

# Policy Guideline

## Mental Health Services Pathways to Care Policy Guideline

**Policy developed by:** Mental Health and Substance Abuse

**Approved at Portfolio Executive on:** 13 May 2014

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### Summary

The Mental Health Services Pathways to Care Policy Guideline articulates an integrated way of working and service delivery. The Policy Guideline describes equitable and respectful care and treatment to people with a mental illness within the resources available. Pathways to care and treatment are described within an environment that provides people with flexibility and choice. The Policy Guideline supports a strong partnership with the diverse network of care and treatment offered in the non-government sector and with other government agencies. The Policy Guideline is to be read / administered in conjunction with the Mental Health Services Pathways to Care Policy Directive.

### Keywords

Mental Health, Pathways to Care, Participation, Access, Care, Partnerships, Transfer of Care, Re-entry, Mental Health Services Pathways to Care Policy Guideline, Policy Guideline

### Policy history

Is this a new policy? **Y**  
Does this policy amend or update an existing policy? **N**  
Does this policy replace an existing policy? **N**

### Applies to

All SA Health Portfolio

### Staff impact

All Staff, Management, Admin, Students; Volunteers  
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology  
Other

### PDS reference

G0136

### Version control and change history

Version	Date from	Date to	Amendment
1.0	01/06/2014	Current	Original version

# Mental Health Services Pathways to Care Policy Guideline

Care which promotes  
individual healing and growth



## Document control information

<b>Document owner</b>	The Office of the Chief Psychiatrist and Policy
<b>Contributors</b>	The Pathways to Care Policy Guidelines have been developed through broad consultation with the Local Health Networks, Not for Profit Organisations, Consumer and Carer Groups, Drug and Alcohol Services South Australia, SA Ambulance Service, Royal Flying Doctor Service, Veteran's Community and the Veterans Health Advisory Council, Health and Community Services Complaints Commissioner, Multicultural Communities Council of SA, The Royal Australian & New Zealand College of Psychiatrists, and professional bodies.
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## Document history

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## Endorsements

Date	Endorsed by
13/05/2014	Deputy Chief Executive, System Performance

## Approvals

Date	Endorsed by
13/05/2014	Portfolio Executive

# Pathways to Care Policy Guideline

## 1. Objective

The Pathways to Care Policy Guideline, developed in consultation with people who experience a mental illness, their support people and service providers, articulates an integrated way of working and delivering care.

South Australia has a stepped model of care, delivering a range of service types and settings to accommodate the varying needs of individuals requiring assistance with their mental health. All settings are part of an integrated whole, providing flexible care and treatment options to adjust to the changing needs of the person, their health status and stage of life.

The Pathways to Care Policy Guideline describes equitable and respectful care and treatment to people with a mental illness within the resources available. Pathways to care and treatment are described within an environment that provides people with flexibility and choice.

This Guideline supports a strong partnership with the diverse network of care and treatment offered in the non-government organisation (NGO) and private sector and with other government agencies.

This Policy Guideline is to be read / administered in conjunction with the Mental Health Services [Pathways to Care Policy Directive](#).

## 2. Scope

The Pathways to Care Policy Guideline applies to all mental health services (MHS) in South Australia that provide care to adults (between 18 years and 65 years) and older persons (over 65 years) inclusive of specific Veteran Services and Forensic Services.

The Guideline extends to the working relationship that these services have with partners such as emergency services, NGOs, Disability, Drug and Alcohol Services South Australia (DASSA) and primary health care.

Services related to children and adolescents under 16 years are provided by the Child and Adolescent Mental Health Services (CAMHS). Youth Mental Health Services (YMHS) are being introduced for 16 – 24 year and will be supported by the Pathways to Care Guideline with specific specialist guidelines where required.

*Note:* The term Aboriginal is inclusive of Aboriginal and Torres Strait Islander people throughout this document.

## 3. Principles

The guiding principles include: participation, inclusion, customer service, resource management, collaboration with partners and professional accountability.

### 3.1 Participation

MHS commitment to a participation principle is achieved through:

- > people actively participating as early as possible in their individual care
- > people participating at all levels of the MHS
- > the MHS involving participation from the beginning of planning and implementation of the service
- > inclusion of a diverse range of people, their families and support persons
- > selection of participants in a transparent process, developing and drawing upon the expertise and resources of people with lived experience of mental illness
- > embracing and enabling people with experience of mental illness, their families and their communities to interact and draw benefit from one another.

### 3.2 Inclusion

MHS commitment to an inclusion principle is achieved through:

- > providing care in accepting and welcoming environments that cater to the needs of persons regardless of ethnicity, social, cultural or religious background, spirituality, gender or sexual orientation
- > removing barriers to people receiving the care they need when they need it
- > providing people (and their support person/s) with information about their health and treatment options to assist them in making informed decisions
- > supporting people to take personal responsibility for their life, mental health and wellbeing
- > supporting people to embrace their strengths to live a meaningful and fulfilling life of their choosing
- > protecting the rights of every person and their support person/s
- > recognising the differences in language and experiences of people and providing interpreters and translators where required
- > recognising the uniqueness of the person, respecting differences in culture, religion, spirituality and philosophy
- > ensuring care and treatment is delivered in a manner that respects the person's uniqueness
- > recognising the possibility that anyone accessing the service may have unresolved trauma underlying their mental distress
- > taking into account the wishes of the person and support person/s in decisions providing a holistic approach to care for people with physical health issues, drug and alcohol issues and disability
- > providing a holistic approach to care for those people who have experienced combat and trauma.

#### 3.2.1 Inclusion specific to Aboriginal people

MHS commitment to an inclusion principle specific to Aboriginal people is achieved through:

- > ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal people are respected through the delivery of culturally appropriate services
- > providing a positive environment which promotes engagement with Aboriginal people with a focus on equity of access to services
- > assisting Aboriginal people to overcome barriers to living life to the full, paying attention to physical, spiritual, cultural, emotional and social well-being
- > strengthening our partnerships with Aboriginal communities and other providers serving them
- > ensuring issues that impact the lives of Aboriginal people are understood and addressed in culturally appropriate ways
- > understanding and compassion.

### 3.3 Customer Service

MHS work to provide quality customer service:

- > working with people at the most vulnerable times in their lives. This is an extremely privileged area in which to work that requires commitment to authentic engagement and respect for the other person
- > working collaboratively and respectfully with the partner services providing treatment, care and support to people in MHS
- > commitment to:
  - being kind and showing interest in the person
  - listening with intent and checking you have understood the person's concerns
  - respecting differences in people
  - being helpful, courteous and knowledgeable
  - ensuring that the interests of the person are a priority
  - providing prompt, helpful and friendly responses to all enquiries
  - providing clear explanations to everyone
  - thoroughly and quickly investigating complaints
  - providing connection to the correct service if MHS is not the right service for the person
  - at all times, acting in a professional manner
  - always maintaining hope, being persistent and finding new ways to engage with people.

#### Who are MHS customers?

- > People with an experience of mental illness
- > The person's support, family, friends and neighbours
- > Emergency services
  - SA Ambulance Service (SAAS) and SA Police (SAPol)
- > All general hospital staff
- > Primary health care providers
- > General Practitioners (GPs)
- > NGOs
- > Private practitioners
- > Private hospital staff
- > Other government agencies
  - CAMHS
  - DASSA
- > General public.

### 3.4 Resource management

MHS commitment to resource management is achieved through:

- > ensuring that resources are geared for prevention and early intervention
- > ensuring that people are responded to as early as possible
- > managing resources to ensure that all people have equitable access to quality care
- > ensuring there is a continual flow within and between MHS to step up and step down options
- > ensuring that transition processes are simple, respectful and demonstrate integrated care
- > using resources in the most efficient and effective manner
- > providing flexible options for people experiencing a mental illness
- > utilising hospital avoidance programs, where appropriate to maintain a least restrictive environment for the person.

### 3.5 Collaboration with partners

MHS commitment to collaboration with partners is achieved by ensuring:

- > the person is fully involved in all aspects of their care and treatment with information presented in a way that the person understands
- > all partners are fully involved, ensuring respectful and equitable working relationships.

## 4. Detail

### 4.1 PTC 01 Participation

#### 4.1.1 Introduction

It is important that MHS seek to improve the quality of services through participation with the people they serve and acknowledge the priorities they advocate.

Participation historically became important in the 1970s when it was recognised globally that health services were not providing needs driven quality services. Rather, these services were typically physician and hospital centric. The World Health Organization (WHO) articulated this at the Alma-Ata conference in 1978. Consequently a campaign was launched by the WHO along with several member governments to promote wellness and the prevention of disease through public empowerment.

This meant that community participation was needed to address health issues through social policy, legislation and engagement in health planning.

At a national and state level, participation has become more valued, with peak bodies providing greater sophistication in their involvement and knowledge base through the National Consumer and Carer Forums. Global recognition with supportive evidence recognises the importance of community participation to the provision of a quality health service.

In 2005 the National Consumer and Carer Forum prepared best practice principles which apply to 'consumer and carer' participation across Australia in the *Consumer and Carer Participation Policy: a framework for the mental health sector*. At the same time, the South Australian Government developed the *Carers Recognition Act 2006* which has at its core the *South Australian Carer's Charter*.

This Participation policy is also supported by the *Mental Health Act 2009* and the *Family Relationship Act 1975*.

#### 4.1.2 Who is involved in participation?

The PTC 01 Participation describes the participation of the person, their family and support person/s, each of whom bring valuable insights into the workings of mental health services and how services can improve.

There have been numerous terms used to refer to for people who have a personal experience of mental illness. They have been called patients, clients, consumers, people with lived experience, but for the purpose of the Pathways to Care guidelines they are described as 'people' or 'the person'. The term 'family' and 'support person/s' is used to describe people who provide unpaid support to the person, previously referred to as family members, carers, relatives, neighbours or supports.

Participation is inclusive of people of all areas of the demographic population the service serves.

#### 4.1.3 What is participation?

The participation of the person, their families and support persons is fundamental to continual MHS reform and improvement. Participation includes opportunities to contribute meaningfully to individual care and treatment, as well as providing feedback into the development, planning, delivery and evaluation of MHS.

Healthy, mental health organisations involve people who have experienced a mental illness, and their family or support persons, throughout the entire process, from the provision of meaningful input into individual care and treatment through to involvement in strategic planning, policy development, implementation, education, training and evaluation of services.

Involvement is required across all service types in mental health and needs to be representative of the populations served. This includes the engagement of Aboriginal people, the elderly, people living with a chronic illness, including mental illness, people with disabilities, people with comorbid conditions, people from culturally and linguistically diverse (CALD) backgrounds, veterans, socially, economically or geographically isolated communities and people with lower levels of literacy. All have experience and knowledge that contribute to improved service provision.

## PTC 01-1 MHS undertake to know and understand the population of the catchment area it provides services for.

### 4.1.4 Reasons for participation

Participation is important for the following reasons.

#### 4.1.4.1 For the person

- > it recognises their rights to be involved in their own care and treatment
- > it improves their opportunities for recovery and promotes a sense of hope and optimism
- > it focuses on the strengths and personal responsibility of the person
- > it recognises the ethical implications of health provision
- > it improves their experience of health services through collaboration
- > it provides an opportunity to better inform service delivery.

#### 4.1.4.2 For family and support person/s

- > it recognises family and support person/s rights to be involved in the person's care and treatment
- > it provides an opportunity to inform and improve services
- > it improves their experience of health services generally.

#### 4.1.4.3 For mental health clinicians

- > it enhances understanding of the person's experience of their illness
- > it provides opportunities for reflective practice
- > it maintains perspective and empathy for people experiencing a mental illness or mental disorder, their family and support person/s
- > it ensures personal accountability
- > it ensures personal growth
- > it provides greater job satisfaction.

#### 4.1.4.4 For Mental Health Services

- > it improves the quality and safety of MHS
- > it helps gain health service accreditation
- > it improves community health outcomes
- > it improves service responsiveness to the needs of people experiencing a mental illness
- > it promotes a socially inclusive environment
- > it ensures MHS accountability.

### 4.1.5 The guiding principles

The effectiveness of the participation is enhanced if the following principles are observed:

- > people actively participate as early as possible in their individual care
- > participation occurs at all levels of the MHS
- > the organisation will involve participation from the beginning of planning and implementation of the service
- > participation will be inclusive of a diverse range of people, their families and support person/s
- > apply culturally responsive practice to all people
- > engage with people in the context of their families and important relationships, and where appropriate other members of the community
- > participants are selected using a transparent process
- > service decision-making and evaluation is a transparent process.

#### 4.1.6 How participation in care can flourish

##### 4.1.6.1 People involved in their own care

People have valuable and unique experiences to share at all times of their illness and wellbeing. Respecting and encouraging people to recognise this unique experience is integral to their involvement in their own care.

#### **PTC 01-2 MHS value the unique knowledge of people with an experience of mental illness.**

Knowledge about the services people are entering, what care and treatment they are likely to receive and knowledge of their rights and responsibilities enables them to have more effective participation in their own care and treatment.

It is important the person's rights and responsibilities are explained by clinicians and repeated as necessary, to ensure their understanding.

#### **PTC 01-3 MHS provide people with information about the MHS, care and treatment available, rights and responsibilities that is understandable to the person in their spoken language.**

All presenting people, their family and support person/s receive information to assist them to better understand the MHS available and implications under the *Mental Health Act 2009*.

#### **PTC 01-4 MHS provide welcome packs for people entering the service, their family and support persons.**

Assistance to navigate the mental health system ensures people are able to participate from an informed and supported perspective.

#### **PTC 01-5 MHS actively assist people to navigate the mental health system.**

The person is encouraged to recognise and work from their strengths to return to optimal living.

##### 4.1.6.2 Support persons' participation in care

Support persons have a unique knowledge that is invaluable in the assessment, care and treatment of persons with a mental illness. It often comes about through supporting and /or caring for the person through difficult and challenging times. The support person/s' voice provides the day-to-day expertise and is valued by mental health clinicians.

#### **PTC 01-6 MHS value the voice and involvement of families and support person/s and respects their rights and safety concerns.**

Support persons are provided with education and support to enhance their knowledge of mental illness, mental health and caring for people with mental illness.

#### **PTC 01-7 MHS ensure that families and support persons receive the ongoing information they require to fulfil their role as a partner in care.**

MHS bring experience and expertise to the partnership in care. Within the partnership MHS participate in upholding hope and optimism and celebrate in people's success stories. The service is able to reflect and encourage the strengths of the person, acknowledging their progress and reframing any setbacks that occur. The service models positive and supportive behaviours in the partnership.

## **PTC 01-8 MHS offer respectful, person centred relationships, practices and service environments that support hope and optimism.**

Cultural competency tools are utilised to ensure that services are recognising, valuing and respecting cultural diversity.

Aboriginal healers are utilised where appropriate to the needs of the Aboriginal person. MHS utilise the Traditional Healer brokerage program and the [South Australian Aboriginal Languages Interpreters and Translators Guide](#).

## **PTC 01-9 MHS utilise cultural competency tools to achieve culturally competent services.**

### **4.1.7 How participation in MHS development can flourish**

The voice of people, their families and support persons is a valuable resource for an organisation seeking to improve its services.

Participation and partnership at all levels of MHS is a hallmark of quality services.

## **PTC 01-10 MHS provide open, transparent and accountable processes in the selection of people wanting to participation.**

### *4.1.7.1 Strategic planning*

People, their families and support person/s are provided with opportunities to actively participate in the strategic planning of the service. Participation occurs as early as possible in the process, the role of participants is clear and the service provides feedback to participants on the outcome of their involvement.

## **PTC 01-11 MHS have procedures that support participation throughout strategic and service planning.**

### *4.1.7.2 Service planning*

Participation of people, their families and support person/s provides advice on health service planning and delivery of services.

The organisation actively seeks and responds to feedback, ideas, knowledge and experience provided from outside the organisation.

Ensure the involvement of people of CALD backgrounds and representative organisations in service design, delivery and evaluation to inform culturally appropriate mental health care and improve health outcomes across all sectors of the community.

Ensure that Aboriginal people are engaged in service design, delivery and evaluation, including the development of culturally respectful and acceptable models of care that meet the specific mental health needs of Aboriginal people and which include the services of Aboriginal traditional healers, interpreters and translators.

## **PTC 01-12 MHS have a communication process that accesses a range of advice from people who wish to participate.**

### *4.1.7.3 Service implementation*

The implementation of services or strategies is a time to constantly review the processes of change.

People with a personal experience of mental illness are able to provide valuable insights into the impact of new services as they impact care and treatment received.

## **PTC 01-13 MHS have a communication process that enables feedback from those directly affected by the implementation of a new or different service.**

### *4.1.7.4 Service evaluation*

MHS engage the participation of people in the meaningful evaluation of services. Feedback from people with a personal experience of mental illness is actively sought by MHS. This feedback is utilised and processes are put in place to provide information to participants on the changes that have occurred as a result.

The processes that ensure participation of people with personal experience of mental illness throughout the service are evaluated in an on-going way and formally as part of accreditation.

## **PTC 01-14 MHS evaluate the processes for meaningful lived experience participation at all levels.**

### *4.1.7.5 Accreditation*

Services are evaluated against national criteria and are part of an accreditation process for continual service improvement. People with a personal experience of mental illness are involved in the accreditation process.

### *4.1.7.6 Feedback process*

The service provides a feedback process for people using services that is respectful, responsive and aims to learn from feedback to improve the service.

### *4.1.7.7 Sentinel events*

Sentinel event reviews actively involve the voice of people who have experienced services.

### *4.1.7.8 Community Visitors Scheme*

As part of a continuous evaluation of services, the Community Visitors Scheme (CVS) was established under the *Mental Health Act 2009*. The CVS provides further protection to the rights of people with a mental illness who are admitted to treatment centres in South Australia, their families and support person/s.

## **4.1.8 Developing the capacity of people to participate**

The service has a welcoming approach, is inclusive and offers and provides support and debriefing of participants. Participants are respected, valued and appreciated.

MHS are supportive of education and training for people with a personal experience of mental illness in advocacy roles.

MHS use innovative approaches to ensure participation reflects the diversity of the population served including strategies to engage Aboriginal people, older people, people living with low and high prevalence mental illness, their families and support person/s, people with disabilities, CALD people, veterans, socially, economically or geographically isolated communities, people with lower levels of literacy and children of parents with a mental illness. Participation occurs equitably throughout all parts of the service and that participation is inclusive of people who represent the characteristics and diversity of the population.

## **PTC 01-15 MHS have processes in place that supports equity of representation that is characteristic of the diversity within the population served.**

Those wanting to participate are encouraged to register their interest in being involved in the on-going development of the organisation.

## PTC 01-16 Mental health clinicians are trained and supported to involve participation in all aspects of the MHS.

Mental health clinical staff will receive training and support to provide opportunities for participation across all levels of the organisation.

### 4.1.9 The peer workforce

Please note: Peer Support Workers and Carer Consultants employed by MHS perform the role of service provider and cannot be involved in participation for the organisation as a representative of people with a lived experience of mental illness or a support person/s.

The peer workforce has much to offer those experiencing a mental illness, their families and support person/s and clinicians. Hearing from people who have shared similar experiences can provide reassurance and hope to those experiencing a mental illness. It is also valuable for an organisation to see that people do get better in spite of their illness. The peer workforce enriches all aspects of service provision across MHS.

#### 4.1.9.1 Service support

The peer workforce is clearly described within the MHS organisational structure and shows a clear career pathway. The culture and values of the organisation support the peer workforce and provides access to the essential resources needed to perform their roles effectively.

MHS provide flexible work environments and conditions and make reasonable adjustments to manage stress in the workplace. MHS have a system of support for individual peer workers. Peer mentoring and supervision occurs within the peer workforce. Processes are provided to support the independence of the worker.

## PTC 01-17 The MHS is inclusive of a structured peer workforce.

The peer workforce is provided with orientation to the organisation and the area of the service in which they work. The training and support provided is relevant to the workplace and ensures the participants are also able to self-monitor for periods of stress and illness and know how to safely seek help or time out. This training supports the peer workers to perform their roles within the organisation. Ongoing personal development is offered to the peer workforce along with professional supervision.

## PTC 01-18 MHS provide training and support for the peer workforce.

#### 4.1.9.2 Role conflict

There will be times when the role of the peer workforce may conflict with organisational parameters. Workers employed by MHS, as service providers, have a conflict of interest if they are asked to represent the voice of people with personal experience of mental illness in strategic planning, service planning, implementation or evaluation. Role conflict may also occur during times of a worker's own illness or that of family. Procedures are in place to protect workers' privacy and minimise the amount of personal disclosure that is required during episodes of illness.

## PTC 01-19 MHS have procedures that minimise the risk of role conflict for the peer workforce and maintains personal confidentiality.

## 4.2 PTC 02 Access to Mental Health Services

The access policy describes a flexible mental health service offering multiple entry points on a continuous basis, taking into consideration varying presentations and appropriate service responses.

The stepped system of care provides multiple care and treatment options for people with a mental illness. This is because care pathways do not follow a prescribed linear path for every person as people have vastly different service needs.

The focus is on ensuring people are supported with the most appropriate service, seamlessly moving to the least restrictive environment of care as they need it. MHS are pre-empting these moves at all times, creating space in the system to allow this to occur.

MHS provide astute management of their services' demand on a daily basis ensuring capacity to assess and treat all presentations. The services offered are able to prioritise their workload, meeting all obligations to assess and treat the full spectrum of presentations.

Services are non-discriminatory, providing services irrespective of where an individual lives, their age or cultural background or level of medical insurance. Every effort is made to reduce stigma and the perception of stigma recognising that in smaller communities the perception of stigma may be greater.

### 4.2.1 Mental health access points

#### PTC 02-1 MHS provide equitable access to all services.

##### 4.2.1.1 Community Mental Health teams

Metropolitan and some country Community Mental Health teams have an acute crisis response role with the ability to assess the person promptly within their own home. There is also capacity for walk-in options located in the community, for face-to-face assessment of people for progression to the right service type for their needs. Depending on the urgency of need, referrals for assessment can be made by telephone where arrangements are then made for a more formal planned assessment which can be achieved via face to face assessment, telephone or telemedicine. Assessments may occur with a community team member and/or a psychiatrist.

Services for older persons have dedicated community mental health teams as the first point of contact in metropolitan regions. Within country areas the initial contact is through local community teams.

##### 4.2.1.2 Mental Health Triage (MHT)

MHS can be accessed through telephoning 13 14 65 for mental health emergency triage and liaison services. Clinicians assess a person's need and provide immediate counselling and support or arrange referral to appropriate services or further assessment by the community team.

##### 4.2.1.3 Emergency departments

Public hospital emergency departments provide an assessment, treatment and referral service for emergency presentations requiring urgent care and assistance.

##### 4.2.1.4 Consultation Liaison Services

MHS provide Consultation Liaison Services in all major hospitals, providing an assessment, consultation and referral service for admitted medical and surgical patients.

##### 4.2.1.5 Forensic Services

Forensic Community Mental Health Service responds to all referrals of people declared 'liable to supervision' by the courts. Prisoners may be referred to the visiting psychiatrist by the SA Prison Health Service.

Referrals for specialist forensic assessment of patients deemed to have a profile of high risk or behaviours can be made Monday to Friday during office hours by telephoning the Forensic Community Mental Health Service.

The Forensic Consultant on-call is available to provide advice after hours.

#### 4.2.1.6 Services for Older Persons

Referrals are made to Older Persons Mental Health Service (OPMHS) community teams during business hours or via the OPMHS receiving unit and Consultant after hours. In country regions OPMHS sit within the community mental health teams.

#### 4.2.1.7 Veteran Services

Veterans can access a mental health service through the same pathways described above but further specific services are available by contacting the Repatriation Hospital Ward 17. Referrals are accepted nationally.

### 4.2.2 Referral source

Referrals to MHS can be made by self-referral or through a GP, carer, NGO worker, private psychiatrist, private hospital, SAAS, Royal Flying Doctor Service (RFDS), SAPol, law courts, general hospitals, Residential Care Facilities (RCF) or interstate mental health facilities.

### 4.2.3 Service response

Community Mental Health services for both adult and older persons play a key role, within the stepped system coordinating care and access to other service settings when required. The community team drives the care plan and the flow of people in and out of services. Public and private mental health services, NGOs and primary health care services all play an important role in facilitating access to appropriate mental health services, to ensure there is a continuity of care for people who experience mental illness.

## PTC 02-2 MHS respond to all referrals in a timely manner.

MHS are responsible for managing the demand for their services and ensuring equitable access to service types.

## PTC 02-3 MHS effectively manage the demand for their services.

### 4.2.4 Initial assessment

People present with a varying degree of urgency and to a variety of settings. The community team, MHT, Emergency Triage Liaison Service, the Digital Telehealth Network and emergency department clinicians triage the mental health presentation and allocate sufficient time for assessment. The time for assessments is guided by the type of presentation, the immediate needs of the person and the assessment site.

## PTC 02-4 The assessing mental health team determines the service that provides the person with the most appropriate care, treatment and support.

The initial assessment determines the care requirements and the service best placed to provide it. The assessing clinician and their multi-disciplinary team determines the most appropriate service choice, giving due consideration to discussion with the person, their family and support person/s. This may require:

- > referral to alternative therapies or services that may better suit the person's needs. MHS for some people may not be the best therapeutic model to use
- > referral for collaborative therapy options with a GP
- > referral to an NGO service
- > referral and transfer to the private sector
- > assignment of the care required within the community team
- > assignment to a bedded service.

The development of a care plan is critical to ensure a person receives the most appropriate care.

## 4.2.5 MHS options

### 4.2.5.1 Adult Community Mental Health Services

Adult Community Mental Health teams are multidisciplinary, comprising a range of mental health professionals, who are dedicated to providing accessible and responsive mental health support for people with a mental illness and their support person/s. Professional disciplines within each team include: social workers, occupational therapists, psychiatrists, nurses and psychologists.

Each team tailors care according to each person's needs. This may include specialised assessment, provision of treatment, administration of medication, assertive care and follow-up, involvement in psychosocial support groups or a tailored program that involves collaboration with other agencies to provide a coordinated support service for the presenting person.

Each Adult Community Mental Health team provides a range of services including: assertive care and clinical support services during normal business hours; and acute crisis response over extended hours and on weekends. In country South Australia Rural and Remote Emergency Triage and Liaison Service provide crisis response over extended hours and weekends.

### 4.2.5.2 Older Persons Community Mental Health Services

OPMHS community teams are multidisciplinary, comprising a range of mental health professionals, who are dedicated to providing accessible and responsive mental health support for people with a mental illness and their support person/s. Professional disciplines within each team include: social workers, occupational therapists, psychiatrists, nurses and psychologists.

Each team tailors care according to each person's needs.

OPMHS community teams work very closely with primary health care services, as the link between physical and mental health is directly related. A psychiatric assessment is required to assist in the development of a care plan.

### 4.2.5.3 Forensic Community Mental Health Services

Forensic mental health is a specialist area that provides services to meet the needs of offenders with mental disorders. The Forensic Mental Health Service (Forensic MHS) has a role in the assessment and management of mentally ill persons at all points in the offending cycle, but is directly responsible for two distinct populations.

The first are those that have been declared liable to supervision under Part 8A, Section 269 of the *Criminal Law Consolidation Act* due to a finding of mental unfitness to stand trial or not guilty by reason of Mental Impairment. These patients are known as "forensic patients" and may be committed to detention or granted conditional release on Licence.

The second group are those persons in the custody of the Department for Correctional Services, either remanded in custody or serving a prison sentence and require mental health assessment and care.

Forensic MHS also provides a range of other services which includes but is not limited to: teaching/education, illness prevention and prevention of offending.

The Forensic MHS operates in close collaboration with the South Australian Prison Health Service, the Department for Correctional Services, DASSA, Disability SA and SAPol.

### 4.2.5.4 Veteran Services

Ward 17 is a dedicated, inpatient unit for veterans and their families providing psychiatric assessment and treatment in the context of veteran experience in areas of conflict and trauma.

### 4.2.5.5 Transitional Care Programs

It is the aim of MHS to treat the person in the least restrictive environment. Whilst much of the care can be provided within the community, there may be times when more prompt or intensive care is required. Depending on the degree of distress or concern, a transitional care program may avert a change to the person's physical location. By addressing the situation that is causing the person distress, an admission to an inpatient facility can be avoided and the person is then more empowered to overcome the issue at hand.

### 4.2.5.6 Bedded services

Access to bedded services are either planned or crisis admissions.

#### 4.2.5.6.1 Planned admission

The stepped model of care provides a variety of bedded service options available to people who require support. Following the assessment of the person, if recommended, a planned admission is arranged by the community team.

### **PTC 02-5 MHS work with a person's strengths to achieve the least restrictive environment for them.**

A planned admission has a defined purpose and includes discussion with the referrer, the person, their family/carer and the admission facility. The plan should accompany the person, outlining the desired outcomes of the admission.

### **PTC 02-6 The assessing clinician will provide an admission plan to accompany the person, outlining the desired outcomes of the admission.**

Depending on the person's needs and consideration for the least restrictive option available, a plan may involve the person remaining at home with additional supports or stepped up care in the community or referral to:

- > Intermediate Care Centre (ICC)
- > Integrated Mental Health Inpatient Units (IMHIU) in country regions
- > Country hospital
- > Acute Inpatient Unit
- > Psychiatric Intensive Care Unit (PICU)
- > Community Rehabilitation Centre (CRC)
- > Rehabilitation Inpatient Unit
- > Acute Inpatient Unit for Older Persons (all admissions to services for older persons are planned following an assessment by OPMHS to determine the psychiatric issue prior to admission).

Planned admissions can be either voluntary or determined under the *Mental Health Act 2009*.

Planning for an admission can occur over a number of days or over a number of hours in response to deterioration in mental state.

### **PTC 02-7 The community mental health clinician accompanies the person (when possible) during the admission process, where a bedded service is required.**

Planned admissions are received directly from the community by the admitting service. A collaborative approach to assessment and care planning occurs with the person, support person/s, community team and admission unit.

Direct admission to a bedded service reduces the level of anxiety that accompanies access via an emergency department. It also reduces the duplication of assessment and provides a seamless service process between the community and the bedded service. Medical examination of a direct admission can be completed by the admitting unit's medical officer.

### **PTC 02-8 MHS have procedures in place for direct admission of the person from the community.**

#### 4.2.5.6.2 Crisis admission

A crisis admission occurs as a result of an unexpected urgent crisis, sometimes resulting in a SAPol and/or SAAS attendance. Protocols exist for emergency services to work together to assess the needs of a person in crisis at home. On occasions the person is taken to an emergency department for urgent assistance.

The decision to admit is not made by a community team in this case but rather within the emergency department or by a country GP, as a response to the urgency and where no other plan of action is appropriate.

A request for a bedded service is made by the staff in a metropolitan emergency department or if the emergency department/ GP is in the country by telephoning MHT on 13 14 65 or to the bed coordinator in the local country hospital.

The transport option used for the person travelling from a country emergency department or hospital will determine the point of entry to a metropolitan service for a crisis admission.

#### 4.2.6 The allocation of an acute bedded service

All people with a mental illness deserve quality mental health services in a timely manner. Reducing the waiting time is important for all those people waiting for a bed. The person should receive an appropriate bed allocation within four hours if the person is awaiting admission from within an emergency department and <24 hours if waiting for a bed in the community. Consideration is given for the prompt allocation of beds for Forensic patients to reduce risk.

### PTC 02-9 The Local Health Networks are accountable for the timely access to beds of all people from their catchment regardless of place of presentation.

MHS are responsible for ensuring that people do not wait long periods of time for a bed.

People requiring a bedded service can wait for the allocation from a wide variety of locations. They wait in the community, in their home, an IMHIU, in a country hospital, a country hospital, ICC, an emergency department or in custody.

All persons referred for bedded services must be given equal priority. Each requires equity of access to achieve treatment at the earliest possible time. It is important that the allocation of beds ensures a good fit for the service needs of the presenting person and their supports. Consideration is given to the continuity of care of the person and their supports.

MHS manage their bed stock to find ways to reduce waiting times and provide best practice across all service types.

The availability of beds and waiting times are known to community mental health teams, MHT and emergency departments so that appropriate services such as Transitional Care Programs are instituted, if necessary, ensuring people are well supported whilst they wait for a bed.

All bedded services are required to provide early and concise information regarding beds becoming available on their units.

## 4.3 PTC 03 Care and treatment in Mental Health Services

People experiencing mental illness are entitled to quality, evidence based care and treatment for all aspects of their health.

Care and treatment is delivered in a respectful, non-judgemental and culturally sensitive way and people are provided with information about their mental and physical health that is understandable to them and enables them to make an informed choice.

People experiencing a mental illness have considerable choice in the care and treatment that is provided by GPs, NGOs, emergency services, the 'for profit' sector and MHS. This choice is maximised through early intervention.

MHS aim to actively engage, early, in a flexible partnership with: people experiencing mental illness, their family and support person/s; to encourage and empower the person to achieve a meaningful life. Communication between people experiencing a mental illness, their family, support person/s and service providers is critical to achieving this.

#### 4.3.1 The therapeutic relationship

The therapeutic relationship is the cornerstone of mental health care. Ways to engage with the person experiencing a mental illness should form part of their care plan.

The service has an attitude of maintaining hope and tries many ways to engage with the person in a meaningful way. This should occur within an environment of inclusion of the person experiencing a mental illness and their family and support person/s and other relevant service providers in treatment options and care plans.

### PTC 03-1 MHS engage in a meaningful way, with people experiencing a mental illness, their family, support person/s and all relevant agencies.

MHS clinicians have an attitude that every request for service is assessed with a view to finding the best care and treatment options for the person.

## PTC 03-2 MHS provide diversity of choice within the design of care and treatment options for people.

Engagement with the person is respectful and empathetic to the specific needs of the person. It reflects the diversity in the community of people with a mental illness, with consideration given to the needs of:

- > Aboriginal people
- > CALD people
- > older people
- > people of lesbian, gay, bisexual, transgender/transsexual, intersexed (LGBTI) orientation
- > people from rural and remote areas
- > veterans
- > people with complex needs
- > people within the criminal justice system.

Specific support is provided for people with a mental illness to assist clinicians to remove any barriers to meaningful engagement, with the person and their family, support person/s. Such supports include; Aboriginal traditional healers, translators and interpreters.

### 4.3.2 The assessment

The assessment is the first step in achieving a care and treatment plan. The assessment tool used in South Australia is designed to improve the process to ensure that people entering the mental health service will be provided with the most appropriate care and treatment.

Whilst assessments are important they can be frustrating for people experiencing a mental illness and often for their family and support person/s, who are required to repeat their stories many times. Every effort is taken to collect information once to reduce repetition. This is critical to the pursuit of an empathetic service.

Immediate assessment is achieved through a telephone interview with members of the MHT or Rural and Remote Emergency Triage Liaison Services or the OPMHS. The call receivers explore the issues at hand and determine a course of action according to a person's needs.

Assessments are conducted by Community Mental Health clinicians as part of planned visits to the person's home or other site as deemed suitable or as an emergency response.

A face-to-face initial assessment is also achievable by attending a community mental health team or an emergency department. In both cases, assessments follow standard procedure.

#### 4.3.2.1 Assessing the person's level of distress

The safety of the person, their family, support person/s, staff and the community is of paramount importance.

## PTC 03-3 MHS ensure the assessment of the person is inclusive of monitoring distress and risk to self and others.

An assessment of the person's level of distress and emotional pain is required to reduce the impact these feelings have on the person and those around them. Concerning responses to distress vary from person to person, and can include severe withdrawal, self-harm, suicidal behaviours and aggression toward others or physical objects.

Mental health workers are skilled in the use of therapeutic self-soothing and de-escalation techniques.

Acknowledgement of a person's distress is critical at this time. It is important that the person is offered safe options for expressing their distress and ensuring all those concerned remain safe.

The care options require close monitoring of changes in behaviour with corresponding appropriate changes to the delivery of care, always seeking to empower the person to take control for themselves within the least restrictive service option that will reduce the person's distress and mitigate any risk to self or others.

#### 4.3.2.1.1 The person exhibiting 'suicidal and self-harming' behaviours

### **PTC 03-4 MHS ensure a senior clinician assesses people who have made a suicide attempt or engaged in serious self-harm and this assessment results in a care plan inclusive of ongoing support.**

Where a person has indicated the desire for self-harm or suicidal behaviour the person receives a comprehensive assessment from a mental health practitioner. The assessment results in a care plan that is approved by a psychiatrist prior to the person being released from care. The person is not discharged without supports in place.

### **PTC 03-5 MHS support the family and support person/s in accessing assistance following a suicide attempt or suicide of a family member.**

Support is also given to the family and support person/s of those who have been affected by self-harm, suicide attempt or a suicide. Support and advice on resources available, and assistance to seek these out, is to be provided in a timely manner to those affected by such events. Referrals are provided to NGO support services.

#### 4.3.2.2 Collateral information

Assessment is not based on presentation alone.

All assessments include discussions with people who have known the person with a mental illness over time. In particular the person's GP, support person/s, and other community services providing support to the person and their mental health case manager are consulted.

Other agencies that may be involved in gaining collateral information include: Emergency Services, a private psychiatrist, Disability Services and DASSA.

### **PTC 03-6 MHS seek collateral information from family, friends and other service/s.**

Family members and support person/s provide valuable information regarding daily activities and changes that occur over time and how rapidly these changes occurred.

At times, people with a mental illness, may insist on confidentiality regarding their care and treatment. Mental health clinicians consider these requests but also the requirements and vulnerability of support person/s. The rights and safety of support person/s is a very important consideration.

### **PTC 03-7 MHS have procedures for sharing information with the person, family, support person/s and other agencies.**

#### 4.3.2.3 When a person expressly restricts the sharing of information

Mental Health Services need to be respectful of the wishes of the person experiencing a mental illness. On occasion the person will not wish MHS to share information with family members or others. The *Mental Health Act 2009* does not allow for disclosure of personal information in contravention of a direction given by the person whom the information relates unless they are a person to whom a community treatment order or inpatient Treatment Order applies.

Disclosure is always provided in consideration of the best interests of the person.

### **PTC 03-8 MHS have procedures that support clinicians, to enact section 106 of the *Mental Health Act 2009* when a person expressly restricts sharing of information that are respectful of the person's wishes and addresses their concerns.**

#### 4.3.3 The SA Mental Health Act 2009

The *Mental Health Act 2009* is enacted when the care and treatment is deemed to be necessary and the individual is an unwilling participant during the assessment process.

People are made aware of their voluntary and involuntary status. Being restricted by an order under the *Mental Health Act 2009* may be distressing to the person, the person's supports and family and information regarding rights and responsibilities can allay this distress.

#### **PTC 03-9 MHS deliver care and treatment in the least restrictive environment possible.**

Continual monitoring of the person's mental state is required to ensure the least restrictive care option is in place.

When a person with a mental illness is involved in a hearing with the Guardianship Board the person, the person's family and support person/s are informed and encouraged to attend.

##### 4.3.3.1 Children

Protecting the person's children is an important consideration once the *Mental Health Act 2009* has been enacted. Where the person is responsible for children, MHS are required to ensure that the children are placed into the care of relatives or with an appropriate service. The person is to be involved in these decisions as much as possible and the detail is to be included in their care plan.

The health and wellbeing of children is of the utmost importance.

#### **PTC 03-10 MHS have procedures that ensure the person's children are cared for adequately by responsible adults or services whilst the person is admitted to a bedded service under the *Mental Health Act 2009*.**

##### 4.3.3.2 Pets and property

Protecting the person's pets and property is another important consideration once the *Mental Health Act 2009* has been enacted.

It is important that their property is secured and a family member notified where possible. Where the person is responsible for pets, MHS are required to ensure that the pets are placed into the care of relatives or with an appropriate service. The person is to be involved in these decisions as much as possible and the detail is to be included in their care plan.

#### **PTC 03-11 MHS have procedures that ensure the person's pets are cared for and their property is secured once the person is admitted to a bedded service under the *Mental Health Act 2009*.**

#### 4.3.4 Translation of assessment into care and treatment

##### 4.3.4.1 The assessment

The assessment is a process by which MHS continually monitor that the person experiencing a mental illness is receiving the most appropriate care and treatment. Assessment occurs around clinically relevant transition points such as admission to a new service setting, review, discharge and follow-up. These assessments allow clinicians to develop workable care plans for the individual and to compare the person's clinical status before, during and after provision of care.

It is not expected that all people who present to MHS require ongoing mental health care. The action, in this instance may be a brief assessment and referral to another more appropriate service. An assessment is required to make the clinical judgement of referral to another service and this should be reflected within the relevant documentation.

For those people who require a mental health service, the assessment will result in the development of a Mental Health care and treatment plan.

#### 4.3.4. 2 Care and treatment options

In many circumstances mental health treatment is delivered within the person's own home. There are a variety of service delivery options within MHS and the relevant and most appropriate service is dependent on the assessed need of the person in the least restrictive environment possible. Clinicians use a range of therapies and services to assist people regain optimal mental health.

Episodic care may need to happen in a bedded service. Where an admission to a bedded service is required the care and treatment provided by the bedded service is congruent with longer term care plans developed in the community with the community team the person and their supports.

#### 4.3.4. 3 Developing the care and treatment plan

The care and treatment plan is a communication tool ensuring the person's aspirations, goals and wishes are respected and supported in all parts of the service that they may come in contact with.

### **PTC 03-12 MHS develop a current mental health plan with each person receiving a mental health service.**

Care and treatment plans are developed and refined with information coming out of the assessment and include the person's perspectives, wishes and goals along with those of the family and support person/s. The Kessler 10 and the Authorised 'Carer' Assessment are utilised when developing a care plan with the person and their support persons.

The capacity of the support person/s is always considered and recorded along with the importance of the level of their current involvement.

Mental Health care plans are a requirement of the Guardianship Board.

#### 4.3.4.4 Linking physical health and mental health

### **PTC 03-13 MHS have procedures to ensure the physical health of people with a mental illness is considered in the planning and provision of any mental health interventions.**

Physical health and mental health are critically linked. It is therefore paramount that people with a mental illness or disorder receive good quality health care. MHS have an important responsibility to ensure that people involved with their service have access to such health care by taking a 'whole of health' approach.

Specifically MHS:

- > encourage all people with a mental illness to receive physical health examinations
- > make sure all care plans address physical health needs and ongoing physical health issues
- > provide information of people so that they can make informed choices about their own health and well-being.

### **PTC 03-14 MHS empower people to improve their self-management in mental and physical health.**

#### 4.3.4. 5 Medication

Practitioners prescribing medication ensure they comprehensively discuss medication adherence and discontinuation issues inclusive of attributes, side effects and effects of ceasing quickly; with the person and their family and support person/s.

The medication information is also provided in written format for the person and their support person/s.

Practitioners ensure that consideration is given to the literacy and first language of the person and the cognitive ability to understand the information given to them. Every effort is made to ensure the person understands the information given.

### **PTC 03-15 MHS provide comprehensive information to the person, their family and support person/s on the medication prescribed and the practitioner checks the person's understanding.**

## 4.4 PTC 04 Transfer of care within Mental Health Services

MHS provide a stepped system of care with a range of services that meet the changing needs of people. It is not unusual for people to progress from one part of the service to another as their needs change. Each transition point poses a vulnerable period as people and service providers adjust to the change.

Planning for the transfer of care ensures the person experiences a seamless service as they transition from one service type to another.

### PTC 04-1 MHS ensure people experience no break in care/or delays when moving between services.

#### 4.4.1 Transfer of care

A 'transfer of care' occurs when a person moves from one service type to another service type. This could be community team to inpatient unit, inpatient unit to community rehabilitation service or emergency department to a community team.

The decision to transfer a person from one section or unit to another part of the same service is made by the treating team in consultation wherever possible with the person's, family, support person/s and their GP.

People experiencing a mental illness receive services in the least restrictive environment. The transfer of a person between units within mental health services occurs when their service needs change. The transfer may be a step-up to increased service intensity or step-down to decreased service levels.

### PTC 04-2 MHS provide flexible options for people to move between services as their needs change.

The stepped system of care provides many service options for clinicians to consider when deciding the care and treatment options that may suit the person's needs.

The time spent by an individual in a bedded service is relatively small.

All areas of MHS are required to manage the demand for their services, to ensure that the pathways to care are not restricted by waiting lists or by delays in transfer between parts of the service.

This involves active management of entry, ongoing care and exit at every step of the system.

No area of MHS is restricted as a service option to people in need of that service.

The transition back to the community can take various pathways. Stepping down to least restrictive environments as early as possible is important to a person's return to a fulfilling life in the community.

#### 4.4.2 Assessing for transfer

People experiencing a mental illness and who are receiving services, are constantly assessed to ensure progress is made against identified goals. Planning for transfer to a less restrictive environment commences soon after admission and is part of the ongoing care and treatment considerations, taking the form of clinical and risk assessments.

### PTC 04-3 The assessing MHS decides the most appropriate service type in consultation with the person and their support person/s

The assessing team, in consultation with other service providers, the person and their family, support person/s discusses the service options available. Ultimately, the assessing team decides and plans the care and treatment required and finds the best fit for the mental health needs of the person.

### PTC 04-4 MHS decision to transfer between services is based upon therapeutic need, the person's personal safety, the safety of others, broader psychosocial needs and service need.

The need to transfer from one service type to another is clearly identified through a process of review that is congruent with the long term goals of the care plan which has involved the person, their family, support person/s and community team.

A transfer from one service to another may also be required if the person moves from one geographical area to another. Every effort should be made by both services to achieve needs based comparable services in the new location.

#### 4.4.3 Planning for transfer

Planning for transfer of care seeks to optimise the person's involvement within mental health services and ensure a timely and efficacious service.

Whilst the decision to transfer from one service type to another is based on the least restrictive environment, the safety of the person and others, their care and treatment needs and broader psychosocial needs are also critical. Close proximity of the location of the person to family and support person/s is also an important consideration.

MHS take a holistic approach to care that ensures the next stepped in the service continuum is able to progress the person's health and wellbeing. The transferring team needs to consider the environment that the person is returning to and the support networks that are/are not available to them.

A plan to deal with deficits is developed ensuring the therapeutic partnership endeavours of the next service are given the best chance to succeed. Advising the next service of any difficulties will provide them with an opportunity to assist with the resolutions.

Special consideration is given to people returning to country locations, to ensure there is a continuity of service and support. Plans need to be put in place early. Direct contact with the new team including the local GP and health service will also provide information on the extent of services available in the local area.

The cultural needs of Aboriginal people and CALD people are taken into account, wherever possible. The need for interpreter services to continue to the next service is also factored in.

#### PTC 04-5 MHS documentation or communication processes do not delay the person's transfer to the next service.

MHS ensure that all necessary documentation is transferred to the next service type, to ensure a 'transfer of knowledge' and to reduce any duplication of assessment and documentation.

A recent risk assessment and service plan is part of the documentation which includes a description of illness symptoms and if applicable behavioural issues and the strategies required to minimise the person's distress.

#### 4.4.4 Communication

##### 4.4.4.1 Involving the person, their family and support person/s

The person, their family and support person/s are involved in developing the care plan for transfer. Copies of this are provided to the person and their supports.

Information about the receiving service type and what the person can expect from the transfer is provided to the person and their supports.

#### PTC 04-6 MHS involve the person, their family and support person/s in the decision to transfer and provide updated information on the proposed date and destination.

Relevant and regular communication occurs between the treating team and the person, family, and support person/s, regarding proposed date and destination of transfer. Contact on the day of transfer is also made with all parties.

##### 4.4.4.2 Involving the next service

Early discussion with the receiving service makes it more likely a seamless transfer of care occurs. This is particularly so for those people being transferred to country regions.

Communication between the transferring and receiving service unit commences at the earliest stage of the person's admission to that unit. This assists in the prevention of duplication in assessment and services.

#### PTC 04-7 MHS transferring and receiving teams work together to achieve seamless, delivery of services.

The transferring service unit provides the transfer date, the urgency for transfer, and gives a specific contact within the transferring service to manage issues of urgency to follow-up.

Consideration must be given for people transferring to the country. The tyranny of distance poses particular difficulties not experienced in the metropolitan areas. Some frequently encountered issues are: What is the type of transport to be used to transfer them to the country? When will they arrive and who will pick them up? Will they require weekend or after hours care? Is there a Clozapine provider in the area if this is required?

#### 4.4.4.3 Involving other services and supports

### **PTC 04-8 MHS inform the referral source, service providers, family and support person/s when a transfer occurs.**

Communication between all referees and service providers is required on transfer of a person between service types. Service providers are kept informed of any changes that occur to plans and the likelihood of their further involvement.

The involvement of other service providers is conveyed to the receiving service to ensure contact with these services is maintained.

Communication and involvement of the current case manager provides valuable advice and input to every team that the person has contact with. This enables accurate information to be utilised by the next team in a timely manner.

#### 4.4.5 Handover

### **PTC 04-9 MHS use the Identify, Situation, Background, Assessment and Recommendation (ISBAR) tool for all clinical handovers, with any additional information to meet the specific needs of the units.**

The handover is an important part of continuing the care and treatment from one shift to another, from one group of clinicians to another and from one services site to another. These are critical points of information exchange that ensure the safety and welfare of all participants in the transfer.

SA Health uses Identify, Situation, Background, Assessment and Recommendation (ISBAR) as a tool to aid the safe transfer of the person's clinical information. This is a generic aid and is adapted to fit the clinical context. Adapting ISBAR for the clinical context is an opportunity for the health care team and the person to decide what essential information should always be handed over.

#### 4.4.6 Receiving the person

The point of transfer is one of the most vulnerable times for a person experiencing a mental illness. MHS foster a welcoming environment for newly transferred people, ensuring they feel safe, secure and comfortable with the transition from one service type to another.

### **PTC 04-10 The receiving MHS ensures the person, their family and supports are well orientated to the service.**

The receiving service will orientate the person to the unit, and provide the support person/s with information on that service.

### **PTC 04-11 The receiving MHS provides a face-to-face clinical and risk assessment to further develop options for care and treatment.**

The person is contacted by the transferring unit within seven days of transfer to a community team, to ensure the person is not lost to services and the transition has progressed well.

### **PTC 04-12 The transferring service follows up the person within 7 days and addresses any issues arising from the transfer.**

## 4.5 PTC 05 Working with other service providers

The 'Working with other service providers' has a wide target audience and hopes to influence all service providers working in the arena of mental health in Adult MHS, Forensic MHS and services for older persons.

It particularly speaks to MHS and the working relationship it has with all its partners including: SAPoI, DASSA, SAAS, NGOs, Disability Services and the private for profit sector. They each work with people with a mental illness.

The landscape of mental health has significantly changed over the last 10 to 15 years. There is greater diversity in choice of service provision for people experiencing a mental illness.

The 'not for profit' and 'for profit' sectors offer services that complement the state mental health system. Integration and partnerships in service provision are also closing the gaps in services available.

The centre piece of all these services is the person experiencing the mental illness. Meeting their unique needs is the glue between service components. The person's family and support person/s also require significant involvement in the care planning. The complexity of multiple service providers is overcome through communication and mutual respect for each other.

PTC 05 Working with other service provider's guideline provides guidance on ways that service providers can work together and form partnerships to maximise overall capacity in the delivery of comprehensive and responsive services that empower the person and support their informed decision making.

SA Health has a significant number of vulnerable high needs people who also receive care and support from other important agencies and services. This alone calls for MHS to work collaboratively across all relevant service areas and agencies to best support these people to bring about holistic and comprehensive care.

### 4.5.1 What is partnership?

Partnership in mental health is the coming together of service providers to work collaboratively to address the service needs of an individual or group of people experiencing a mental illness. The partnership can be formal or informal. The partnership is formed around working towards common goals.

Mental health partners may be MHS, emergency services, the 'not for profit' sector, public health and the 'for profit' sector.

Often people experiencing a mental illness are recipients of numerous services providing a diverse range of service options that address the varying and often complex needs of the person.

The partnership and collaboration between all relevant providers and the person experiencing mental illness and their family and supporters has many benefits. The most important benefit is to achieve optimal service provision for the person.

## PTC 05-1 MHS develop partnerships that benefit people experiencing a mental illness, their family and support people.

### 4.5.2 Types of partnerships

Partnerships can be formed from existing networks, or where there is a history of collaborative work, between potential partners but it may also include an invitation to new partners.

Partnerships may involve day to day operational partnerships or strategic partnerships where organisations work to bring about new programs or ways of responding to individuals or groups.

#### 4.5.2.1 Operational partnerships

Operational partnerships identify:

- > the aims and objectives of the partnership
- > common procedures
- > protocols and systems for sharing information
- > joint training opportunities
- > arrangements for monitoring and evaluation.

#### 4.5.2.2 Strategic partnerships

Strategic partnerships identify:

- > the aims and objectives of the partnership
- > the range of agencies that could be engaged
- > the commissioning and management arrangements
- > arrangements for sharing information
- > arrangements for multi-agency training to promote mutual understanding
- > monitoring and evaluation arrangements for both the partnership and the service.

#### 4.5.3 Developing successful partnerships

### PTC 05-2 MHS support partnership development, valuing all members of the partnership.

Communication is a key component of successful partnerships that is achieved through trust, openness and honesty between partners. The communication between the partners is regular and the changes that occur are communicated to all members of the partnership.

Successful partnerships:

- > share values such as respectful behaviour and place the person at the centre of care
- > have clear goals and objectives that are understood by all the partners
- > have clear and effective leadership
- > have roles of each partner that are known to all members
- > have shared ownership of the partnership
- > have recognition of different organisational cultures within the partnership
- > have arrangements where each partner dedicates time and resources for the administration and operation of the partnership
- > have environments that are supportive within the partnership, where suggestions, ideas and information are freely exchanged
- > include a process to resolve conflict.

#### 4.5.4 Operational partnerships

##### 4.5.4.1 Partners in care

Within MHS, care is provided in the least restrictive environment and utilises a number of partners who bring specific expertise to benefit the person experiencing a mental illness and/or their family and supporters.

Partnerships are formed to address specific issues and may be short or long term. Partnerships are formed between a number of individuals, agencies or organisations with a shared interest. There is usually an overarching purpose for partners to work together and a range of specific objectives.

Likely partners in the care of people experiencing a mental illness are: GPs, NGOs, emergency services, housing (both public and private), Disability Services, DASSA, Forensic MHS, psychiatrists, psychologists and general health.

### PTC 05-3 MHS inform, consult, involve, collaborate and empower others in the partnership.

The partners identify the aims and objectives of the partnership and clarify the role each service performs. Each partner is committed, willing and supported by their organisation to enter into the partnership. Those involved in the partnership set up meeting times for review and evaluation of the working relationship and the care provided to the person and their family and supporters. The partners decide on a lead agency.

#### 4.5.4.2 Partnering with the person

### PTC 05-4 MHS place the person experiencing a mental illness at the centre of care.

At the very crux of a successful partnership is the relationship that is formed with the person experiencing a mental illness.

MHS act to put people at ease and engage with them in meaningful ways. What is familiar to practitioners can be strange and intimidating to someone experiencing a mental illness. Providing information on the nuances of the service, what can be expected from services and what emergency care is available are important to allaying their anxiety and fears.

The service effectively engages with the person, to empower them to make informed care decisions that incorporate the limitations of their choices.

### PTC 05-5 MHS ensure that services are appropriate for the needs of the person.

Care planning is a collaboration of MHS and the person. The person's perspectives, interests and strengths to overcome any issues are discussed. The MHS assesses and evaluates the mental and physical health needs, and medication history and discusses with the person, the actions recommended from the assessment. The service is sensitive to the person's age, gender preference, cultural, language, religious background, veteran background and family beliefs.

#### 4.5.4.3 Partnering with family and support people

### PTC 05-6 MHS work in partnership with the person's family and support person/s.

The person's family and support persons provide an invaluable support networks. MHS recognise the need to foster and enhance this support network.

The person's family and support persons are uniquely placed to provide information on the changing nature of the person's health and how this impacts the person's life and relationships. They are encouraged to participate in all stages of care planning to achieve common goals.

#### 4.5.4.4 Partnering with others

MHS plan and carry out activities in a collaborative approach so each stage complements the others.

### PTC 05-7 MHS recognise and utilise the strengths and expertise of all partner agencies involved.

Clinicians communicate with other professionals and make appropriate referrals, if needed, and link with other services so the person receives coordinated advice and support.

MHS make information about their services available to other services providers. This information focuses on the practical areas of the service such as operating hours, service and referral options, what people can expect from the services and what contingencies are in place for emergency care. All services in the partnership need to be well informed on the nature of the services provided by the other partners.

### PTC 05-8 MHS have guidelines for sharing clinical information.

#### 4.5.4.5 Clinical information sharing

Successful partnerships share information between all service agencies. The objectives of this information sharing is to support people experiencing a mental illness, by providing them with appropriate and well-coordinated interventions from all organisations involved in their care and support.

Early and well-coordinated action as a result of information sharing creates an opportunity for the person, their family and support persons to receive the necessary support services required to prevent any relapse and further to promote wellbeing.

The SA Mental Health Act 2009 has specific provision for the sharing of information between agencies to achieve better outcomes for consumers and carers. A *Guide to Sharing Consumer Information for Mental Health Practitioners* is available from the Office of the Chief Psychiatrist and Policy (OCPD).

#### 4.5.5 Strategic partnerships

### PTC 05-9 MHS work with the local community to achieve long term priorities to sustain and improve care provision.

A strategic partnership brings together key agencies and organisations to identify long term priorities to sustain and improve care provision. Through community planning, the partnership develops a sustainable community strategy where, by working together, partners make a significant difference.

Strategic partnerships are made up of many organisations including:

- > local councils
- > emergency services
- > health organisations
- > local businesses
- > the voluntary and community sectors.

Leaders and senior officers usually represent each of these organisations to ensure that decisions are made and that the money and resources needed for action are available.

#### 4.5.5.1 Formal working partnerships

### PTC 05-10 MHS enter into formal working partnerships with others where there is a common need to improve service provision.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes, timelines and the review/monitoring requirements of the agreement.

Key elements of a formal working partnership are that it is organised, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: service charters, memoranda of agreement, written service agreements, formal liaison, referral and discharge planning processes, formal and routine consultation, protocols, partnership working groups and case conferencing.

#### 4.5.6 Overcoming barriers to working in partnership

### PTC 05-11 MHS work to overcome barriers to working in a partnership.

Barriers to partnerships occur when there is:

- > a misunderstanding of the reasons for the partnership
- > a lack of leadership commitment to the partnership
- > no clear boundary between partners' responsibilities
- > reluctance to share information and data with other partners
- > lack of time available to commit to the partnership
- > a history of misconceptions or previous negative experiences for some partners
- > potential conflict in philosophies of the partners
- > lack of training/experience among service staff on substantive issues and partnership working models.

MHS reflect on the partnership and clarify why the partnership needs to exist. What does the partnership need to deliver and have there been clear aims and objectives for the partnership to follow?

## 4.6 PTC 06 Exiting Mental Health Services

MHS seek to facilitate the health and wellbeing of people experiencing a mental illness. The ultimate goal is for each person to live a fulfilling life in the community supported by a community network. Planning to exit MHS begins early and continues throughout the episode of care within all parts of the services.

There is no one exit point as people can exit from anywhere along a continuum of care. MHS ensures the care needs of the person are addressed prior to exit so that any on-going care can occur in the private or primary health care sector.

MHS are constantly reviewing occupancy to ensure the people most in need of service are able to receive it. There is diversity in the provision of care available to people in a stepped system. This extends to services available as part of the primary health and private sectors. The system allows for the transfer of persons and documentation between these elements.

Preparation and planning for exit is critical to the success of community tenure. The person, their family and support person/s are involved in the exit process.

The person is provided with information and education aimed at achieving independent living. Discussions regarding services and support available within the community occur in groups or individually with mental health staff. Overcoming any barriers to utilising these community networks is discussed, along with how the person feels about using such services and supports.

People who have exited the MHS are welcomed back through re-entry when their needs change and a mental health service is required to address those needs.

### 4.6.1 Preparing for exit starts on day one

#### PTC 06-1 Planning to exit MHS begins early and continues throughout the episode of care within MHS.

Following the initial assessment within MHS, the expected length of stay is discussed with the multi-disciplinary care team, the person and their family and support persons, as part of their care planning. The duration of involvement with MHS is frequently reviewed by the multi-disciplinary care team.

#### PTC 06-2 MHS harness the person's capacity to be independent in preparation for exit.

Preparation for exit includes the perspectives of the person, their family and support person/s, their GP and other agencies likely to be involved in the provision of services after exit.

##### 4.6.1.1 Preparation

Preparation is critical in exit-planning. It occurs throughout the involvement with MHS.

Preparation involves:

- > reconnection to existing supports
- > the provision of information on available community services
- > discussion groups about support services available
- > referrals to support services
- > joint visits to support services.

MHS recognise the vulnerability of people experiencing a mental illness and the general reluctance of people for change or when entering unfamiliar environments. Services ensure people are provided with every opportunity for successful transition to community support networks. Overcoming any barriers to utilising these community networks and support is discussed along with how the person feels about using such services or supports.

#### PTC 06-3 MHS exit no person to homelessness.

At the point of exit, MHS ensure the person has:

- > an offer of available and suitable accommodation
- > financial resources
- > transport
- > food available to them
- > someone to talk to
- > knowledge of re-entry to MHS.

#### 4.6.1.2 A least restrictive option

### **PTC 06-4 MHS utilise hospital substitution programs to achieve the least restrictive environment for people seeking assistance including assistance with transition while exiting the service.**

Not all people seeking assistance from MHS require on-going involvement with the service. A least restrictive option following assessment may involve hospital substitution services or NGO counselling services for further support. In these circumstances, MHS involve the specific NGO or use Transitional Care Services to ensure the person receives the care they need.

#### 4.6.2 Exiting Mental Health Services

##### 4.6.2.1 The decision to exit

The decision for a person to exit from MHS is made by the multi-disciplinary team in consideration of the person's wishes and those of the family and support persons and should be consistent with the care and treatment plan.

### **PTC 06-5 MHS utilise the expertise of the multi-disciplinary team in the decision to 'exit' a person from the MHS.**

In order for an exit to occur, the goals of the care plan should be achieved and the multi-disciplinary team involved has provided the person with options for any continued care in the primary health sector.

The mental health team uses the Health of the Nation Outcome Scale (HoNOS), LSP 16 & K10+ as tools for helping to make informed decisions regarding the exiting of the person from MHS. The areas of concern identified by the HoNOS are addressed during the period of care within the MHS.

The multi-disciplinary team's final assessment ensures the person is ready to claim independent living, suitable accommodation, has a support structure in place and there is no legal reason for the person to remain in the service.

##### 4.6.2.2 Involving the person

### **PTC 06-6 MHS involve the person and acknowledge their choice/s in the decision to exit the service.**

The person is involved in a meaningful way in the decision to exit MHS.

Opportunity is given to the person to feedback to the service on how they feel they are coping and to discuss their readiness for exit.

MHS discuss the person's care plan goals and what has been achieved.

The HoNOS category scores are discussed with the person and they are provided with the opportunity to provide feedback on these ratings. Any areas of concern raised by the person are further discussed with the multi-disciplinary team and resolved within the exit plan.

A self-assessment tool such as the Kessler 10 Psychological Distress Scale (K10) is offered to the person and is discussed with them. Any concerns are addressed as part of the exit plan.

Importantly, the person is comfortable with the decision to exit the service.

The person is invited to provide feedback about their service experience with MHS and what impact MHS has had upon their experience of mental illness.

### **PTC 06-7 MHS collect the National Consumer Experience of Care Tool at exit.**

#### *4.6.2.3 Involving the family and support person/s*

### **PTC 06-8 MHS involve the family and support person/s in the decision to exit.**

The person's family and support person/s are also involved in the decision to exit the service providing insightful comment from a perspective that is different to the service providers. The reasons for exiting MHS are provided and a clear pathway is made available to re-enter services if the person's needs change.

### **PTC 06-9 MHS check that the family and support person/s are able to cope with the level of care they are required to provide.**

The family and support person/s are made aware of any people or services involved in on-going care. Further consideration is given to the level of support the family and support person/s are required to provide and how this impacts on them.

The family and support person/s are informed, educated/trained about the person's mental illness, the signs of relapse and triggers that may cause a relapse. The MHT number of 13 14 65 is given to connect the person to MHS if necessary. The person, their family and support person/s leave MHS better informed about mental illness and available resources than when they arrived.

### **PTC 06-10 MHS ensure the person, their family and support person/s leave the service better informed.**

The exit plan is discussed with the family and support person/s and information is provided about respite services and community support available to them.

#### *4.6.2.4 Other agencies*

### **PTC 06-11 MHS involve the GP and other service providers who continue care upon the person's exit.**

MHS clarify the personnel involved in the person's care and assist the person to stay connected to these services.

MHS involve continuing services in the planning for the person's exit and clarify the perspective of the service when considering exit.

#### *4.6.2.5 At exit*

At the point of exit, MHS ensure the person, their family and support person/s are provided with the exit plan.

### **PTC 06-12 MHS provide an exit plan to the person and their GP.**

The exit plan is provided to their GP and any other agencies providing an on-going mental health service to the person.

### **PTC 06-13 MHS ensure that all people exiting MHS receive details of Mental Health Triage Liaison Services.**

The person, their family and support person/s are provided with the MHT 13 14 65 contact telephone number for any future need for service. They are also made aware of an appointment time to attend their GP or the need to visit their GP within the week.

Exiting a mental health inpatient unit occurs as early as possible during the day.

### **PTC 06-14 MHS have procedures to ensure that exiting a mental health inpatient unit occurs as early as possible in the day.**

#### 4.6.2.6 Follow-up

MHS ensure the exit plan has been effective by making telephone contact with the person within one week of exit.

For persons exiting from an emergency department, a post-card/brief note is sent to remind them of the need to contact their GP and how to contact MHS if they require further services.

### **PTC 07-15 MHS follow-up with the person to ensure the exit plan is occurring and is adequate for the person's needs.**

#### 4.7 PTC 07 Re-entry to Mental Health Services

This policy applies to all people seeking re-entry to Adult MHS and OPMHS where further care within MHS is required.

People who have previously received services are welcomed back. MHS provide a stepped system of care that provides for the diverse needs of people experiencing a mental illness. In the event of a relapse, the person re-enters the service at the most appropriate level to address their needs.

A person who has had previous contact with MHS within the past 7 years is eligible for re-entry.

Persons experiencing mental health issues have the right to comprehensive and integrated mental health care that meets their individual needs. MHS seek to have all people requiring care and treatment reach appropriate services in a timely manner. A person, entering the system through re-entry, receives fast-tracked access to the most effective service option and entry point because previous knowledge in the form of assessments and care plans are utilised to intervene early and prevent further deterioration.

MHS seek to facilitate the health and wellbeing of people experiencing a mental illness. The ultimate goal for all people who have experienced mental illness is for them to live a fulfilling life in the community, supported by a community network. Priority access to the most appropriate service facilitates an early return to optimum health for the person.

Re-entry is best facilitated through community mental health teams, who assess the level of need and the care required along the continuum. All people who have a planned exit from MHS receive an exit plan, which informs the re-entry according to each person's needs. People are encouraged to recognise early warning signs and seek help early in relapse. The preferred pathway for re-entry is through the Community Mental Health team.

##### 4.7.1 Re-entry to Mental Health Services

People who have received a previous MHS intervention are welcomed back when a relapse of mental illness occurs. Early intervention to address a relapse of illness assists the person to regain previous functioning.

In the first instance, the re-entry pathway is identified as the previous exiting community MHS.

Re-entry via an emergency department is a last resort for people known to MHS.

### **PTC 07-1 MHS welcome back people who have received previous care.**

MHS acknowledge individual needs, choices and preferences and build upon the personal strengths and resources of the person to regain health and wellbeing.

MHS recognise, respect, value and support the importance of the family and support person/s to the well-being, treatment, and recovery of people with a mental illness.

##### 4.7.2 Referral source

Early intervention and referral to a community team is the preferred pathway. Referral can be made by the person experiencing a mental illness, their family, support person/s, private mental health services, NGOs, GPs, SAPol, DASSA, Disability Services, SAAS and housing agencies (public or private).

### **PTC 07-2 MHS informs the referral source of the care plan.**

The decision to re-enter MHS is not taken lightly by people experiencing a mental illness. Respect for the person seeking help is paramount and their expressed needs are acknowledged in the assessment for further support.

Professional respect is afforded the referring agencies so that early intervention is achieved when people are identified as being in need of a mental health service review, or intervention.

### 4.7.3 The assessment

#### PTC 07-3 MHS use the previous exit plan and assessments to inform the re-entry.

The previous exit plan and assessments are used in the assessment process for re-entry to MHS.

Community MHS direct person/s in need to the most appropriate service according to the person's presentation and need.

MHS ensures the on-going care needs of the person are assessed and that care is provided in the least restrictive and most appropriate treatment setting.

The decision to receive a known person into the service is based on the presenting issues identified.

All sources of referral, including personal referral, lead to an assessment.

Assessments should be achieved in the community where possible.

The re-entry assessment is inclusive of:

- > a clinical assessment, which identifies:
  - Mental state examination
  - Risk assessment
  - HoNOS, LSP16 & K10 that reflect the person's identified issues
  - the goals to be achieved
- > input from the person and their family and support person/s
- > a discussion with the referring agency or services involved in ongoing care.

The re-entry plan considers the presenting issues and the most appropriate service fit.

MHS acknowledge the person's, family and support person's rights and shows sensitivity to cultural and language issues, which may affect assessment and application of interventions.

### 4.7.4 The re-entry

Re-entry to MHS is prompt and timely, utilising the stepped process to enable the person to access interventions to prevent further relapse of their mental illness.

#### PTC 07-4 MHS ensure re-entry to the service is timely utilising the step-up system of care.

The provision of care is provided in the least restrictive service setting.

Re-entry to MHS is sensitive to the ethnic and cultural needs of the person, their family and support person/s and their defined community.

Following assessment, the person is transferred to the most appropriate MHS area, namely:

- > Community MHS
- > Intermediate care services
- > Inpatient services.

MHS uphold the rights of the person to have their needs understood in a way that is meaningful to them and arrange appropriate advocacy when required to support these rights.

Gap services are instigated where transfer delay occurs.

### 4.7.5 Continuity of care

Continuity of care is important. People returning, after a short time, return back to the service where they were last seen to continue care with the same multi-disciplinary team previously seen. If the person has greater care needs than that service offers then a clinician from the treating team provides a handover to the next treating team.

*'Previous discharge needs to be examined to ensure that what works is done again and what didn't work isn't repeated with the next discharge'. Clinician.*

#### 4.7.5.1 *The person returning from being absent without leave*

People receiving an episode of care from time to time leave the service without consent or knowledge of the treating team. When the person is found, they are returned to the treating team for assessment. The treating team will either readmit the person or arrange transfer to a more appropriate service.

**PTC 07-5 MHS have procedures that allow people who have been absent without leave to return to the treating team for assessment to determine the appropriate treatment level.**

#### 4.7.6 **The homeless person**

Homelessness is an issue that affects many people experiencing a mental illness. The potential instability of a person's wellness can significantly impact a person's ability to maintain suitable accommodation.

People who become homeless after exiting services return to the region that predominantly cared for them.

It is particularly challenging to provide consistent care to a person who is homeless and thus efforts need to be made to stabilise the person's living environment wherever possible.

**PTC 07-6 When returning to MHS in a state of homelessness the person's care is provided by the region where their predominant, treatment history occurred.**

### 4.8 PTC 08 Transport

#### 4.8.1 **Transport considerations**

**PTC 08-1 MHS choose the most appropriate transport option for the person's safety and the safety of those transporting them.**

Transport is a point of care in itself, requiring preparation and planning.

MHS and other agency professionals (for example SAAS-MedSTAR) involved in determining the most appropriate way to transport a person with mental illness should consider:

- > the person's immediate mental health status
- > the person's transport preference
- > the person's need for familial or personal support during transport
- > the risk of harm the person poses to themselves and others
- > the person's immediate physical health status
- > the distance to be travelled
- > the person's need for clinical support, supervision and/or sedation during transport
- > what transport is available
- > the likely effect of the proposed transport on the person
- > the person's mental health, safety and/or transport history
- > information from other agencies, family or support person/s
- > any advanced directives the person has made about transport.

#### 4.8.2 **Use of restraint and medication**

**PTC 08-2 MHS only use physical, mechanical and/or chemical restraint for safety or risk management reasons where there is no other least restrictive option.**

On occasion the use of physical, mechanical and/or chemical (medication/sedation) restraint, is required to manage the transport of a person. The use of any form of restraint should only occur for safety or risk management reasons, where there is no other less restrictive option and never for service or staff convenience.

#### 4.8.3 Keeping the person's, family and support person/s involved

**PTC 08-3 MHS involve the person's family and support person/s whenever practicable and keeps them informed of the whereabouts and status of the person.**

Whenever practicable, the person's family and support person/s are kept informed of the whereabouts and status/wellbeing of the person, prior to, during and after transport.

#### 4.8.4 Cultural, developmental and experiential needs.

MHS specifically consider the:

- > cultural needs of Aboriginal people, and CALD people
- > the age of the person, be they young people or older people. Each have different needs and level of understanding of what is occurring and may need the assistance of a support person
- > consideration of veteran status is also required to determine the level of support that is required.
- > personal experiences of people who have experienced trauma that may impact the experience of the transport used.
- > needs of family, children and parents of the person requiring transport.

**PTC 08-4 MHS consider the age and cultural and experiential needs of the person wherever possible in transportation.**

#### 4.8.5 Involving other agencies

Agencies work together to meet a person's health and safety needs.

The agency of first contact maintains responsibility for safety until there is an agreed handover of the person and their information.

**PTC 08-5 MHS and other agencies work together to meet a person's health and safety needs.**

#### 4.8.6 Forms and other instruments

**PTC 08-6 MHS utilise the forms in use for the safe transport of people where appropriate.**

There are a number of forms in existence that are used in the transport of people experiencing a mental illness:

- > Person Transport Request
- > Mental Health Assistance Form (PD145)
- > Transfer of an involuntary inpatient between treatment centres/hospitals in South Australia
- > Interstate Person Transport Request (if required by Ministerial Agreement).

#### 4.8.7 Transport options

There are numerous transport options available and all are conducted in such a way as to reduce trauma and stigma wherever possible.

**PTC 08-7 MHS seek wherever possible to ensure transport is conducted in ways that reduce trauma and stigma.**

#### 4.8.7.1 Transport by private vehicle or taxi

A private vehicle driven by a family member or friend or a taxi with a person travelling either alone or accompanied by a family member or friend, may provide the most accessible and acceptable mode of transport.

When deciding whether transport by private vehicle or taxi is appropriate, MHS consider:

- > the person's understanding and acceptance of the purpose and destination of the transport and their level of willingness to be transported.
- > the driver's understanding of the purpose and destination of the transport, and their knowledge of the person to be transported
- > the person's and driver's relationship
- > any safety or risk issues that may impact on the driver or other passengers, including erratic or unpredictable behaviour
- > the distance to be travelled.

Process stages	Transport via private vehicle or taxi
Assessment	The health provider assesses risk for the person's health and safety and for the proposed transport.
Liaison/information sharing	The health provider contacts the receiving health service to share information and arrange assessment/admission.
Transport	The support person or taxi driver transports the person to a health service.
Admission/discharge	The health service triages, assesses, treats and admits/discharges the person

Table 1 Transport via private vehicle or taxi.

#### 4.8.7.2 Transport by Mental Health Services

MHS vehicles may be the most accessible mode of transport in instances where the person is known to the treatment team and there are no health or safety issues requiring the use of an ambulance.

When deciding whether transport by MHS vehicles is appropriate, MHS consider:

- > the person's understanding of the purpose and destination of the transport, and their level of willingness to be transported
- > the mental health clinician's knowledge of the person and their history of interaction
- > the placement of the person in the vehicle (in the back seat next to a clinician, not behind the driver).

Process stages	Transport via MHS
Assessment	The health provider assesses risk for the person's health and safety and for the proposed transport.
Liaison/information sharing	The health provider contacts the receiving health service to share information and arrange assessment/admission.
Care	MHS takes care of the person.
Transport	MHS transport the person to the receiving health service.
Admission/discharge	MHS hand over to the receiving health service, who triage, assess, treat and admit/discharge the person.

Table 2 Transport via MHS.

#### 4.8.7.3 Requests for transport by SA Ambulance Service

Transport by ambulance may, in many instances, be the most appropriate and practicable way to transport a person from a community setting to a health service. The referrals received by SAAS are triaged according to urgency, ensuring the fastest possible transport to care considering level of risk and as assessed by SAAS and Medstar when air retrieval is necessary.

SAAS-MedSTAR is South Australia's single emergency medical retrieval service.

##### 4.8.7.3.1 On request by another agency

Transport carried out by SAAS at the request of another agency, usually MHS, SAPol or a private health provider.

Process stages	Transport via ambulance on request of another agency
Assessment	The responsible agency assesses risk for the person's health and safety and for the proposed transport.
Liaison/information sharing	The responsible agency contacts SAAS and the receiving health service to share information and arrange assessment /admission.
Care	The responsible agency hands over the person to SAAS.
Transport	SAAS transports the person to the receiving health service.
Handover/admission	SAAS hand over to the receiving health service, who triage, assess, treat and admit/discharge the person.

Table 3 Transport via ambulance on request of another agency.

##### 4.8.7.3.2 As part of SAAS service delivery

SAAS responds to requests for assistance in the assessment, care and transport of a person from community settings such as homes, public places, and residential care facilities.

Process stages	Transport via ambulance as part of SAAS service delivery
Assessment	SAAS assesses risk for the person's health and safety and for the proposed transport. Further assessment by MHS may be requested through MH Triage.
Liaison/information sharing	SAAS contacts the receiving health service to share information and arrange assessment /admission.
Care	SAAS takes care of the person and may arrange community based referral.
Transport	SAAS transports the person to the receiving health service if required.
Handover/admission	SAAS hands over to the receiving health service or provider who triage, assess, treat and admit/discharge the person.

Table 4 Transport via ambulance as part of SAAS service delivery.

#### 4.8.7.3.3 Transfer from health service to health service

From time to time a person receiving inpatient mental health care is transferred between hospitals to receive care and treatment in a more appropriate setting.

Process stages	Via ambulance as transfer from health service to health service
Liaison/information sharing	The current health service contacts SAAS and the receiving health service to share information and arrange assessment/admission.
Care	SAAS takes care of the person.
Transport	SAAS transports the person to the health service.
Handover/admission	SAAS hands over to the receiving health service, who may admit the person.

Table 5 Transport via ambulance as a transfer from health service to health service.

#### 4.8.7.3.4 Escorting

On occasion, another individual may accompany a person experiencing a mental illness, during transport by ambulance. This individual may be a family member, support person, mental health professional or police officer. The need for this additional support is determined by SAAS and any other involved agency in collaboration, taking into account where practicable and safe, the wishes of the person and family.

#### 4.8.7.4 Transport by Royal Flying Doctor Service

The use of the RFDS is decided by SAAS-Medstar after consideration of the distance and level of distress and anxiety of the person. The person needs to be under an order of the *Mental Health Act 2009* and it must be clear that all other transport options are not suitable for the person. Often distance is a deciding factor along with a risk assessment and safety of self, crew and others involved in the flight.

People experiencing a mental illness and exhibiting violent or unpredictable behaviour can be transported safely by air if they have been adequately sedated and restrained prior to the flight. Management of the patient and ensuring transport safety is undertaken by an adequately skilled service provider.

Air safety requirements prevent RFDS from loading and departing with a person who is combative and cannot be adequately restrained and sedated.

Transfers at night are limited due to emergency resources available across the state. In these instances, it may be beneficial to admit the person to a local hospital overnight, when safe to do so. Resource limitations at the sending hospital can prompt a need for more urgent retrieval.

Process stages	Transport via SAAS-MedSTAR and RFDS
Assessment	SAAS-MedSTAR and RFDS assesses risk for the person's health and safety and for the proposed transport.
Liaison/information sharing	RFDS local clinicians (with SAAS-MedSTAR if required) contacts the receiving health service to share information and request assessment and admission.
Care	SAAS-MedSTAR and RFD takes care of the person.
Transport	SAAS-MedSTAR and RFDS transports the person to the receiving health service.
Handover/admission	SAAS-MedSTAR and RFDS hands over to the receiving health service, who triage, assess, treat and admit/discharge the person.

Table 6 Transport via SAAS-MedSTAR and RFDS.

#### 4.8.7.5 Transport by SA Police

Transport by SAPol may in some cases, be the safest and most practical way to transport a person from a community setting to a health service, especially in country areas. However, police are only to provide transport when there are significant safety issues.

##### 4.8.7.5.1 As part of own service delivery

In some cases police are called to attend a situation by a member of the public, or they have an encounter in the course of their usual duties, where they will assess a person as appearing to have a mental illness and to be unsafe. If it is unsafe to request transport from another agency at that time, police may transport the person to an appropriate health provider or service.

Process stages	Via SA Police as part of own service delivery
<b>Assessment</b>	SAPol assesses risk for the person's health and safety and for the proposed transport. Further assessment by MHS may be requested through MH Triage.
<b>Liaison/information sharing</b>	SAPol contacts the receiving health service to share information and request assessment/admission.
<b>Care</b>	SAPol takes care of the person.
<b>Transport</b>	SAPol transports the person to the receiving health service.
<b>Handover/admission</b>	SAPol hands over to the receiving health service, who triage, assess, treat and admit/discharge the person.

Table 7 Transport via SA Police as part of own service delivery.

##### 4.8.7.5.2 On request by another agency

On occasion another agency assesses a risk to safety as requiring the assistance of SAPol which may, after collaborative assessment by both agencies, result in transport by police.

Process stages	Via SA Police on request by another agency
<b>Assessment</b>	The other agency assesses risk for the person's health and safety and for the proposed transport.
<b>Liaison/information sharing</b>	The other agency contacts SAPol and the receiving MHS to share information and request assessment/admission.
<b>Care</b>	The other agency hands over the person to SAPol.
<b>Transport</b>	SAPol transports the person to the receiving health service.
<b>Handover/admission</b>	SAPol hands over care to the receiving health service, who triage, assess, treat and admit/discharge the person.

Table 8 Transport via SA Police on request of another agency.

##### 4.8.7.4.3 Escorting

On occasion another individual may accompany a person experiencing a mental illness, during transport by police. This individual may be a family member, friend, mental health professional or ambulance officer. The need for this additional support is determined by police and any other agency involved, in collaboration, taking into account where practicable and safe, the wishes of the person and family.

#### 4.8.8 Returning home after exit from a bedded service

MHS are responsible for returning the person to their accommodation following an exit from an inpatient unit where admission has occurred under the *Mental Health Act 2009*. Consideration should be given to where the person lives and how close to the home this transport can be arranged. Special consideration needs to be given to people returning to the country where transport options can be difficult to arrange.

#### 4.8.9 Transport between jurisdictions

At times, it is necessary for a person to be transferred interstate. The transfer of a person interstate is reviewed by the Office of the Chief Psychiatrist and Policy. Valid reasons are required before a transfer is approved.

### PTC 08-8 The Office of the Chief Psychiatrist and Policy provides oversight of all transfers interstate.

The transfer of people between jurisdictions occurs differently from state to state. The principles of the transfer however, are similar and involve the Office of the Chief Psychiatrist and Policy in the first instance. A representative of the Office of the Chief Psychiatrist and Policy describes the options available to the health service for them to arrange the transfer under the South Australian *Mental Health Act 2009* and the other jurisdiction's Mental Health Act equivalent.

Process stages for transport between jurisdictions	
Liaison/information and sharing	The health service contacts the Office of the Chief Psychiatrist and Policy and shares information about the possible transfer.
Assessment	The Office of the Chief Psychiatrist and Policy describes the options available to the health service for them to arrange the transfer under the South Australian <i>Mental Health Act 2009</i> and the other jurisdiction's Mental Health Act equivalent.
Care	The transferring MHS takes care of the person.
Transport	The transferring MHS ensures the person has safe transport to their destination interstate.
Handover/admission	The transferring MHS hands over care and control to the receiving health service, who triage, assesses treat and admit/discharge the person.

Table 9 Transportation between jurisdictions.

#### 4.8.10 Escorting

When transferring a person interstate or overseas, the safety of the person and their escort/s is of paramount importance. The transfer may require a MHS escort. The need for additional support is determined by MHS and the other agency involved in collaboration, taking into account where practicable and safe the wishes of the person, their family and support person/s.

#### 4.8.11 Transport of persons in the custody of SA Police or Correctional Services who require MHS

On occasion, a prisoner or offender requires MHS assessment and treatment outside of a correctional or police facility. In the metropolitan area, correctional services may request the services of SAAS to safely transport a person.

The care and control of persons in custody remains the responsibility of SAPol, G4S or Correctional Services.

For persons in police custody who require mental health assessment and care, assistance in decision making and logistics is provided by MHT which may include arrangement for MHS to assess the person at the police cells.

The transport of prisoners requires collaboration between the health agency involved and the Department of Correctional Services. The Forensic MHS provides logistical support for prisoners admitted to the general mental health facilities.

The person's family and support person/s are advised of any change to the location where they are held.

Process stages for transport of prisoners and offenders requiring MHS	
<b>Assessment</b>	Correctional services, G4S and/or SAPol assess risk for the person's health and safety and for the proposed transport.  SAPol may request further assessment by MHS through MHT. Correctional services may discuss the need for assessment with Forensic MHS.
<b>Liaison/information and sharing</b>	Correctional services and/or police contact the receiving health service to request further information.
<b>Transport</b>	Correctional services and/or police transport the person to the health service. In country South Australia, transport may be by SAPol, correctional services or by ambulance or RFDS.
<b>Custody</b>	In some situations Correctional services, G4S and/or police, maintain custody of the person whilst in the MHS.  In other situations custody is maintained through the <i>Mental Health Act 2009</i> by MHS.
<b>Treatment</b>	The receiving health service triage, assess, treats and admits discharges the person.
<b>Discharge/return to custody</b>	The health service contacts correctional services and/or police to provide information and to make transfer of custody arrangements possible.
<b>Transport</b>	Correctional services and/or police transports, the person back to custody.

Table 10 Transport of prisoners and offenders requiring MHS.

In country South Australia, correctional services and SAPol may request the assistance of SAAS or RFDS to safely transport a person to Adelaide when distances are too great. In these situations the logistical support is provided by Emergency Triage Liaison Service for people in police custody.

## 5. Roles and Responsibilities

The Pathways to Care Policy Guideline applies to all MHS in South Australia that provide care to adults (between 18 years and 65 years) and older persons (over 65 years) inclusive of specific Veteran Services and Forensic Services.

Youth Mental Health Services (YMHS) are being introduced for 16 – 24 year and will be supported by this policy guideline.

### 5.1 Executives

The Chief Executive of the Department for Health and Ageing, Chief Executive Officers of the Local Health Networks, Chief Psychiatrist, General Managers of Mental Health Services, and Clinical Directors of Forensic Mental Health Services, Area Mental Health Services and Emergency Departments promote, monitor and evaluate the use of this Policy Guideline, and ensure managers and clinicians are trained and supported in its implementation.

#### 5.1.1 Executives:

- > provide strategic direction for MHS
- > provide policy that guides and instructs safe and effective care to people with a mental illness
- > foster an environment of learning and personal growth
- > maintain standards of best practice
- > foster an environment of no blame and reporting of incidents
- > provide a safety system that monitors and reviews incidents and complaints from MHS.

### 5.2 Managers and Clinicians

Managers and Clinicians implement this Guideline, adhering to the principles of this guideline to ensure they operate in accordance with the associated Pathways to Care Policy Directive.

#### 5.2.1 Managers:

- > provide a clear organisational reporting structure
- > provide policy and procedures which support clinicians in their work
- > provide opportunities for clinicians to be involved in service design, planning and policy development
- > ensure clinicians are supported, to maintain clinical skills and participate in professional development, mentoring and clinical supervision
- > ensure structures are in place that support participation of people with a personal experience of mental illness
- > ensure mechanisms are in place that support the transfer of care between services
- > ensure all incidents are reviewed and recommendations guide service improvement.

#### 5.2.2 Clinicians:

- > respect the rights of the person and maintain professional standards when working with people with a mental illness, their family and support person/s
- > are respectful and value the contribution of other clinicians and the lived experience workforce
- > participate in professional development programs
- > participate in the Mental Health Professional Online Development (MHPOD) modules e-learning tool
- > seek out mentoring and participate in clinical supervision
- > are responsive to service demand and unmet need, ensuring access to services is always maintained
- > are knowledgeable in the recognition and treatment of comorbid disorders
- > ensure their practice does not deviate from the standards and protocols set by MHS
- > record information in the electronic record
- > report incidents according to MHS protocols and standards set actively participate in state-wide planning and policy development.

## 6. Reporting

All incidents related to the Pathways to Care Policy Guidelines and Policy Directive will be reported via the Safety Learning System.

1. A refusal of a service to accept an allocated assessed person into their service.
2. Returning a person to the emergency department following refusal to accept the person.
3. The handover from the transferring service lacking information which is critical for ongoing care.
4. A person waiting for a bedded service longer than 24 hours in an emergency department or longer than 72 hours in the community.
5. All deaths that occur whilst a person is receiving care in MHS.
6. Exit to homelessness.
7. Acute medical deterioration in a Mental Health Unit requiring emergency response and/or transfer to a medical facility.
8. Admission of a child under 18 years to a facility not specifically set aside for the treatment and care of individuals of that age group.

## 7. EPAS

The Pathways to Care Policy Guideline is in alignment with the EPAS work already occurring in South Australia for MHS.

## 8. Associated Policy Directives / Policy Guidelines

The following Policy Directives and Policy Guidelines are associated with the Mental Health Pathways to Care Policy Guideline.

### 8.1 Policy Directives

[Mental Health Services Pathways to Care Policy Directive](#)

[Forensic Mental Health Patient Admission to SA Health Facilities Policy Directive](#)

[Aboriginal Cultural Respect Framework Policy Directive 2007](#)

### 8.2 Policy Guidelines

### 8.3 Standards

[Chief Psychiatrist Standard: Cross Border Arrangements – Transferring the care of Mental Health Patients between South Australia and Other States and Territories](#)

[South Australian Aboriginal Languages Interpreters and Translators Guide](#)

## 9. References, Resources and Related Documents

The Pathways to Care Policy Guideline supports national and state strategic documents and standards.

### 9.1 National context

- > [The National Health Reform Agenda](#)
- > [Fourth National Mental Health Plan 2009 -2014 and Roadmap 2012](#)
- > [COAG National Action Plan on Mental Health 2006-11](#)
- > [Mental Health Statement of Rights and Responsibilities 2013](#)
- > [National Recovery Orientation Framework 2013](#)
- > [The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013](#)
- > [The National Compact: working together 2011- which articulates the shared values and principles of the Government and the not-for-profit sector](#)
- > [National Standards for Mental Health Services, 2010](#)
- > [The National Safety and Quality Health Service Standards \(NSQHSS\) June 2011](#)
- > [National Safe Transport Principles 2011](#)
- > [Framework for Veterans Health Care 2012-2016](#)
- > [Consumer Focus Collaboration, \*Improving health services through consumer participation: A resource guide for organisations\*. Commonwealth Department of Health and Aged Care: Canberra, 2000.](#)

### 9.2 South Australian context

- > [South Australia's Strategic Plan 2011](#)
- > [SA Health Care Plan 2007-16](#)
- > [Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007 – 2012, South Australian Social Inclusion Board](#)
- > [Aboriginal Health Impact Statement Policy Directive](#)
- > [SA Health Reconciliation Action Plan 2008-2010](#)
- > [South Australia's Mental Health and Wellbeing policy 2010-2015](#)
- > [Mental Health Act 2009](#)
- > [Memorandum of Understanding \(MoU\) between SA Health, SA Police \(SAPOL\), SA Ambulance Service \(SAAS\) and Royal Flying Doctor Service \(RFDS\) 2010](#)
- > [The South Australian Carers Recognition Act 2005](#)
- > [SA Health Mental Health Unit Summary Report: State-wide Aboriginal Mental Health Consultation February 2009](#)
- > [Recovery-orientated Rehabilitation Framework 2010](#)
- > [State-wide Mental Health Lived Experience Register 2012.](#)

## 10. National Safety and Quality Health Service Standards

The Mental Health Pathways to Care Policy Guideline aligns with *The Australian Commission on Safety and Quality in Health Care 10 National Safety and Quality Health Service Standards* (the Standards) in the following ways.

									
National Standard 1	National Standard 2	National Standard 3	National Standard 4	National Standard 5	National Standard 6	National Standard 7	National Standard 8	National Standard 9	National Standard 10
Governance for Safety and Quality in Health Care	Partnering with Consumers	Preventing & Controlling Healthcare associated infections	Medication Safety	Patient Identification & Procedure Matching	Clinical Handover	Blood and Blood Products	Preventing & Managing Pressure Injuries	Recognising & Responding to Clinical Deterioration	Preventing Falls & Harm from Falls
✓	✓		✓		✓			✓	

## 11. Other

The Pathways to Care Policy Guideline is supported by the MHPOD 1 and MHPOD 2 topics on the eLearning portal. All clinicians are encouraged to participate in this on-line training by visiting the MHPOD website <http://www.mhpod.gov.au>. The training topics support all aspects of the policies by providing greater detail and understanding.

### 11.1 PTC 01 Participation

- > Ethics (two topics)
- > Rights and responsibilities (four topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Cultural Diversity and Awareness (three topics)
- > Mental Health across the Lifespan (eight topics)
- > Health Promotion, prevention and early detection (three topics)
- > Carer Participation.

### 11.2 PTC 02 Access to Mental Health Services

- > Health Promotion, prevention and early detection (three topics)
- > Rights and responsibilities (four topics)
- > Recovery based practice (three topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Clinical Mental Health (three topics)
- > Cultural Diversity and Awareness (three topics)
- > Evidenced Based Practice and Quality Care (six topics).

### 11.3 PTC 03 Care and treatment in Mental Health Services

- > Generic skills for practice; engagement, assessment and treatment (eight topics)
- > Rights and responsibilities (four topics)
- > Recovery based practice (three topics)
- > Evidenced Based Practice and Quality Care (six topics)
- > Clinical Mental Health (three topics)
- > Interventions (three topics)
- > Cultural Diversity and Awareness (three topics)
- > Managing co-occurring conditions (six topics)
- > Mental Health Across the Lifespan (eight topics)
- > Impact of medical conditions.

### 11.4 PTC 04 Transfer of care within Mental Health Services

- > Service integration and partnership (six topics)
- > Recovery based practice (three topics)
- > Rights and responsibilities (four topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Generic skills for practice; engagement, assessment and treatment (eight topics).

### 11.5 PTC 05 Working with other service providers

- > Service integration and partnership (six topics)
- > Recovery based practice (three topics)
- > Rights and responsibilities (four topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Generic skills for practice; engagement, assessment and treatment (eight topics)
- > Clinical Mental Health (three topics)
- > Interventions (three topics)
- > Cultural Diversity and Awareness (three topics)
- > Managing co-occurring conditions (six Topics).

### 11.6 PTC 06 Exiting Mental Health Services

- > Service integration and partnership (six topics)
- > Recovery based practice (three topics)
- > Rights and responsibilities (four topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Cultural Diversity and Awareness (three topics)
- > Managing co-occurring conditions (six topics).

### 11.7 PTC 07 Re-entry to Mental Health Services

- > Health Promotion, prevention and early detection (three topics)
- > Rights and responsibilities (four topics)
- > Recovery based practice (three topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Clinical Mental Health (three topics)
- > Cultural Diversity and Awareness (three topics)
- > Managing co-occurring conditions (six topics)
- > Generic skills for practice; engagement, assessment and treatment (eight topics).

### 11.8 PTC 08 Transport

- > Rights and responsibilities (four topics)
- > Recovery based practice (three topics)
- > Consumers and Carers: Rights Roles and advocacy (four topics)
- > Evidenced Based Practice and Quality of Care (six topics)
- > Culturally diversity and awareness (three topics)
- > Carer participation
- > Impact of medical conditions
- > Generic skills for practice; engagement, assessment and treatment (eight topics).

## 12. Risk Management

SA Health is committed to developing and maintaining effective risk management principles and practices to protect itself and its employees, the government and Minister from situation or events that would prevent it from achieving its strategic goals and objectives.

Mental Health Services are involved in the Safety Learning System that enables the service to reflect on practice and continually improve services.

## 13. Evaluation

A comprehensive approach will be taken in the monitoring and evaluation of services against the Pathways to Care Policy Guideline.

This will be achieved through:

- > The measurement of the 12 Key Performance Indicators recommended by the Key Performance Indicators for Australian Public Mental Health Services Second Edition 2011.
- > Rolling audits of practice in Mental Health Services by the Office of the Chief Psychiatrist and Policy within the powers in the *Mental Health Act 2009*.
- > Data provided by the Community Visitors Scheme.
- > Data collected from the Safety Learning System.
- > The evidence of procedures written by MHS against the Pathways to Care Policy Guideline and Directive.
- > The monitoring of targets set against the Policy Directive which will change over time as the focus areas change.
- > Utilisation by staff of the MHPOD e-learning programs.
- > SA Health will request quarterly reports from SAAS and the RFDS regarding the number and nature of mental health transfers.

## 14. Attachments

## 15. Definitions

In the context of this document:

<b>Acute care</b> means:	Specialist psychiatric care for people who present with acute episodes of mental illness.
<b>Community MHS</b> means:	MHS and teams that provide mental health care services in the community, outside of hospital settings.
<b>Culturally appropriate</b> means:	Services are culturally appropriate if they respect and take into account the cultural background, spiritual beliefs and values of a person and incorporate this into the way healthcare is delivered to that person.
<b>Least restrictive</b> means:	The concept of allowing the person to be cared for in an environment which places the least amount of restriction on freedom of movement while maintaining the safety of the person and others.
<b>Support person/s</b> means:	A person who provides ongoing care or assistance to a person with a mental illness, usually a family member and including young support person/s. This does not include a person who provides care or assistance pursuant to a contract for services.



## For more information

**For further information please contact the  
Office of the Chief Psychiatrist and Policy:  
[ocp@health.sa.gov.au](mailto:ocp@health.sa.gov.au)**

If you require this information in an alternative language  
or format please contact SA Health on the details provided  
above and they will make every effort to assist you.



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SA Health