



# Wellbeing and Social Support for Long Stay Patients

*What patients need to stay well*

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Advocacy for Inclusion incorporating People with Disabilities ACT<sup>1</sup> is a leading independent organisation delivering reputable national systemic advocacy informed by our extensive experience in individual advocacy and community and government consultation. We provide dedicated individual and self-advocacy services, training, information and resources in the ACT.

As a Disabled People's Organisation, the majority of our organisation, including our Board of Management, staff and members, are people with disabilities. Advocacy for Inclusion speaks with the authority of lived experience. It is strongly committed to advancing opportunities for the insights, experiences and opinions of people with disabilities to be heard and acknowledged.

Advocacy for Inclusion operates under a human rights framework. We uphold the principles of the United Nations Convention on the Rights of Persons with Disabilities and strive to promote and advance the human rights and inclusion of people with disabilities in the community. Advocacy for Inclusion is a declared public authority under the Human Rights Act 2004.

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<sup>1</sup> On March 24, 2021, Advocacy for Inclusion (AFI) officially merged with People with Disabilities ACT (PWDACT), a systemic advocacy organisation based in the ACT. Herein, reference to 'AFI' also acknowledges the values and philosophies of PWDACT.

Authorised by Nicolas Lawler, Chief Executive Officer

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## **Wellbeing and Social Support for Long-Stay Hospital Patients**

*Evidence Base and Policy Landscape in Australia (including what patients need to stay well – a menu of options)*

*A public paper for the CHS Consumer and Carer Advisory Committee, March 2026*

### **Introduction**

This brief examines the evidence base and policy landscape for supporting the wellbeing of long-stay hospital patients – people who, through circumstance rather than choice, spend months or years living in a hospital environment. It is a population that receives relatively little attention in health policy: most research and most system effort focuses on reducing length of stay, leaving those for whom an extended admission is unavoidable without a clear framework for what good care should look like.

The brief draws on published research, a scan of Australian policy frameworks across jurisdictions, and the ACT's own commitments as a human rights jurisdiction – including the ACT Wellbeing Framework and the National Safety and Quality Health Service Standards – to argue that the gap between policy aspiration and ward-level practice is significant, and that the ACT is well placed to close it. It is intended to inform thinking about what a structured, rights-based approach to long-stay care might look like, and to provide a foundation for more detailed service design work.

It also provides a practical menu of service enhancements and options noting that these require work in a context.

### **Defining 'Long Stay': Why the Threshold Matters**

There is no single definition of a long-stay hospital patient, and the threshold that applies varies meaningfully by clinical setting. In Australian hospitals, the administrative definition most consistently used is 35 days – both SA Health and Queensland Health formally define a long-stay patient as one who has been continuously admitted for more than 35 days, at which point specific patient contribution charges and care review obligations apply. In intensive care settings, thresholds are considerably lower: stays of 21 days or more are commonly used in the clinical literature to identify patients with prolonged ICU admission, particularly those requiring extended mechanical ventilation, and some definitions begin as early as 14 days.

These differences are not merely technical – they reflect the fundamentally different environments and care needs that arise across settings. A patient who has spent three weeks in ICU and a patient who has spent six months in a rehabilitation or complex care ward are both, in different senses, long-stay patients, but the wellbeing supports each requires differ considerably. This brief is primarily concerned with the latter group: patients for whom an extended admission is not a temporary disruption but an extended period of living in hospital, and for whom the question of how to sustain quality of life across that time is both practically urgent and largely unaddressed in policy and research.

## The Evidence-Practice Gap

### What the Evidence Shows

Research demonstrates that long-stay hospital patients spend minimal time in meaningful physical, cognitive, or social activity outside scheduled therapy sessions. However, interventions addressing this gap show measurable benefits:

- **Multi-component self-management programs** (e.g., “My Therapy”) safely increase therapy dosage and participation time cost-effectively, though functional gains may require additional strategies.
- **Occupation-based interventions** improve occupational performance, participation outcomes, and patient experience through structured group programs and real-world practice.
- **Social support and connection** demonstrate health impacts comparable to major clinical risk factors – lack of social connection carries mortality risk equivalent to smoking in cardiovascular populations, and reduces hospital readmission and depression in heart failure patients.
- **Oral healthcare programs** can be successfully co-designed and implemented in geriatric units, yet oral care remains widely recognised as important but rarely embedded in inpatient routines.

See here for relevant papers: [Evidence-base - Preliminary](#)

### What Policy Frameworks Assume

Australian jurisdictions universally reference whole-person care in policy, but operationalisation varies dramatically:

- **Commonwealth:** National Safety and Quality Health Service (NSQHS) Comprehensive Care Standard explicitly defines comprehensive care as “health care that is based on identified goals for the individual patient, including social and functional needs.” Oral health expectations are clear.
- **NSW and Queensland:** Articulate rehabilitation and participation more explicitly through models of care and capability frameworks. Queensland’s Clinical Services Capability Framework embeds wellbeing and social supports through structured capability expectations.
- **Victoria and South Australia:** Policy language supports wellbeing and independence, but delivery of social activation remains inconsistent in practice.
- **Mental health sector:** Has gone furthest in naming the harms of prolonged institutionalisation and the importance of psychosocial supports, though delivery remains uneven. The ACT’s mental health rehabilitation models explicitly embed recovery-oriented psychosocial supports.
- **Dental and primary care:** Weakest and most fragmented area across all jurisdictions, generally relying on national standards rather than clear local pathways.

See here for a jurisdictional comparison: [Cross-Jurisdiction Scan - Australia](#)

### Where the Gap Lies

**Aspiration without operationalisation.** National standards and most state frameworks assume whole-person care but this is often implicit rather than translated into service delivery

expectations, workforce roles, physical environments, or outcome measures. Long-stay patients – precisely those who would benefit most from structured wellbeing support – fall through gaps between policy intent and ward-level practice.

### Critical Evidence Limitations

While evidence supports wellbeing interventions, three significant limitations affect direct application to long-stay hospital patients:

Limitation	Implication
<b>Population mismatch</b>	Most research focuses on subacute rehabilitation (stays of weeks) rather than months-long hospitalisations. Evidence from shorter stays may not fully translate to patients facing extended hospital residence.
<b>Prevention vs. enhancement focus</b>	Literature emphasises reducing length of stay and preventing readmissions rather than improving quality of care during unavoidable extended stays. Limited evidence exists on what works for patients who must remain hospitalised for months.
<b>Methodological inconsistency</b>	Systematic reviews show heterogeneous results with limited contextual detail. Evidence for medically complex and vulnerable populations – those most likely to experience long stays – is particularly inconsistent. Quality-of-life measurement lacks standardised frameworks.

*Despite these limitations, converging evidence from rehabilitation settings, post-acute care, and specific patient populations (geriatric, heart failure, stroke) supports comprehensive, multi-component interventions addressing psychological, social, and occupational needs alongside medical care.*

### What Good Practice Looks Like: Transferable Models

Several Australian examples demonstrate how evidence can be translated into practice:

- [Queensland’s rehabilitation capability framework](#) explicitly structures service expectations around multidisciplinary care, functional optimisation, and patient enablement rather than leaving these to implicit assumptions.
- [NSW’s rehabilitation model of care](#) links rehabilitation explicitly to participation in life roles, supporting the argument that inactivity and social isolation in hospital directly undermine rehabilitation goals.
- **Mental health rehabilitation frameworks** (including in the ACT) name the harms of prolonged institutionalisation and embed psychosocial supports and recovery-oriented principles, though implementation remains uneven.
- **Occupation-based group programs and co-design approaches** (documented in Australian literature) demonstrate how structured meaningful activity can be integrated into ward routines with improved patient experience and outcomes.
- **Self-management programs like “My Therapy”** show scalable, cost-effective models for increasing therapy dosage without proportional increases in staffing.

## Wellbeing Beyond the Clinical

The ACT Wellbeing Framework identifies twelve domains that together constitute a good life for Canberrans. For long-stay patients, the hospital becomes the totality of their lived environment, and the ordinary means by which people maintain their wellbeing – social connection, meaningful activity, personal care, autonomy over daily life – are interrupted or removed. Where that happens, the health system assumes a responsibility to actively substitute for those conditions. This is not an aspirational add-on to clinical care; it is the practical expression of the ACT's existing obligations as a human rights jurisdiction.

While the evidence base does not specifically address patients hospitalised for months or years, the Framework itself provides a clear account of what keeps people well: connection, dignity, purpose, autonomy, and belonging. Drawing on these principles, a practical menu of supports has been developed across eight areas that reflect the Framework's domains: social connection; access and connectivity; identity, belonging and personal dignity; health, environment and the body; time and meaningful occupation; mental health and spiritual wellbeing; health beyond the admitting condition; and home, autonomy and living standards.

See here for the full menu of supports and illustrative examples: [Wellbeing beyond the clinical](#) (also as [Attachment A](#))

### The ACT Opportunity

The ACT is well positioned to lead Australian jurisdictions in translating policy aspiration into structured, rights-based care for long-stay patients. That positioning rests not on ambition alone, but on commitments the ACT has already made.

- **A human rights jurisdiction with an existing account of what a good life requires.** The ACT Wellbeing Framework sets out, across twelve domains, what quality of life means for Canberrans. The ACT Human Rights Act gives those commitments legal and institutional weight. For long-stay patients – people living in hospital for months or years through no choice of their own – these commitments do not pause at the hospital door. The ACT has an opportunity to be the first jurisdiction to operationalise this logic explicitly: to treat the Wellbeing Framework not as a population-level reporting tool but as a practical standard against which the care environment for long-stay patients is designed and assessed.
- **An existing obligation, not an aspirational one.** The Commonwealth NSQHS Comprehensive Care Standard already mandates whole-person care that includes social and functional needs. Current ACT practice for long-stay patients falls short of this existing requirement. Framing action in this space as innovation misrepresents the situation: the ACT is not being asked to go beyond what is required, but to meet it. The human rights framing reinforces this – the question is not whether these conditions are warranted, but how the system will deliver them.
- **Proven frameworks ready to be extended.** The ACT's mental health rehabilitation models already embed recovery-oriented psychosocial supports and name the harms of prolonged institutionalisation explicitly. The logic underpinning those models – that the environment of care shapes outcomes, that people need connection and purpose and autonomy to recover and live well – applies equally to all long-stay patients regardless of diagnosis. The ACT does not need to build this argument from scratch; it needs to extend it.

- **Learning from the best of what other jurisdictions have built.** Queensland’s clinical services capability framework demonstrates how wellbeing expectations can be embedded structurally rather than left to individual goodwill. NSW’s rehabilitation model makes explicit the link between hospital-based care and participation in life roles. Both offer practical mechanisms the ACT can draw on and adapt, rather than starting from first principles.
- **Leading on the gaps no jurisdiction has yet closed.** Dental and primary care access for long-stay inpatients remains fragmented across all Australian jurisdictions – acknowledged as important, rarely embedded in practice. The ACT has an opportunity to establish clear pathways and set a national precedent. More broadly, by grounding its approach in the Wellbeing Framework and its human rights obligations, the ACT can articulate a model of long-stay care that goes beyond what any other jurisdiction has yet attempted: not merely reducing harm, but actively sustaining the conditions for a good life.

### Recommended Next Steps

The evidence base, policy analysis, and wellbeing framework set out in this brief together make a clear case for action. The following steps are recommended to translate that case into structured, deliverable support for long-stay patients in the ACT.

1. **Engage patients, families, and clinicians first.** Any framework for long-stay care must be grounded in the lived experience of those most affected. Structured consultation with patients currently experiencing long admissions, their families and carers, and the clinicians supporting them should be the foundation for all subsequent work – shaping the gap analysis, informing service design, and ensuring that the wellbeing supports developed reflect real need rather than assumed need. This is not only good practice; for a human rights jurisdiction, it is an obligation.
2. **Map current ACT practice against existing obligations.** A structured gap analysis should assess current ACT practice for long-stay patients against two benchmarks: the Commonwealth NSQHS Comprehensive Care Standard, which already requires whole-person care including social and functional needs; and the ACT Wellbeing Framework domains, which provide the organising logic for what that care should include. This analysis should cover workforce roles, physical environments, service availability, and referral pathways – with particular attention to social activation, occupational therapy access, and dental and primary care, where gaps are most consistently identified across jurisdictions.
3. **Examine exemplar models in detail.** Queensland’s Clinical Services Capability Framework, NSW’s rehabilitation model of care, and the ACT’s own mental health rehabilitation frameworks each offer practical mechanisms for embedding wellbeing expectations structurally. Detailed examination of these models – specifically how they translate aspiration into service standards, workforce roles, and physical environment expectations – will identify what can be directly adapted for the ACT context and what requires further development.
4. **Develop an ACT framework for long-stay care grounded in the Wellbeing Framework.** Drawing on the consultation, gap analysis, and exemplar review, the ACT should articulate minimum expectations for the comprehensive care of long-stay patients. The ACT Wellbeing Framework should serve as the explicit organising structure for this work – not as a reporting tool but as a practical standard against which the care environment is designed and assessed. The framework should address service

delivery expectations, workforce responsibilities, physical environment requirements, and the rights of patients to participate in decisions about their own care.

## **Conclusion**

The evidence base supports multi-component interventions addressing social, occupational, and wellbeing needs for long-stay hospital patients. Australian policy frameworks universally assume whole-person care – but assumption has not become practice, and the patients who would benefit most from structured wellbeing support are precisely those falling through the gap between policy intent and ward-level delivery.

The ACT is not starting from scratch. It has already committed, through the ACT Wellbeing Framework and the ACT Human Rights Act, to a specific and detailed account of what a good life requires. It has already accepted, through its mental health rehabilitation models, that the environment of care shapes outcomes and that connection, purpose, and autonomy are not optional extras but conditions for living well. And it is already obligated, under national standards, to deliver comprehensive care that addresses social and functional needs alongside clinical ones.

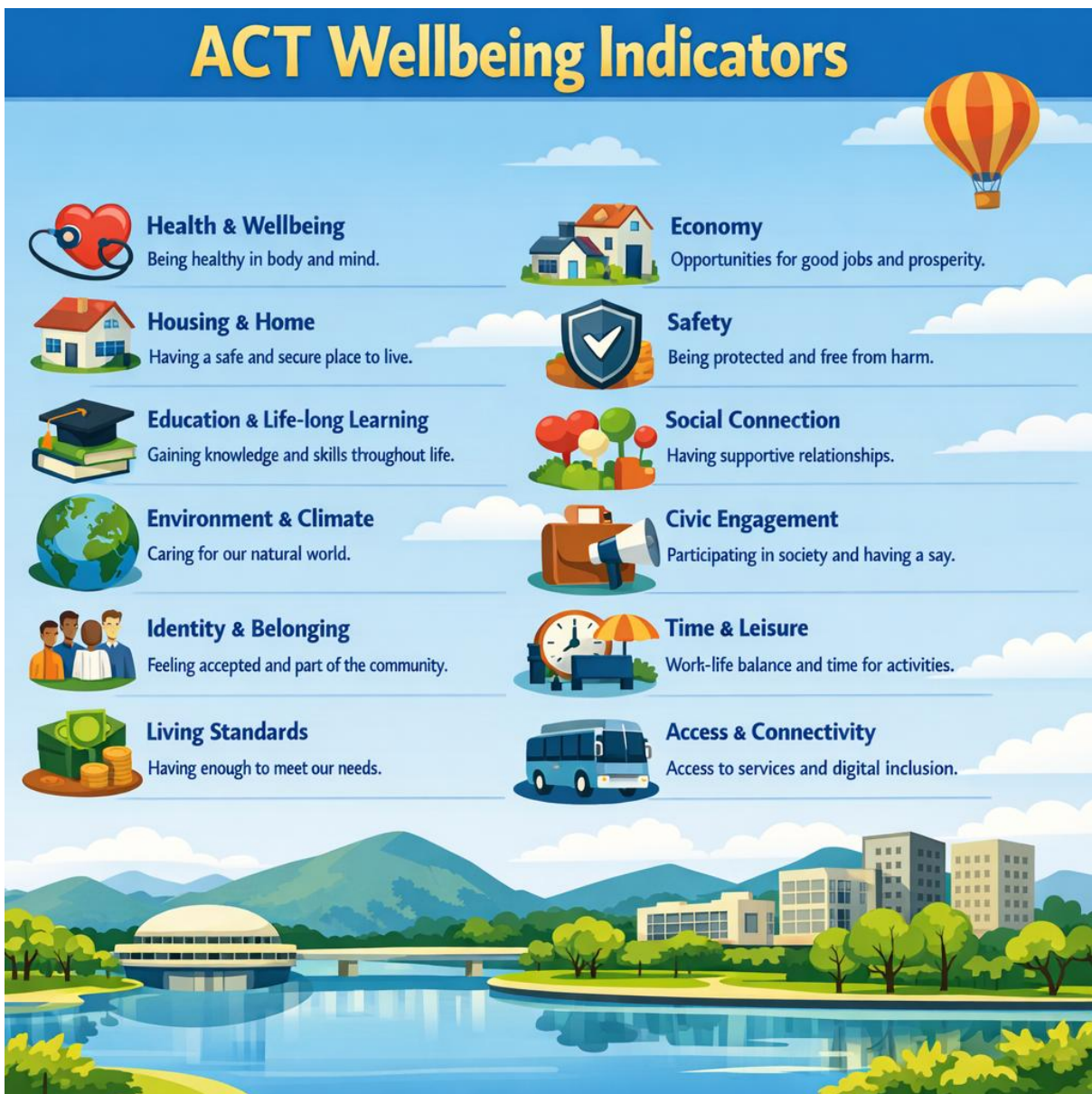
What remains is operationalisation. The question this brief puts to the ACT is not whether long-stay patients deserve care that sustains the conditions for a good life – the ACT's own frameworks already answer that. The question is whether the ACT will be the jurisdiction that turns that commitment into something a patient living in hospital for a year can actually experience.

This paper suggests that more work needs to be done but we also suggest that we need to start, test and learn and we finally commend the ideas at Attachment A as a commencement point.

Drafted by AFI Policy Team – Dr Jo Luetjens with Craig Wallace, March 2026

## Wellbeing Beyond the Clinical: What Long-Stay Patients Need to Live Well

The ACT has committed, as a human rights jurisdiction, to a specific account of what a good life looks like. The ACT Wellbeing Framework identifies twelve domains – social connection, health, identity and belonging, meaningful use of time, access to services, and others – that together constitute quality of life for Canberrans. That commitment does not pause at the hospital door. The illustrative graphic below summarises the indicators for ease of reference\*



(\*Basic AI image public domain/illustrative purpose only in accordance with AFI policy March 26)



For a patient hospitalised for long period of time, the hospital is not simply where treatment happens – it becomes the totality of their lived environment. The ordinary means by which people maintain their own wellbeing – seeing family and friends, getting a haircut, attending a place of worship, spending time outdoors, having some say over their day – are interrupted or removed. Where that happens, the health system assumes a responsibility to actively substitute for those

conditions. This is the practical expression of the ACT’s existing obligations: not an aspirational add-on to clinical care, but a baseline expectation for any jurisdiction that has named wellbeing as a framework for government decision-making.

The evidence base reviewed elsewhere in this brief does not tell us in detail what works specifically for patients hospitalised over months or years – that literature is largely non-existent. But we do not need clinical trials to know what keeps people psychosocially well. The Wellbeing Framework itself provides the answer: connection, dignity, purpose, autonomy, and belonging are not clinical concepts – they are human ones and apply inside hospital walls as much as outside them.

The menu below does not attempt a one-to-one mapping against the Framework’s twelve domains – to do so would be both mechanical and reductive. Rather, it draws on the Framework’s account of what a good life requires and asks what that looks like in practice for someone living in a hospital for an extended period. It is illustrative rather than exhaustive, and is intended as a starting point for a more detailed service design conversation.



(Image – Helen Hayes Hospital recreation program, NYC)

### **Social connection and relationships**

Staying connected to family, friends, and community is the most consistently cited determinant of wellbeing. The Framework recognises that social connection – including participation in cultural, spiritual, and community life – is foundational to quality of life. For long-stay patients this requires more than an open visiting policy.

- Flexible visiting arrangements that accommodate working families and carers
- Structured volunteer visitor programs providing reliable, ongoing companionship
- Social work support to maintain and repair family and community relationships over the course of a long admission
- Facilitated connections to community groups, cultural organisations, and religious or spiritual communities
- Therapy animals and pet visits, where infection control permits
- Humour and music programs – evidence-supported and valued by patients as normalising elements of daily life

### **Access and connectivity**

The ability to reach services, people and information is foundational to wellbeing and full participation in community life. For long-stay patients, this extends to the physical and digital means of staying connected to the world.

- Reliable internet access as a basic condition of social and civic participation
- Devices – tablets or equivalent – for patients who do not have their own, including those in isolation
- Communication boards and augmentative communication supports for patients with speech impairments
- Library access, including physical books, audiobooks, and e-reader options
- Working equipment for daily life – mobility aids, glasses, hearing aids – maintained and accessible throughout the admission

### **Identity, Belonging and Personal Dignity**

The Framework recognises that all Canberrans should be able to participate on equal terms and express their identity fully. For long-stay patients, maintaining a sense of self – through appearance, personal effects, and cultural expression – is directly connected to identity, self-esteem, and social confidence. These are not amenity issues; they are conditions for remaining a person rather than a patient.

- Regular haircutting and grooming services, including culturally appropriate options
- Personal clothing rather than hospital gowns, with laundry support for patients without carers or family to assist
- Routine provision of personal hygiene and self-care items – deodorant, shampoo, razors, moisturiser – for patients who cannot readily access or afford these
- Comfort items including familiar objects, preferred bedding, and sensory supports
- Weighted blankets for neurodivergent patients and others for whom these provide meaningful benefit
- Routine oral health and dental care, not only acute dental treatment

### **Health, Environment and the Body**

The Framework treats physical health and access to the natural environment as distinct but related contributors to wellbeing. Movement, fresh air, and physical engagement with the world are ordinary components of a healthy life – and access to nature and green space carry well-documented benefits for mental health. Both are distinct from clinical rehabilitation goals and should be treated as such.

- Regular supported access to outdoor spaces – gardens, courtyards, or hospital grounds – as a routine feature of care, not contingent on individual staff initiative
- Structured exercise and movement programs suited to functional capacity
- Access to adaptive and recreational sports programs, including through community sporting organisations
- Non-clinical equipment needed to participate in physical activity within the hospital environment

### **Time and Meaningful Occupation**

The Framework identifies time – specifically, having time to do things that benefit wellbeing and a sense of control over how that time is spent – as a distinct domain of quality of life. For long-stay patients, unstructured time is both abundant and potentially harmful if it is empty. How people spend unstructured time matters significantly for mental health and sense of purpose.

- Arts, craft, and creative activity programs, both facilitated and self-directed
- Music programs and access to personal music and media
- Education access for younger patients, and learning opportunities for adults including online courses
- Peer support roles and volunteering opportunities for patients able and willing to contribute
- Weight management and healthy lifestyle support, framed around wellbeing rather than clinical risk

### **Psychological and spiritual wellbeing**

The Framework places mental health alongside physical health as an equally important and explicitly named component of wellbeing. Prolonged hospitalisation involves real losses – of role, independence, relationships, and anticipated futures. Support for psychological wellbeing should be routine rather than crisis-driven, and should address the full range of what it means to live through a lengthy admission.

- Regular psychological support and counselling as a standard feature of long-stay care, not triggered only by acute presentations
- Psychotherapy for patients with identified need
- Structured support for grief, adjustment, and meaning-making across the admission
- Spiritual and chaplaincy care, available across cultural and religious traditions and understood broadly for patients without religious affiliation

### **Health (beyond the admitting condition)**

The Framework recognises that good health requires access to services across all stages of life and all areas of need. Long-stay patients remain people with health needs extending well beyond their admitting diagnosis. The risk of prolonged admission is that the presenting condition crowds out all other healthcare, leaving people worse off across multiple dimensions of health by the time of discharge.

- Ongoing primary care for conditions unrelated to the admitting diagnosis
- Regular dental and oral health review
- Optometry and vision care
- Podiatry, dietetics, and allied health for general wellbeing, not only rehabilitation
- Infection control supports including access to N95 masks for immunocompromised patients and those at elevated risk

### **Home, Autonomy and Living Standards**

Patients should retain meaningful control over their daily lives and immediate environment where clinically safe. The Framework identifies home as a place of safety, constancy, and personal control – and recognises that living standards include not just financial resources but the ability to manage one’s life with dignity. For long-stay patients, the ward becomes their home, and the degree to which it can be shaped to feel like one matters for wellbeing over time.

- Choice over daily routines – when to sleep, eat, bathe, and how to spend unstructured time
- Support to personalise their immediate space with photographs, plants, and personal objects
- Access to food that reflects personal preferences and cultural identity
- Private space for family visits, personal relationships, and confidential conversations

This menu sets a floor – a set of conditions that should be universally available for long-stay patients. Good practice requires ongoing conversation with each patient about what matters most to them: the Framework is explicit that wellbeing looks different for different Canberrans, and that is no less true inside a hospital. Wellbeing assessment should be as routine as clinical assessment, and as responsive to change over time. The question is not whether these conditions are warranted – the ACT’s own framework already answers that – but how the health system will systematically deliver them.