SA Health

Mental Health 72
Rehabilitation Inpatient Beds Model of Care
Draft Version 4

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Submitted to:
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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002 with a focus on the private sector. All members of our Board and staff have mental health lived experience as either a consumer, family carer or both.

Our core business is to advocate for systemic change to improve mental health care (including psychosocial disability) across the whole Australian health system and within each State and Territory jurisdiction. This includes advocating for empowerment of people with mental health lived experience (people with mental health conditions and their family, carers and kin) in the broad range of issues that impact their mental and physical health, and their lives more broadly. It includes empowering them in their own care and contact with health and social services, promoting their engagement and inclusion within system design, planning and evaluation and most importantly, advocating for systems promote choice, inclusion, justice and fairness, and address stigma, discrimination and prejudice.

This submission comes from the perspectives and experiences of consumers, families, carers and kin with lived experience of mental health challenges. We welcome the opportunity to provide our submission to the SA Office of the Chief Psychiatrist on this important new Inpatient Rehabilitation service option to SA consumers and the community.

In Summary….

The draft Model of Care has been developed to assist with the implementation of the 2022 South Australian state election commitment to deliver 72 mental health rehabilitation inpatient beds, established as three 24-bed non-acute units as part of or adjacent to three existing hospital sites – Modbury, Noarlunga and the Queen Elizabeth Hospital.

The purpose of the Model of Care is to provide an overarching document that will inform and guide SA Local Health Networks on how to operate the new mental health inpatient rehabilitation units. Specific operational guidelines will be developed and managed by the relevant Local Health Networks.

Our Response to the Draft

These new mental health rehabilitation units and the Model of Care that will be implemented there offer a significant opportunity to deliver on the rhetoric that has often pervaded mental health reform. Getting the content and tone of the Model of Care right is so important to help ensure real service and workforce cultural change is achieved, and the delivery of care matches the intent of this important reform to mental health service options for the people who use them. Otherwise, they remain as words, less helpful traditional cultures of care that do not support recovery remain dominant, inpatient rehabilitation units remain in danger of reinforcing traditional institutionalised care, and real support for consumers to live and thrive in the community remain elusive.

With these thoughts in mind, we make the following suggestions for how the Draft Model of Care could be improved.

We appreciate the guiding statements made in the Philosophy of Service which are important is setting the tone upfront and note that these have been adapted from the NICE Guidelines ‘Rehabilitation for adults with complex psychosis’:

The new non-acute Mental Health Inpatient Rehabilitation Units should:

- *Be embedded in a **local comprehensive mental health care response**, in particular linking to a community-based rehabilitation pathway that supports successful discharge.*

- *Acknowledge that a process of recovery and rehabilitation may begin when a person is still experiencing active symptoms.*
- *Provide a recovery orientated approach that has shared ethos and agreed goals, a sense of **hope and optimism.***
- *Have a rehabilitation program that is **accessible and inclusive** for people from all cultural backgrounds.*
- *Provide rehabilitation-based care that is **person centred**, trauma informed, and based on a dynamic and respectful partnership with the consumer, their carers and/or family.*
- *Provide evidence informed rehabilitation interventions, therapy and support to the person that is **meaningful** to the individual and **strengths based.***
- *Provide an approach which supports the **development of life skills** and facilitates access to housing, education or employment opportunities.*
- *Promote **human rights** which are inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status.*
- *Provide care in the **least restrictive** environment. This relates to potential physical, chemical and social restrictions.*
- *Provide a clear and agreed **pathway** for consumers to experience a safe and sustainable transition to community living.*
- *Recognise that not everyone returns to the same level of independence they had before their illness and may require other supported alternatives as a short or long-term option.*

p.3 "*Cultural safety requires the person providing care to reflect on their own cultural and social assumptions in order to work in a genuine partnership with people from diverse backgrounds. Culturally safe and respectful environments must be provided where consumers are not exposed to bias, discrimination or inappropriate behaviour.*"

We think it would be useful to provide more explicit detail about what is meant by 'bias, discrimination or inappropriate behaviour'. We note 'racism' and 'stigma' are not mentioned?

p.4 "*Trauma Informed Care*
Trauma informed care aims to shift enquiries from 'What's wrong with you?' to 'Can you tell me what has happened to you?'
The approach seeks to:
> *Provide an understanding of the impact of trauma and recovery pathways*
> *Acknowledge the signs and symptoms of trauma in people, families, and staff*
> *Transfer awareness about trauma into practices and procedures and*
> *Avoid re-traumatisation at every opportunity.*"

We think the upfront sentence which sets up the definition of trauma-informed care is limited and remains service-centric, not person-centred, clinically driven and therefore not enough to provide guidance on creating a safe environment for consumers. A trauma-informed approach shouldn't need to ask the question; it should acknowledge that people who use the service come with traumatic experiences and work in compassion ways that mean the person does not need to retell their experiences of trauma (past or present) unless they choose to and when they chose to.

We note that the wording used comes directly from the US-based Trauma-Informed Care Resource Centre https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/
We encourage you to consider the Australian-based Blueknot resources which also incorporate Safety, Trustworthiness, Choice, Collaboration and Empowerment into the definition.

https://blueknot.org.au/resources/blue-knot-fact-sheets/talking-about-trauma/applying-trauma-informed-principles-to-conversations-about-trauma/

p.4 "*Carer Engagement*
A carer is someone who provides unpaid care and support to a person with a mental illness. Carers can be a person's partner, child, sibling, parent, relative, neighbour or friend. The role of carers must be recognised by including carers in the assessment, planning, delivery, and review of services that impact them and the role of carers (South Australia Carers Recognition Act 2005)."

We believe this statement continues to frame carers as mere providers of tasks and information. It fails to capture that the carer has a mutual and reciprocal relationship with and emotional bonds to the person. By not also stating this, carers are merely seen for their utility to the service, their needs and experiences remain largely invisible, and the full picture needs, implications and planning for return to the community is not realised.

p.5 *"Environment…*
An enabling environment allows for consumers to participate in a broad range of meaningful activities, including activities of daily living. The environment enables participants with a range of skills to be supported to develop in areas that they have identified."

This statement seems vague and somewhat 'cold' and 'technical' which may inadvertently suggest delivery of care where what is determined as meaningful may not include or be driven from the person's perspective. The limits of focus on 'skills' development is also of concern. We would hope that the environment also creates and builds the person's sense of hope, self-worth, belief in themselves, and that 'an enabling environment' is as much about how staff create the conditions for these.

p.5 *"Consumer Pathway…*
While not precluding a consumer based on their age, gender or sexual orientation, consideration will need to be made on the current mix of consumers in the units at the time of the referral. Safety of an individual is paramount, and consideration on allocating certain pods to females or other vulnerable groups should be taken into account when considering referrals."

Coverage of several ideas is being attempted in the above statement, with the result that none are really covered very well. Please consider revising the wording. Respect and reassurance would seem important to mention. Do you intend to make reference to related policies? E.g., the Policy on Sexual Safety which we understand is currently also in review.

p.5 "On arrival to the unit a peer worker will greet the consumer and provide a tour of the unit to assist with orientation to the facility. Following this a meeting will be held with the consumer, carer and\or family, and staff to begin to plan the admission and potential outcomes."

Will the peer work (as staff) also be included in this group meeting? Also, as part of the welcome and orientation tour, the peer might help the person to identify and note down any questions they might want to ask ready for the group meeting. The current wording doesn't really capture the importance for the person of having the peer as the first contact upon arriving in the unit. Again, being explicit in this document can help set the desired tone and culture for other staff.

p.6 *"A range of therapies and activities….*
>Enjoyable activities which consumers may wish to pursue when discharged, this may include with support such as through the NDIS. These activities such as art, craft, games, music, book club, movie outings and may be individual or shared with other participants."

This section appears to include the expected focus on self-care, living and social skills, vocational pathways, and so forth. We are concerned that 'Enjoyable activities' may be perceived as add-ons. We know that these types of activities are important parts of life because they are about who we are, our identity, beyond illness and diagnosis; they are an important source of self-worth and build confidence and genuine connections with others beyond services.

p.7 *"Strategies to manage access to alcohol, tobacco or other drugs should be discussed at the time of admission and incorporated into a person's care and rehabilitation plan."*

We think the person should be asked not only at the time of admission because they may feel overwhelmed with information at this point and not ready to consider the question fully or taking any action at this point. This question needs to be revisited, as the person's makes progress and has time to consider.

p.7 *"Where relevant, organisations who will provide support to the consumer in the community and should be encouraged to visit the unit and engage as soon as feasible, including in the development of a care and rehabilitation plan."*

There seems to be a grammatical problem with this statement? Remove 'and' where we have underlined above? Also, we believe that should not merely be 'encouraged' but should be a key aspect of the Model of Care' given the planning for transition to community/leaving the unit is such an important part of the process. Also, this statement gives no sense of when, at which stage and how often the relevant community organisation support persons would make connection.

p.8 "Measurement of Success….
Depending on individual circumstances these could include:
> *General Practitioner*
> *Community Mental Health Teams*
> *Drug and Alcohol Services*
> *State funded non-government organisations*
> *Private providers – allied health, psychiatry.*
> *Housing providers*
> *National Disability Insurance Scheme*
> *Commonwealth government facilitated assistance for income support payments*
> *Employment agencies*
> *Education providers*
> *Other support providers as required"*

We note that many of these measures are service focused which we agree is appropriate and necessary. However, we also think that more measures that reflect potentially important rehabilitation achievements for the person would also be good to include. For example, sense of self-worth and hope, and restoration or improvements in relationships and connections with others, including significant others in the person's life.

p.9 "*Gender safety*
> *Implementation of new units creates an opportunity to support and accommodate gender safety. This indicates consideration of specific areas or specific staffing to support safety for women and other vulnerable people."*

We think the wording of this section could be improved and that specific Lived Experience expertise and advice should be sought on this.

Contact

We thank the SA Office of the Chief Psychiatrist for the work it is doing on this important service for SA mental health consumers, and the family, carers and kin who support them. We wish you every success with the next steps and would be keen to be involved in any future discussions about this important topic.

Your sincerely

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