



## **SA Health**

### **Model of Care- Mental Health Community Beds (Hospital in the Home)**

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Submitted to:  
The South Australian Office of the Chief Psychiatrist

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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, including within State and Territory jurisdictions. 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.

Our current feedback on the draft Model of Care for the SA Hospital in the Home (HiTH) service comes from the perspectives and experiences of consumers, families and carers with lived experience of mental health challenges. We welcome the opportunity to provide this feedback to the Office of the Chief Psychiatrist.

## Our Feedback on the Draft

p.4 The Background section of the model document would benefit from an upfront brief statement about the purpose of the service, centred on consumer-centred values and rationale from a trauma-informed perspective.

The documents states that 'The full range of biopsychosocial interventions indicated in an acute setting' will be delivered. How this will be achieved isn't clear and our experience has been that, in its operation, HiTH has largely focused on medication with some brief supportive interaction. We hope that this service will be adequately resourced to ensure that it is not just a 'flying visit' to the person at home.

We note that pharmacotherapy is mentioned first, then supportive therapy and then specific psychological therapies.

p.5 In the section on 'Principles', we think that there could be mention of the importance for families also feeling safe and supported?

p.5 The aims statement following the principles: The person may not have family or carers present living with them in the home or involved in their lives. Also, would be good to mention the issue of feeling safe and supported without going to hospital where they may have experienced trust and trauma as part of prior admissions.

p.5 The 'Philosophy of Service' statement could be stated better perhaps as a 'working with the person' listening and negotiating plan of support with them and revisiting that regularly over the period of HiTH visits to support their self-determination.

This is a real opportunity to practice supported decision-making and Trauma-informed interactions.

p.5 Many of the points in 'The new service should' section could inform that upfront person-focused background statement that is currently missing from the document, especially the first 2 points about ensuring decision-making about hospital versus HiTH sits as far as possible with the person, and that home represents a place of safety, control, comfort and connection for most people.

We note that this comment does, however, sit in contrast the upfront statement to this section that 'the decision to admit a person to HiTH rests with the relevant LHN or service provider.... And that a person needs to agree to admission to the HiTH. We think this language could be more inclusive whilst still acknowledging the service system responsibilities and caveats.

Point 6 re the 'caring role' as voluntary and should not be 'imposed or assumed' could be clearer that you are talking about family/informal carers or friends who are natural supports to the person in their lives.

p.6 The last point in the 'The new service should' section on human rights is less clear. It is just a statement and doesn't explain 'how' human rights would be promoted. Several of the points are operational (eg. always ask the person what they need to feel safe) whereas statements like this one are not and are therefore more rhetorical and don't guide the work on what they actually need to do to achieve this.

It looks like more prominence has been given to the 'considerations' on p.6 than the dots points preceding this section. These 'cut and paste' statements appear across several models of care documents. Their placement and prominence in bolder font and layout may detract from the earlier information about the HiTH model. An integration between the HiTH statements and their Rhetorical statements is missing from the document.

p.7 Statement about the 'consequence of this inequality equates to poor physical health' reads as if it is an add-on under this subheading 'Human Rights Based Approach'. Surely the consequence equates to both poor mental and physical health, and the potential for poor quality care and/or more coercive care.

p.7 Section on 'Access to HiTH'

The first sentence states 'The HiTH staff will assess the individual needs of people referred to the service'. This could be revised to reflect that determining needs is a shared process with the person, and their family/carers where relevant to the person's situation.

p.8 In the list of 'Target Criteria', these points would seem to be crucial. At present, they are displayed as a dense, tightly packed list. Perhaps you could consider how the format ensures that the reader doesn't miss and scan over these points. The point stating 'If there is a co-resident or guardian they must consent to a HiTH admission' is 'buried' somewhat in this list. The co-resident could also be family/carer so this should be included. Also, the consent process should be revisited regularly given the day-to-day fluidity of the person's support needs and acuity whilst receiving HiTH.

The statement about ECT probably needs its own dedicated dot point or the wording revised to indicate that it is an example of what can be delivered within HiTH care, where indicated. Currently it runs directly after a more general statement about criteria for HiTH. Perhaps it could state 'For example, the HiTH team could arrange for ECT to be delivered on an outpatient basis where this is part of the person's treatment plan'.

p.8 In the section listing criteria for 'who may not be able to be managed by HiTH', perhaps consider better language to replace 'managed' with 'better supported' or something like this.

The final dot point about risk could also make mention of people who may share the living environment with the person, not just the HiTH works visiting the home.

p.8-9 The section on 'Specific Cohorts' that may be suitable for HiTH: There is mention of people with physical or intellectual disability who may be supported better in the home. It would be good to explain this more from the person's perspective so that it isn't used as a 'convenience' for services which then don't need to accommodate all people who may need acute admission to hospital. Also, it would be good to also mention people with complex communication needs, to be more inclusive, especially as their family member may be their 'communication partner' and the person may use an augmentative and alternative communication (AAC) device.

p.9 The inclusion of 'Regional and rural areas' in this list seems logical, so long as it does not replace quality acute care at the level that meet the needs of people in these locations or that perpetuate access and equity concerns.

p.9 In the 'What occurs' section, this is the first mention of the presence and role of a peer work in the document. It would be good to note it somehow earlier, perhaps where comments about safety and trauma-informed approaches are mentioned.

p.9-10 There is no mention of how family/carers might be involved in the description of what occurs. There is mention of a 'jointly developed' care plan and then the 'co-development of a safety plan' is mentioned. However, it isn't stated who is involved in these and how they may differ.

p.12 In the 'Measurement of Success' section, we note that self-management is mentioned twice. Also, the wording could be improved to reflect that the various improvements reflect 'the person's' own sense of this too. 'Connection and participation in support systems' is listed, however, a measure of success may also be how connections have been maintained, not lost or disrupted because of receiving HiTH rather than being admitted to hospital. For some individuals, ease of return to employment or study may be an important measure. Sense of hope could also be measured.

Overall, this section seems under-developed.

p.12 The 'Staffing Considerations' section appears at the very end of this document. We wonder if it should appear earlier, perhaps just before the information about 'What occurs'?

## Contact

We thank the SA Office of the Chief Psychiatrist for the work it is doing on the development of this important service. 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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