



Office of the Public Advocate

Long-Stay Patient Project Full Report

April 2009

Contact: Colleen Pearce

Public Advocate

The Office of the Public Advocate

Prepared by: Liz Dearn

Policy & Research Officer

The Office of the Public Advocate

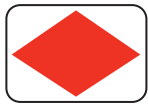
Office of the Public Advocate

Level 5, 436 Lonsdale Street, Melbourne, Victoria 3000

PO Box 13175 Law Courts, Victoria 8010. DX 210293

Tel: 1300 309 337 Fax: 1300 787 510

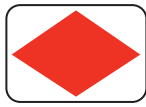
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Contents

Message from the Public Advocate	3
Introduction.....	4
Background.....	4
Methodology.....	8
Findings.....	10
Discussion.....	22
Recommendations.....	26



Message from the Public Advocate

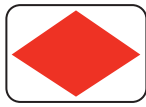
The Office of the Public Advocate has been concerned for some time about Community Visitor reports on patients in mental health facilities who have stayed long past the time when they need treatment. Our concerns were corroborated when between 2007-8, they found ninety-nine long-stay patients in Adult Acute Units, Secure Extended Care Units, Community Care Units and other units, some of whom had lived in institutional settings for between ten and twenty years.

Mental health units are not intended to provide life long accommodation and support yet many involuntary patients appear to be living out the course of their lives in these settings, many which are locked, because there is no where else for them to go. OPA believes this constitutes a breach of the civil and political rights outlined in the *Victorian Charter of Human Rights and Responsibilities* as it is not reasonable to limit a person's rights where their circumstances are dictated by a service system failure to meet their needs.

The systemic under funding of community-based accommodation and support options needs to be addressed as a matter of urgency and appropriate accommodation and support discharge options made available for long stay patients to prevent their continued marginalisation and exclusion from the life of the community.

Colleen Pearce

The Victorian Public Advocate



Introduction

The 2006 Community Visitors Annual Report indicated that one of the themes of Visitors' reports over many years was the 'inappropriate long-term placement of patients'¹. Community Visitors had previously undertaken an accommodation needs snapshot in four regions in 2004 asking facility managers to identify how many people could be discharged if suitable accommodation options were available. Seventy-seven people were identified. In 2007, the Community Visitors Board in conjunction with the Advocate/Guardian program decided to undertake a more focussed twelve-month data collection project and in April, Community Visitors commenced collecting data across all nine regions.

Information was collected in Adult Acute Units, Secure Extended Care Units (SECU), Community Care Units (CCU) and specialist units including the Brain Disorder Unit at Mary Guthrie House, Thomas Embling Hospital (Forensicare) and in Aged Mental Health units. The resulting information was originally presented in summary form in the 2008 Community Visitors Annual Report, tabled in parliament in December 2008. This report is the full analysis of the findings.

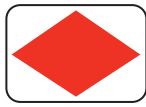
Background

While much reform has occurred in mental health policy and service delivery over the last two decades in Australia, the process of deinstitutionalisation has failed to adequately address the long-term accommodation and support needs of many people with enduring mental illnesses or complex conditions².

One of the consequences of shortages of appropriate community-based accommodation and support for inpatients with enduring mental illnesses is the lack of discharge options from bed-based care into the community. Hence, despite the adoption of the policy of deinstitutionalisation in the 1990s and the closure of the remaining stand alone institutions during that time, some people with a long-term mental illness do not have the opportunity to live and participate in the life of the community.

¹ Office of the Public Advocate (OPA) 2006, *Community Visitor Mental Health Annual Report*, p 1.

² See for example, Mental Health Council of Australia 2005, *Not for Service, Experiences of injustice and despair in Mental Health Care in Australia*; Boston Consulting Group 2006, *Improving Mental Health Outcomes in Victoria: The next wave of reform*; Department of Human Services 2008, *Because Mental Health Matters, A new focus for health and wellbeing in Victoria*. Consultation paper.



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While it is sometimes argued that long-stay patients are all consumers who present a risk to public safety due to behavioural issues relating to their mental illness, reports by Community Visitors suggest that shortages of discharge accommodation are a significant causal factor in length of stay for long-stay patients in mental health units³.

The 1993 report from the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Report) stated that ‘the policy of deinstitutionalising psychiatric patients (or of not hospitalising them in the first place) was conceived in the belief that most people with a mental illness would be better off living and being treated in the community’ but there was little evidence that a commensurate commitment to resourcing had occurred⁴.

There is evidence today, as there was sixteen years ago, that the closure of psychiatric facilities has not gone hand in hand with the adequate expansion of community-based accommodation and support. The influential 2005 report from the Mental Health Council of Australia, ‘Not for Service’, tells of a ‘crumbling mental health system that brought about anguish and desperation’ concluding that ‘the process of de-institutionalisation has not been accompanied by corresponding supports for mentally ill people who live in the community.’⁵

The need for more affordable and supported housing was raised as a key issue in the Burdekin Report and has been repeatedly raised in reports and inquiries since that time⁶. Accommodation was one of four key outcome areas for the 2006 COAG National Action Plan on Mental Health⁷ and in the 2008 follow-up report to the National Senate Mental Health Inquiry, accommodation was identified as a key issue for people with a mental health issue across jurisdictions⁸.

³ See OPA *Community Visitor Mental Health Annual Reports 2004, 2005, 2006 and 2007*.

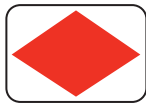
⁴ Burdekin B, Guilfoyle M and Hall D 1993 *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, Australian Government Publishing Service, Canberra, p 338.

⁵ Mental Health Council of Australia, Brain and Mind Research Institute and Human Rights and Equal Opportunity Commission 2005, *Not for Service Report*. Australia.

⁶ See for example, Senate Select Committee on Mental Health 2006, *A National approach to mental health – from crisis to community*; Senate Standing Committee on Mental Health 2008, *Towards Recovery – Mental health services in Australia*; Mental Health Council of Australia 2004, *Time for Service*; Mental Health Council of Australia 2005.

⁷ Council of Australian Governments 2006, *National Action Plan on Mental Health 2006-2011*, p i.

⁸ Senate Standing Committee on Mental Health 2008.



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People with dual disabilities and complex needs are particularly likely to experience long-term stays because of shortages of specialised accommodation and support. Community Visitors have reported this for a number of years and in the 2005 Community Visitor Mental Health Annual Report they stated that:

‘Community Visitors have remained concerned that clients with multiple and complex needs cannot access appropriate accommodation or services and remain inappropriately placed in acute or long-term psychiatric units for unacceptable periods of time.....there is limited evidence of cooperation between mental health services and relevant service providers to progress the provision of services and accommodation for these clients.’⁹

Many patients remain in Adult Acute units, with their associated practices and restrictions, well past the time when they need this level of clinical care¹⁰. In 2007, Community Visitors reported that one patient with an intellectual disability had spent 180 days in an Adult Acute Unit because Disability Services was unable to provide a placement in a Community Residential Unit¹¹. Community Visitors have consistently reported long-stays for patients in Adult Acute units due to shortages in SECU and CCU beds, shortages which in many cases result from a lack of discharge options for CCU and SECU patients. In 2006 they reported that:

‘The shortage of beds is also affected by the long-term placement of some patients in inappropriate environments...Community Visitors have become increasingly aware of the number of patients with a dual disability who have been in either acute or extended care units for a considerable time because at present there is no facility suitable for their special needs... One patient with a dual disability has occupied a secure extended care unit bed for many years, yet leaves the unit each day to attend a day placement and returns each afternoon to the locked unit.’¹²

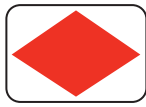
In 2006, the Department of Human Services (DHS) commissioned the Boston Consulting Group (BCG) to undertake an examination of outcomes for consumers in the Victorian mental health system. BCG found that many consumers in the bed-based

⁹ Office of the Public Advocate 2005, *Community Visitor Mental Health Annual Report*, p 5.

¹⁰ Office of the Public Advocate 2007, *Community Visitor Mental Health Annual Report*.

¹¹ Office of the Public Advocate 2007, *Community Visitor Mental Health Annual Report*.

¹² Office of the Public Advocate 2006, *Community Visitor Mental Health Annual Report*, p 6-7.



Office of the Public Advocate

system (Adult Acute units, SECUs and CCUs) are long-stay patients who could be shifted to lower-cost downstream accommodation options if alternatives were available. They estimated that 46% of Adult Acute beds are blocked and could be unblocked by the development of low cost alternatives. They reported that up to 25% of SECU consumers were ready for discharge but remained in the system due to the lack of available exit options¹³.

Australia's ratification of both the *International Covenant on Economic, Social and Cultural Rights* (the ICESCR) and the United Nations' *Convention on the Rights of Persons with Disabilities* (the Disabilities Convention) and the introduction of the *Victorian Charter of Human Rights and Responsibilities Act 2006* (the charter) places an obligation on the Victorian government to ensure that mental health service delivery is compliant with human rights.

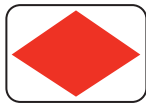
Australia's willingness to support the provision of appropriate mental health services is implied by the ratification of the ICESCR which outlines in Article 12(2)(d) 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.¹⁴ Read in conjunction with Article 12 of the Disabilities Convention (Equal recognition recognition before the law), Article 14 (Liberty and security of the person) and Article 19 (Living independently and being included in the community), it establishes a strong framework for examining the human rights of long-stay mental health patients.

The charter provides a complementary domestic legislative framework for the protection and promotion of human rights. It specifies that any limitation on human rights by law must take into account the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relationship between the limitation and its purpose and any restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve (s 7 (2)).

Many long-stay patients appear to be indefinitely detained under the Victorian *Mental Health Act 1986* due to the lack of availability of less restrictive accommodation and

¹³ Boston Consulting Group 2006, *Improving Mental Health Outcomes in Victoria: The next wave of reform*, Melbourne.

¹⁴ McSherry, B 2008 'Mental health and human rights: The role of the law in developing a right to enjoy the highest attainable standard of mental health in Australia.' *Journal of Law and Medicine* 15(5), p 774.



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support options. The basis for their detention is that they meet the grounds for involuntary treatment including that they ‘cannot receive adequate treatment for the mental illness in a manner less restrictive of his or freedom of decision or action’.¹⁵

The Public Advocate has serious concerns about reports on long-stay patients and the findings of this project which show that the current capacity of the mental health system to meet its human rights obligations with regards to the treatment and care of long-stay patients is compromised by shortages in community-based accommodation and support discharge options.

This is a time of significant mental health reform in Victoria and there is a strong commitment to change. The current policy and legislative context provides an opportunity to consider the framework under which long-stay patients are involuntarily detained and treated as well as the role of the law in the provision of services for long-stay patients. The Public Advocate is clear that the failure of the mental health system to secure less restrictive accommodation options for long-stay patients warrants further scrutiny.

Methodology

The aims of the project were to:

1. Examine the situation of people who are ‘inappropriately placed’ in psychiatric facilities.
2. To develop recommendations for resolution of these problems at both an individual and a systemic level.

The term ‘inappropriately placed’ came from observations by Community Visitors of people who were ready to be re-located outside the mental health unit they were in but were unable to relocate due to systemic barriers to their discharge. The term was drawn from a previous OPA publication which stated the following:

‘Defining inappropriate housing and support services is a complex and subjective endeavour, going beyond assessment of the physical and health support needs of individuals to include, arguably, the extent to which

¹⁵ The Act, s 8 (5).



Office of the Public Advocate

conditions enable people with a disability to meet emotional, social and aspirational objectives.’¹⁶

The assessment of patients as being ‘inappropriately placed’ was undertaken in consultation with patients, carers and unit nurse managers. In addition, patients needed to meet the long-stay duration criteria outlined in table 1.

Type of unit	Period of stay
Acute Unit	> three months
Community Care Unit	> two years
Secure Extended Care Unit	> six months
Other units	> six months

Table 1. Long-stay duration

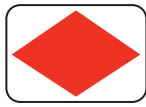
Over a twelve month period, between May 2007 and June 2008, Community Visitors Program, in partnership with the Advocate/Guardian program, collected information about long-stay patients as part of their regular monthly visits.

Community Visitors were instructed by Regional Convenors to speak to nurse unit managers to assist them to identify long-stay patients. It was agreed that they would collect information on patients identified who were ‘ready for discharge’ or ‘requiring alternative accommodation’. It was agreed that where an extended period of stay was identified but where the patient was not seen to be ‘ready for discharge’, information would still be collected for further exploration.

The collection of information was divided into two stages. In the first stage, long-stay patients were identified and in the second stage, additional detail was collected to enable action as well as a more detailed analysis. The following information was collected in the second stage

- Disability type
- Date of admission
- Where discharged (if during the period)
- Legal status (voluntary/involuntary/being reviewed)

¹⁶ Office of the Public Advocate 2003, *Experiences of inappropriate accommodation support for people with a disability: Research proposal submitted to the Disability Advisory Council of Victoria by the Office of the Public Advocate and Action for Community Living Inc.* Melbourne.



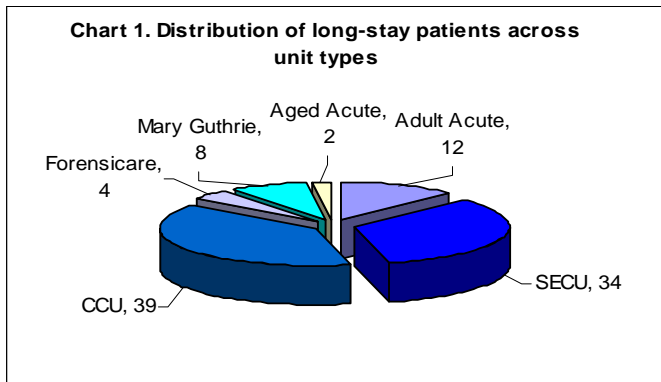
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- Security of unit (locked/unlocked)
- Date patient was ready for discharge
- Accommodation discharge plan
- Level of support patient requires
- Barriers to discharge

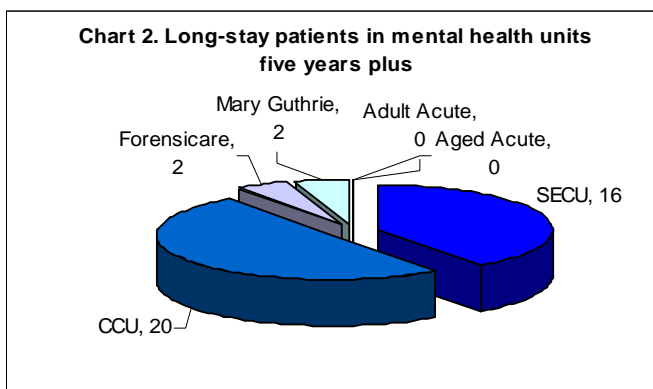
Findings

Summary Data

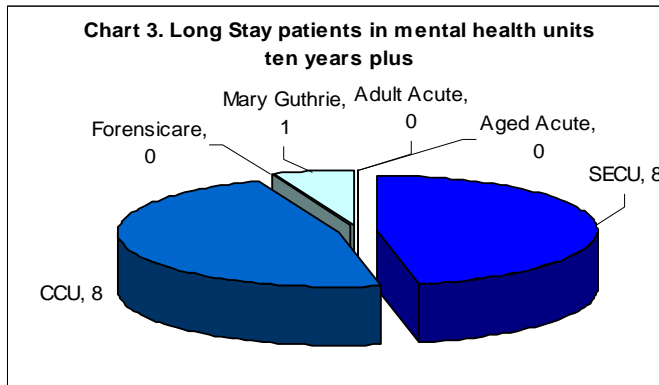
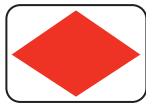
Community Visitors identified 99 patients in total across the state, the majority in CCUs and SECUs (chart 1).



A total of 40 long-stay patients had been in mental health units for five years or more, most of these in SECUs and CCUs (chart 2).



A total of 17 long-stay patients had been in mental health units for ten years or more (chart 3)



The mean age of long-stay patients, excluding patients in aged acute, was 44 years. The mean age of long-stay patients in SECUs was 45 and the mean age of long-stay patients in CCUs was 40. (Note, the mean age of patients in other units is not provided as the number of patients was too small for the average to be meaningful).

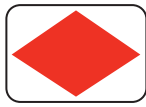
Barriers to Discharge

Community Visitors identified multiple reasons for the lack of discharge of long-stay patients. These fell into three categories: ‘not able to be discharged’, ‘no suitable accommodation available’ and ‘waiting on a vacancy’. As table 2 shows, the majority of long-stay patients (a total of 75%) were either waiting on suitable accommodation or there was no suitable accommodation available to enable their discharge.

Unit long-stay patient identified in	A. Not able to be discharged	B. No suitable accommodation available	C. Waiting on a vacancy	Total
SECU	9	15	10	34
CCU	10	21	8	39
Acute unit	5	1	6	12
Forensicare	-	1	3	4
Brain disorder unit	-	7	1	8
Aged acute	-	2	-	2
Total	24 (24%)	47 (47%)	28 (28%)	99

Table 2. Barriers to discharge for long-stay patients

A range of accommodation and support discharge barriers were identified in the information reported by Community Visitors. Table 3 provides a summary of the accommodation and support types required by long-stay patients, based on



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information attained in cases where ‘no suitable accommodation was available’ and patients who were ‘waiting on a vacancy’.

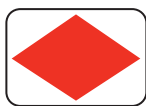
Accommodation and support type	TOTAL
Categorised as ‘not able to be discharged’	24
SECU	14
CRU (dual diagnosis)	7
Public housing with support (e.g. Multiple and Complex needs funding; MST; PDRS)	7
Specialist high dependency facility (e.g. for Huntington’s disease, ABI)	7
CCU	6
CRU	6
Suitable SRS and package	6
Community-based accommodation with appropriate non-clinical support (e.g. PDRS)	7
Long-term aged care with mental health component (includes psycho-geriatric)	4
Community based accommodation with appropriate clinical support	3
Secure SRS with MST support	3
Secure community-based accommodation with high level support and behavioural management	3
Forensic residential accommodation	1
Share house/unit	1
TOTAL	99

Table 3. Summary of accommodation and support types needed by long-stay patients

Multiple and Complex Needs

For the purpose of this report, dual disability and complex needs are defined as dual diagnoses (mental illness and intellectual disability or mental illness and ABI/polysubstance abuse), aggressive and unmanageable behaviour and physical health problems exacerbated by cognitive incapacity and complex conditions (for example, Huntington’s disease).

Approximately half (49.5%) of the long-stay patients identified in the snapshot period were found to have dual disabilities or complex needs as outlined in table 4. The highest proportions were found in SECU settings and in Mary Guthrie House as would be expected.



Disability type	Unit type long-stay patients were residing in						
	SECU	CCU	Acute	Mary Guthrie	Aged Acute	Forensic	Total
Dual disability (mental health and intellectual disability)	10	8	1	-	-	2	21
Dual disability (mental health and ABI/polysubstance abuse)	3	1	1	4	-	-	9
Complex needs (physical, high level supervision required, behavioural)	13	5	-	1	-	-	19
TOTAL (out of total number of long-stay patients in each unit)	26/34 (76%)	14/39 (36%)	2/12 (17%)	5/8 (62%)	0/2 (0%)	2/4 (50%)	49/99 (49.5%)

Table 4. Summary of location of patients with multiple and complex needs

Community Visitors found that people on waiting lists for accommodation and support (28%) were less likely to have dual disabilities and complex needs. People in the categories ‘not able to be discharged’ or ‘no suitable accommodation available’ (58%) were more likely to have dual disabilities and complex needs (see table 5).

Barrier to discharge category	Total number of long-stay patients in each category	Number with dual disabilities and complex needs (and % of total no long-stay patients)
‘not able to be discharged’	24	14 (58%)
‘no suitable accommodation available’	47	27 (57%)
‘on waiting list’	28	8 (28%)
Total	99	49 (49.5%)

Table 5. Number of people with dual disabilities and complex needs in each ‘barrier to discharge’ category

Around half of the long-stay patients were discharged within the twelve month period of the project. Table 6 shows how many patients remained on completion of the project. Note, twenty-eight of these patients have been in units for five years or more.

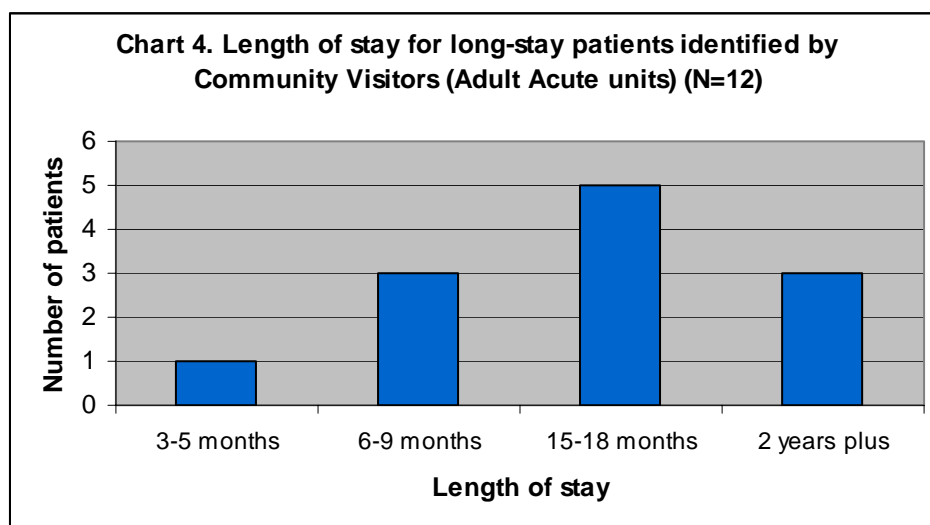


Type of unit	No. of patients
Acute	1
SECU	25
CCU	20
Forensicare	3
Mary Guthrie	8
Aged acute	0
TOTAL	57

Table 6. Number of long-stay patients remaining at end of project

Acute Unit Data

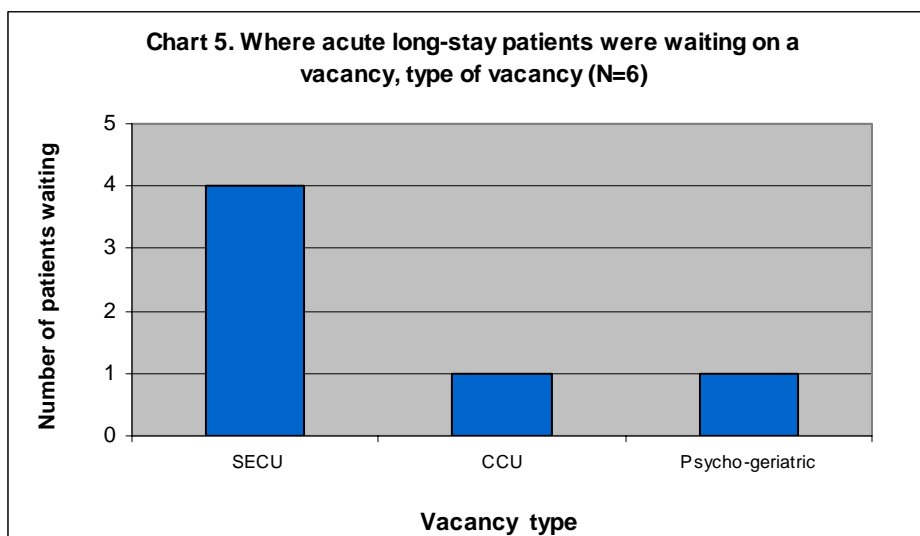
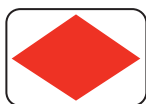
Patients exceeding a three month stay in an Adult Acute unit were included in the project. A total of twelve long-stay patients were identified by Community Visitors. Most had been acute patients for 15-18 months. Three had been in Adult Acute Units for two years or more (chart 4).



As shown in table 2, barriers to discharge for acute patients fell into three categories: ‘waiting on a vacancy’, ‘no suitable accommodation available’ and ‘not able to be discharged’. This is described in more detail in the following sections.

Waiting on a vacancy

Six patients were categorised as ‘waiting on a vacancy’. Most of these patients were found to be waiting on a SECU (chart 5).



No suitable accommodation available

One patient was categorised as not able to be discharged due to ‘no suitable accommodation (being) available’. This was identified as being due to difficulties the patient had in gaining eligibility for a Community Residential Unit (CRU) because of his dual disability (mental illness and intellectual disability).

Not able to be discharged

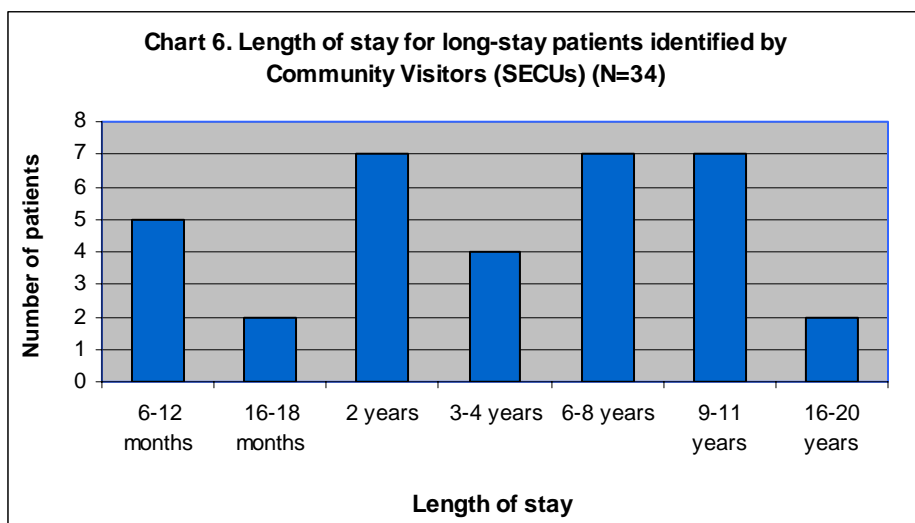
Five patients were reported ‘not able to be discharged’. This was due to several factors which included failure of previous discharge placements; going absent without leave then returning; poor compliance with medication, substance abuse and a continuing need for acute care.

These patients were included in the project because of the impact of their length of stay on blockages in the acute system. All patients were involuntary patients. Four of the six units in which long-stay patients were identified were locked.

Secure Extended Care Unit Data

Patients exceeding a six-month stay in a SECU were included in the project. A total of thirty-four SECU patients were identified by Community Visitors.

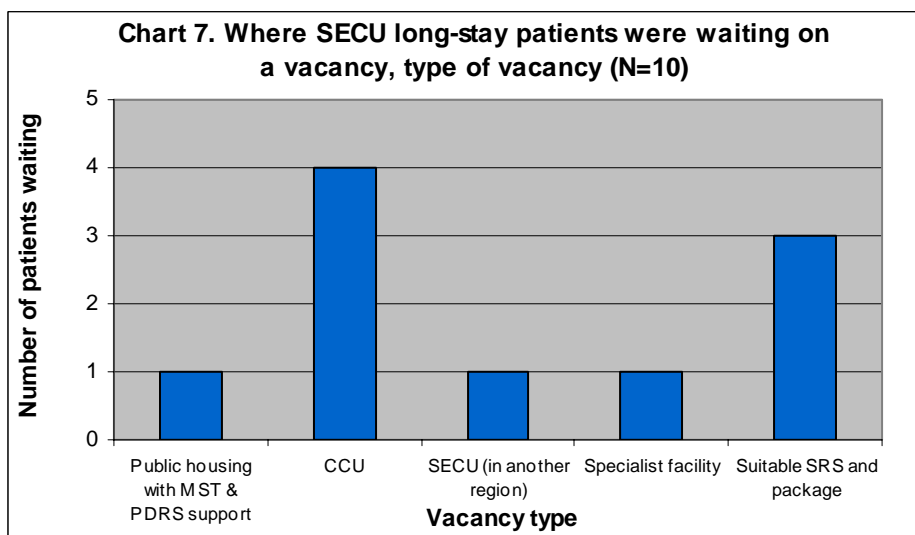
Of those thirty-four patients, eighteen had been in the unit for from six months to four years. Sixteen had been there for between six and twenty years (see chart 6).



As shown in table 2, barriers to discharge for SECU patients fell into three categories: ‘waiting on a vacancy’, ‘no suitable accommodation available’ and ‘not able to be discharged’. This is described in more detail in the following sections.

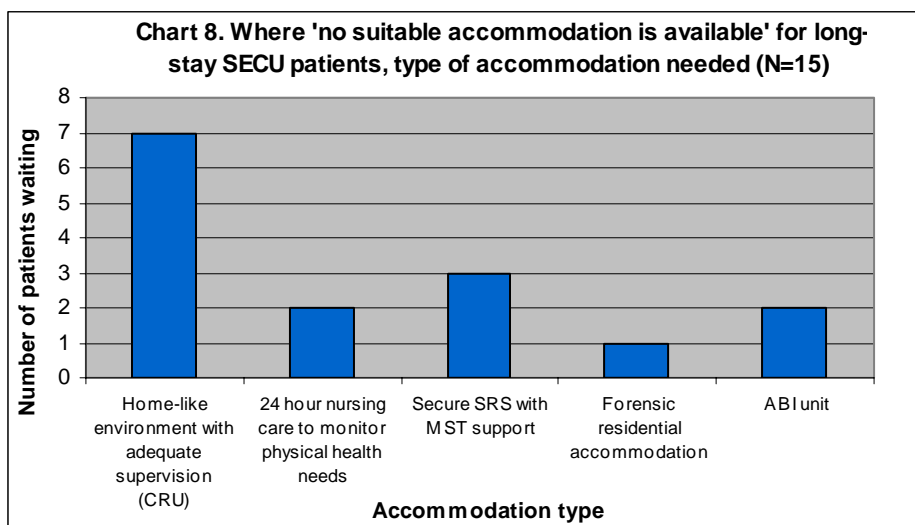
Waiting on a vacancy

Ten patients were categorised as ‘waiting on a vacancy’. The largest number of patients were waiting for a CCU vacancy (chart 7).



No suitable accommodation available

Fifteen patients were categorised as not able to be discharged due to ‘no suitable accommodation (being) available’. Chart 8 shows the type of accommodation that would be required for them to be discharged.



Seven SECU long-stay patients were waiting on CRU (dual diagnosis) accommodation. This included six people with a dual diagnosis of intellectual disability (two with Autism) and mental illness aged between 46 and 52 years where in most cases the primary diagnosis was intellectual disability. The duration of stay for this group was from between 7 and 20 years.

Not able to be discharged

Nine patients were reported 'not able to be discharged'. These patients were included in the project because the failure to discharge them prevents throughput in the system overall.

Eight patients categorised as 'not able to be discharged' were identified as having complex needs and a history of aggression and/or unpredictable and violent behaviour. It was reported that they required long-term secure facility with 24-hour nursing care and/or monitoring. The one remaining patient in this category required 24-hour care due to physical health issues that he had in addition to his mental illness.

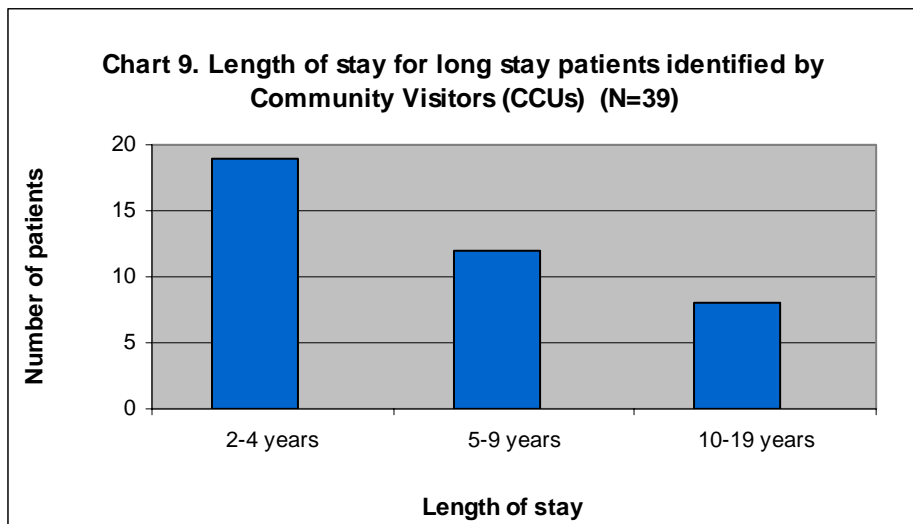
Twenty-three SECU patients were involuntary; three were voluntary and eight were being reviewed. All units were locked.

Community Care Unit Data

Patients exceeding a two year stay in a CCU were included in the project. A total of thirty-nine long-stay patients were identified by Community Visitors.



Of those thirty-nine patients, eighteen had been in the unit for from six months to four years. Sixteen people had been there for between six and twenty years (chart 9).

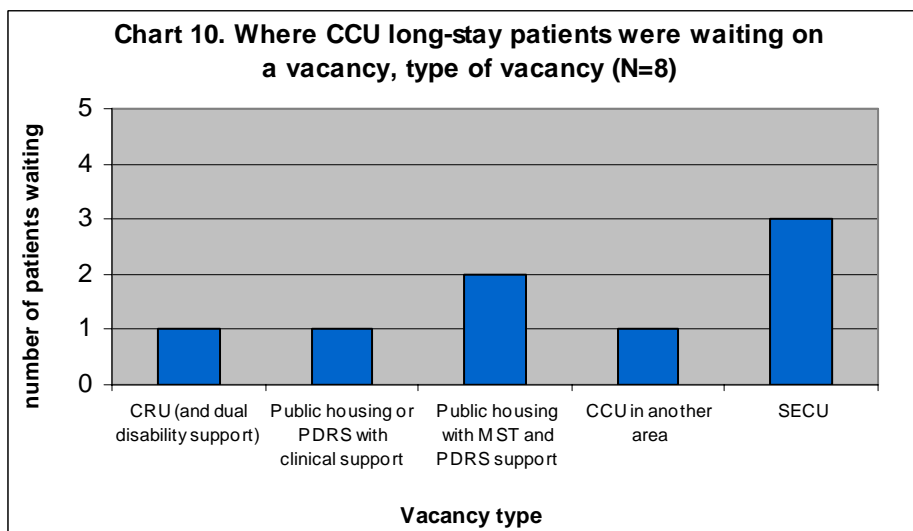


As shown in table 2, barriers to discharge for CCU patients fell into three categories: ‘waiting on a vacancy’, ‘no suitable accommodation available’ and ‘not able to be discharged’, as described in more detail in the following sections.

It was found that the failure to discharge CCU patients was due to a lack of alternative accommodation and support options in most cases.

Waiting on a vacancy

Eight patients were categorised as ‘waiting on a vacancy’. Many of these patients were waiting on a SECU vacancy (chart 10).



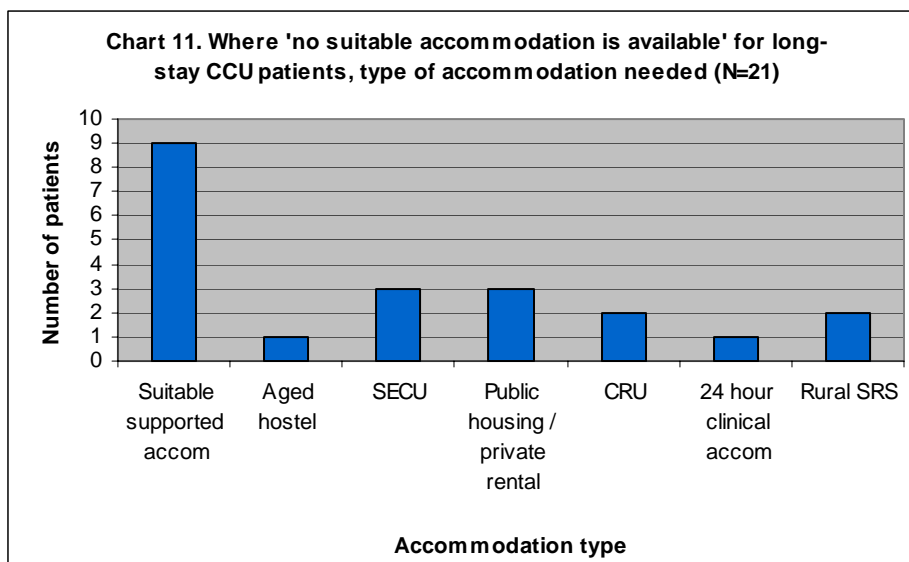


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Several people 'waiting on a vacancy' were people with a dual disability. One of these patients had been in the CCU for 8 years and another for 13 years. The three people waiting on a SECU vacancy had been in the CCU for three, four and 11 years respectively.

No suitable accommodation

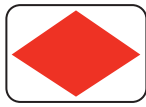
Over half (twenty-one patients) of the CCU long-stay patients were categorised as not able to be discharged due to 'no suitable accommodation (being) available'. These patients were not on waiting lists as the type of accommodation they required was not seen to be available. Chart 11 shows the type of accommodation that would be required for them to be discharged.



Barriers to them accessing accommodation include that there was no suitable accommodation in their geographical region, they did not meet the eligibility criteria for (immediate) public housing or CRUs, they were too young or too old for the type of accommodation they required, did not meet eligibility criteria more generally or they did not have the funding required.

Not able to be discharged

Ten long-stay CCU patients were categorised as 'not able to be discharged'. In three cases this was due to family concerns. In other cases the patient was identified as too unsettled or unstable for discharge. Two patients had a history of assault.



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Eight patients 'not able to be discharged', had been in the CCU for between three to five years and one for eight years.

Twenty-two CCU patients were involuntary, eight were voluntary, and two were being reviewed. In eight cases, Community Visitors were unable to gain this information.

Forensicare Data

Patients exceeding a six month stay in Forensicare who were no longer on custodial sentences were included in the project.

Four long-stay patients were identified. All were involuntary patients, they were aged between 30 and 57 years and their length of stay ranged from two to seven years.

Of the four patients identified, two had a dual diagnosis (intellectual disability and mental illness) and two had a mental illness. All were seeking individualised secure accommodation in a less restrictive environment.

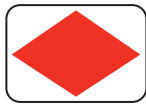
One was on a waiting list for a SECU; one required SECU-type accommodation but was not eligible, one was on a waiting list for a secure CRU and the one was waiting for community-based accommodation with specialist support (Multiple and Complex Needs Initiative).

These patients are examples of clients who have completed their sentence but continue to reside in a high-security custodial environment due to a lack of alternative secure accommodation options.

Mary Guthrie House (Brain Disorders Unit) Data

Patients exceeding a six month stay in Mary Guthrie House were included in the project if it was seen that there were no further benefits to be gained from rehabilitation and if the facility was not considered appropriate to their long-term needs.

Eight long-stay patients were identified. Four were involuntary patients and four were voluntary. Aged between 37 and 58 years, their length of stay ranged from six months to fifteen years. One patient who had resided in the unit for two months was included



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as she had dementia and was inappropriately placed due to no alternative accommodation being available.

Of the eight patients identified, one had dementia and the other seven had an Acquired Brain Injury (ABI) and associated behavioural issues and/or a mental illness. In all cases, the facility was not considered appropriate to their long-term needs.

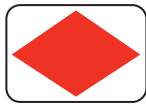
In some cases this was due to the patient no longer requiring care in a clinical environment. For example, five patients were seeking specialist secure community-based 24-hour non-clinical accommodation and support. Three of these patients were aged in their thirties (37, 38 and 39). Their behavioural management issues and relating to their ABI presented a barrier to their being re-housed in a more home-like environment.

In other cases, a rehabilitative environment was not seen as appropriate because further rehabilitation was not required. One long-stay patient was not admitted to Mary Guthrie for rehabilitation but because no other facility was prepared to admit him due to behavioural management issues. Similarly, several of the younger patients with ABIs continued to live in the unit even though they required no further rehabilitation due to a lack of alternatives.

Several patients were identified as requiring a different type of clinical care. Two patients, 56 and 57 years old, required high level nursing home care with a dementia unit. Another patient was on the waiting list for SECU accommodation.

Several patients, in addition to their need for a different type of care, needed accommodation in a different region to be closer to family networks and support. The areas they were seeking included Bendigo, Geelong, Southern Region and the Eastern region.

Only one Mary Guthrie long-stay patient was on a waiting list for alternative accommodation. In all other cases, there were no immediate plans for alternative care due to a lack of available options.



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Aged Acute Patient Data

Patients exceeding a six month stay in Aged Mental Health Acute units were included in the project. Two patients were identified.

These patients, aged 68 and 73 years, both suffered from chronic depression and were seen to require long-term aged care with a mental health component. These patients had spent one year and 6 months respectively in the acute aged care setting.

They were long-stay patients in this acute setting due to barriers accessing appropriate alternative accommodation.

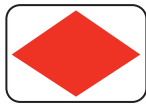
Discussion

The 'inappropriate long term placement of patients' has been a theme raised by Community Visitors since 2005. The long-stay patient project provides evidence to substantiate this problem showing that shortages of accommodation and community-based support are the biggest obstacles to discharge for long-stay patients.

This project shows that the lack of community-based accommodation and support discharge options impedes throughput in Adult Acute, SECU and CCU settings, creating blockages in the mental health system as a whole and hindering the capacity of patients in other parts of the system to progress to the next level of care.

Long-stay patients are often assumed to be consumers who present a risk to public safety due to intractable behavioural issues relating to their mental illness. This is an incorrect assumption which is not born out by the findings of Community Visitors whose reports show that only ten patients were classified as 'unable to be discharged' due to a history of violence or aggression.

Long-stay patients are detained in mental health units often in locked settings where their freedom and movement are restricted. As a consequence they are marginalised and unable to participate in the life of the community. In addition, settings that attempt to provide a service for people with a range of complex and challenging needs and behaviours can be un-therapeutic and in many cases are not safe or suitable for vulnerable patients.



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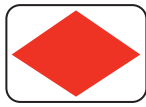
This project identified vulnerable patients including people with physical health conditions (e.g. Huntington's disease and Chronic Obstructive Airways Disease) and people with Autism, who had been living in SECUs alongside people with Acquired Brain Injuries and serious behavioural disturbances for extended periods of time. Community Visitors and advocate/guardians and nurse unit managers have all identified cases where this environment has had a serious detrimental effect on the well-being of the patient.

The findings show that discharge delays were due to a combination of factors including blockages in inpatient beds, shortages in community-based accommodation and support and the complexity of patient need. OPA believes that service system failure to facilitate the discharge of long-stay patients into more appropriate accommodation needs to be considered in relation to Victoria's human rights obligations in light of the ICESCR, the Disabilities Convention and the charter.

Article 12(1) of the ICESCR establishes a framework for the right to health and the right to access to health services and facilities. General Comment no 14 states that 'the right to health must be understood as the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health'¹⁷. OPA believes that long-stay patients, by virtue of being detained long-term in institutional settings or by not being able to progress to the next level of care, are prevented from realising the highest standard of health.

Article 14(b) of the Disabilities Convention states that persons with a disability 'are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty'. People with dual disabilities and complex needs face significant barriers in meeting the eligibility criteria for services and this project found that there was a direct relationship between patient discharge status and their disability. People with dual disabilities and complex needs were found to be more likely to be in the categories 'not able to be discharged' or 'no accommodation available' than on a waiting list for accommodation. For example, a group of six people with intellectual disabilities who had been residing in one SECU for from

¹⁷ UN Committee on Economic, Social and Cultural Rights, *General Comment No 14* (22nd Sess), UN, 11 August 2000, cited by McSherry, B 2008.



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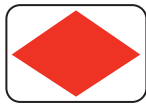
between 7-20 years were unable to gain access to CRU accommodation because DHS considered them already housed or because their dual disability made them ineligible.

Most patients with dual disabilities and complex needs identified in the project were people with a combination of a mental illness and an intellectual disability or mental health issues and ABI and/or substance abuse. In most cases, alternative community-based accommodation was identified as a preference to the inpatient setting.

However, in most cases patients did not meet the eligibility criteria for available accommodation or they were on waiting lists for programs with limited funding (multiple and complex needs program, dual disabilities programs) or were unable to gain access to the specialist accommodation because of their behaviour (for example they did not meet the criteria for specialist acquired brain injury, Huntington's' disease or dementia accommodation).

Article 19 of the Disabilities Convention states that people with a disability have a right to 'full inclusion and participation in the community' and article 14(2) states that when liberty is curtailed, persons with disabilities are entitled to the 'provision of reasonable accommodation'. The system is clearly failing the many long-stay patients who are living out the course of their lives in institutional settings because there is nowhere else for them to go. For example, the project identified a 50 year old patient with an intellectual disability who was considered ready for discharge from a locked secure extended care unit in 2000 yet in 2008, the patient still remains in this unit. The patient leaves the unit each weekday to participate in a day program then returns each afternoon.

Article 12(4) of the Disabilities Convention states, that measures relating to the exercise of legal capacity will 'apply for the shortest time possible and are subject to regular review'. Many long-stay patients are subject to significant deprivations of liberty and were found to have been involuntarily residing in institutional settings for extensive periods of time. The existence of sixteen people who had been residing in CCU and SECU units for ten years or more was clear evidence that no systematic effort was being made to ensure their deprivation of liberty was for the shortest possible period of time. Similarly, involuntary patients waiting on less restrictive accommodation who are residing in Adult Acute Units, often locked due to a lack of high dependency beds, are deprived of their liberty for longer than necessary.



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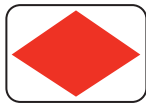
In addition, the only external review mechanism required under the *Mental Health Act* 1986 (the Act) is a twelve monthly external review by the Mental Health Review Board. In light of the significant limitations on liberty experienced by long-stay patients, this is clearly inadequate and more external reviews are required.

Section 7(2)(e) of the charter states that a human right may only be limited where there are no 'less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.' OPA argued in our submission this year to the review of the Act that the grounds for involuntary detention allow too much scope for people to be detained for extended periods of time. The long-stay project demonstrates that in many cases that indefinite detention occurs because there is no suitable accommodation or support to allow the safe discharge of long-stay patients. OPA believes this constitutes a breach of the civil and political rights outlined in the charter as it is not reasonable to limit a person's rights where their circumstances are dictated by the failure of the service system to provide less restrictive options.

Section 8 of the charter and article 12 of the Disabilities Convention state the principle of a right to 'recognition and equality before the law'. A significant human right emerging from this project is the indefinite involuntary detention of people with a history of violence. Community Visitors reported on two patients in CCUs and eight involuntary patients in SECUs who were categorised as 'not able to be discharged' due to unremitting mental health issues combined with a threat of violence/history of violence. OPA questions the use of a civil mechanism like the *Mental Health Act* 1986 to indefinitely involuntarily detain individuals who have not been tried and committed for any violent crime. More safeguards are required to protect the rights of long-stay patients and to ensure the compliance of mental health laws with human rights principles when seeking to balance the three objectives of protecting the public, protecting civil rights and providing services'.¹⁸

Further to this, section 22 of the charter states that 'a person detained without charge must be segregated from persons who have been convicted of offences, except where reasonably necessary.' This project identified four Forensicare patients for whom this right is not being realised. They were people no longer on custodial sentences yet who

¹⁸ Hale, B, 'Justice and Equality in Mental Health Law: The European Experience', 2007, *International Journal of Law and Psychiatry* 18, cited by McSherry, B 2008, p776.



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continued to reside in high security custodial institutional facilities due to a lack of alternative accommodation options.

OPA argued in our submission to the review of the Mental Health Act that all long-stay patients should be provided with intensive case management support, in exchange for the limitation on their freedoms, thus placing the onus on the Mental Health Branch to account for how it intends to facilitate their eventual (safe and appropriate) discharge. This project identified two long-stay CCU patients who were originally identified as ‘not ready for discharge’ who were assisted into independent living by an intensive case management project, demonstrating the ways that additional resourcing may overcome barriers to discharge for long-stay patients.

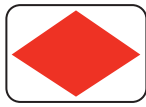
Recommendations

Community Visitors have advocated for many years for additional SECU beds and more individualised (home-like) secure options and more community-based exit options, particularly for patients with unremitting mental health symptoms and complex needs.

The Public Advocate would like to see more investment in an intensive case management program for long-stay patients capable of living independently in the community and well as those who will need ongoing support. The program must be adequately funded so that it incorporates assessment of the needs of patients, funding to ensure that they are provided with the level of support they require to live successfully in the community as well as an ongoing research and monitoring component.

The Public Advocate hopes that the introduction of the Mental Health Act in 2010 will provide a stronger legal framework for the protection and promotion of the human rights of long-stay patients. We believe that advocacy, legal representation, regular monitoring and review of long-stay patient cases is needed to ensure Victoria complies with the principles enshrined in the charter and the Disabilities Convention.

The Public Advocate calls for the establishment of a cross-sectoral taskforce comprising OPA, cross-departmental representatives from the Department of Human Services (DHS), the Victorian Mental Illness Awareness Council (VMIAC), the Mental Health Legal Centre (MHLC) and the Victorian Human Rights and Equal

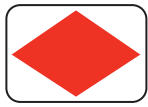


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Opportunity Commission (VHREOC). The Taskforce would undertake an analysis of the circumstances of long-stay patients, explore the ways in which current laws, policies, practices and services contribute to the long-term institutionalisation of the target group and develop measures to facilitate the design and delivery of person-centred solutions.

The Public Advocate submits the following recommendations:

- Recommendation 1. More investment in step-up/step-down care options.
- Recommendation 2. Additional SECU beds.
- Recommendation 3. Increased clinical capacity in the community to provide intensive post-inpatient discharge support for acute patients.
- Recommendation 4. More investment in PDRS services.
- Recommendation 5. More investment in Home Based Outreach Services and Mobile Support Teams.
- Recommendation 6. More public housing nomination rights for organisations facilitating the discharge of long-stay patients.
- Recommendation 7. More investment in intensive community-based clinical and non-clinical support for long-stay patients discharged into the community.
- Recommendation 7. More investment in services for clients with complex needs and dual disabilities allocated specifically to long-stay patients.
- Recommendation 8. Additional resources allocated to an intensive case management model like the Integrated Rehabilitation Care and Recovery Project both for people who are capable of living independently in the community and those who will require 24-hour clinical and non-clinical support.
- Recommendation 8. The provision of advocacy services and legal representation to long-stay patients.



Office of the Public Advocate

Recommendation 9 More regular monitoring and review of long-stay patients by the Mental Health Review Board.

Recommendation 10 The development of a cross-sectoral Taskforce to explore current laws, policies, practices and services pertaining to long-stay patients and solutions.