions that assist with improved role functioning, independence and the development of skills and resources. These are measurable and time limited. Rehabilitation services provide a spectrum of interventions to meet the needs of consumers including:

- *Structured Assessment:* Baseline and periodical assessments of ability using recognised assessment measures, e.g. measures of psychological functioning, real-life functional capacity, neuropsychological capacity, family functioning and consumer need.

- *Life Planning:* Using techniques such as Motivational Interviewing, Values Clarification and Goal Setting to assist in life planning and improving skills in communication, self-esteem/confidence, activity scheduling, time management and structuring the day.

- *Skills Training*: To enhance competence in areas such as self-care, home management, shopping, meal planning, cooking, budgeting and using public transport. Also includes assistance in identifying and pursuing leisure interests and provision of social skills training to address areas such as communication, assertiveness and confidence building.

- *Mental Health Self-Management, Recovery Promotion and Education strategies:* Including relapse prevention strategies, medication adherence therapy and education, and recovery based self-management promoting programs, including involvement in the South Eastern Sydney Recovery and Wellbeing College.

- *Effective Pharmacotherapy:* Provides a sound foundation to enable psychosocial strategies to be implemented helps prevent relapse and can effectively target enduring symptoms. This forms a key part of inpatient rehabilitation service provision.

- *Physical Health and Wellbeing:* Includes strategies targeting nutrition and weight management, personal health and fitness, smoking cessation, spiritual needs, education addressing sexual health, drug taking plus assessment and interventions for metabolic syndrome.

- *Vocational Strategies:* Includes the development of close linkages and networks with specialist employment services, the implementation of Individual Placement and Support (IPS) or Enhanced Intersectoral Links Programs, specialised vocational assessments and vocational support interventions, plus support for study and promotion of educational opportunities.

- *Specialised Cognitive Assessment and Interventions:* Includes cognitive remediation and adaptation strategies, Cognitive Behaviour Therapy (CBT) plus programs targeting anxiety, stress or anger management.

- *Psychological Therapies:* Includes the development of therapeutic alliance and may include therapies such as Dialectical Behaviour Therapy (DBT), Narrative Therapy, Brief

Solution Focused Therapy, Acceptance and Commitment Therapy (ACT), creative therapies (including art, music and drama) and supportive counselling to promote an active sense of self.

- *Family Interventions:* Therapy, support and education.

- *Community Development/Capacity Building and Linkage:* Advocacy and education to promote access and reduce stigma, partnership building with Community Managed Organisations (CMO) partners and other providers of mental health support, practical assistance for consumers to access community activities.

- *Programs for Specific Target Groups:*
    - *Youth and Early Intervention* – Developed and delivered in line with the early intervention evidence base and in consultation with Youth Mental Health and early psychosis clinicians.
    - *Co-Existing Conditions:* Specific strategies may be employed to address co-existing issues such as drug and alcohol addictions, gambling, intellectual disability or people with challenging behaviours or persistent, distressing symptoms.

Each of the rehabilitation sites in SESLHD serve a unique population and may develop particular areas of specialisation and focus. Please see APPENDIX D for a prompt sheet that includes questions you may be able to ask consumers to ensure that they are being offered evidence-based rehabilitation practices. It may be that many of these questions have been covered as part of the assessment process or earlier in the care planning.

Section 11 – Rehabilitation Documentation

Rehabilitation is a specialist clinical stream within the SESLHD MHS. Staff work collaboratively with consumers to assist them on their individual recovery journeys. The use of the Rehabilitation Initial Assessment Tool and goal-oriented rehabilitation care plans ensure the rehabilitation clinical pathway is followed and that interventions are recovery focused. Further to this, it is important that all documentation reflects this philosophy and is approached in a consistent manner across the SESLHD in accordance with SESLHDGL/074 - Clinical Documentation in Mental Health.

Rehabilitation documentation should aim to:

- Reflect the recovery philosophy and strengths based approach promoted by rehabilitation services
- Reflect the rehabilitation clinical pathway
- Be consistent across rehabilitation services of the SESLHD.

Guidelines for the use of language that supports personal recovery

Documents that are produced during the recovery process can be important communication tools. Using recovery oriented language can promote honest and respectful communication which builds trust, facilitates successful therapeutic relationships and encourages partnerships between individuals who use services and individuals who provide them (Mental Health America Allegheny County, 2012).

Some points to consider when documenting rehabilitation interventions

Does the document encourage a culture of hope by communicating positive expectations and messages about recovery?

All staff can contribute to recovery outcomes by offering respectful, person-centred relationships, practices and service environments that inspire hope and optimism (National Framework for Recovery-Oriented Mental Health Services, 2013).

Is the document strengths-based rather than deficit-based?

A strengths-based perspective examines ‘what works’ and ‘how to do more of what works’ rather than focusing primarily on identifying and eliminating problems. Documentation should not focus on deficits, but focus on the person’s strengths and include what he/she has been able to achieve.

Does the document include jargon?

Documents should reflect language that is understood and chosen by the client. Where applicable, explicitly own words and concepts such as diagnosis or assessment as coming from a medical/service provider opinion/perspective, rather than as a pronouncement of universal truth (Mental Health Coordinating Council, 2013).

Does the document include the client's stated perspective?

This could include information about what is important to him/her, the reasons why a particular choice was made, and the client's agreement or disagreement with treatment recommendations etc.

Does the document include information related to client-identified goals?

Self-determination is one of the fundamental components of recovery. Correspondence must clearly describe the person's current rehabilitation pathway and progress towards goal attainment, as documented in the rehabilitation plan.

Has the client been given an opportunity to read, respond to and revise the document?

Be aware that letters and reports are constructions rather than objective descriptions. Where possible, write reports with the person they are about, while at the same time preserving the integrity and authenticity of your own viewpoint. Where there are different views between the person writing a note and the person, it is important to: include recognition of that awareness; describe the person's viewpoint in his/her own words, describe how his/her viewpoint contrasts with the author's viewpoint (Mental Health Coordinating Council, 2018).

Does the document include what the client stated will assist him/her in his/her recovery?

Clients have essential information about what has helped and will help them in their recovery. Recognition of the value of lived experience is an essential component of recovery-oriented practice.

Related Policy

All SESLHD employees must be familiar and comply with:

- NSW Health Policy Directive PD2021_039 - Mental Health Clinical Documentation
- NSW Health Guideline GL2014_002 - Mental Health Clinical Documentation
- SESLHDGL/074 - Clinical Documentation in Mental Health

The above documents do not replace the responsibility of staff to comply with this guideline. Rehabilitation staff must also abide by MH-OAT documentation protocols at all times.

Recovery Focused Documentation References

- Recovery Oriented Language Guide – Second Edition Revised (Mental Health Coordinating Council 2018)
- A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers© (Commonwealth of Australia, 2013)
- A Guide to the Use of Recovery-Oriented Language In Service Planning, Documentation and Correspondence© (Mental Health America Allegheny County, 2012)

Section 12 – Rehabilitation Review

The consumer rehabilitation review extends from the MH-OAT review to incorporate an in-depth progress report of how the person is progressing on their recovery journey NSW Health Policy Directive PD2021_039 - Mental Health Clinical Documentation. The review should comply with SESLHDPR/642 Clinical Review in Mental Health.

Progress is reviewed through ongoing assessment and planning both informally and formally. Formally the processes are:

Inpatient Mental Health Clinical Review

Inpatient rehabilitation review occurs regularly through clinical reviews and care planning meetings every two to four weeks, depending on need. Inpatient review planning should include early discussion of strategies to promote and support transition to the community and any barriers to discharge. This may occur via specific length of stay review meetings or within regular review processes. All reviews are documented in eMR using the MH Clinical Review Template.

Consumer-driven planning and review should be central to rehabilitation processes. In inpatient settings this can be facilitated by the Personal Planning and Review (PP&R) process developed at Prince of Wales Hospital or the Multidisciplinary Care Reviews developed at Sutherland Hospital, both of which include the consumer and his/her family and/or other support people as part of review and planning meetings. Review should also be inclusive of the Consumer Wellness Plan.

As required, the Rehabilitation Units may hold a 'length of stay' meeting to address any issues that may arise for consumers with complex, enduring needs who are facing barriers to transition into the community. This may require the site to hold a preventative case conference inviting key stakeholders to work collaboratively to facilitate transition planning.

13 week Community Mental Health Clinical Review

Formal review is to occur every 13 weeks in the community as per MH-OAT requirements (NSW Health Policy Directive PD2021_039 - Mental Health Clinical Documentation) and in line with SESLHDPR/642 - Clinical Review in Mental Health.

Pathways to Community Living Initiative (PCLI)
The Pathways to Community Living Initiative (PCLI) is a coordinated state-wide approach supporting people who have had a long stay in hospital to re-establish their lives in the community, and is underpinned by the following understandings:

- People want to live and be valued in the community.
- A hospital is not a home.
- Community living is enhanced through the provision of recovery focused supported accommodation.
- Recovery begins at home and opens opportunities for work, inclusion and citizenship.

The PCLI AIMS TO:

1. Enable people with extended hospital stays (or at risk of) and severe and persistent mental illness (SPMI) to transition into the community, including developing new service models for appropriate care; and
2. Create practice change in inpatient and community services in a strengths-based and person-centred approach to decrease the number and length of long stay admissions.

   The PCLI is a key component of the Strategic Plan for Mental Health in NSW 2014 – 2024 and aligns with the major recommendations of the NSW Mental Health Commission document Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024.

The PCLI Assessment and Treatment Guides outline a process for assessment, evaluation and transition planning with SESLHD Inpatient and Community Teams. These processes are guided by the PCLI clinicians and implemented alongside the SESLHD MHS staff during the hospital stay and post transition in the community.

The PCLI assessment and follow up tools complement and extend existing NSW Health mandated outcome measures by providing a clinical profile of each individual's personal strengths, capacities and functioning from which change and wellbeing can be objectively monitored. The tools inform the individual decision making of consumers, their families and carers (including health staff and services), to identify the type of support needed for transition to community living and help monitor and support the transition process. Rehabilitation services will support and collaborate in this process.

- For each person who has been in (or is at risk of being in a) hospital for over 365 days the PCLI assessment and follow up process aims to: ascertain their strengths, needs, potential and goals in order to develop, review and facilitate an individual plan to enable them to live a meaningful life in the community where possible.
- For the PCLI program the aggregated data collected from the assessment and follow-up process aims to: further inform the development of a variety of community living models for people with a mental illness and complex and enduring needs who are experiencing a long stay in hospital.

Section 13 – Completion of Rehabilitation and Re-Entry

Separation and transfer of care from rehabilitation services is a planned process that occurs alongside review of the consumer's rehabilitation service plan. The process of a graduated separation can begin from when first working with consumers, to explain the rehabilitation clinician role of being a support person for the short term, with the aim linking the person into long-term sustainable community supports beyond the SESLHD MHS.

The following factors are incorporated:

- The length of involvement in rehabilitation will be dependent on the rate of skill and role development, the individual recovery goals and the nature of the services being provided.

- Rehabilitation intervention ceases when skills, roles and resources have been developed relative to the consumer's needs and recovery goals; or when it becomes clear that needs are support only, and appropriate community resources can be established.

- Rehabilitation programs are flexible to allow for a process that can be gradual and continuous, or consist of broken, discontinuous periods of time (often interspersed with periods of acute illness).

- Separation is a collaborative process that is based on how the service is able to support a consumer's progress towards his/her recovery goals.

- Expectations of service provision include the notion that consumers will move through the rehabilitation program towards independence and participation in the wider community. This reflects a recovery philosophy, reduces reliance on the service and also improves access for others as people move through the system.

- Families/carers and service providers involved in the care of the consumer (both internal and external) are consulted regarding the exit of the consumer from rehabilitation. Additional supports and/or services may also need to be established to facilitate this.

- Rehabilitation may be re-engaged/re-initiated as needs change, readiness develops, or as resources become available. Consumers who have been separated from a community rehabilitation service for more than three months will generally need to go through a new referral and assessment process.

- Outcomes data is collected at the completion of the consumer's involvement with the service, in accordance with the requirements of MH-OAT.

In the instance of a consumer not wishing to work with the rehabilitation service or wishing to cease involvement, a full range of engagement strategies should be trialled, with support provided to the rehabilitation clinician from the multidisciplinary team e.g. requesting

support at Strengths Group Supervision. Where the consumer decides that he/she does not want to or no longer wants to engage at this time, the aims are:

- He/she is aware of what rehabilitation could offer him/her.
- Alternative service options have been offered where relevant.
- He/she has a positive experience of contact and engagement with the MHS.

This way, if the person chooses to work with a rehabilitation service in the future or comes into contact with mental health services again, he/she will have had a positive experience and the rationale is that with a process of re-referral, the person may feel ready to make changes or work with rehabilitation/mental health services at a later time.

Related Policy Documents

- NSW Health Pathways to Community Living Initiative: Journey to Home Guide (September 2020)
- PD2021_039 - Mental Health Clinical Documentation
- National Safety and Quality Health Service (NSQHS) 2nd Edition (Sept 2017): Standard 1. Clinical Governance Organisations (1.27)
- National Standards for Mental Health Services 2010: Standard 10. Delivery of Care (10.5.2)
- SESLHDPR/418 - Relationships with External Clinical Care Providers – Mental Health Services
- SESLHDGL/074 - Clinical Documentation in Mental Health
- SESLHDPR/615 - Engagement and Observation I Mental Health Inpatient Units
- SESLHDBR/058 - Referral, Prioritisation and Allocation for Non-Acute Community Services (including Priority Grid)
- SESLHDPR/642 - Clinical Review in Mental Health

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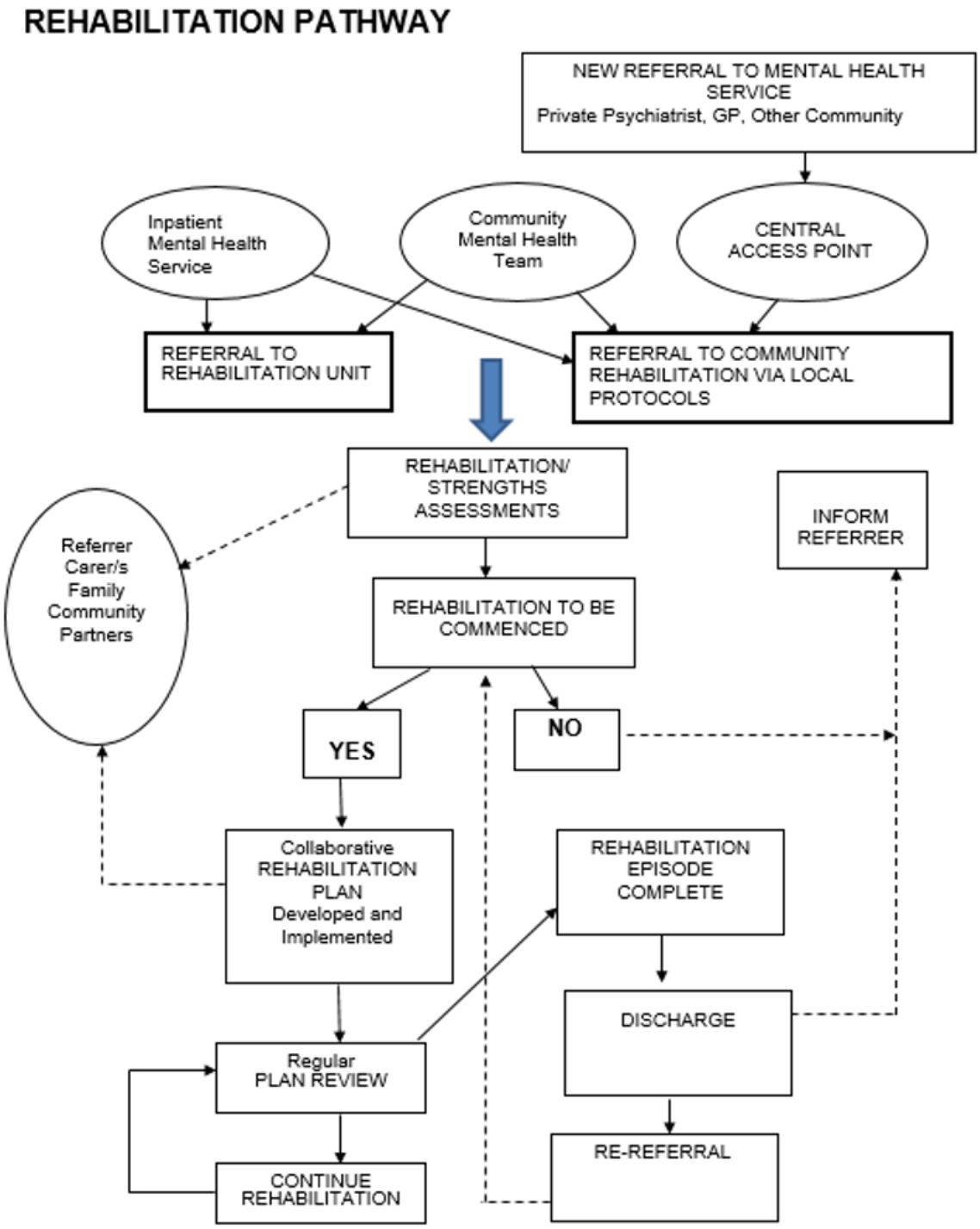
- Rapp CA & Goscha RJ 2012, The Strengths Model, Oxford University Press
- *The Mid-Atlantic Addiction Technology Transfer Center (1999-2011) website:* www.motivationalinterviewing.org
- Various local policies and guidelines from various Rehabilitation Teams throughout the SESLHD and former South Eastern Sydney Illawarra Area Health Service Mental Health Program

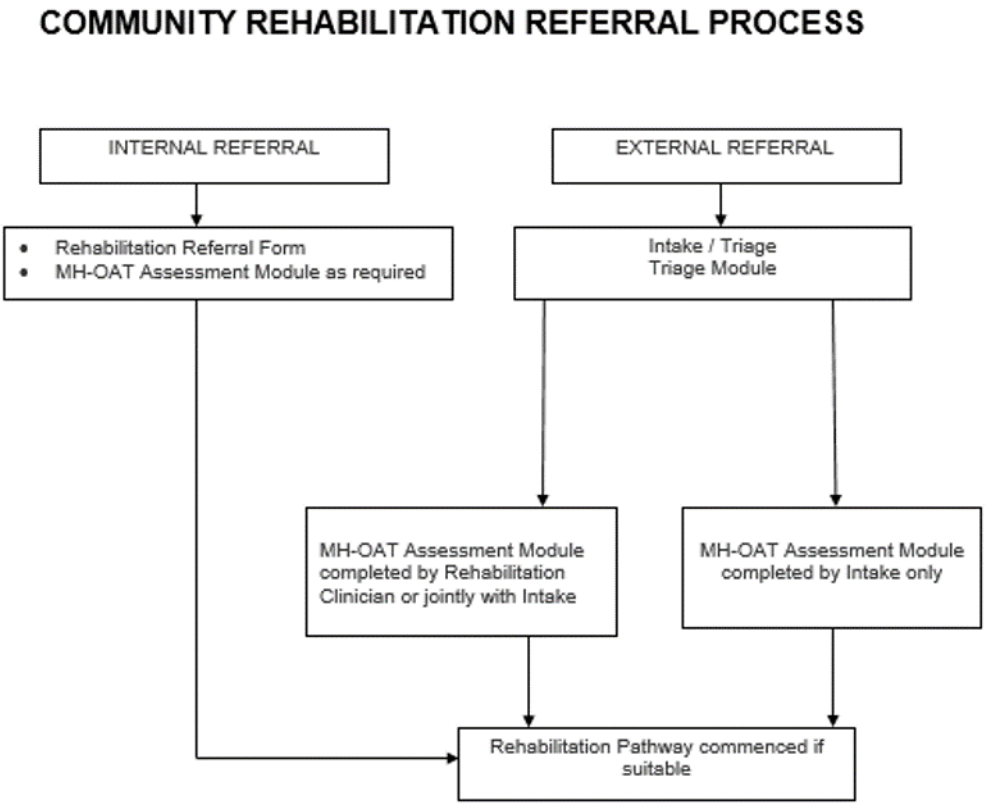
Revision and Approval History

Date	Revision no:	Author and approval
January 2012	1	Rehabilitation Clinical Process Guidelines – endorsed by SESLHD MHS Clinical Council
January 2012	2	Rehabilitation Care Pathway Policy – endorsed by SESLHD MHS Clinical Council
July 2016	3	New document – combined Guideline and Policy, now titled 'Mental Health Service Rehabilitation Clinical Pathway and Process' Guideline – endorsed by SESLHD MHS Clinical Council
October 2016	3	Endorsed by Executive Sponsor
November 2016	3	Endorsed by Clinical and Quality Council
August 2021	4	Reviewed and updated by PCLI Coordinator, SGMHS/TSMHS Rehabilitation Coordinator and ESMHS Rehabilitation Coordinator
December 2021	4	Minor review, minor changes. Endorsed MHS Document Development and Control Committee. Endorsed MHS Clinical Council. Approved by Executive Sponsor.

Appendix A: Rehabilitation Pathway



Appendix B: Community Rehabilitation Referral Process



Appendix C: Priority Grid for Rehabilitation Referrals

PRIORITY GRID FOR REHABILITATION REFERRALS

Considerations for Rehabilitation	Need for Community Rehabilitation to Support Recovery	Need for Inpatient Rehabilitation to Support Recovery
Level 1: High Priority	Urgent need with considerable risk of deterioration: e.g. pending or recent discharge from inpatient facility, recent move to independent living requiring clinical interventions to assist with successful community living OR Urgent Occupational Therapy Independent Living Assessment needed OR Direct referrals to specialised rehabilitation programs such as Early Intervention/Youth Mental Health, time limited groups/programs/interventions	Urgent need with considerable risk of deterioration if no access to inpatient rehabilitation Intensive rehabilitation required in order to manage community living, which cannot be provided by community rehabilitation and other services Either due to: 1. Pending discharge from acute inpatient service 2. Deterioration in the community with successful community living in jeopardy
Level 2: Medium Priority	Delay in access to rehabilitation is perceived to have some impact on recovery OR Non-urgent Occupational Therapy Independent Living Assessment needed	Moderate need with some risk of deterioration if no access to inpatient rehabilitation (as for High Priority) OR Consumer returning to inpatient rehabilitation following unsuccessful previous admission but demonstrating shift in 'readiness' or circumstances
Level 3: Low Priority	Delay in access to rehabilitation is perceived to have minimal impact upon recovery OR Consumer is progressing independently towards recovery	Non-urgent need whereby current community supports are sufficient to maintain successful community living, however a period of inpatient rehabilitation would provide opportunity to further build skills and independence

Appendix D: Rehabilitation Evidenced-Based Practice Prompt Sheet

REHABILITATION EVIDENCE-BASED PRACTICE PROMPT SHEET

1. Do you have family members who you would like to attend your appointments? Do your friends and family members want support and information about mental health, relationships and caring?

2. If you are linked with a community mental health clinician, do you want outreach visits to your home or in a community setting?

3. Would you like a strengths assessment?

4. Do you want to work? If so, if you are not already would you like to be linked with an employment consultant? Would you like support with your education e.g. accredited courses, TAFE, university, workplace training

5. Do you want support with any issues related to your use of drugs and alcohol?

6. Are you interested in learning psychological strategies for social and emotional wellbeing? e.g. CBT, DBT, mindfulness

7. Do you want education about self-management strategies? If so, would you be interested in attending the South Eastern Sydney Recovery and Wellbeing College?

8. Are you interested in consumer participation in mental health services? Would you like information about the Mental Health Service Consumer Advisory Committee and NSW Being? (BEING is the independent, state-wide peak organisation for people with a lived experience of mental illness)

9. Would you like support with your physical health? e.g. dental health, metabolic health, sexual health

10. Would you like to see a Peer Support Worker?

11. Do you have information about community organisations that may be able to support you? e.g. mental health support services, employment agencies, family and parenting services, neighbourhood centres, housing, cultural service