

MENTAL HEALTH GUIDELINE COVER SHEET

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SUMMARY	This guideline outlines the service model that guides the delivery of specialist inpatient and community based mental health rehabilitation services in 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 Rehabilitation Model of Care (2016) and SESLHD MHS Guideline 'Rehabilitation Clinical Pathway and Process' (2021)

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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 and Community Rehabilitation Services in South Eastern Sydney Local Health District (SESLHD). This Guideline is to be read in conjunction with SESLHD Mental Health Service (MHS) policy documents.

Rehabilitation services in SESLHD are provided by specialist rehabilitation professionals within three Community Mental Health services, two Inpatient Rehabilitation Units, and the Rehabilitation Program at the Mental Health Virtual Care Centre (MHVCC) 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.

Guiding Strategic Documents

Key documents informing this Model of Care and guideline include:

- A National Framework for Recovery Oriented Mental Health Services 2013
- Fifth National Mental health and Suicide Prevention Plan 2017
- Living Well: A strategic plan for Mental Health in NSW 2014-2024
- National Safety and Quality Health Service Standards Second edition, Australian Commission on Safety and Quality in Health Care 2021
- NSW Health Mental Health Inpatient Rehabilitation Model of Care Framework, Mental Health Branch April 2024 (unpublished and for NSW Health use only)
- Pathways to Community Living Initiative: Planning, Assessment and Follow-Up Guide. NSW Ministry of Health (July 2023)
- SESLHD Strategic Plan 2022-2025 Exceptional Care, Healthier Lives

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
- Culturally safe
- Individualised and person-centred
- Integrated
- Targeted, Time Limited and Evidence-Based

Rehabilitation services seek to facilitate:

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

Section 3 – Definitions

Mental Health Rehabilitation is defined as ‘a whole systems approach to recovery from mental illness that maximises an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.’ (Killaspy et al 2005).

The focus is on enabling individuals’ functioning, rather than simply addressing clinical symptoms and incorporates the importance of services maintaining therapeutic optimism for recovery. It is an active process, with short, medium and long-term goals designed to “restore or optimise physical, mental and social capability (NICE Guidelines 2020).

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:

- Recovery-oriented services focus on supporting people to identify what recovery means to them. They support people to gain or regain control of their identity and life, have hope for the future, and live a life that has meaning for them – whether that be through work, relationships, community engagement or some or all of these. They acknowledge that mental health and wellbeing does not depend predominantly on being ‘symptom free’, and that people can experience mental health issues and still enjoy a full life (WHO, 2021).
- A trauma-informed recovery-oriented approach is person-centred and person-led and involves sensitivity to an individual’s particular requirements, preferences, safety, vulnerabilities and general wellbeing. It is an approach that recognises lived experience and empowers people to genuinely participate in decision-making that affects their life and the supports, care and treatment they receive (Mental Health Coordinating Council 2022).
- SESLHD rehabilitation services have adopted a strengths-based model of practice as described in The Strengths Model: a recovery-oriented approach to mental health services (*Rapp and Goscha 2011*). The Strengths Model is both a philosophy of practice and a set of tools and methods designed to enhance recovery. It is an example of evidence-based rehabilitation best practice.

Six Principles of the Strengths Model

1. Focus is on strengths rather than deficits
2. The person receiving services is the director of the helping relationship
3. The community is an oasis of natural resources
4. All people have the capacity to recover, reclaim and transform their lives
5. The relationship is primary and essential
6. The primary setting for our work is in the community

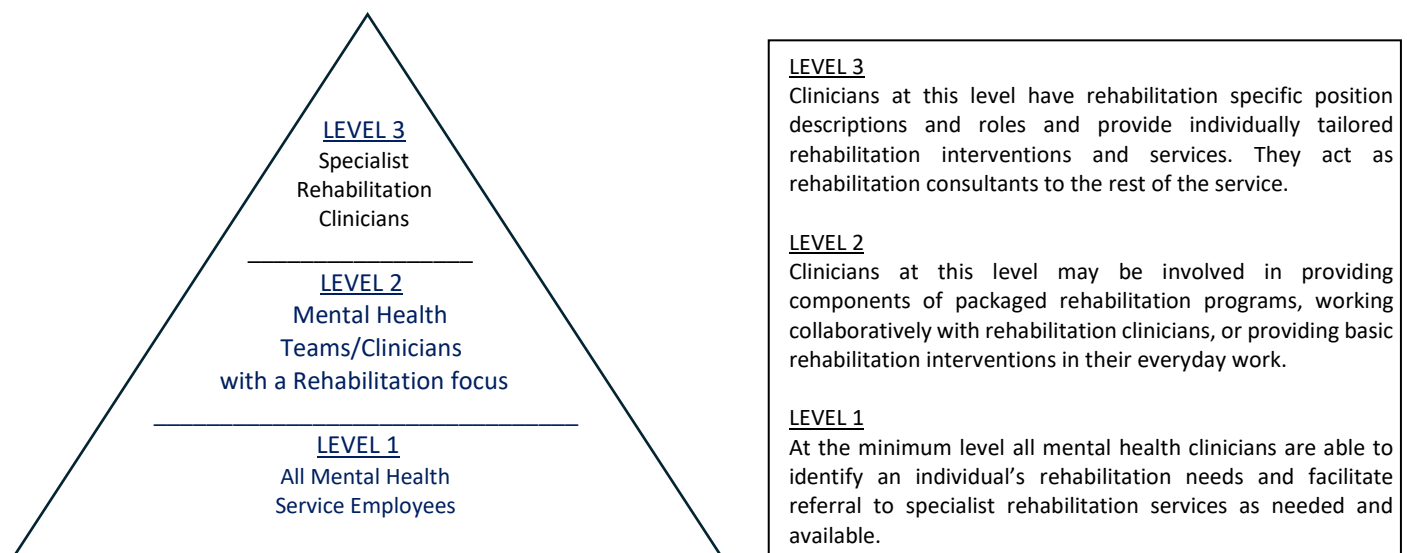
Section 4 – Rehabilitation Service Structure

Public Mental Health Services

In NSW, rehabilitation is identified as a specialist core component of the public mental health service which should be across all settings. It should be an essential focus of work for all mental health clinicians in both community and inpatient settings and an integral part of service planning and provision from a person's first presentation. It is important that all mental health workers have a general understanding of rehabilitation, are able to identify rehabilitation needs and are able to facilitate referral to specialist rehabilitation services as needed.

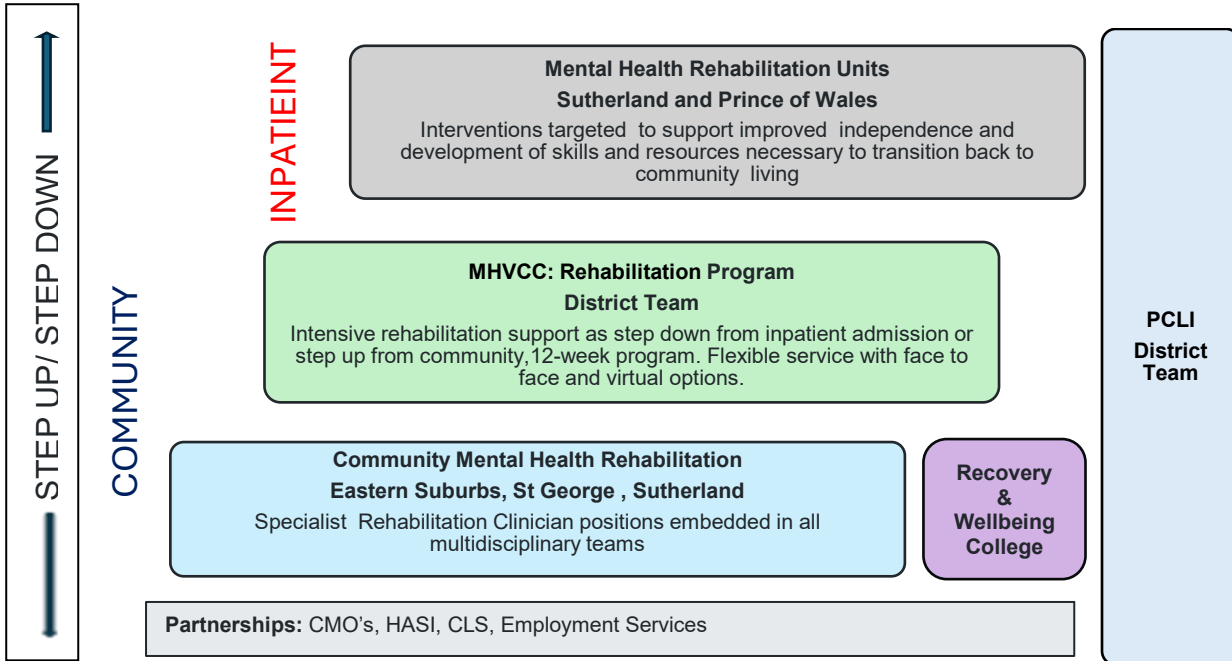
Many people accessing public mental health services have complex needs, requiring tailored tools and interventions that are delivered through specialised rehabilitation services to address each person's unique needs (*van der Meer L, Wunderink C, 2019*). The framework below articulates the different levels of rehabilitation skills and knowledge required, depending on a clinician's role and position within the mental health service. In SESLHD, community rehabilitation clinicians and inpatient rehabilitation teams are positioned at Level 3 of the framework, enabling the delivery of specialist services.

In services where Level 3 clinicians are not present, general mental health clinicians may struggle to provide comprehensive rehabilitation programs in addition to their routine duties.



Adapted from Mottaghir and Bickerton, Working with Families: Sutherland Division of Mental Health, 2000

SPECTRUM OF REHABILITATION SERVICES IN SESLHD



Rehabilitation services in SESLHD provide access for consumers in SESLHD to specialist rehabilitation clinicians within three Community Mental Health Teams, two Inpatient Rehabilitation Units and the MHVCC. These teams are managed operationally through local service structures but also have a strategic line of accountability to the SESLHD Rehabilitation Clinical Coordinator.

Rehabilitation Coordinators

The District and Site Rehabilitation Coordinators (St George and Sutherland and Eastern Suburbs) provide leadership and strategic direction to ensure that the mental health service provides contemporary, effective, specialist, recovery oriented mental health rehabilitation services. Locally these roles incorporate coordination of various partnerships including inter-agencies, consumer representation and advisory committees plus employment services partnerships. They also have a key role in promoting recovery supporting practices and models, including the Strengths Model and the Recovery and Wellbeing College.

Adult Community Mental Health Rehabilitation Clinicians

In the SESLHD, community-based rehabilitation is provided by specialist clinicians in collaboration with care coordination services. Rehabilitation clinicians may be the primary clinician for some consumers however they do not provide case management services. Rehabilitation clinicians may provide services as a one-off assessment, short-term (one to three months), medium term (three to 12 months) or, on occasion, longer term (more than 12 months). Community rehabilitation clinicians primarily provide one-to-one individualised services, with some clinical/therapy groups offered as required. Community Rehabilitation

Clinicians are located in all the Adult Community Mental Health multi-disciplinary teams. Each site has a Youth Rehabilitation Clinician dedicated to working with people aged 16-24yrs.

Community Development

A Community Development Coordinator position works across St George and Sutherland Mental Health Services. The position involves working closely with mental health consumers, CMOs, local councils, funding bodies and other government organisations to identify, plan, deliver and evaluate activities and programs for mental health consumers. There is a strong commitment to consumer empowerment and supporting consumers to participate in program planning within the Mental Health Service. This position also involves identifying and delivering education to community services in collaboration with clinicians from the mental health teams

Mental Health Rehabilitation Units

Short term intensive inpatient rehabilitation services are provided by two Mental Health Rehabilitation Units (MHRUs) at:
Prince of Wales Hospital – 14 beds
Sutherland Hospital – 5 beds

The aim of these services is to provide a time-limited rehabilitation service (three to six months is desirable) in a supported therapeutic environment, promoting the dignity and rights of consumers and involving them, their carers and community support partners in individualised programs. The focus of this service is on wellness and recovery with strengths-based assessments, groups and individualised care planning and goal setting, plus comprehensive discharge planning. The Rehabilitation Units provide individually tailored programs that address psycho-educational, living skills and social needs. These may occur either as a one-to-one session or in groups either on the unit or by accessing community resources.

It is recognised that whilst working in a team, each discipline has its own unique skills to contribute. It is also recognised that consumers benefit from continuity of care. As such, staff work in a primary clinician (Care Coordinator) model. Coordination, communication and the establishment of a working alliance with the consumer are fundamental elements of this role, and together with a strengths-based, recovery-oriented approach represent one of the cornerstones of the service provided to consumers by the MHRU.

Mental Health Virtual Care Centre: Rehabilitation Program

The MHVCC's Rehabilitation Program uses a step-up, step-down model for people who require intensive clinical, functional and psychosocial rehabilitation to develop skills for personal recovery at home and in the community, support that cannot be adequately provided by less intensive community services. Using a hybrid care (face-to-face and online) the Program aims to assist consumers to transitioning to or maintain independence in community. This is achieved by placing the consumer at the centre of care to offer personalised, goal-directed support. With an MDT comprising of a Staff Specialist, Senior Occupational Therapist, Registered Nurses and a Peer Support Worker, the program offers specialised interventions designed to promote autonomy and build sustainable living skills, with a strong emphasis on supporting consumers in independent medication management and functional skills such as home management, meal preparation, budgeting, and community engagement.

Individuals accessing the program will be provided with an iPad and internet to engage for the duration of the Program, with the device remaining the property of SESLHD MHS and being returned upon completion of the program.

This service is available for both consumer's with and without a current SESLHD community mental health team.

Pathways to Community Living Initiative

The Pathways to Community Living Initiative (PCLI) is a co-ordinated state-wide approach to support people with a severe and persistent mental illness who have been in hospital for more than 12 months or at risk of a long stay in hospital re-establish their lives in the community.

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 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.

South Eastern Sydney Recovery and Wellbeing College

The Recovery and Wellbeing College provides a broad curriculum of courses aimed at helping people with mental health conditions recognise and develop their personal resourcefulness, so they become experts in their own care, make informed choices and achieve their goals and aspirations. The Recovery and Wellbeing College also provides individual support to students accessing the college in the form of a student learning plan. This plan identifies student values and goals and aims to identify suitable courses that match these.

The model brings together lived experience of mental health conditions and professional expertise, within an adult education model. With the contemporary practice of valuing the lived experience and knowledge base of consumers and carers, it is appropriate in many cases for traditional rehabilitation groups to be converted to the Recovery College model, whereby courses are co-developed and co-facilitated by a Peer Educator and a Clinical Educator.

Rehabilitation clinicians have a key role in co-producing Recovery College courses and in supporting consumers to access the College.

Partnership Building

Rehabilitation clinicians work with community interagency partners, including private practitioners and CMOs with the view to assisting consumers to develop sustainable support networks and achieving outcomes in chosen life roles and goals eg accommodation, employment, education, relationships. This collaborative working recognises that no one service can meet all the needs of those with complex support needs. Rehabilitation clinicians are well placed to conduct comprehensive assessments of community functioning and roles and work with consumers with clinical evidence-based interventions and in collaboration with CMOs which are well placed to support consumers with longer term needs.

Rehabilitation clinicians can lead this process by coordinating a care planning meeting of consumers, carers, family members and CMO services involved to have a clear plan of how support will be provided to consumers. SESLHD Rehabilitation clinicians and services need to develop partnerships and work collaboratively with these services to provide comprehensive and integrated mental health rehabilitation to people in SESLHD.

Service Integration

Rehabilitation services form part of the continuum of mental health care. An effectively integrated mental health system ensures that consumers receive the service that best meets their needs at that point in time, in the least restrictive way.

The SESLHD rehabilitation pathway is designed to provide flexibility, smooth transitions and enables people to join and leave at different points and move between part of the pathway that provide higher or lower level of support according to their changing needs. Regular reviews of rehabilitation needs and progress with the individual is essential to flag a change in level of support and need for a step up or step down in the rehabilitation service type.

This means that the transitions between the various services need to be actively managed. To facilitate this the inpatient and community rehabilitation teams work in close collaboration to assist inpatient consumers to access community-based activities and with community clinicians providing an in-reach service to assist people transitioning out of the inpatient service.

Section 5 – Responsibilities

Multidisciplinary Mental Health Rehabilitation Workers are responsible for:

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

Site 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.
- Monitor and report compliance to this guideline to the District Rehabilitation Coordinator

Service Managers are responsible for:

- Ensuring service compliance to this guideline

District Rehabilitation Coordinator is responsible for:

- Providing consultation to service managers and Rehabilitation Coordinators to ensure rehabilitation services maintain alignment with this guideline
- Ensuring the guideline continues to reflect SESLHD and NSW Ministry of Health policy directives, guidelines, and evidence-based mental health rehabilitation.

Section 6 – Referral and Access

The Rehabilitation Service Pathway is summarised in **Appendix A**.

6.1 COMMUNITY REHABILITATION

6.1.1 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).

In general, the role of a community rehabilitation clinician should be that of a secondary clinician, enabling them to maintain the capacity to deliver specialist rehabilitation services and provide consultation to the multidisciplinary team, as well as support a broader range of consumers. In addition to individual clinical care, the rehabilitation clinician is responsible for facilitating rehabilitation groups, delivering education and training (eg through the Recovery and Wellbeing College), providing specialist interventions (such as cognitive remediation) and assessments, and fostering partnerships with community and vocational services.

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.
- In circumstances where service capacity necessitates, a specialised rehabilitation clinician may be allocated as the Primary Clinician for a consumer. In such instances, the consumer must Have primary needs which are within the domains of rehabilitation interventions (see Section 10)

6.1.2 Referral and Allocation

Referrals for community rehabilitation are collected, reviewed and allocated as appropriate to an individual rehabilitation clinician within a Community Mental Health Team (CMHT). 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.

6.1.3 Prioritisation

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

6.2 INPATIENT REHABILITATION

6.2.1 Service Access

- Inpatient rehabilitation is available for a stay of up to three months or longer as indicated. The MHRUs provide a service to existing consumers of the SESLHD 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 via the State-Wide Mental Health Telephone Access Line (SMHTAL) as per usual protocols for new referrals to the MHS in accordance with [SESLHDPR/418 Relationships with External Clinical Care Providers – Mental Health Services](#). The MHRU will then follow the referral process outlined in 6.2.2 and assess suitability. External referring agencies must agree to resume responsibility for mental health service provision once rehabilitation is complete or deemed unsuitable for any reason.

Entry Criteria:

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

- Reside within the catchment area of SESLHD.
- Aged 18-65yrs. Consumers over 65yrs or under 18yrs may be assessed and considered on an individual basis.
- The person experiences 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 by community rehabilitation service options.
- They have been assessed as having the ability 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 substance use issues, developmental disability or personality vulnerabilities, suitability will be assessed depending on current rehabilitation needs and willingness to engage in the rehabilitation process.

- 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 the rehabilitation program. 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.

6.2.2 Mental Health Rehabilitation Unit Referral Process

The referral stage represents the first part of the engagement and assessment process. Ideally, 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. Discussions would include unit programming, personal priorities and aspirations, length of stay, and any other topics which are relevant to the individual.

The following outlines the steps to refer a consumer to a MHRU:

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. Referral must include:
 - a) Reason for referral
 - b) Consumer's expectations of the rehabilitation unit 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) Comprehensive Risk Assessment, including
 - g) Current accommodation issues and legal status
 - h) Any other information deemed relevant to the referral.
3. Follow-up face to face assessment meeting between the nominated MHRU team member and consumer, family/supports and primary clinician.
4. Discussion between medical teams and allied health teams as relevant.
5. Referral and assessment discussed at weekly referral meeting.

6.2.3 Allocation and Prioritisation of Referrals

Consumers who meet the entry criteria for a MHRU 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, 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 in **Appendix B**.

Section 7 – 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 Primary Clinician, using virtual care to contact the consumer (SMS, phone call and/or videoconferencing) and meeting them in an environment of their choice.

Engagement is an essential component of the rehabilitation process. Strategies are employed to build a collaborative, therapeutic relationship/alliance and 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, video conferencing or other forms such as in writing or via email. 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.

Discussions would include what rehabilitation services can provide, types of rehabilitation interventions are offered, personal priorities and aspirations, values and shared understandings, length of stay or length of community interventions, and any other topics which are relevant to the individual.

Section 8 – Assessment

Assessment is a critical element of the rehabilitation and recovery process. In community settings, all referrals should be accepted for assessment unless clearly contraindicated ie 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:

1. 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) in Progress Notes. 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)

2. 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. A PowerNote is included in the Mental Health catalogue for documentation of the MH Strengths Assessment in eMR.

3. 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, they are responsible for completion of the Mental Health Outcomes and Assessment Tools (MH-OAT) assessments and measures.

INPATIENT: On admission the allocated RN should complete the MH-OAT outcome tools and update the consumers phase of care.

4. 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.

NSW Health [GL2021_006 Physical Health Care for People Living with Mental Health Issues](#)

5. Other Rehabilitation Assessments

Additional recognised assessment tools or discipline specific assessment are offered to guide rehabilitation planning eg measures of psychological functioning, physical health, daily living skills, sensory needs, neuropsychological capacity, vocational assessment, 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
- 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 what is important to them to work towards in their recovery
- 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.

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. 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

Staff are encouraged to utilise a Motivational Interviewing approach to their assessment. This approach is a collaborative, respectful and curious style of communication designed to assist people to explore and resolve ambivalence, and to increase motivation for change.

“Motivational Interviewing is a particular way of talking with people about change and growth to strengthen their own motivation and commitment.” (Miller & Rollnick, 2023)

Section 9 – Rehabilitation Goal Setting and 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 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.

The MH Care Plan form in eMR must be used to document all rehabilitation plans. The Personal Recovery Plan template may be used in the MH Care Plan. When updating the MH Care Plan, clinicians are expected to use the 'modify' function rather than creating a new MH Care Plan.

Rehabilitation Plans should incorporate the following:

- Description of the person's personal recovery goals and detailing of the steps and strategies towards achieving their goal(s). Strategies should indicate who is responsible for each ie 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.

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. Using a strengths approach throughout rehabilitation planning and goal setting process helps build confidence which in turn increases the likelihood of the person persisting through challenges and barriers to their recovery goals.

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. An example of this is the process of upside-down goal setting where a goal is explored between a clinician and a consumer to identify meaning and values behind these goals. At times someone’s initial goal will change over time through this process and can often work towards adapting an “unrealistic goal” into an equally meaningful alternative goal. It can also be useful in breaking down bigger goals into smaller achievable goals in working towards those larger goals.

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?)

“But the consumer I am working with has no goals”

At times consumers may be feeling overwhelmed and uncertain and may need assistance from staff to help them discover what they do want. People often find it difficult to see beyond their current life situation and they may face barriers that make it difficult for them to engage in ‘self-directed’ support. 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.

The word “goal” could be a barrier to engagement in rehabilitation planning, and it could be useful to use other terms such as priority, aim, hope, desire or phrases, for example:

- Let’s talk about what’s important to you.
- Tell me something that’s worth working towards
- What would you like to be able to do?
- What is one thing that would make a difference?

(From [Agency for Clinical Innovation Engagement in self-directed planning](#))

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. Values-clarification exercises, the Strengths Model, and Motivational Interviewing can assist with this process. It is important to continuously review a person’s motivation and readiness to change through tools like motivational interviewing.

Section 10 – Rehabilitation Intervention

Rehabilitation interventions can be delivered within inpatient & community settings through one to one or structured group activities. Rehabilitation interventions and strategies will aim to support the development of skills & resources that maximise the individual's quality of life, improve functioning and promote independence and autonomy in the community in line with their goals, hopes and wishes. Interventions will be recovery orientated to recognise the consumers strengths and skills, purposeful & individualised to accommodate the consumers goals & needs and time limited and measurable to ensure outcomes are evaluated.

Rehabilitation interventions will be delivered by multidisciplinary clinicians (including nursing, allied health & peer support workers) who work within the scope of practice for their relevant discipline to provide evidence mental health rehabilitation interventions, that are uniquely tailored to the consumer's goals.

Mental health rehabilitation clinicians are specialist clinicians deliver specific, measurable, targeted, individually tailored interventions that assist with building capacity and skills to improve functioning, skills and resources and independence. Rehabilitation services provide a suite of interventions and strategies which may include, but are not limited to:

- Structured Comprehensive Assessment
- Life Planning. Daily Living Skills
- Interpersonal and Social Skills
- Psychological and Cognitive Therapies
- Vocational and Educational Strategies
- Physical Healthcare and Wellbeing Interventions
- Pharmacotherapy and Medication Adherence Approaches
- Mental Health Self-Management, Recovery Promotion and Education
- Family Intervention
- Community Development/Capacity Building and Linkage

See **Appendix C** Evidence-based rehabilitation interventions informed by:

- NICE guideline: Rehabilitation for adults with complex psychosis (2020)
- Package of interventions for rehabilitation for schizophrenia. Module 8. Mental health conditions (WHO, 2023)
- NSW Health: Mental Health Inpatient Rehabilitation Model of Care Framework (2024)

In addition, Rehabilitation Services may tailor 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. Orygen identify the importance of functional recovery interventions for young people who develop psychosis and recommend be commenced as early as possible (Orygen 2016)

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- *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 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

The use of the Rehabilitation Initial Assessment Tool, Strengths Assessment and Personal Recovery Plan 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](#).

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 they have been able to achieve.

Does the document include the consumer’s stated perspective?

This could include information about what is important to them, the reasons why a particular choice was made, and the consumer’s agreement or disagreement with treatment recommendations etc.

Does the document include information related to consumer-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 consumer been given an opportunity to read, respond to and revise the document?

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 and describe the person’s viewpoint in his/her own words, The principles of recovery can be reflected in documentation through being respectful and non-judgemental, avoiding terms that are not easily understood and writing as though the person you are speaking about will read what you have conveyed. (Mental Health Coordinating Council, 2022).

Section 12 – Rehabilitation Review

A comprehensive rehabilitation review is conducted in line with [SESLHDPR/642 Clinical Review in Mental Health](#) and [SESLHDGL/074 Clinical Documentation in Mental Health](#).

The review should always use the eMR Module “MH Clinical Review”. During the MH Clinical Review, the consumer’s MH Care Plan should also be presented, discussed and endorsed by the consumer’s consultant psychiatrist.

To ensure that the review maintains fidelity to the principles of rehabilitation, services should ensure the consumer’s perspective of treatment goals and progress is at the centre of the discussion.

Formally the processes are:

Inpatient Mental Health Clinical Review

Inpatient rehabilitation review occurs at least once per fortnight. 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 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 at least once every 13 weeks. This review focuses on the consumer’s progress during the review period, the consumer’s goals and needs, effectiveness of rehabilitation interventions being delivered, and to plan care for the next review period, in conjunction with the multidisciplinary team. The MH Care Plan should be updated following the review, which may include updates to the person’s goals and rehabilitation interventions.

Section 13 – Completion of Rehabilitation and Re-Entry

Discharge 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 discharge or transfer 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 individual. 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.
- Discharge and/or transfer of care is a collaborative process that is based on how the service can 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 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.
- Outcomes data collected by rehabilitation services on admission, at 13 weeks and/or at discharge include:
 - Health of the Nation Outcome Scales (HoNOS), completed by the clinician
 - Life Skills Profile 16 (LSP-16), completed by the clinician
 - Activity and Participation Questionnaire (APQ6), a measure of vocational and community participation completed by the consumer

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 the following aims:

- They are aware of what rehabilitation could offer them.
- Alternative service options have been offered where relevant.
- They have a positive experience of contact and engagement with the MHS.

Section 14 – References

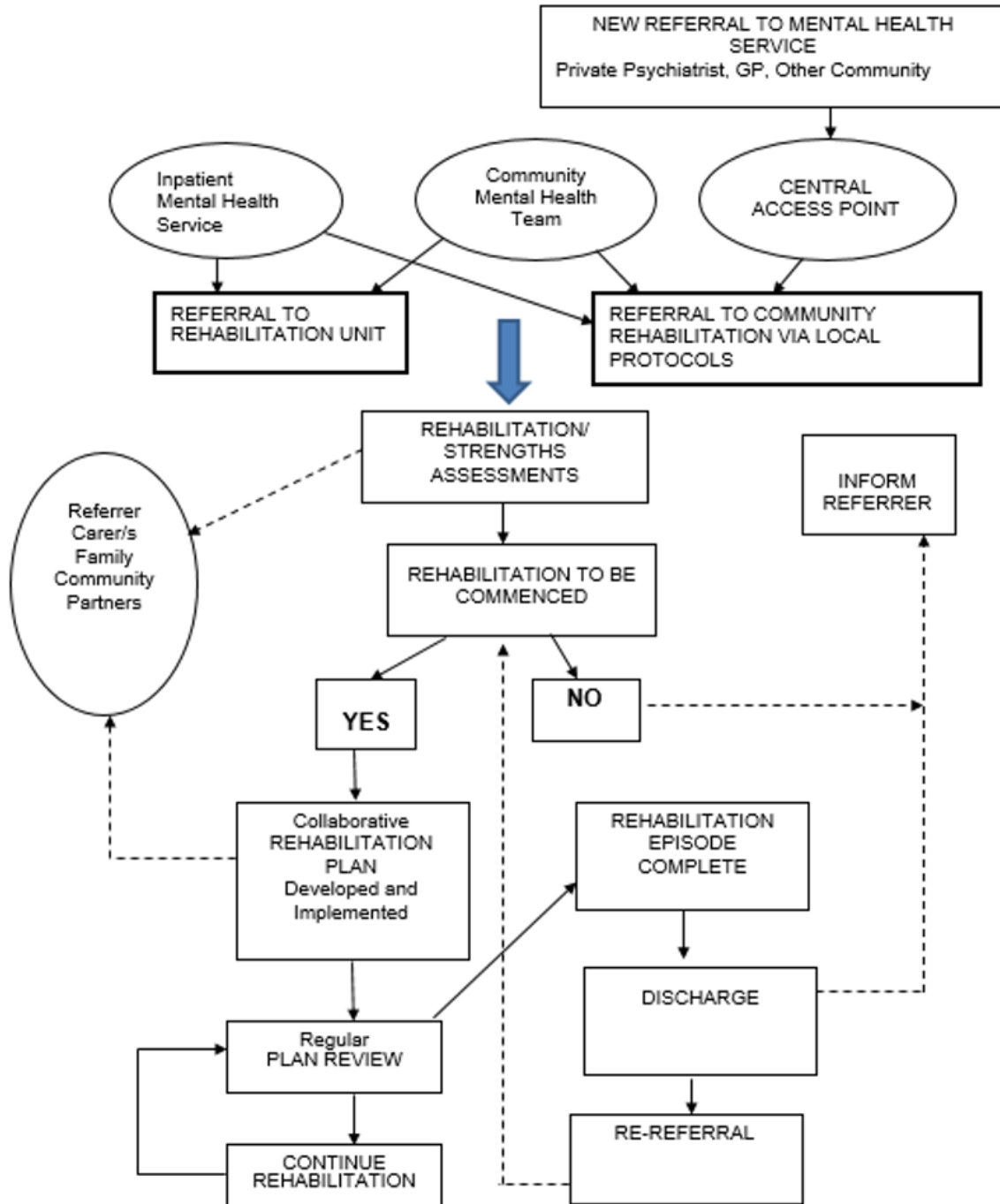
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Section 15 – Version and Approval History

Date	Version	Version and approval notes
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.
29 October 2025	5	Comprehensive review by SESLHD Rehabilitation Clinical Coordinator and SESLHD Rehabilitation Steering Committee. Reviewed and endorsed out of session DDCC. Reviewed and endorsed out of session Clinical Council. Endorsed for publication by the Executive Sponsor.

Appendix A: Rehabilitation Pathway

REHABILITATION PATHWAY



Appendix B: 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	<p>Urgent need with considerable risk of deterioration: eg pending or recent discharge from inpatient facility, recent move to independent living requiring clinical interventions to assist with successful community living</p> <p>OR</p> <p>Urgent Occupational Therapy Independent Living Assessment needed</p> <p>OR</p> <p>Direct referrals to specialised rehabilitation programs such as Early Intervention/Youth Mental Health, time limited groups/programs/interventions</p>	<p>Urgent need with considerable risk of deterioration if no access to inpatient rehabilitation</p> <p>Intensive rehabilitation required in order to manage community living, which cannot be provided by community rehabilitation and other services</p> <p>Either due to:</p> <ul style="list-style-type: none"> • Pending discharge from acute inpatient service • Deterioration in the community with successful community living in jeopardy
Level 2: Medium Priority	<p>Delay in access to rehabilitation is perceived to have some impact on recovery</p> <p>OR</p> <p>Non-urgent Occupational Therapy Independent Living Assessment needed</p>	<p>Moderate need with some risk of deterioration if no access to inpatient rehabilitation (as for High Priority)</p> <p>OR</p> <p>Consumer returning to inpatient rehabilitation following unsuccessful previous admission but demonstrating shift in 'readiness' or circumstances</p>
Level 3: Low Priority	<p>Delay in access to rehabilitation is perceived to have minimal impact upon recovery</p> <p>OR</p> <p>Consumer is progressing independently towards recovery</p>	<p>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</p>

Appendix C: Evidence-based interventions for Mental Health Rehabilitation

Domain	Interventions
Structured Comprehensive Assessment	A comprehensive, holistic rehabilitation assessment is documented capturing key domains to guide rehabilitation planning as outlined in Section 7.
Life Planning	Motivational interviewing, values clarification, goal setting, activity scheduling, structuring the day
Activities of Daily Living (ADL)	ADL training is directed towards an individual's goal to improve independence in daily living and consists of education, guidance and training techniques in the context of functional tasks such as including self-care, laundry, shopping, budgeting, using public transport, cooking and home management.
Interpersonal Interactions and relationships	Structured individual and group activities aimed at improving interpersonal and social skills such as verbal and non-verbal communication, assertiveness, problem solving and confidence building
Mental Health Self-Management	Identify and develop skills that best suit the individual to enhance self-management of physical and mental health conditions. This includes medication adherence therapy and education, relapse prevention strategies, stress management, psychoeducation and involvement in the Recovery & Wellbeing College
Psychological and Cognitive Therapies	Initial cognitive screening to determine need for comprehensive cognitive assessment. Cognitive remediation and adaptive strategies. Individual or group programs targeting anxiety, stress, distress tolerance or anger management. Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness
Education and Vocation	Includes the development of close linkages and networks with specialist employment services, specialised vocational assessments and vocational support interventions, plus support for study and promotion of educational opportunities.
Physical Health and Wellbeing	Strategies targeting nutrition and weight management, metabolic syndrome, personal health and fitness, smoking cessation, education addressing sexual health, substance use, oral health.
Pharmacotherapy and medication adherence approaches	Effective pharmacotherapy provides a sound foundation to enable psychosocial strategies to be implemented. This forms a key part of inpatient rehabilitation service provision.
Community and Social Life	Support identifying and pursuing leisure interests, and engagement and participation with community activities
Carer and Family Supports	Provision of education and support, involvement in care planning, support to maintain relationships, referral to specialist services
Community Development/Capacity Building and Linkage	Advocacy and education to promote access and reduce stigma, partnership building with CMO partners and other providers of mental health support, practical assistance for consumers to access community activities.

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 eg 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? eg 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? eg 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? eg mental health support services, employment agencies, family and parenting services, neighbourhood centres, housing, cultural service