

Submission to Inquiries into the Provision of Supported Accommodation for Victorians with a Disability or Mental Illness

I am the former medical officer at Austin Secure Extended Care Unit (SECU) and remain acutely interested in the welfare of the patients within the unit. This submission is independent of Austin Health and is made on the basis of my individual concern for patient outcomes.

Legislative requirement for least restrictive option

The necessary level of restriction within the environment of SECU makes the adequate provision of alternative accommodation for those who are suitable to be housed elsewhere an ethical and moral responsibility. This occurs both independently from and in conjunction to the legal responsibilities imposed by the Mental Health Act. Current deficiencies in supported accommodation options within the mental health and intellectual disability systems contribute significantly to deterioration in patient morale, engenders frustration and exponentially increases safety risk to staff, patients and visitors.

Inappropriate co-location of people with behaviours that complicate and destabilise management of those with intellectual disability

Of significant concern has been the ongoing co-location of intellectually disabled adults with other individuals of quite disparate intellectual function whose primary disability is of psychiatric origin. The mixed cohort of patients primarily disadvantages the intellectually disabled patients through environmental disturbance, whilst stigmatising persons with mental health issues as they feel they are labelled as being of correspondingly low IQ. Similarly, accommodation of persons with borderline personality disorder within SECU cohorts adds further complexity. This continues to hold potential for significant adverse events and negative impact within the therapeutic environments of SECUs across the state.

The devastating effect of inappropriate co-location of patients with borderline personality disorder, intellectual disability and psychiatric illness has been well illustrated by events in Austin SECU in 2008. The enduring deleterious nature of inappropriate patient mix continues to be evident through profound behavioural disturbance in a patient with intellectual disability who had been previously stable for many years. Patients, such as this individual, with pervasive developmental disorders and low functional ability are better housed in facilities appropriate to their needs with low levels of stimulation and regular routine. Destabilisation of the therapeutic milieu, through psychiatric or personality based behavioural disturbance, occurs to the detriment of patients with intellectual disability.

Severe negative behaviour also diverts staff time and energy toward specific individuals and away from other very vulnerable people. It creates an environment where other patients may also feel that outrageous and negative behaviour is the only way to engage with staff and get any reasonable time allocation with them. This sets in place a destructive and non-therapeutic milieu with violence being used by patients to express frustration and get their needs met. Patients see resources being allocated toward those who cause the most unrest and the most harm. This disrupts staff attempts to focus on the broad mental health needs of the entire patient base rather than reacting to the demands and safety risks of individual patients.

General resources are prone to be sequestered toward rehabilitation of a patient minority in an unstable and volatile environment. Patients with borderline personality disorder may

In discussions with the representatives of the Office of the Public Advocate and Legal Aid, it would seem that it has been difficult to make any headway in achieving change and find suitable alternative accommodation for the intellectually disabled cohort of Austin SECU. I believe the OPA is submitting statistics regarding "long stayers" in statewide SECU's to present to these inquiries. However, cumulative statistics do not give significant insight as to what is happening at the individual patient level.

Lack of access to community based or government funded programs due to hospital inpatient status

Patients who are inappropriately housed as in-patients lose rights to significant services and choices. As they are ineligible for Medicare rebates they cannot access their own GP for general medical care. Medical care is predominantly provided by hospital medical officers or psychiatry registrars who may not be up to date with protocols used in general practice that are outside the mental health field. The patients are also ineligible for enhanced primary care services funded by Medicare relating to complex patients. Treatments (including dental) cannot be claimed for treatment where the patient is an in-patient of a hospital.

Regional and local service providers in disability and mental health fields may refuse in-patients access to services that would further enable individuals to transition smoothly into community based settings. This includes employment, recreational, educational and social activities, central to successful rehabilitation and re-integration to the community.

Requirements for appropriate staffing to mitigate risk and maximise rehabilitation potential

The complexity and level of acuity of the patients in units such as SECU highlights the need for adequate medical, nursing and allied health staffing levels to enable appropriate and comprehensive risk assessments and psycho-education. Medical and nursing staff can find themselves dealing with crises, without any significant opportunity for therapeutic work or increasing patients' awareness of their illness. This reactive rather than proactive clinical involvement by staff can exacerbate patient frustration. It limits the ability of all parties to form an understanding of the individual's illness. Patients should feel that their specific issues are being heard and considered and that active discharge planning is fundamental to the rehabilitation process and their stay in a SECU.

Inadequate funding allocation to employ sufficient specialist allied health staff and limitations imposed by use of significant numbers of graduate nurses and agency staff also impact upon the effectiveness of the therapeutic milieu. Allied health staff can have their time diverted to placating demands (such as attending to buying cigarettes and cola) whilst their professional and clinical skills could be better utilised in progressing patients along a rehabilitation pathway toward discharge to a potentially less restrictive environment.

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