



# Case Studies in Deinstitutionalisation

Implementing Supported Housing  
Programs in Two Australian States

**Meg Carter, Terry Burke & Sue Moore**

SWIN  
BUR  
\* NE \*

INSTITUTE  
FOR SOCIAL  
RESEARCH

# **Case Studies in Deinstitutionalisation**

Implementing Supported Housing Programs in  
Two Australian States

**Meg Carter**

**Terry Burke**

**Sue Moore**

**Institute for Social Research  
Swinburne University of Technology  
PO Box 218, Hawthorn 3122  
[www.sisr.net](http://www.sisr.net)**

August 2008

## **Cover**

*City Houses/Abstract Village*, by Sharon Guy  
Coloured pencil on paper, 2006 (58 x 83 cm)  
Courtesy of the artist and Neami Splash Art Studio

## **Abstract**

This paper is one of a pair examining implementation in two states of programs that provide housing and support to people discharged from psychiatric hospitals. The first paper describes the implementation in Victoria of a program established in 1995 by a non-government agency called Neami (Carter 2008). This second paper takes the Neami Community Housing Program as a point of reference against which to examine the implementation since 2005 in South Australia of a program called Returning Home.

The paper begins by outlining some of the debates that have informed the delivery of mental health services in Australia, and considers ways in which mental health reform objectives articulate with changes in public and private provision of housing. It describes some of the programs developed in Australia to provide housing and support to people with psychiatric disabilities, and identifies similarities and differences in the models adopted in different states. After introducing the current study, the paper outlines findings in relation to two programs implemented in Victoria and South Australia. It concludes with a discussion of critical differences in context, program design and approach to implementation that influence the capacity of these programs to meet their objectives.

Compared with the situation in Victoria a decade previously, planning for redevelopment of mental health services in South Australia has been advanced in an environment that is suspicious of deinstitutionalisation and in which public discussion of mental health policy has been politically sensitive in the extreme. In addition, attempts to find housing for people with high and complex needs were hampered by problems with supply of housing that had not existed when the National Mental Health Strategy was established.

Gerrand (2005a, 2005b) argues that the lessons to be learned from service redevelopment in Victoria in the 1990s are, firstly, that in order to generate sufficient savings in the mental health budget to adequately fund a community-based system of care it is necessary to close all psychiatric institutions; and secondly, that additional funding must be provided to enable replacement services to be established and operating *before* the institutions are closed. Findings from the present study would

add a further point: in an environment in which the cost of housing is high and increasing, and supply available through public programs has substantially decreased, dedicated funding is needed to provide housing as well.

Findings from this study suggest a direction for further research. Existing studies indicate the extent to which programs have succeeded in delivering the services they are funded to provide, but they are unable to say what happens to people who leave services and lose contact with their support agency. To find out if support and housing provided as part of a deinstitutionalised service system is effective, research would need to follow individuals as they use, and exit from, and move between a variety of services. It is possible to do this. A project that accessed quantitative data held by health services, housing providers, homelessness services and possibly Centrelink, and supplemented this with qualitative material collected through a longitudinal panel study supported by incentives to minimise sample attrition, would be a good place to start.

## Contents

1	Introduction	5
2	Asylum and community care: historical debates	6
3	Deinstitutionalisation in Australia	9
4	Mental illness and treatment: contemporary debates	11
5	Disability support and psychosocial rehabilitation	14
6	Mental health and housing	16
7	Programs providing supported housing	20
8	‘Out of the Institution’: the study	23
9	Victoria: the context	26
10	Neami Community Housing Program	30
11	South Australia: the context	33
12	Returning Home Program	38
12.1	Inception	38
12.2	Program design	40
12.3	Perspectives on implementation	41
12.4	Difficulties and how they were overcome	46
12.5	Outcomes for clients	51
12.6	Reflecting on process	59
13	Critical differences between Returning Home and the Neami CHP	61
14	Conclusion	64
	References	65
	Appendix 1: Summary of supported housing programs in three states	74
	Appendix 2: Findings from survey of Glenside staff	76

## List of tables

Table 1:	Returning Home clients at interview and follow-up: living situation	57
Table 2:	Returning Home clients at interview and follow-up: LSP scores	58

## **1 Introduction**

This paper is one of a pair examining implementation in two states of programs that provide housing and support to people discharged from psychiatric hospitals. The first paper describes the implementation in Victoria of a program established in 1995 by a non-government agency called Neami. The present paper takes the Neami Community Housing Program as a point of reference against which to examine the implementation since 2005 in South Australia of a program called Returning Home.

Expertise in providing housing and support in non-institutional settings for people with psychiatric disabilities has developed over some time in Australia. A wealth of practice knowledge exists among people who work in agencies that deliver those services, and among the clients who receive support from them. Lessons learned through this work have been communicated among specialist audiences of clinical, disability support or housing practitioners, which in turn link through largely discrete avenues into policy development and program design (Smith 2007). Specialist audiences have particular perspectives on the issues they address and may use language that is not easily accessible to outsiders. One aim of this paper is to draw on perspectives articulated in diverse disciplinary contexts and present these in a manner accessible to a non-specialist policy audience.

In Australia, broad directions in mental health policy are agreed at national level, and design and delivery of services are managed by the states. Plans endorsed under the National Mental Health Strategy have required that treatment for people with mental illness should be provided in the least restrictive possible settings, with clients residing wherever possible ‘in the community’ rather than in psychiatric institutions (Meadows et al. 2007: 70). People living in the community need housing and, as the cost of housing increases, accommodation that is secure and well located may be beyond the means of someone living on a Disability Support Pension. In addition, many people who experience disability associated with mental illness need ongoing support in order to sustain tenancies (Bleasdale 2007).

Various programs have been established in Australia to facilitate access to housing linked with support for people who experience disability associated with mental illness, and some of these have been the subject of substantial longitudinal

evaluations (Muir et al. 2007; Meehan et al. 2007). Studies to date have not examined differences between models of supported housing delivered in different states, or the extent to which their implementation has been affected by context. The present paper aims to do this.

The paper begins by outlining some of the debates that have informed the delivery of mental health services in Australia, and considers ways in which mental health reform objectives articulate with changes in public and private provision of housing. It describes some of the programs developed in Australia to provide housing and support to people with psychiatric disabilities, and identifies similarities and differences in the models adopted in different states. After introducing the current study, the paper outlines findings in relation to two programs implemented in Victoria and South Australia. It concludes with a discussion of critical differences in context, program design and approach to implementation that influence the capacity of these programs to meet their objectives.

## **2 Asylum and community care: historical debates**

Debate around whether care for people with mental illness is best provided in settings that offer ‘asylum’ or ‘in the community’ has been happening in Australia since the 1800s. The first lunatic asylum in this country was established in 1811; the first enquiry into conditions in an asylum reported in 1846. Since this time, debate has encompassed advocacy of asylum as place of sanctuary for those unable to cope in society, alongside a view that care is more effectively provided in less restrictive settings (Singh et al. 2007; Singh 2007: 65-6). In the 1950s and 1960s, care ‘in the community’ was understood to consist of programs provided in settings such as day hospitals and sheltered workshops (Dax 1961 cited in Chesters 2004). The name ‘community care’ is currently used to describe a wide variety of activities, including clinical services provided in any setting other than a psychiatric hospital, and clinical and non-clinical support provided by outreach in service users’ homes.

A variety of treatments have been prescribed for patients inside, and out of, institutional settings. In the early twentieth century, barbiturates were widely used for their hypnotic and sedative effect upon people suffering from psychosis and mania. By the mid-1940s, the ideal of suppressing symptoms to an extent that would

enable psychotic patients to regain 'normal' levels of functioning was pursued through the use of physical methods such as electro-convulsive therapy (ECT) and, less commonly in Australia, through the practice of surgical lobotomy (Appignanesi 2008; El-Hai 2005; Lewis 1988). From the 1950s, new and more effective anti-psychotic drugs such as chlorpromazine and lithium offered the possibility of suppressing psychotic symptoms to an extent that many patients could self-manage their illness outside an institutional setting with support from clinicians and carers.<sup>1</sup>

In the 1960s and 1970s, an 'anti-psychiatry' critique of mental illness services came to prominence, finding expression in the view that mental illness did not exist or was exacerbated by institutionalisation (see for example Laing 1960, 1967; Szasz 1974; Rosenhan 1973; Goffman 1963). Some critics held that psychiatric treatments were instruments of social control, with people who dissented from social norms being confined in institutions without good reason. The anti-psychiatry critique represented madness as shaped and defined by context. It argued that asylums did not live up to their protective name, in part because of the way in which role-driven behaviours overwhelm the 'moral values' of people engaged in delivering care in institutional settings. The influence of this critique was promoted by popular representations in movies such as *The Snake Pit* (1948) and the adaptation of Ken Kesey's novel *One Flew Over the Cuckoo's Nest* (1975) that depicted depersonalisation of patients and the normalisation of cruelty to patients in institutional settings.

The relative importance of drug therapies and the anti-psychiatry critique in promoting acceptance of deinstitutionalisation as an ideal has been disputed (Gerrand 2005a). A number of psychiatrists in charge of institutions in the UK and other northern European countries had initiated significant reforms in the 1950s, prior to the availability of the new anti-psychotic medications. The reforms included the unlocking of institutions, the introduction of 'therapeutic communities' with the aim of re-socialising institutionalised patients, and the establishment of supervised

---

<sup>1</sup> Lobotomy was thought to act by preventing emotions and impressions from being experienced so acutely, so that while obsessive and hallucinatory thoughts might continue, the afflicted person would take less notice of them. Its practice was claimed to be effective in enabling patients to live 'useful' lives, defined as 'engaged in work or helping around the house', although success came at the cost of reducing or removing motivation or initiative. When chlorpromazine and lithium were developed in the early 1950s, the new drugs were marketed as delivering 'chemical lobotomy'. El-Hai (2008) has argued that, in the US, it was the new drugs' comparable rates of effectiveness to surgical intervention and relative ease of administration that rendered surgical lobotomies obsolete. Although its use is now extremely rare, psychosurgery has not disappeared from mental health practice in Australia (Victorian Department of Human Services 2007).



hostels and day hospitals to support patients after discharge. The reforms introduced in the 1950s by activists such as R. D. Laing in the UK had no counterpart in the US, so that the availability of new anti-psychotic drugs 'had a more revolutionary impact in the United States, where there were more backward asylums in 1955, than in those parts of northern Europe where social therapy prevailed' (Warner 1987: 87).

In Australia as elsewhere, the advent of effective drug treatments helped make it possible to advocate for widespread delivery of mental health treatment outside of institutional settings. Without the availability of drugs that enabled the symptoms of psychosis to be suppressed, policies promoting deinstitutionalisation would not have been acceptable politically or to the voting public, as while the ideal of 'asylum' was represented as providing safety for inmates, it had the additional effect of being seen to provide protection to the public from concerns about the supposed unpredictable behaviour of people who were floridly insane. In Australia, the increasing prescription of anti-psychotic drugs along with the development of community-based services made possible a dramatic reduction in the number of beds in psychiatric hospitals, so that of the 30,000 beds operating in the mid-1960s, 22,000 had closed by 1992 (Australian Government Department of Health and Ageing 2003a).

Concurrent with these developments was the increasing recognition in policy discussion of a distinction between illness and disability. Where the term 'mental illness' defines a service user in terms of 'patienthood', the idea of psychiatric disability invites a focus on social context. In practice, disability has been understood in various ways. A medical view of disability places an emphasis on functional deficits, constructing rehabilitation as treatment designed to redress functional limitation. This view has been most influential in services relating to physical and intellectual disabilities. In Australia, many services providing disability support to people diagnosed with mental illness have framed their work within a social model of disability, understanding rehabilitation as grounded in a focus on strength, hope and recovery (Fossey 2007; Gray 2007; Papakotsias 2007; see also Jacobson 2004).

The critique of institutional service delivery that developed in the 1970s and 1980s became increasingly influential in social policy in Australia in the 1990s.

Governments already influenced by an anti-psychiatry critique adopted neo-liberal agendas concerned with reducing the scope and cost of services provided by

government and promoting individualised, medicalised forms of care. The two agendas found common ground in a shared view that the long-established institutional complexes should be closed, with services being delivered by public hospitals and in the community (Chesters 2005).

### **3 Deinstitutionalisation in Australia**

Under the umbrella of the National Mental Health Strategy, to which all states signed up in 1992, successive National Mental Health Plans set out a series of strategies for a redevelopment of mental health services based on the view that care should be provided wherever possible outside of institutional settings. The strategy did not envisage the closure of all institutional facilities. The National Mental Health Policy stated:

Although ... in general, prolonged psychiatric hospitalisation is undesirable, there is a small number of people who require such care. [Service redevelopment] may involve the development of new facilities, or the upgrading of existing facilities, to accommodate these people (Australian Health Ministers 1992).

The first National Mental Health Plan (1993-98) supported 'mainstreaming', defined as moving psychiatric services from specialist to mainstream hospitals, and 'integration', which referred to coordination of clinical services delivered through hospital-based and community-based settings. The second (1998-2003) required that planning and delivery of these devolved services should be enacted by 'partnerships' that included consumers and carers, disability support agencies, and other government services. Both plans established targets to achieve in these and other specified areas, and funding was provided by the Commonwealth government to support states in meeting those targets. Where the first National Mental Health Plan had a clear focus on services for people who experienced disabling psychotic illnesses such as schizophrenia, the second extended its scope to include the more common 'high prevalence' disorders such as depression. The third National Mental Health Plan (2003-08) focused on broad public health objectives. This plan was not specific about targets and timelines, and had no new funds attached to it (Meadows et al. 2007).

The National Action Plan for Mental Health 2006-2011 (Council of Australian Governments 2006) maintains the focus on prevention and early intervention that was articulated in the 2003 National Mental Health plan. The plan extends its focus to identifying young people at risk of developing psychotic disorders, as well providing services for people suffering from high prevalence disorders. Significantly, it recognises a need to extend provision of home-based outreach support and day programs for people with high levels of psychiatric disability, and to improve access for this group to secure, affordable housing linked with support. Under this plan, all the states and the Commonwealth committed funds to expand the supply of support services, but only New South Wales, Queensland, Tasmania and Western Australia committed additional funds for housing.

As a result of service redevelopments undertaken by state governments since 1993, the overall number of acute psychiatric beds has remained unchanged, but the number of beds in stand-alone psychiatric hospitals decreased by 60 per cent between 1993 and 2002. The percentage of mental health funding spent on non-hospital-based services increased from 29 to 51 per cent, and funding to non-government organisations increased from 2 to 5.5 per cent of total government spending on mental health (Australian Government Department of Health and Ageing 2003b). Across the states, establishment of non-institutionally-based services has been uneven. Current service models have not been systematically evaluated. Such evaluations as have occurred have focused on the effectiveness of specific programs in meeting their particular objectives, rather than on the effectiveness of the service system as a whole. On existing evidence, it is not possible to make an assessment of the extent to which reforms have been successful (Richmond and Savy 2005).

With policy formulated through a national strategy and implementation managed by the states, reform of mental health services in Australia has been described as ‘a natural experiment’ (Rosen 2006). Implementation of reforms agreed under successive National Mental Health Plans has happened differently in different states. The greatest contrast is between the two that are the focus of the present study.

#### **4 Mental illness and treatment: contemporary debates**

Over the past 20 years, the ideals of deinstitutionalisation and community-based care have formed the 'dominant narrative' in mental health policy in Australia. However, ideas about what is and should be happening in mental health services continue to be contested. In the 'asylum' versus 'community' debate, each approach has at different times been advocated as better than the other. Each generation has reinvented the movement towards community care, overlooking its earlier expressions to represent the current form as novel and progressive (Barrett and Parker 2006; Chesters 2004). Because service reviews have occurred at times when the supply of existing services has been inadequate to meet demand, policy makers have found it difficult to distinguish problems intrinsic to the model they are examining from those associated with inadequate resourcing (Singh 2007; Gerrand 2005a)

Barrett and Parker (2006) argued that, in the narrative of deinstitutionalisation, the concept of community is defined in opposition to the hospital, acting as a 'summarising symbol' encompassing the ideals of freedom, responsibility, autonomy and belonging, all of which are seen to be the antithesis of a patient's experience in hospital. Alongside this there exists a 'counter-narrative' promoting the virtues of institutionally-based care that offers 'asylum'. This view appropriates the virtues that in the official view adhere to community – belonging, acceptance, sanctuary – and attributes them to an older and now endangered model of institutional care.

In their ethnographic study of a community-based clinical team, Barrett and Parker identified this counter-narrative expressed in 'back-stage' conversations by clinical staff. The counter-narrative maintains that for some people the ideal of independent living, even with support, is unrealistic, and that services providing care and supervision in congregate residential environments should be revived and expanded. It has been articulated by families and carers in public forums, and is becoming increasingly visible in policy debates (Victorian Auditor General's Office 2002; Mental Health Council of Australia 2005; Meadows et al. 2007; Duff 2008). Contemporary critiques of deinstitutionalisation argue that people who would formerly have been accommodated in institutions have been effectively abandoned without sufficient support to enable them to live in the community.

The decade and a half since the inception of the National Mental Health Strategy has seen an increase in the numbers of people experiencing homelessness, accompanied by a steadily increasing demand for 'safety net' services provided through government-funded and charitable organisations. Many factors, including changes to housing markets and labour markets, and changes in arrangements for delivery of pensions and benefits, have contributed to the increased demand experienced by crisis services. At the same time, policy responses have increasingly construed social problems and their proposed solutions as relating to individuals and their personal deficiencies, rather than to structural factors (Jamrozic 2001). Of all the factors that have contributed to the increase in the number of people who are homeless in Australia, shortcomings in the delivery of services to people with mental illness are among the most visible in the current policy environment. The proportion of homeless people who also experience serious mental illness has remained relatively constant over this period at around 30 per cent (Chamberlain et al. 2007).

A change in the location of treatment from hospital to community entails greater consideration of the context in which clients live and the circumstances of their lives. In a community-based model of service delivery, the disciplines of mental health nursing, psychology and social work have more authority and prominence than in hospital settings. The move to community-based care represents a further challenge to the authority of psychiatrists, whose entitlement to define the nature of a patient's problem and set parameters for its treatment had been contested, but not usurped, in hospital practice by these clinical disciplines since the 1980s (as demonstrated most elegantly by Rob Barrett in his 1996 book *The Psychiatric Team and the Social Definition of Schizophrenia*). Although a diverse range of views is represented in contemporary debates about best practice in treatment and support, the central role of drug therapies in clinical treatment provided in community settings reflects the continued dominance of a bio-medical model for understanding mental illness (Richmond and Savy 2005; Richmond 2006).

One challenge to this bio-medical view of comes from the consumer/survivor movement that gained momentum in the US in the 1980s (Deegan 1996a, 1996b, 2005; Fisher 2007). This movement has been influential in mental health policy and practice in New Zealand (New Zealand Mental Health Commission 1998; O'Hagan 2004) and to a lesser extent in Australia (Australian Government Department of

Health and Ageing 2003a; Scotman 2004; Mind Australia 2008). In contrast to a bio-medical view that sees schizophrenia as an organic disorder requiring in most cases lifelong treatment with drugs, this view holds that ‘madness is a legitimate human experience’ (O’Hagan 2007) from which useful lessons can be learned and from which people can effectively recover.

In this context, recovery has been defined most succinctly as ‘living well in the presence or absence of my madness’ (O’Hagan 2007). Proponents argue that for some people diagnosis and treatment can act as an obstacle to recovery, as being ‘under the doctor’ involves accepting your psychiatrist’s view of your situation as more legitimate than your own. In the process of treatment, attaining what clinicians describe as ‘insight’ into your condition – which means coming to accept the view of your treating professionals – can be inimical to recovery.

There is an extensive literature of accounts from users/survivors of mental health services, within which diverse views about what recovery consists of and how it is best achieved are advanced and contested (for diverse examples, see Lapsley et al. 2002; Saks 2007; Fisher 2007). The US literature is individualistic in its focus, giving little attention to the influence of material circumstances and cultural differences in individuals’ experience of mental illness, and in some cases (for example, Saks 2007) advancing no critique of a bio-medical model of mental illness (Scotman 2004; O’Hagan 2004). Interpretations of a recovery approach adopted by services in New Zealand and Australia give more consideration to contextual factors, and are more critical of a bio-medical understanding of mental illness (O’Hagan 2004).

The ideal of recovery has been adopted as part of mental health policy in Australia since 2003 when, defined as ‘a way of living a satisfying, hopeful and contributing life ... beyond the effects of psychiatric disability’, it was identified as a goal of service delivery in the National Mental Health Plan 2003-2008 (Australian Government Department of Health and Ageing 2003b). Although views arising from the consumer/survivor movement, and the ideal of recovery as a framework for service delivery, are given a respectful hearing in mental health forums in Australia (for example, at the TheMHS conference in 2007 and VICSERV’s conferences in 2006 and 2008), their tenets pose a fundamental challenge to existing models of clinical practice.

The challenge advanced by the consumer/survivor movement is supported by a growing body of literature that has critically examined the evidence basis for the effectiveness of drug therapies as a primary mode of treatment for mental illness, and concluded that evidence in support of their effectiveness has been substantially overstated and the extent and severity of withdrawal effects overlooked (Breggin 1994; Rowe 2002; Gosden 2001; Rose et al. 2003; McLaren 2004; Richmond 2006; Henderson 2006; Wykes 2007). Information produced for service users and carers by government agencies and funded agencies in Australia does not reference this literature, continuing to recommend drug therapies as a first recourse for treatment (for example, see SANE Australia 2007a, 2007b).

Ideas contested in the debate around a recovery framework versus a bio-medical understanding of mental illness appear repeatedly as areas of dispute in relation to delivery of supported housing. Supported housing programs are built on cooperation between staff working with mental health services, non-government agencies and housing providers. People employed in these service sectors may have training and qualifications obtained through a variety of clinical and non-clinical disciplines that each proceed from their own understanding of what mental illness is and how it should be treated.

## **5 Disability support and psychosocial rehabilitation**

A variety of non-government agencies have been engaged in providing support to people with mental illness since the early years of the last century. The profile of support provided through this sector was raised in the 1970s as some agencies succeeded in obtaining funding to expand their services, and the sector continued to take shape in the 1980s as funding arrangements were formalised through the Commonwealth Disabilities Services Act (Gray 2007).

Provision of disability support developed in different ways in different states. In Victoria in the 1980s, non-government agencies were funded to provide assistance to people living in public housing or properties provided through clinical services, to enable them to sustain their tenancies. Similar programs developed in other states, most significantly in the 1990s as successive National Mental Health Plans identified

the role of support provided by non-government agencies in complementing delivery of clinical services in community-based settings.

In the early 1990s, the psychiatric disability support sector in Victoria adopted the principles of psychosocial rehabilitation as the foundation for its practice. Since 2002, funded agencies have been known as psychiatric disability and rehabilitation support (PDRS) services (Clanchy and Clarke 2002; Clarke 2003; Victorian Department of Human Services 2003; Bleasdale 2007). PDRS services provide support that is grounded in a social rather than a medical model of care, with an emphasis on clients' strengths rather than their illness and a focus on challenges faced in the present, rather than on events of the past. Their service is 'client directed', acknowledging clients' right and responsibility for self-determination, and the aim of support is to equip them with skills and promote independence. Funding guidelines provide that services should be delivered in as normalised an environment as possible (Victorian Department of Human Services 2003). The peak body VICSERV provides training and advocacy for the PDRS sector in Victoria (see for example Pepper 2002; Brooks 2002; Wissman 2003; VICSERV 2006). The identity and staffing profile of the sector has become increasingly professionalised over the past decade, drawing its membership from a variety of disciplinary backgrounds (Wissman 2003; Clear 2007; Papakotsias 2007).

An approach to service delivery informed by the principles of psychosocial rehabilitation is consistent, although not identical, with a recovery framework for service delivery. Both approaches hold that support should be client-directed. Both have been influential in the non-clinical service sector in New South Wales, South Australia and Victoria. In terms of everyday practice, these approaches have potential to bring PDRS and equivalent services into conflict with clinicians, whose practice may be informed by conflicting views about what mental illness is and how it should be treated. In some service settings, the work of rehabilitation is seen to be rightly the domain of the clinical sector. PDRS agencies have reported that, in some locations, the legitimacy of their role in providing psychosocial rehabilitation rather than purely disability support has not been recognised by the clinical staff the agencies seek to work with (Papakotsias 2007).



## 6 Mental health and housing

Mental health services delivered in community settings founder when the people receiving them are not able to secure or maintain adequate and affordable housing (O'Brien et al. 2002; Bleasdale 2007). Housing is not seen as part of a mental health service system in most discussions of clinical services (Newman 2001). In Australian mental health policy, it is identified as an essential component of a community-based service system, but mechanisms to ensure adequate supply of appropriate and affordable housing for users of mental health services are rarely addressed.

Over the past two decades, housing markets in Australia have been characterised by increasing costs of home ownership relative to average incomes, increasing demand for and cost of private rental, and decreasing supply and increased targeting of public housing. For many users of mental health services, low income is a barrier to securing secure and well-located housing. People identified as 'mad' face additional barriers associated with stigma (O'Brien et al. 2002). In planning for mental health services, it cannot be assumed that access to clinical services supplemented by provision of PDRS or disability support will be enough to enable access to housing.

Since the inception of the National Mental Health Strategy, it is as if the housing system has conspired to undermine deinstitutionalisation. In 1992 social housing,<sup>2</sup> particularly public housing, was funded more generously than it is now, and the supply of properties was increasing annually. Home purchase was affordable, supporting a pattern in which private rental was for most people a transitional tenure: people would rent for a while, then move on to buy their own home. Compared to the present time there was a relative abundance of affordable rental housing, although even then it was not sufficient to meet demand.

Since the mid-1990s, the capacity of Australia's housing system to provide for people in lower income households has declined dramatically. Successive iterations of the Commonwealth-State Housing Agreement (CSHA), through which funds are provided for social housing, sharply cut funding to the degree that there was a nett reduction in public housing stock between 1995 and 2006 (Productivity Commission

---

<sup>2</sup> The term 'social housing' is used to refer to housing provided through public sector agencies and other agencies funded under the CSHA. It encompasses a number of service streams including public housing, community housing, and transitional and crisis housing.

2008). This new funding environment was experienced differently in different states. With an unexpected decline in funding there was less available to spend on maintenance of existing public housing stock. Community expectations about the capacity of state governments to provide affordable housing to particular communities were unable to be met. A reduction in funding was felt more acutely in states such as South Australia that had a relatively large public housing sector, than in Victoria where supply of public housing had been historically much smaller (Hall and Berry 2006).

Increasing difficulties experienced in the public sector were matched by those in the private market, as the supply of low-cost rental properties contracted sharply (Yates et al. 2004). By 2008, vacancy rates in all capital cities had fallen to historic low levels. Rents were increasing rapidly, particularly in areas close to central business districts, where many key support services are located (Real Estate Institute of Australia 2008).

By the mid-1990s, fewer people were exiting from public housing, as they had nowhere to go. No alternatives were available that could be afforded by low income households. Combined with a nett decrease in the number of public housing properties, this meant that new applicants who would normally have been provided for through those systems were unable to be accommodated. This persisted through the 1990s and into the present decade. As we have noted above, one effect of these changes is increased homelessness (Chamberlain and MacKenzie 2003). These changes in the supply and cost of housing, through private markets and the public sector, have made deinstitutionalisation more difficult to achieve today than in the early 1990s.

State jurisdictions made a number of changes to their public housing systems in response to the constricted funding environment. One practice adopted in several states is the targeting of social housing to those identified as being in greatest need. Ways of doing this have varied, but most employ a priority-based allocations system that gives priority to people designated, for example, as homeless (Burke and Hulse 2004; Hulse et al. 2007). Victoria and South Australia were the first states to implement such systems.

While they are effective in giving access to long-term housing to people who would otherwise be unable to obtain it, priority allocations systems create problems of their own. Estates may become areas of concentrated disadvantage, witnessing an increase in anti-social behaviour that may create and amplify stigma associated with public housing (Jacobs and Arthurson 2003). Increased targeting was accompanied in some states by the establishment of programs (such as HASP, which is discussed below) intended to provide support to tenants whose complex needs may make it difficult for them to sustain a tenancy. Housing providers have consistently reported that the scope and capacity of such programs has not been sufficient to meet demand for support (Bleasdale 2007).

The public housing sector has also been subject to substantial organisational change during the period under discussion. One such change has been the relocation of what had been stand-alone Housing Departments into larger Human Services Departments. Such changes took place in South Australia, Tasmania and Victoria. Governments assumed that co-location of administrative function would encourage better communication and program linkages between social housing and areas such as disability services, mental health and aged care. The extent to which this actually occurs is unclear. Experience in these three states has shown that communication and effective partnership between program areas remains difficult, even within the human services model. Program areas work with different professional subcultures, employ different management information systems, operate within discrete funding streams and may report to different ministers. Communication between housing and health and human services programs is further constrained by legislated requirements to protect the privacy of service users.

This relocation of Housing Departments in the 1990s was not the only organisational response to problems in administration of social housing. There have been a multitude of internal restructures, generating in some cases a degree of 'reform fatigue' and diverting the energy and time of staff from their agencies' core functions. These restructures have not masked the reality that state housing authorities are being required to expand their roles (for example, to provide affordable housing as well as housing support, programs for estate or community renewal, and the pursuit of non-shelter outcomes), while being provided with fewer resources than when their role was a simple one of providing shelter for low income households. One result has

been that when an initiative which has implications for housing is proposed by a program area such as disability or mental health, the state housing authority may not be ready to respond. In a tightly constrained funding environment they may not have the housing stock, or the finances, to enable them to deliver the services requested. An organisation managing the legacy of reform fatigue and an associated loss of corporate knowledge may lack the capacity, or the interest, to respond to the opportunities a new initiative presents.

Another major change in housing in the 1990s was the establishment of 'community housing' as a funding stream in the CHSA. This was intended to provide 'an alternative to public rental housing [with] the ability to integrate a range of community services to meet tenant needs' (Australian Institute of Health and Welfare 2008). The states welcomed the opportunity to establish community housing as a sector, although on a smaller scale than they may have wished. Many practitioners in public housing were unenthusiastic about the new sector, as they saw it (with some justification) as taking funds that could otherwise have been used to maintain or expand public housing stock. The advent of community housing as a program in this very tight funding environment may have encouraged the development of an adversarial 'we and them' culture in the housing sector that did not support a close and cooperative working arrangement between agencies. This may have weakened the ability of the community sector to obtain housing stock that could be used for specialist client groups, including people who were being released from psychiatric institutions.

As state governments proceeded with the downsizing and closure of psychiatric and other institutions, housing providers have been concerned with the form housing should take when provided for a client group with high needs, and how it should be linked with support. Two models have been used most commonly in Australia.

One model involves an independent dwelling (which may be a unit or a detached dwelling) formally linked to off-site support services by appropriate agreements and protocols, involving support packages and/or case management. Such dwellings could be dispersed through the community, or close together to facilitate social interaction as part of the support process. An alternative model employs specially designed or purchased dwellings of a form which enables an on-site support

presence. These may include small unit complexes with a live-in housekeeper/carer and 24 hour on-call assistance, or rooming house-type accommodation with a live-in or day manager providing a limited form of support. While accommodation that has on-site or live-in staff may be seen as quasi-institutional, it is argued to be appropriate for some client groups, especially those who encounter stigma or extreme difficulty in living in the community (O'Brien et al. 2002). For social housing agencies it is usually cheaper, and certainly quicker, to provide funding for a few detached dwelling units than to fund the design and construct of a purpose-built complex. Time involved in design and planning for staffed facilities can mean that establishment of such projects may take years. When institutions are closing, such lead-time may not be available.

## **7 Programs providing supported housing**

Models of housing and support can be seen as located on a continuum between 'custodial housing', in which clients live in quasi-institutional settings with high levels of control by staff, and 'supported housing', in which clients live alone or with others of their choosing, support varies as their needs change, and clients' entitlement to tenure continues in the long term, irrespective of their support needs. A service type known as 'supportive housing' sits between these two models, providing self-contained accommodation in high-density settings with 24 hour on-site staffing (Gordon 2008). The programs considered in this paper operate according to a supported housing model, providing client-directed support to individuals living in their own homes.

It is difficult to make a comparative reading of research examining the efficacy of different models of accommodation and support for people with psychiatric disabilities. Studies have examined programs that work with different client groups, offer different arrangements for housing, and provide differing types and levels of clinical and non-clinical support. In research reports, the models considered may not be named consistently or described clearly enough to enable comparison (Meehan et al. 2007). While being unclear about details, studies have shown that programs providing stable, affordable and long-term housing, relevant supports and risk management strategies, together with some choice about where and with whom residents can live, have been successful in enabling people with psychiatric

disabilities to live in the community (Arthurson and Worland 2007). Researchers in Australia and the US have concluded that more problems arise from inadequate supply of affordable housing associated with support for people with psychiatric disabilities, than from shortcomings of any of the models examined (Newman 2001; Arthurson and Worland 2007; Meehan et al. 2007).

In Australia, programs using a supported housing model include the Victorian Housing and Support Program (HASP) established in 1992, Project 300 established in Queensland in 1995, the New South Wales Housing and Support Initiative (HASI) established in 2002, and the Independent Living Program in Western Australia. Longitudinal evaluations of Project 300 and HASI have shown them to have been effective in enabling clients to remain living in their own homes, over periods of seven years and three years, respectively. Clients reported an increase in independence, and the amount of non-clinical support required declined over time. Measures of clinical functioning showed little change (Meehan et al. 2007; Muir et al. 2007).<sup>3</sup>

Supported housing programs implemented in different states have differed from each other in some respects. Project 300 was designed to support clients discharged after long stays in psychiatric hospitals, while HASP and HASI were intended to support people with psychiatric disabilities who may not have had extended periods of institutional care. In each program, clients' most common diagnosis is schizophrenia. Under Project 300, funding was provided to establish dedicated positions in community-based clinical services to support these clients, while in HASP and HASI clients received support from existing clinical services.

Services provided by non-government agencies are described differently in different programs. Non-clinical support provided through HASP and HASI is characterised as psychosocial rehabilitation. Providers are known as PDRS services in Victoria, and Accommodation Support Providers (ASPs) in New South Wales. Non-clinical support provided under Project 300 is aligned more closely with a disability services model than with psychosocial rehabilitation. The Queensland Department of Disabilities

---

<sup>3</sup> A study examining outcomes for clients in Victoria who were discharged to Continuing Care Units (which deliver a model of custodial housing that closely resembles a hospital environment) reported outcomes similar to those seen in evaluations of supported housing. Clients remained housed in the units, but clinical measures indicated their experience of symptoms and associated disability was unchanged (Trauer et al. 2001).

funds 'host agencies', most of which worked previously providing services to clients with intellectual disabilities. Host agencies subcontract workers to provide 'lifestyle support' to clients funded under Project 300. Support is described as 'similar to that provided by families', and workers as 'like paid friends'. In contrast, PDRS support in Victoria and Accommodation Support in New South Wales is represented as a service provided by workers who are professionals in their field.

The programs differ in their arrangements for housing. Evaluation reports indicate that HASP and HASI included funding for purchase or construction of new properties to be managed through the state housing authority or a community housing provider, while clients supported under Project 300 had priority access to existing public housing. Each program included funds for purchase of furniture for each client. Under HASP and HASI, the agency that provides support should not act as landlord, although there were some exceptions to this where clients were housed in properties headleased by support providers. In HASI and HASP, clients' tenure is ongoing, subject to standard leasing arrangements, so that clients do not need to move if they no longer require or wish to receive support. In these programs, most properties are in dispersed locations, with a small number co-located as 'clusters'. In HASP, clients lived alone or shared with one other: there were many problems associated with sharing, and clients who lived alone were more satisfied with their accommodation than those who shared. In HASI, clients lived alone, with some informal arrangements for sharing. The evaluation of Project 300 provides little information about housing management.

Each program reported that, over the term of the evaluation, most clients retained their tenancies, and while instruments designed to measure clinical functioning showed no improvement, use of clinical services declined over time as clients became better able to recognise and manage their symptoms. In each program, developing good working arrangements between clinical staff and support workers was difficult, and took time. In Queensland, support workers reported wanting more training to enable them to deal more effectively with clients. In Victoria and New South Wales, support workers identified a tension between their desire to maintain a focus on rehabilitation when it was simpler, and took less time, to do things *for* clients instead. A clear theme in the three evaluations is the extent to which clients valued relationships with their support workers, describing them as companions and friends

(Robson 1995; Muir et al. 2007; Meehan et al. 2007). Appendix 1 presents a summary of findings from the evaluations of HASP, Project 300 and HASI.

Programs implemented in different states differ also in the context in which they are delivered. Research to date has not shown how differences in context, in program design, or in approach to implementation are associated with outcomes for clients. The present study, which examines implementation of supported housing programs in contrasting environments in two states, aims to do this.

## **8 ‘Out of the Institution’: the study**

‘Out of the Institution’ is an Australian Research Council Linkage Project conducted by the Institute for Social Research at Swinburne University of Technology.<sup>4</sup> The study begins by documenting the development and implementation of the Neami Community Housing Program. It then asks: Has the program been effective in enabling clients to sustain tenancies and live in the community? and, Is the model it employed transferable to other settings? To examine transferability of the Neami model, the project takes as a case study implementation of the Returning Home Program in South Australia.

To examine the processes of implementation, the study draws on documents produced by the agencies involved and on interviews with individuals involved in the development and implementation of the programs, including managers and staff working in service delivery roles in non-government agencies, clinical services and housing agencies. It also draws on data collected through a survey of clinical and allied health staff working in extended-care wards at Glenside hospital.

To examine outcomes for clients, the study uses qualitative methods that collate data from multiple perspectives to create an account of each client’s situation. All clients living in their own homes with support, through either the Neami Community Housing Program in Victoria or Returning Home in South Australia, were invited to participate in the research. In order to access a larger number of clients in South

---

<sup>4</sup> Chief investigators are Professor Terry Burke and Professor Sue Moore. Industry partners for the project are Neami and Supported Housing Limited. The South Australian Department of Health provided additional funding to extend the scope of the study in South Australia. The study received ethics approval from the Swinburne Human Research Ethics Committee, Austin Health Human Research Ethics Committee and Melbourne Health Research and Ethics Committee.



Australia, those who were ‘in transition’ towards discharge from Glenside with support under Returning Home were also invited to participate. Eleven clients took part in the research in Victoria, and 25 in South Australia.

The first author of this report conducted individual semi-structured interviews with each client and with their support worker<sup>5</sup> and, where the client gave permission, sought information through open-ended surveys from their clinical workers and from a nominated family member. Face-to-face interviews were conducted with some clinical workers and family members. Most client interviews took place in their homes, and other interviews were conducted in the offices of support agencies. Interviews took place in South Australia between January and March 2007, and in Victoria in April 2007. In December 2007, supplementary information was sought, with clients’ consent, from support workers in relation to clients interviewed in South Australia, to obtain an update on their situation.

Interviews were audio-recorded (with the exception of those with four clients who did not wish this to happen) and transcribed verbatim. Transcripts and survey responses, along with ethnographic notes made directly after interviews, were coded according to themes and collated as case studies, providing a variety of perspectives on each client’s experience.

Sociologists have used methods that engage multiple perspectives to look at a particular situation, in studies examining interactions in families. These methods are useful for eliciting and understanding accounts from family members whose voices are likely to be overlooked in research that collects only a singular account of the family (Ribbens McCarthy et al. 2003; Carter 2004, 2006). They are particularly relevant to the present study which is interested in the experience of people who, because of their diagnosis and situation, are more vulnerable than most to having their perspectives overlooked. Methods that use data from multiple perspectives provide an opportunity to place clients’ views at the centre of concern, and take the views of workers and family members as an aid to interpretation of accounts created by clients.

---

<sup>5</sup> These workers are known in Victoria as PDRS workers or keyworkers. In South Australia the name ‘keyworker’ refers to a client’s case manager in a clinical service; support workers employed by non-government agencies are referred to as ‘NGO workers’. In this section we refer to workers employed by non-government agencies as support workers.

In this study, client interviews were constructed as conversations, using open-ended questions without administration of clinical instruments or quantitative measures. Interviews with workers and family members also used open-ended questions, designed to elicit accounts from respondents' perspectives of the client's experience of housing and support and the respondent's experience of providing support to that client. In the cluster of stories around each client, we can see where the various accounts of their experience are consistent and where they differ.

Interviews with support workers included one quantitative instrument completed in respect of the client. This was the Life Skills Profile (Rosen et al. 1989, 2006).<sup>6</sup> The Life Skills Profile had been completed in respect of Victorian clients at the time of their discharge from hospital in 1995, so its use in this study provided a comparison for these individuals after twelve years. Support workers in South Australia completed the Life Skills Profile for this study on two occasions, first in early 2007 and again in December of that year.

Material generated by the study in relation to Victorian clients' experience of entering, remaining in and leaving hospital, their subsequent housing and the support they have received since discharge has been considered elsewhere (Carter 2008). That related to the experience of clients in South Australia will be examined further in other publications. The focus of this paper is program implementation, especially the influence of context and program design on outcomes for clients.

The following sections consider implementation of the Neami Community Housing Program and the Returning Home Program in relation to the contexts in which they

---

<sup>6</sup> The Life Skills Profile (LSP) is a 39-item forced choice questionnaire about five life skill areas (self-care, turbulence or anti-social behaviour, social contact, communication skill, and responsibility). For each of the 39 statements, workers rated their client on a four-point scale ranging from 1 in which little difficulty with the skill is present or low/no levels of the anti-social behaviour are evident, to 4 in which there are extreme difficulties evident with the skill or high levels of the anti-social behaviour. Example items include *Is it generally difficult to understand this person because of the way he or she speaks (e.g., jumbled, garbled or disordered)?* (Not at all difficult, slightly difficult, moderately difficult, extremely difficult), and *Is this person generally angry or prickly toward others?* (Not angry at all, slightly angry, moderately angry, extremely angry). Item ratings are added to form a total score in which higher scores represent higher levels of disability. Scores can range from 39 to 156. Comparison with other studies and normative data requires caution as a range of scoring methods and versions of the LSP have been used, including scoring in the opposite direction (high scores representing lower disability), scoring 0-3 rather than 1-4 per item, using shortened versions (LSP-16 and LSP-20), and alternative names for the subscales (Rosen et al. 2006). For this reason, in the current project we have presented mean subscale and total scores on the LSP as item means (dividing total by number of items), so that item means of around 1.0 represent few or no problems, 2.0 represents minor/mild problems, 3.0 represents significant problems and means close to 4.0 are reflective of severe problems.

were developed, the characteristics of the models adopted in each state, and strategies employed in their implementation. This discussion will identify characteristics of the models that have been essential to their success in meeting program objectives, and critical factors influencing their implementation.

## **9 Victoria: the context<sup>7</sup>**

The closure in 1988 of Willsmere hospital, a Melbourne psychiatric institution established in 1872, has been identified as pivotal in preparing the way for the substantial reform of mental health services that took place in Victoria during the 1990s. Inpatients were relocated to a variety of newly established services, and the process generated a body of expertise among senior clinical staff, service managers and bureaucrats who in the following decade became advocates for further service reform (Gerrand 2005a).

In 1992, after ten years of Labor government at state level, a Liberal government under the leadership of Premier Jeff Kennett was elected in Victoria and began to undertake an ambitious program of reform across all areas of public administration. A neo-liberal approach to policy had become influential at federal level under the Labor governments of the 1980s, but reform to delivery of services provided by government found its most vigorous expression under Kennett. In its first term of office, this government enjoyed a majority in both houses of parliament and faced little effective opposition (Western et al. 2007; Costar and Economou 1999).

The idea that expensive and inefficient institutions, mostly located on prime urban real estate, should be closed and replaced with services delivered in decentralised locations was consistent with the neo-liberal agenda. The challenge was to implement the reforms set out in the National Mental Health Plan without incurring additional cost to the state budget (Meadows and Singh 2003). An ambitious plan for redevelopment of mental health services, involving the closure of all the state's stand-alone psychiatric institutions, was advanced by an entrepreneurial senior bureaucrat, Dr John Paterson. He succeeded in engaging support for the program from the Health Minister Marie Tehan and, through her, from the Cabinet (Gerrand 2005b).

---

<sup>7</sup> This section draws extensively on the work of Valerie Gerrand (2005a, 2005b).

In 1992 the previous Labor government had obtained funds through the Commonwealth Building Better Cities program to put towards the cost of capital funding for new facilities. The newly-elected Liberal government obtained transition or 'hump' funding through the First National Mental Health Plan to cover the cost of operating new services during the period of 'overlap' before the institutions were closed. The *Framework for Service Delivery*, released in 1994, proposed a suite of services including Crisis Assessment and Treatment Services, Mobile Support and Treatment Services, and Community Mental Health Clinics, to be established in each administrative area across the state. Acute inpatient units were to be co-located with general hospitals, with all beds gazetted to accommodate 'detained admissions'. Purpose-built Community Care Units with 24 hour staffing provided long-term residential accommodation, and secure extended-care beds were allocated in three hospitals (Victorian Department of Health and Community Services 1994; Meadows and Singh 2003).

The planned closure of institutions met with opposition from some senior clinicians, and from the union representing mental health nurses. The *Framework for Service Delivery* deflected opposition from psychiatrists by confirming the role of that profession in providing 'clinical leadership' in the new community-based services. In the new service models, psychiatrists retained authority over detention, assessment and review of clients, and provided 'clinical supervision' to other professional staff (Victorian Department of Health and Community Services 1994). Mental health reform was among a package of major changes implemented by this government in its first term of office; in an environment of radical and sweeping reform enacted by a government without effective opposition, resistance from unions was rendered ineffective.

Implementation was rapid, with 22 adult mental health services established across the state and fourteen new Community Care Units built, bringing the total number of such facilities to sixteen. New services were in place before the institutions closed, with priority given to establishing outreach teams with a 24/7 response, to reduce the number of new and repeat admissions to bed-based services. By the end of the 1990s all stand-alone psychiatric hospitals in Victoria had closed, and until 1998 all recurrent funds saved through this process were redirected to cover the operational costs of replacement services (Gerrand 2005a; Meadows and Singh 2003). The 1994

*Framework* identified psychiatric disability support as a central component of Victoria's mental health service system, and the sector expanded rapidly over the following decade. As noted in the previous section, these services adopted an increasingly explicit focus on rehabilitation as well as disability support, becoming known in 2002 as 'psychiatric disability rehabilitation and support services' (Victorian Department of Human Services 2003).

The Victorian social housing system has probably changed more dramatically than that of other states over the period which this report is concerned. In 1988 the state's public housing was administered by a stand-alone department with a charter to provide housing to low income Victorians. The department at that time allocated housing by wait turn and had 56,867 properties, of which 2,965 new dwellings had been added in the previous year. At the same time, 8,686 tenants were allocated housing, which represents 26 per cent of the 33,000 on the waiting list (Victorian Department of Housing 1989).

In 2007 public housing in Victoria was administered by an Office of Housing located in a Department of Human services. The Office of Housing added only 119 new dwellings to its stock in that year, and housed only 5,168 (12.7 per cent) of the 40,911 households on the waiting list. In the intervening 20 years period, new additions to public housing stock have virtually ceased, the rate of turnover in tenancies has halved and, although tightly focused targeting means that fewer households are eligible, the waiting list has increased markedly.

Beyond the statistics are more fundamental changes. The process by which allocations are made has been reformed, not only to reduce the number of households eligible but to target those in greatest need. A segmented waiting list was introduced in the mid-1990s with Segments 1 and 2, which give the highest priority, concentrating on households experiencing crises associated with immediate homelessness, and with ongoing complex needs. Although it has created management problems for the department, the segmented waiting list has greatly facilitated the likelihood of people who are homeless being housed, including many who in another context might have found their way into institutions.

The public housing sector in Victoria is now complemented by a community sector which, although smaller than in some other states, has often been a leader in terms of initiative and management practices. In its early years, the community housing sector was highly fragmented and its relationship to public housing unclear. The latter often provided stock to be managed by community housing, but the process of tenant movement between the two sectors was not transparent. There was also a lack of clarity about the relationships between housing stock intended for provision of crisis, medium-term and long-term accommodation.

In the late 1990s, Victoria's community housing sector was fundamentally reformed, and it now offers what is probably Australia's best example of a 'continuum model' of housing assistance. The community sector provides short-term housing to people in crisis, and 'transitional' housing, available for up to six months, most commonly to people referred through homelessness services. People accommodated in transitional housing exit, subject to vacancies, to public housing via the segmented priority waiting list; or to properties intended for long-term tenure that are provided through community housing providers. This system works reasonably well for people who enter it through crisis or homelessness services. However, other households that may be experiencing difficulties in securing housing or sustaining their tenancies, for example, people who are seeking to enter or are struggling to remain in the private rental market, find it difficult to obtain access to housing provided through public or community programs.

Compared to other states, Victoria has put substantial new funding, outside of the CHSA process, into the community sector over the last decade. In so doing, Victoria has built up its community housing sector to a greater extent through providing additional funds, than through transfer of stock from the public housing sector, as has been the case for example in New South Wales. In recent years much of Victoria's additional funding for community housing has gone towards establishment of a new community sector model, the Housing Associations (one of these, Supported Housing Limited, is a partner to this project). Housing Associations are large community-provided housing companies, registered under a specific act of parliament and with a broad charter to provide affordable housing. Some, such as Supported Housing Limited, target specific groups and work in conjunction with support agencies. Although it has suffered from constraints in funding and supply, the Victorian social

housing sector has probably been more effectively structured and resourced than its equivalents in other states to deliver outcomes for clients with high support needs.

## **10 Neami Community Housing Program<sup>8</sup>**

Neami is a non-government agency established in 1986 to provide psychiatric disability support to people living in the north-east suburbs of Melbourne. Until the 1990s, this area had the largest institutional complex in the state. By the early 1990s, Neami received funding from a variety of sources including the HASP program (discussed above) and the Group Housing Program which provided long-term support to clients with less intensive support needs. Neami also supported clients living in public housing and in properties that had previously been managed by local clinical services.

In 1995, when the local institutional complex was marked for closure, Neami was successful in obtaining funds from a major Commonwealth Community Housing initiative to purchase properties to house 30 former extended-stay patients. Neami obtained recurrent funding from North Eastern Metropolitan Psychiatric Services (NEMPS), which ran the institution, to provide psychiatric disability support to people housed in the properties. Patients eligible to be discharged into the program were identified by NEMPS from those who remained in the institutional complex when its closure was imminent and who were considered to require a high level of disability support over the long term. Patients for whom this level of support was considered to be insufficient were discharged to Community Care Units, which had 24 hour on-site clinical staff. Those aged 65 years or older were discharged to specialist psycho-geriatric facilities. Clinical staff from the NEMPS institutional complex formed dedicated Mobile Support and Treatment Teams intended to ‘follow’ the patients into the community, operating out of the local community mental health service to provide ongoing, extended hours, clinical support.

Neami entered into an arrangement with a community housing provider, Supported Housing Limited (SHL),<sup>9</sup> whereby SHL would purchase and manage the properties.

---

<sup>8</sup> The name Neami originated as an acronym for North Eastern Alliance for the Mentally Ill. The organisation has been known as ‘Neami’ since 1998. Information presented in this section is drawn from interviews with managers and service delivery staff involved in implementation of the program, interviews with clients and PDRS workers, and material provided by clients’ family members and clinical case managers (see Carter 2008).

Seventeen properties, in the form of detached and semi-detached units of three, two and one bedrooms, were purchased in dispersed locations in the north-eastern suburbs of Melbourne.

The model of housing and support implemented by Neami in its Community Housing Program was based on that established through HASP. Tenancy management and support were provided by separate agencies, with clients leasing properties directly from SHL, signing a standard lease with rental set at 25 per cent of the Disability Support Pension. Clients would live alone, or share in groups of two or three with others of their choosing. Houses were rented as furnished, with a weekly levy of \$5 added to cover replacement of furniture and fittings as needed. Tenancies would be ongoing, subject to standard conditions under the Residential Tenancies Act and not dependent on continued engagement with support through Neami. SHL did not vet applications for tenancy, seeing their role as to work with ‘whoever Neami decide’ (Connellan 2007). Clients had privileged access to clinical services, with dedicated Mobile Support and Treatment Teams established to provide clinical support. There was a commitment that the PDRS support provided by Neami would continue for as long as the client feels they need it.

In interviews, respondents who had been involved in the initial implementation of the program indicated that its early days had been characterised by significant difficulties in communication between Neami and staff working in clinical services. Some hospital staff opposed the decision made by NEMPS to fund psychiatric disability support from within its budget for clinical services, and the program was established in an environment of industrial unrest.

A working group of staff from Neami and NEMPS oversaw implementation of the program, holding forums for patients and their families to provide information about the opportunities it offered. Selection of patients suitable for discharge to the program was an area of disagreement between Neami and NEMPS staff. As Neami saw it:

They wanted to give us the easy people and we wanted more difficult clients. They [told] us we didn’t understand how disabled these people were, and we [said] that in fact the most disabled people were on the streets already. We

---

<sup>9</sup> SHL was at that time known as the Supported Housing Development Foundation. It currently operates as Housing Choices Australia.



wanted to push the envelope and risk having some failures [in order to] get this service to the people most in need (Tobias 2007).

Family members of some patients were also apprehensive, fearing that support or housing would be withdrawn after their relative was discharged. The number of patients discharged into the program was less than had been planned, being 28 instead of 30. Most had been diagnosed with schizophrenia and many had spent many years in psychiatric hospitals.

In the early years of the program, establishing good working relationships between Neami workers and clinical staff who had transferred from a hospital setting was a significant challenge. To advance this, a series of policies and protocols was developed by Neami in collaboration with the Area Mental Health Service, and staff took part in joint training sessions.

For clients, many difficulties arose in relation to share housing. In part, this was because the 'pool' of potential housemates from which clients could choose had been smaller than intended, and clients felt they had little choice about with whom they would share. In the first years of the program, a number of clients moved among Community Housing Program properties and some relocated to other properties supported by Neami. Over time, Neami arrived at a view that the maximum number of tenants per property should be limited to two, and that living alone was a more sustainable arrangement for most clients.

An early evaluation of the program commissioned by Neami in 1996 found that, at one year after discharge from hospital, only one of the 28 clients discharged to the program had returned to hospital. Several had had brief admissions then continued to receive clinical support in their homes. Clinical staff and family members reported that outcomes for clients over this time were better than they had expected. Support provided by Neami workers focused initially on activities of daily living, then on activities that would form connections with the local community. Once these skills and connections were established, the focus of support moved to progress towards clients' goals in relation to schooling or paid or unpaid work (Cox 1996).

Twelve years after the program was established, fourteen of the original 28 clients were still in contact with Neami and, of these, ten continued to receive home-based outreach support. Twelve clients remained living in properties purchased under the program, six in share houses and six living alone. One client, who had suffered a major physical injury, was living temporarily in a Supported Residential Service. Of clients who had moved to Office of Housing properties outside of Neami's catchment, some were known to be receiving support from other PDRS agencies, while about others no information was available. Data from the LSP instrument administered in 1995 and again in 2007 are available for five of the clients who participated in the research in Victoria. Results indicate no deterioration in levels of functioning for these clients over the twelve-year period.

Factors identified as critical to the success of the program in enabling clients to sustain tenancies concerned (unsurprisingly) the nature of housing, the nature of support, and the communities and activities to which they have access. Clients supported through this program have security of tenure, living alone or with someone of their choosing, in housing that is affordable and well located in dispersed locations in communities that are accepting of diversity. They have access to clinical support that is flexible in response to their needs. PDRS support is directed by priorities identified by the client, and clients are confident that support will 'always be there for me' when they need it. From the foundation provided by this housing and support, clients have access to activities that enable them to form meaningful relationships and participate in communities of their own choosing (Carter 2008).

## **11 South Australia: the context**

Of the three stand-alone psychiatric hospitals established in South Australia since 1870, two – Enfield and Hillcrest – closed during the 1980s. Anticipating the direction of the National Mental Health Strategy, the intent of the Labor state government was to extend the process of deinstitutionalisation to encompass closure of Glenside. Savings generated by the closures, supplemented by revenue from sale of the land on which the hospitals stood, were to be used establish services in regional centres. Although some such services were established, the policy encountered significant opposition, particularly from clinicians who 'questioned the wisdom' of institutional closures (Ash 2007: 110). A series of reviews and restructures occurred

under a Liberal state government during the 1990s with the outcome that, by 2000, most community mental health services were managed by regional health authorities, while intensive-care, extended-care and rural and remote inpatient services remained located at Glenside.

Achieving community acceptance for mental health reform was not easy in South Australia. Resistance to institutional closures was supported by media portrayals of people who use mental health services as dangerous, and policies of deinstitutionalisation as foolhardy. The state had witnessed a number of murders committed by inpatients, including in the 1980s that of a medical officer at Hillcrest, and in 1992 of a doctor working at Glenside (Sweet 2005: 127). Throughout the 1990s, clinical staff at Glenside successfully resisted change to institutional practices. For example, in 1996 industrial action taken by nursing staff was effective in averting changes to ward-based nursing rosters, maintaining the existing practice of 'two days on, two days off' instead of moving to an arrangement more in line with nursing practice in community settings (Sweet 2005: 128).

Delivery of mental health services in South Australia has been shaped also by the characteristics of the housing systems in that state. From its inception, the South Australian social housing system has been somewhat different from that of the rest of Australia. Public housing has made up around 8 per cent of overall housing stock in the state over the past 30 years, compared with an average of 5 per cent in other states. The South Australian Housing Trust has often pursued a broader set of goals and had greater support from government than in some other states (Hayward 1996). Public housing has been a more 'mainstream' form of tenure, carrying less of a stigmatised association with low income than elsewhere.

This relative strength of public housing also made it particularly susceptible to the impact of changes in funding that occurred through the CSHA throughout the 1990s. As public housing came to be construed as a residual tenure, with a smaller pool of funds targeted towards providing for more specific client groups, the costs involved in making the change were greater for agencies with larger stock. Households given priority through segmented waiting lists required higher levels of subsidy, through rebated rents, than those accommodated under the previous system. The Housing Trust had a large number of dwellings that were obsolete or needed expensive

maintenance or upgrade, while the amount of money for capital investment was in decline. In addition, it had accumulated a large debt (\$810 million) as a result of funding the substantial growth of earlier decades (Hall and Berry 2006).

Operating alongside the public sector, South Australia also had a largish community sector managed through the South Australian Community Housing Authority (SACHA). While SACHA worked with the South Australian Housing Trust, the two were independent of each other. As most funds for SACHA came via the CSHA, the sector was also under financial pressure.

By the mid-2000s, the South Australian social housing system had been forced to abandon its broad role and to come into line with other state housing authorities. Rather than continuing to increase the supply of public housing stock, the sector was forced to contract, from 45,351 dwellings in 2002 to 42,527 in 2007 (Productivity Commission 2008). There was some growth in the community housing sector, but this was insufficient to compensate for the loss of numbers through public housing. South Australia has confronted intensifying demand for public housing at the same time as stock availability has contracted. The reduction in stock has been compounded by reduced turnover in public housing, as fewer tenants exited the system.

In 2005, there was a major reform of the South Australian social housing system. The South Australian Housing Trust and SACHA were restructured into a new organisation, Housing SA. This was intended to be the gateway for all housing services in the state, linking people to a broad range of housing and related information and supports. While the new structure has potential to offer better organisational outcomes, the new organisation is substantially constrained by the external funding environment. For eighteen months or so after the announcement of the reforms, management and staff were still digesting the implications of the new structure and setting it in place. This was not an environment conducive to bringing together organisational resources to respond to the challenges posed by a program of institutional downsizing.

Constrained by a difficult policy environment, from a position of acknowledged leadership in clinical practice in the late 1980s, by 2000 South Australia had not

made the same progress as other states in terms of the objectives set out by the National Mental Health Strategy. In 1999-2000, the proportion of the mental health budget directed to psychiatric hospitals at 45 per cent was the highest of any state, and that spent on community-based services the lowest at 37 per cent (Australian Government Department of Health and Ageing 2002). Of all states, South Australia spent the smallest proportion (2 per cent) of its mental health funding on services provided by non-government agencies, and devoted the least amount of funding to community-based accommodation. Clinical services operating in regional areas were overwhelmed by demand, exacerbated in turn by a shortage of housing and an absence of non-clinical support. With a large proportion of funding going towards running costs for a single hospital, the state had limited capacity to resource regionally-based services sufficiently to enable them to meet local needs.

In 2000, a psychiatrist named Margaret Tobin was appointed as Director of Mental Health in South Australia, with responsibility for developing plans for the downsizing of Glenside and establishment of alternative arrangements for service delivery.<sup>10</sup> Tobin had previously overseen institutional closures in Victoria, and most recently had been instrumental in restructuring psychiatric services in New South Wales. Under her direction, an *Action Plan for Reform of Mental Health Services* was released in 2001 that committed to redeveloping Glenside as a 'centre of excellence for mental health rehabilitation'. Service devolution was to be supported by arrangements for supported accommodation based on collaboration between housing services, mental health providers, general practitioners and disability support providers (South Australian Department of Human Services 2001).

In 2002, Tobin was shot in the lift when returning to her office by an assailant who was identified in media reports as a psychiatric patient. She died almost immediately. The man who was subsequently convicted of the murder was a deregistered psychiatrist who had practised under Tobin's management in New South Wales (Sweet 2005).<sup>11</sup> The high profile of Tobin's role, and the shocking and public nature of her murder, added to public misgivings about deinstitutionalisation in South Australia. It lent support to the view promoted in local print and radio media that people who use mental health services are dangerous and need to be contained. After

---

<sup>10</sup> In this section we draw on the work of journalist Melissa Sweet, whose book *Inside Madness* gives an account of Tobin's career.

<sup>11</sup> This conviction was overturned at appeal in May 2008 and the case will be subject to a retrial(see Sweet 2008).

2002, the possibility that Glenside might be downsized or closed became an even more highly sensitive political issue. For the state Labor government re-elected shortly after Tobin's murder, the possibility that Glenside might be decommissioned was not something it wished to pursue.

During the years that followed Tobin's murder, plans initiated under her leadership continued to be developed by departmental staff. In 2003 the South Australian parliament commissioned an inquiry into supported accommodation for people with disabilities. Its report recommended that the responsible minister should develop a plan that would 'ensure completion of deinstitutionalisation' [in the disability and mental health sectors] within 5 to 10 years' (Parliament of South Australia 2003). In evidence to the inquiry, the Director of Mental Health, Dr Jonathan Phillips, reported the existence of plans 'consistent with a clear deinstitutionalisation agenda, [that] include the devolution of Glenside in its current form' (Parliament of South Australia 2003: 154). Dr Phillips noted that in the absence of such reform 'We will be shackled with a very old-fashioned and a very costly system. To maintain Glenside ... is going to drain dollars away from the people who need it' (Parliament of South Australia 2003: 150). Accommodation options linked with 'non-clinical psychiatric disability support services' were identified as a necessary component of reform.

The inquiry found that the current supply of supported housing was 'grossly inadequate', particularly for people with complex needs. However, most respondents identified the reason as 'lack of funding for the provision of ongoing support services rather than a lack of available housing' (Parliament of South Australia 2003: 51). In its submission to the inquiry, the South Australian Housing Trust proposed a contrary view. It reported that affordable housing was increasingly difficult to obtain, and argued that '[with] respect to people with mental illness exiting institutional care, the expectations on the Housing Trust being able to provide timely responses to housing need, in the locations requested, are high and unrealistic, particularly in the climate of diminishing funds' (Parliament of South Australia 2003: 58).

In 2006 the state government commissioned its Social Inclusion Board to examine the South Australian mental health service system and recommend a strategy for reform. The report *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*, released in March 2007, recommended establishing a 'step up

step down' model of service delivery, with services provided in a sequence of less to more secure settings. These included supported accommodation, Community Rehabilitation Centres, and facilities providing intermediate care, acute inpatient beds and secure care. Glenside would be redeveloped as a 'centre for statewide specialist services', specified as including drug and alcohol, early psychosis and services for Aboriginal people (South Australian Social Inclusion Board 2007). The report left open the possibility of alternative uses for sections of the site, to 'encourage interaction between people using mental health services and the general community'.

The state government response, released concurrently with the report, accepted its recommendations and committed to establishment of a 'stepped system of care' (Government of South Australia, Department of Health 2007a). A detailed plan for the redevelopment of services on the Glenside site was released in September 2007 (Government of South Australia, Department of Health 2007b). This confirmed the intention to retain the identified mental health services on site at Glenside, and outlined plans for the sale of sections of land for commercial and residential purposes. Some land was set aside for development of low cost housing and supported accommodation for service users.

Implementation proceeded rapidly after release of the report and, by early 2008, a range of new facilities was in operation. These included three new acute-bed facilities and two Community Rehabilitation Centres. A further six Community Rehabilitation Centres, four specialist intermediate care facilities and new forensic facility were in development. The new system included a substantial increase in funding to non-government organisations to provide psychosocial rehabilitation and disability support to service users living in the community (Premier and Cabinet of South Australia 2008).

## **12 Returning Home Program**

### **\* 12.1 Inception**

The Returning Home Program was initiated in 2004, during the period of hiatus in public discussion of mental health policy between the murder of Margaret Tobin and the commissioning of the Social Inclusion Board report. In that year, the South

Australian Department of Health contracted the Victorian agency Neami, in partnership with the Lyell McEwin Health Service, to assess and identify the support needs of 127 Glenside patients residing in extended-care wards that, under plans developed by Tobin, had been earmarked for closure. This assessment identified 75 patients for whom transition towards discharge could start immediately if housing and support were available. Of the remaining 52 patients assessed, 40 were identified as being potentially suitable for discharge into supported housing if their condition improved after treatment and their rehabilitation needs were met. Supported housing was considered to be unsuitable for the remaining twelve, mostly as a result of health problems associated with age or physical disability (Neami and Lyell McEwin Health Service 2005).

The Returning Home Program was established in 2005 to provide support that would enable 55 of these patients to be discharged. Initial funding provided for an additional staff member in each of the community-based clinical teams that would be supporting the clients (on a ratio of 1:10 for a twelve month period) and funding to non-government agencies to provide non-clinical support to 50 clients. Funding agreements describe the support to be provided by non-government agencies as 'programmed services incorporat[ing] non-clinical psychosocial rehabilitation support'. Three non-government agencies were funded to deliver these services: Neami in the northern suburbs of Adelaide, Richmond Fellowship of South Australia (now known as Mind) in the southern suburbs, and Life Without Barriers in the eastern and western suburbs. Additional funding was to be provided as client numbers increased. Funding under the Returning Home Program is recurrent, with agencies funded through renewable contracts, each for a period of up to three years. From a program perspective, Returning Home is ongoing; from an agency perspective, the agency's own continued funding is uncertain. Funding under Returning Home contained no component for housing, as it was expected that clients could access existing public housing properties through the usual applications process.

As was necessary in the sensitive policy environment of the time, the program was established without fanfare. There was no program launch, and no information about it was publicised through departmental websites. At a time when debate about service reform was off the agenda in political terms, Returning Home had a strategic as well



as a practical function. Its success would show, as had been shown already in New South Wales, Queensland and Victoria, that people who had had long stays in psychiatric institutions could live successfully in the community with appropriate support. Establishing the program without publicity was politically necessary in the environment of the time. This strategy had unintended consequences, discussed below.<sup>12</sup>

The state Department of Health convened a Partnership Planning Group to oversee implementation of Returning Home, comprising representation from the three funded non-government organisations, two area mental health services, Housing SA, a carer representative, and the Rehabilitation Services area of Glenside. This group met monthly at Glenside to discuss progress and deal with problems as they arose, generating a number of subcommittees to work on specific issues that emerged as obstacles to implementation.<sup>13</sup>

## \* **12.2 Program design**

The supported housing model adopted by the program was similar to that implemented by Neami in Victoria. Clients would live alone in properties in dispersed locations, receiving clinical support from a mobile outreach team (known in South Australia as a MAC team), and additional support from Neami, Richmond Fellowship or Life Without Barriers. Support provided by these agencies has no particular title in South Australia, being generally referred to as ‘NGO support’ or just ‘support’. Its initial focus would be on establishing competency and routines in relation to ‘activities of daily living’, and from there moving on to support clients in identifying goals in relation to activities and connection with their community, and working towards achieving those goals.

Returning Home differed from the Neami Community Housing Program in some respects. Where the Victorian program had included funding to support the

---

<sup>12</sup> One outcome of the low profile approach was that when the present research was undertaken it was very difficult to find material about the program in the public domain. Web searches located some information on sites of the non-government agencies funded to provide support, some articles in the Mental Health Unit newsletter, and one mention in South Australian parliamentary papers. Various departmental working documents describing the program and its strategic intent were made available informally to the researchers, most showing their source as Margaret Tobin’s computer. One departmental officer remarked at the time: ‘It’s not something that we’re shouting from the rooftops about’.

<sup>13</sup> The first author of this paper was invited to attend several meetings of this group and its subcommittees. The assistance provided by the Partnership Planning Group and its individual participants was invaluable and is much appreciated.

establishment of dedicated teams of clinical staff to 'follow' clients into the community, under Returning Home existing MAC teams each received funding for additional staffing at a ratio of 1:10. The Neami Community Housing Program, like HASI in New South Wales, had included funding for purchase of properties to house the clients who would be receiving support. Under Returning Home, as had been the case with Project 300 in Queensland, housing was to be sourced through an existing supply of public housing, with clients eligible for priority status under the segmented waiting list. Although arrangements for access to housing were discussed in meetings of the Partnership Planning Group, they appear to have not been formally documented.

During the period of establishment of the program, some unspent funds were repackaged as one-off funding for support packages similar to those provided under Returning Home, under a funding stream called Strategy 6 (Government of South Australia, Department of Health, Mental Health Unit 2005). Support under Strategy 6 was available to patients leaving Glenside whose need for additional support was assessed as being less than that of Returning Home clients, and likely to be short-term only. Agencies received funding under Strategy 6 through contracts that were renewed annually. In the 2007-08 state budget, funding became recurrent, with ongoing delivery of services being put to tender in 2008.

Agencies funded under Returning Home used funding received through both streams to establish their services. At a program and management level, the distinction between Returning Home and Strategy 6 is important, referring to clients' assessed intensity of need and likely required period of support, and the likely duration of funding to support them. At a practice level, the distinction is less apparent, as workers provide support that is flexible in response to clients' needs, irrespective of the category through which they are funded.

\* **12.3 Perspectives on implementation**

Interviews conducted for the present project revealed that one consequence of the low profile approach to implementation adopted in South Australia, and its associated lack of documentation, was that different people involved had different understandings of the program's structure and intention. The most significant areas

of misunderstanding concerned its intent in relation to access to and arrangements for housing, and duration of support.<sup>14</sup>

In relation to housing, there were disparate views in three areas: whether receiving support under Returning Home conferred automatic entitlement to public housing, whether clients' applications had priority status in public housing waiting lists, and whether funding provided to NGOs included an amount for furnishing client's homes.

Some respondents interviewed in mid-2007 believed that individuals receiving support under Returning Home were automatically eligible for public housing. This expectation had been articulated at early meetings of the Partnership Planning Group. It was also in line with practice adopted in the Neami Community Housing Program, where the view of the housing agency was that they should work with 'whoever Neami recommends'. Others held that housing workers were ultimately responsible for forming a view as to whether the client's disability or illness would prevent them from being able to sustain a tenancy, and that support from an NGO was not sufficient to guarantee this. These respondents felt that

At the end of the day [Housing SA] has to assess whether that tenancy is going to be successful. With all the supports in the world, people get dumped as soon as they get housed, and then the housing managers are left to manage.

Some respondents expressed the view that clients referred for support under Returning Home would be eligible for priority access to public housing under Category 1, intended for 'applicants in urgent need of housing', by virtue of their exiting institutional care with a level of disability that requires ongoing support (Government of South Australia, Department for Families and Communities 2007). Others maintained that this was not the case.

Where clients had obtained housing, there was a disparity in views around whether program funds paid for set-up costs such as purchase of furnishings (the agencies' funding agreements make no mention of furnishing or set-up costs). Among the non-government agencies, one view was that this was clearly part of Returning Home

---

<sup>14</sup> This section draws on material collected in interviews with managers and service delivery staff in Glenside, community-based clinical services, Housing SA and non-government agencies. To preserve anonymity we have not identified the organisation or role in which any cited respondent is employed. These interviews were conducted in early and mid-2007, before and after the release of the Social Inclusion Board report and before the release of the Glenside Master Plan.

funding (as was the case in similar programs in other states); another was that funds were available but agency practice was to seek support from other sources wherever possible; and a third was that Returning Home did not include funds for furnishings. The views of respondents in other sectors ranged from certainty that funds for purchase of new furniture and white-goods were part of a Returning Home package, to uncertainty. One respondent said: 'I don't know. I'd be curious to find out'.

There was also variation in views about for how long clients could continue to receive support under Returning Home. Some respondents were confident that support would be ongoing:

We had as a foundation principle that these people may need services for life. People might have lifelong disabilities or support requirements that mean for them to safely maintain that they're going to need a modicum of support forever.

More respondents felt the intended duration of support was unclear. Some providers planned their services on the assumption that support would be short-term, with clients then transferred to 'mainstream services'. One respondent said: 'My understanding is that the funding is ongoing. But when you test that I think it's about five years.' Another said: 'We don't see our service as being for life. Our role is to move people, over time, into independence, whatever that might mean for them. Maybe three to five years, not forever.'

A number of respondents expressed the view that uncertainty about the intended duration of support undermined the credibility of the model. Concerns about the possible duration of support under Returning Home were expressed by people working in each of the service sectors involved in delivering the program, and by family members and carers of clients. Comments included:

If this [program] runs out there's not a lot we've got to turn to. We're potentially taking out a lot of complex high needs people without a lot of certainty about what might be happening in five years time.

Support is ongoing but only for as long as the funding is there. There is a concern that if the funding is ceased, who's going to pick it up?

There's no way you can release these people without support being ongoing.  
We couldn't leave these people without support.

A minority of respondents expressed a view that clients who had spent a long time in Glenside would be unable to live in the community, even with support available through Returning Home. One said:

Some of these people can't even brush their teeth. You don't just take them from this setting and put them in accommodation and have an NGO worker to integrate them into the real world. It's unrealistic.

Respondents who advanced this view argued that hospital offers 'asylum' to patients and safety to families, and that most patients would prefer to stay there. They saw Returning Home as 'driven by [a political agenda], but not by what the consumer wants'.

The disparity in views that emerged from interviews with participants whose work involved implementation of Returning Home was unexpected, and striking. A pattern appeared that could be mapped as a series of concentric circles. At the centre was an understanding which maintained that people supported under Returning Home were entitled to priority access to public housing, and that support under the program would continue for clients' lifetimes if need be. In the next circle was a cluster of responses stating that access to housing was a matter for local negotiation, and that while support could be provided for an extended period, it would ultimately be of limited duration. In a further circle could be mapped a confusion of views expressing a fear that clients could be abandoned without support, leaving families and other parties to deal with the consequences and clients at risk of becoming homeless.

Very few respondents referred to, or when asked were able to identify, documentary evidence to substantiate their understanding of arrangements provided under Returning Home. Most referred to conversations between significant individuals or to discussions that had occurred in various forums. It appeared that an absence of information in the public domain contributed to the creation of an environment in which uncertainty flourished. In this environment, confidence in the program was easily eroded.

A diversity of views about deinstitutionalisation in general and the Returning Home Program in particular was evident also in responses to the survey of Glenside staff. A copy of the survey was given to each member of staff working in the Rehabilitation Services area of Glenside in late 2006. The survey asked open-ended questions about the policy of deinstitutionalisation and its implications for people with mental illness; what an appropriate system of housing and support would look like; and the anticipated impact of changes at Glenside on respondents' own professional practice and careers. Of approximately 100 staff, 20 responded. Respondents had worked at Glenside for between one and 27 years in positions including psychiatric nurse, general nurse, psychiatrist, psychologist, social worker and ancillary therapist.

Respondents expressed a range of views. Some were dismissive (one said, 'What policy?'), but most were thoughtful. Some responses framed deinstitutionalisation as a good thing, at least for some patients; others framed it as irresponsible and cruel, even as 'institutionalised genocide'. The majority of respondents gave qualified support for the establishment of community-based services as part of a range of options that include a continuing role for institutional care at Glenside. A substantial number regarded non-institutional care as acceptable only if it was provided with a very high level of staffing and support, some noting that such arrangements create what is effectively a 'mini-institution'. Respondents who supported the development of a range of options as alternatives to institutional care expressed concern about the adequacy of planning for services, the limited range of options available for housing and support, difficulty finding housing, and the perceived insecurity of funding to ensure necessary duration of support.

A number of respondents expressed misgivings about the way the non-government agencies funded under Returning Home approach their work. They described agency workers as 'semi-trained' or untrained, and held that they should be supervised by, and act at the direction of, clinical staff. These workers should deliver 'functional support' with a focus on activities of daily living, ensuring that clients maintain hygiene and eat well. Several characterised clients as lacking capacity to improve their functioning, and as likely to be unable to cope without institutional support.

The tenor of responses from Glenside staff ranged from optimistic and cautious to pessimistic and cynical. Many were striking in the intensity with which views were

expressed. These responses indicated strong feelings of hurt, of not being listened to and not shown respect. Views were not associated with age: those who were most positive about change were among the oldest respondents. There was some association between attitudes expressed and the length of time respondents had worked at Glenside, but this was not uniform.

Survey responses suggest that most staff saw the redevelopment of services as a good thing if it was planned for and resourced, in order to offer a range of options for accommodation and support, underpinned by adequate and ongoing funding. However, these staff members were apprehensive, believing that planning had been patchy, offering too few options, with inadequate access to housing, and that funding may be cut later leaving clients unsupported. A minority of staff regarded devolution of services from Glenside as bad, because they saw their patients as having no capacity for improvement, and as needing to be confined and supervised. These views were incompatible with the approach taken by the non-government agencies funded under Returning Home, whose work is informed by a recovery framework (responses to the survey of Glenside staff are discussed in more detail in Appendix 2).

\* **12.4 Difficulties and how they were overcome<sup>15</sup>**

Discharge of clients with support under Returning Home happened more slowly than anticipated. This was partly the result of differences in views between support agencies and clinical staff about whether supported accommodation was a suitable option for a client and, if it was, whether the client was ready to be referred to an agency and begin working on 'transition' and then, whether the client was ready to be finally discharged. A number of clients spent many months in 'transition', working with their support agency and spending some time each week at their new home and some time at Glenside.

Many patients who had been assessed in 2005 as eligible and ready for the program had been discharged without support by the time arrangements under Returning Home were established. Others were later discharged with support under Strategy 6. As funds had been allocated under Returning Home to provide support for 55 clients,

---

<sup>15</sup> Information in this section is drawn from responses provided in interviews and surveys by clinical staff based at Glenside and working in community settings, and by staff of NGOs funded to provide support.

individuals who had not been part of the original assessment came to be considered for inclusion in the program.

By late 2007, individuals remaining in extended-care wards at Glenside were seen by most clinical and some non-government agency staff as having far higher and more complex support needs than those for whom the program was originally intended. In respect of many of these clients, there were disagreements between support agencies and clinical staff about the appropriateness of supported housing as an option for discharge. Where clients were assigned to the Returning Home Program, there were many disagreements about the pace and timing of transition.

Some clinical staff regarded some support agency workers as ill-informed and foolhardy. They saw the non-government agencies as encouraged by their funding arrangements to underestimate the risks associated with clients' discharge. Many support agency workers felt that hospital-based clinical staff were motivated by a political agenda to obstruct processes for discharge of patients under Returning Home. Where Returning Home was perceived to be associated with plans for closing wards, Strategy 6 was not; support agency staff reported that it was easier to negotiate arrangements for a patient's discharge if they were referred under Strategy 6 rather than under Returning Home. Respondents from both sectors reported that NGO workers were consistently more likely than clinical staff to see a patient as suitable for discharge into supported housing, as ready to begin the process of transition and, if in transition, as ready to be discharged.

When support agencies and clinical staff agreed that a patient was ready to leave, another obstacle to discharge was difficulty in finding housing. Housing was easiest to obtain in outer suburban areas that were seen as less desirable, having limited access to public transport and other facilities. Clients wishing to live in popular and more well-resourced suburbs were obliged to choose between going to a Supported Residential Facility (SRF)<sup>16</sup> as an interim measure or enduring a long wait for public housing. Some clinical staff regarded discharge to an SRF as an appropriate option, as clients could be expected to receive regular meals and some degree of supervision. Most support agency workers felt these facilities were counter-productive for clients,

---

<sup>16</sup> Supported Residential Facility is the name given in South Australia to a privately owned and operated pension-level boarding house. These facilities are known in Victoria as a Supported Residential Service (SRS).



placing them at risk by living in close proximity with other residents who may be engaged in use of illicit drugs and other illegal activities.

Support agencies in some areas had an understanding with their local offices of Housing SA that their clients' applications for housing would be granted priority status under Category 1. In other areas this was not the case. Some staff of Housing SA held the view that it was their role to assess the likelihood of an applicant being able to sustain a tenancy, and some applications were rejected by staff who judged support under Returning Home as inadequate to meet a client's needs. In certain areas there were no properties available. In several cases, support agencies secured housing through the process of 'headleasing' whereby clients were placed in transitional properties leased by or managed through the support agency. In spite of the best efforts of the agencies concerned, a number of patients eligible for support under Returning Home were discharged to SRFs because there was no housing available.

Support agency workers reported difficulty in establishing good working relations with clinical staff, both those in Glenside and those based in community teams. Most clients supported under Returning Home started working with their support agency well in advance of their discharge from hospital.<sup>17</sup> Patients identified as suitable to be discharged with support under Returning Home would be referred to the support agency contracted to deliver services in the area where they wished to live, and would begin working with a support worker from that agency on the process of transition towards discharge. This would begin with establishing a relationship between the worker and the client that would enable them to communicate effectively and work towards articulating the client's goals and devising plans through which these could be realised. To some hospital-based clinical staff, the early stages of this work looked like 'a lot of just going out for coffee'.

Views expressed by clinical staff suggest their expectation is that workers employed by non-government agencies should provide services that more closely resemble disability support provided to clients in the Intellectual Disability sector, than support based on principles of psychosocial rehabilitation as it is practised in Victoria and New South Wales. This expectation conflicts with the approach used by support

---

<sup>17</sup> NGO workers described some exceptions that occurred in the early days of the program in which patients were discharged with little preparation, and with little or no notice provided to the NGO.

agencies, who see their work as psychosocial rehabilitation delivered within a recovery framework. NGO workers have been seeking to establish working relationships with clinical staff who see them as untrained or 'semi-trained' workers, and expect that their role is to provide 'functional support' (especially 'ensuring' that clients maintain their nutrition, hygiene and grooming) under the direction of 'trained' (clinical) staff. The sector in South Australia is new, and the work done by support agencies does not even have an agreed name. In contrast with Victoria, a claim for the skilled status of non-clinical support is not well established.

Some changes were made to the model of support implemented under Returning Home as result of difficulties in getting clients discharged. One change noted already is that in response to difficulty finding housing, some agencies established transitional arrangements involving 'headleasing', in which clients sublet from the agency that provides their support.

Other more substantial changes have been considered. In 2006 the idea of a 'core and cluster' model of housing, denoting a cluster of units in proximity to a 'core' unit which housed staff, was suggested in response to concerns that some clients leaving hospital would require a higher level of support than could be provided if they were living alone. This idea was discussed at many meetings (at some of which the first author of this report was present), but what the model might actually look like was not elaborated. Accounts provided by participants in interviews made it clear that 'core and cluster' meant different things to different people. Those who had taken part in various discussions had come to diverse understandings about the number of units there could be in a cluster, how they would be located, and what the staffing arrangements would be. Some respondents said on-site staff would be NGO workers, and others that they would be clinical staff; some said staffing would be daytime only, and others that staff would be present on a 24 hour basis.

Most interviewees spoke of core and cluster as a positive option that should be investigated, but they identified as positive very different things. For some, potential for increased 'supervision' of clients was a benefit. Others saw on-site staffing as contrary to the recovery objectives of Returning Home, and as opposed to the principle of providing care in the least restrictive environment possible. They felt that a core and cluster would operate, in effect, as a 'mini-institution' in the community.

Among respondents who voiced these concerns, some saw a possible benefit in units being located near each other.

Discussions about the possibility of developing a core and cluster model intensified during a lengthy period in 2007 during which no clients were discharged with support under the Returning Home Program. At a time when the program appeared to be stalled because of an inability to reach agreement between clinical staff and NGOs about clients' suitability for the program and readiness for discharge, and ongoing difficulties in accessing housing, it was as if the idea of 'core and cluster' acted as a 'fetish', an ambiguous concept that represented a solution to everyone's concerns. It addressed the concerns of hospital-based clinical staff who felt that some clients needed an environment that provided 24 hour supervision, as these staff interpreted the model as providing quasi-institutional care. It addressed the concerns of NGOs who were frustrated that referrals were not happening; they could see advantages in co-location or proximity of properties, in providing efficiencies in staff time and access. It was a pragmatic response to the view that 'It's tragic that a person needs to be in an institution because there is no housing available'. As one respondent said: 'I don't mind how they do it, as long as it works.'

The possibility of establishing a core and cluster model had been considered since late 2006. Unsurprisingly, within a public housing system undergoing radical change, no suitable properties were able to be identified to use for the purpose. As of mid-2008, the model had not been realised.

The combined effect of all these factors was that referrals to Returning Home happened much more slowly than expected. By January 2007 a total of 27 clients had been discharged with support under Returning Home. After release in March 2007 of the Social Inclusion Board report that recommended downsizing of Glenside, staff at Glenside took industrial action imposing bans on any work towards discharging clients under Returning Home. These bans were 'suspended' (not lifted) in July 2007. During this time, patients continued to be discharged to Supported Residential Facilities, some with support under Strategy 6. By December 2007 a total of 48 clients had been discharged. By April 2008 a total of 54 clients had been discharged with support under Returning Home.

## \* **12.5 Outcomes for clients**

Interviews with clients and workers took place in January, February and March 2007.<sup>18</sup> Of the 25 clients interviewed, nineteen were men and six were women. Most were born in Australia, two in Vietnam, one in Greece and one in the UK. Twelve were aged in their 20s, eight in their 30s, three in their 40s and two were over 50. One client had been diagnosed with schizo-affective disorder; the other clients had been diagnosed with schizophrenia. As in the Victorian sample, the client group was divided between those who had had continuous inpatient stays over a long period (up to and exceeding 20 years), and those who had experienced repeated admissions of between one and two years at a time. Some clients reported having difficulties with physical health, including being overweight (eight) and having diabetes (three). Eighteen clients were smokers and, of these, eight smoked very heavily. Six were non-smokers and one had recently quit.

Data generated by the LSP instrument administered at the first interview indicated relatively low levels of disability across the 39 areas assessed. Greater levels of disability were demonstrated on work capabilities, making and keeping friends, being involved in social organisations, having interests and being active, as well as some problems with budgeting and managing health. On these items, the scores reflected moderate problems on average. The group exhibited very few problems in several areas, including cleanliness, speech difficulties and any type of turbulent or reckless behaviour. Apart from being some years younger, the demographic and health profile of this client group is similar to that of clients interviewed in Victoria.

---

<sup>18</sup> Recruitment of clients to participate in the research was highly successful, with 25 clients agreeing to participate. (This number is made up of seventeen of the 27 clients who had been discharged by January 2007 with support under Returning Home, plus a further eight who were working with agencies 'in transition' toward discharge. As I have been unable to obtain information about the total number of clients who were 'in transition' at any given time, I cannot determine what proportion of the total number of Returning Home clients at January 2007 took part in the research.). The assistance provided by support agencies was essential in achieving this good result, as workers talked to their clients about the research and encouraged them to take part. Several other factors were significant also. The research was described as being conducted by a sociologist employed by a university, who had no connection with the mental health system or with Glenside. Support workers had met the interviewer before they talked to clients about the research, and were able to recommend her to clients as being friendly and respectful. Clients understood that interviews were to be conducted in a place and at a time of their choosing, that their support worker could be present, or not, as the client preferred, and that interviews would be audio-recorded only if clients were happy with this. Clients did not have to decide whether they would give permission to audio-record, or permission to contact their clinical worker or a member of their family, until after they had met the interviewer and had an opportunity to see if they felt comfortable with her. Finally, a gift of \$30 in the form of a voucher was offered in appreciation of their participation.

At the time of the interviews, fifteen clients were living in their own units, and one was living with his parents and siblings. Most properties were provided through Housing SA, and several through ROOFS, a community housing agency. A small number of clients were living on a temporary basis in properties managed as transitional accommodation by their support agency. Nine clients had not yet been discharged. Four were residing at Glenside, and five were living in ‘the Village’ Community Treatment Unit.<sup>19</sup> The remaining client interviewed had returned to Glenside after having been discharged with support under Returning Home.

Qualitative data generated by interviews with clients and support workers shows themes that are familiar from interviews with clients in Victoria and are consistent with findings from the evaluations of Project 300, HASP and HASI. Clients reported being very pleased to have the opportunity to live in their own place, and to be happy with the support provided to them by the support agencies, particularly in the form of companionship and regular activities. Clients who had houses (most were units, semi-detached or detached, some were free-standing houses) were very happy with them. With few exceptions, the properties seen by the interviewer were well located, close to transport and shops. All were in good condition, and some were new (to Melbourne eyes, some of the properties were very flash). One client’s house was in a less well-resourced location and was in relatively poor condition, but it was comfortable and welcoming; both the client and their support worker felt the property was well suited to this person’s particular needs.

Of clients interviewed while in ‘transition’ towards discharge from Glenside, most were spending some days each week in their own house or unit. Some were apprehensive about leaving hospital, but most felt confident that they would be supported in dealing with whatever challenges they might face.

When asked about the time they had spent in Glenside, most of those who had been discharged said that being there had been awful. Several said ‘there’s nothing to do but smoke’. Some said they had been uncomfortable there because there were too many people using illicit drugs, especially cannabis. Most said the best thing about having their own place is ‘freedom’. When asked to elaborate, clients identified

---

<sup>19</sup> This is a complex of two houses on the site of the former Hillcrest hospital, with nursing and other clinical staff presence in the daytime and staff on-call at night.

‘freedom to get up when you want, go to bed when you want’, ‘freedom to eat what you want’ and ‘freedom to smoke inside’.

A minority of clients expressed fear associated with their housing. Some said they would like to have more locks, or bars on windows or, in one case, guard dogs and towers for snipers. Interviews with the workers who supported these clients indicated that each of them had in the past been subject to harassment and violence, in some cases from individuals in the communities to which they had returned or would be returning. The solutions proposed to allay their fears seemed extreme, but some of their fears may have been well founded.

A small minority of clients became agitated during interviews, describing what appeared to be delusional scenarios that were clearly distressing to them and, in some cases, very disturbing for the interviewer. Several described perceiving a material object associated with their fear as located in the fabric of their house. One client remarked in a matter-of-fact manner that there was ‘hepatitis in the floor’ of his kitchen; another, in the course of a digression characterised by floridly delusional content, described his house as a ‘biomechanical facility’ with ‘blood in the walls’.

Most clients appeared to be happy to take part in the research. Some appeared to see this as a courtesy extended to the support worker with whom they were establishing, or had established, a relationship of trust. Others were clearly very interested in the \$30 voucher they would receive at the conclusion of the interview. All the clients for whom money appeared to be a motivation to participate were smokers; the money was spent immediately, on tobacco. (The eagerness of these clients made the interviewer wonder about the extent to which consent can be seen as given freely by a person who is offered money they can use to purchase a substance to which they are intensely addicted.)

Support workers interviewed came from diverse backgrounds, and varied in their qualifications, experience and repertoire of skills. This was reflected in differences in emphasis in their approach to support. Some workers gave high priority to support in areas to do with physical health and exercise, while others not. Some paid close attention to cooking and home care, others did this to a lesser extent. Among workers with the broadest repertoire of skills were some who had personal experience caring

for family members with mental illness or as users themselves of mental health services. Personal experience appeared to be an advantage when accompanied by relevant training and work experience. Many workers appeared fond, and some very protective, of their clients. In turn, many clients described their worker as 'like a friend'.

In discussing their work, most support workers made reference to a recovery framework. In all cases, their accounts indicated a focus on establishing a relationship with a client and encouraging them to form and articulate goals for their life after hospital. At a practical level, support was provided in the process of setting up and becoming established in a new house, looking after physical and mental health, and engaging in activities in the community. Work with each client included learning to identify early signs of illness and developing with the client an agreed plan for action that could be taken to prevent problems from escalating. Many clients took part in groups and day programs run by disability agencies in local areas. As PDRS workers had done in Victoria, support workers in South Australia identified an ongoing tension in finding the balance, for each client, between providing disability support (doing things for the client) and rehabilitation (supporting the client to do things for themselves).

Workers described a number of clients having difficulties, in their time with the program, that had put their health and in some cases their tenancies at risk. For some, using illicit drugs, usually identified by workers as cannabis, had caused problems and led to a resurgence of symptoms. For others, an increase in intensity of delusional experiences had led to behaviour resulting in readmission to hospital. A minority had engaged in behaviour that was disturbing or offensive to neighbours. Although most crises were managed effectively and disasters averted, workers identified no processes used by their agencies to document what had been learned from potential crisis situations to inform future practice.

In some cases, NGO workers appeared to know very little about their client's background and clinical history. These workers reported that information had not been provided with the client's referral.

Not all clients gave permission for the researchers to seek information from their clinical worker and, of those to whom surveys were sent, many did not respond. Most responses received from clinical workers said they see their clients as doing well so far. The main concern expressed was to do with possible problems with compliance with medication.

In relation to a small minority of clients, NGO workers reported having seen no evidence of symptoms. This was most striking in the case of an individual who had been for some years in Glenside before being discharged on Community Treatment Order. The clinical case manager who had been working with this client expressed the view that they had been misdiagnosed, possibly as a result of misunderstandings associated with differences in language and culture, and should never have been detained.<sup>20</sup> For this individual and for one or two others, Glenside appeared to have provided sanctuary when they had nowhere to live and were unable to care for themselves.

Family members who took part in the research reported feeling, or having felt, apprehensive about their adult offspring or sibling leaving hospital. The fear most commonly expressed was that support would be withdrawn, and the family would be left to cope. Accounts provided by family members of some clients were heartbreaking. These families were exhausted, hurt and afraid that, when their relative was discharged, things would go bad again and the family would be left to cope. Some had suffered violence and abuse from their family member, and feared further harm coming to themselves and to the client if they were discharged.

Families were not well informed about the support that would be provided under Returning Home. In one instance, they were not aware of the involvement of a support agency. Some family members expressed concern about what would happen as they aged and were no longer able to provide support. In contrast to these responses, members of other clients' families said they were eager to see their sibling or offspring get out of Glenside. A common view among this group was: 'All she did there was smoke'. A number of NGO workers, clients and family members mentioned easy access at Glenside to illicit drugs, especially cannabis, as a problem.

---

<sup>20</sup> When research findings were presented by the first author of this paper at a meeting of the Partnership Planning Group in July 2008, members expressed the view that the experience of this client should properly be described as an 'inter-episode period of remission' as they had become ill again later in the year. Members felt strongly that support workers and community-based clinical staff should have more respect for and confidence in diagnoses made by their colleagues in Glenside.



Responses from most family members expressed caution about support under Returning Home, arising from a fear that it would be discontinued. Apart from this, most families welcomed the involvement of NGO workers, with comments like: 'It takes the pressure off me'. Some expressed the view that the client would be likely to respond more positively to support and encouragement from someone who was not part of their family.

Families, like clients, differed from each other. Some were passive in their relation to their relative's engagement with the mental health service system, while others were assertive. Some families effectively advocated with treating doctors to engage support for their views about appropriate care. Where views were contested about whether a patient was ready to be discharged, and whether support available under Returning Home would be sufficient to enable them to live safely in the community, families with more cultural and financial resources to draw on were more likely to see their views prevail than those whose skills in advocacy were less developed. Families' views about mental illness varied also according to their cultural background, as those from different cultures experienced stigma associated with mental illness in different ways.

A second round of data collection in relation to these 25 clients took place in December 2007. Clients were asked if they would give permission for their workers to provide an update on what had happened in relation to the client's health and circumstances in the time since the interviews, and 21 clients gave consent for this. Of the fifteen clients who had been living in their own unit at the time of the interviews, three did not give consent for their workers to provide further information.<sup>21</sup> Of the twelve for whom further information was provided, seven remained in the same unit. One of these clients (whose clinical worker believed them to have been incorrectly diagnosed) was no longer receiving support from an NGO or clinical service.

Of the five clients who had left their units, two had moved to live with family, two had been evicted (one then moved to other unit, the other to SRF), and one had been

---

<sup>21</sup> One client declined to participate in the follow-up because the researcher had indicated at the initial interview that she would return for another interview later in the year. While it had been our intention to do this, there turned out to be neither the time nor resources to enable a second round of face-to-face interviews. This client was disappointed – and legitimately so – that an undertaking had been given by the interviewer and not honoured. The interviewer sent a written apology to the client via their support agency when this circumstance was discovered.

admitted to a Community Rehabilitation Unit. The client who had been living with their family of origin at the time of the interviews was still living there at the time of the follow-up.

Of the clients who at the time of the interviews had not been discharged from Glenside, two who had been in a ward there had been discharged and had moved to their own unit, and the other two were still in the ward (one was spending some days each week at their unit, and the other was planning to go to an SRF). The five clients who had been residing in ‘the Village’ at the time of interview were all living in their own units in December 2007. The client who was interviewed in Glenside after being readmitted had been discharged into a Community Rehabilitation Unit. The support agency was unable to contact him to ask if he would participate in the follow-up.

Changes in clients’ living situations between the two waves of data collection are summarised in Table 1 below.

*Table 1: Returning Home clients at interview and follow-up: living situation*

<b>Early 2007</b>		<b>Late 2007</b>	
Not yet discharged	8 clients	2 clients	Still in Glenside
		6 clients	Discharged to own unit
Had been in own unit but returned to Glenside	1 client	1 client	Discharged to Community Rehabilitation Unit
With family	1 client	1 client	Still with family
In own unit	15 clients	7 clients	Still in own unit
		<i>3 clients no consent for Wave 2 – possibly still in own unit</i>	
		2 clients	Moved to family
		1 client	Evicted, moved to SRF
		1 client	Evicted, moved to new unit
		1 client	Admitted to Community Rehabilitation Unit

Comparative data from the LSP indicates no decline in functioning between the time of the initial interview and the follow-up for the 20 clients for whom this is available.

As noted above, pre-test LSP data for 25 clients collected as or just before they left hospital to move into community housing indicated relatively low levels of disability across the 39 areas assessed. Data collected at interview and follow-up in respect of 20 of these clients show no significant change. Six had improved their total score on the LSP, four had remained steady and ten had deteriorated. In all cases, changes were small (improvement up to 16 per cent of total score, deterioration up to 13 per cent of total score) and, as discussed below, not statistically significant.

Table 2 shows the item means for the five subscales and the total score of the LSP. The means reflect few problems with turbulence (anti-social behaviour and aggression), communication or responsibility (mostly concerning responsibility for medications). There are, however, mild problems reported in self-care and moderate problems with social contact. For the group as a whole, there were no significant changes in subscale or total LSP scores between pre-testing and follow-up (using paired sample t-tests); participants on average did not improve or deteriorate, although there were instances of both occurring as mentioned above. Age was unrelated to LSP score in this small sample.

*Table 2: Returning Home clients at interview and follow-up: LSP scores*

Subscales (item mean)	Mean 2007	SD 2007	Mean 2008	SD 2008
Self-care <sup>1</sup>	1.80	.35	1.82	.48
Non-turbulence	1.50	.44	1.45	.36
Social contact	2.43	.42	2.45	.53
Communication	1.53	.32	1.46	.29
Responsibility	1.56	.30	1.59	.52
Total	1.73	.26	1.72	.33

Note: <sup>1</sup> Score range = 1-4; lower scores represent higher functioning; No significant differences between 2007 and 2008 scores. (N=25, 2007; N=20, 2008)

The relatively mild nature of the problems reflected in the LSP, along with an overall lack of change in participants' life skills since leaving Glenside, together suggest success in selecting, re-housing and supporting these individuals. The small deterioration of half the sample is of interest, however, and possibly relates to initial difficulties in settling into housing after leaving hospital. A further follow-up in

another year could ascertain whether these changes were likely to be short- or longer-term. Data from the Victorian sample (Carter 2008) showing changes over twelve years suggest that social isolation and inactivity remain problematic for deinstitutionalised individuals, that some of these problems can worsen with age, but that for the most part, the problems are assessed by case workers/support workers as mild to moderate only.

Evaluation of Project 300 in Queensland, which followed over 100 individuals resettled into the community after stays in psychiatric hospitals, found similar patterns of LSP data to the current study, that is, mild to moderate problems only in any area. Clients supported by Project 300 showed relatively stable LSPs across five time periods (six weeks pre-discharge, and six, eighteen, 36 and 84 months post-discharge), with no statistically significant differences in total scores across time periods. One area which did show significant improvement over time was a reduction in anti-social behaviour (Meehan et al. 2007).

Data collected for this study give only a very early indication of outcomes for clients. So far, the experience of clients in South Australia is consistent with patterns reported in other states. Clients experience a period of adjustment over the first twelve to eighteen months living in their own homes, with support hours increasing as they adjust to independence, and having choice. Support needs then stabilise.

#### \* **12.6 Reflecting on process**

The most substantial difficulty encountered by the Returning Home Program in its first years of implementation was that the number of clients discharged with its support was so many fewer than intended. In interviews conducted in mid-2007, after the release of the Social Inclusion Board report, but before the release of the Glenside Master Plan and at the height of industrial action against the Returning Home Program, managers and service delivery staff were asked why implementation had been so difficult.

Responses had several themes in common. All identified the lack of an explicit statement of intention at a policy level as a central concern. Some associated this with the political environment in which service system reform is being undertaken. One respondent said:

The minister is supportive [but] we don't have a [former Victorian Premier] Jeff Kennett who stands up and argues, we don't have a Marie Tehan who said her political career would stand or fall on this change. We don't have any of that. Once the Glenside Master Plan's released and people actually see it in their face [things will change]. At the moment it's a bit like death by a thousand cuts.

Several respondents noted that a lack of clarity had contributed to what they perceived to be obstruction by hospital-based staff. They observed that planning for discharge of patients with support under Returning Home had become an adversarial process, and that supporting implementation was difficult for managers as well as staff. Comments included:

If it was an open and transparent process, and you could have discussion and debate, it would be a lot easier. Staff always thought this was about closing Glenside down, so they were never cooperative. If there was some clear decision about what was going to happen at Glenside it would have made life easier, because people would have had to make a decision [about what to do], instead of the trench-digging that actually happens. That's the hard bit. That's been very successful for the last fifteen years, why should it change?

Because the Glenside plan is not known there has been no [opportunity for] change management. The whole process then becomes adversarial. Everybody feels they're completely in the dark, they haven't been given any information. It's very difficult for [anyone] to manage change if you don't know what's the change you're managing.

Respondents' conclusions about the prospects for Returning Home ranged from pessimism to optimism. At one extreme were views like this:

Nothing's ever going to work. There's too much administration, too many meetings, too many layers. At the end of the day they spend too much time worrying and not actually doing. Nothing's ever going to get off the ground, that's my opinion.

An alternative view was more positive:

We need to give this time. When support needs are so high it's going to require some exceptional work, so there's got to be some longevity [to it]. Let's not panic. We've got people who are making significant progress. Keep some faith in the model and work with it, because from our point of view it is working.

### **13 Critical differences between Returning Home and the Neami CHP**

From the data presented here, it is too early to see what the outcomes will be for clients supported under Returning Home. Our finding that of fifteen clients who were living in their own units early in 2007, five had left that property by December that year, does not indicate failure. These findings are consistent with those from other studies which showed a period of increasing intensity of support as clients leave hospital and settle in own homes, and they start to enjoy their freedom, make mistakes and learn from them. If the experience of clients supported under Returning Home is similar to that in other states, the intensity of support needs should be expected to plateau after approximately eighteen months, then decline and settle at a lower level as clients become confident in the support provided and develop strategies to cope with their particular experience of mental illness (Robson 1995; Cox 1996; Meehan et al. 2007; Muir et al. 2007; Carter 2008). With continued support from NGO workers and access to responsive clinical support as needed, clients who have housing linked with support under Returning Home are likely to achieve good outcomes over time.

What is most striking in our data from South Australia is what it shows about differences in the experience of implementing supported housing programs in the two states that have been the subject of the study. This section reflects on the significance of differences in three areas: in context, in program design, and in strategies adopted for implementation.

In terms of the context in which implementation of a supported housing program was initiated, the contrast between Victoria in 1995 and South Australia a decade later could not be more stark. In Victoria, a reformist government had been elected with support to enact radical change to delivery of government services. An ambitious plan for reform that was consistent with directions established in the new National Mental Health Strategy was supported by funds secured outside the state treasury process.

These external funds enabled replacement services to be developed and operating before institutions closed, and new services were established prescriptively across the state in accordance with a comprehensive and widely publicised *Framework for Delivery of Mental Health Services* (Victorian Department of Health and Community Services 1994). Closure of all the state's psychiatric institutions enabled substantial savings to be redirected into recurrent funding of alternative services. With redevelopment on a comparable scale happening in a variety of community service sectors in Victoria during this period, resistance from public sector professional groups and unions was undermined and ultimately ineffective. It was in this environment that Neami obtained funding to establish its Community Housing Program (Gerrand 2005b). In developing this, Neami built on a model of service delivery that was already established in Victoria through the HASP program (Robson 1995).

In contrast, Returning Home was initiated in South Australia at a time when policy debate around mental health reform had disappeared from the public domain. The hiatus in public discussion of service system redevelopment reflected the cautious response of a government that had learned to be wary of publicity that might be generated by an alarmist local media. Where plans for redevelopment of services at Glenside were discussed, these did not encompass complete closure. Resistance to implementation of Returning Home was encouraged and empowered in this environment. Staff who saw the program (correctly) as part of a strategy for devolution of services from Glenside could reasonably believe that obstructing implementation of the program would be an effective impediment to change. In the words of one respondent, 'They hoped that if they kept their heads down it would all blow over'. In addition to this, in South Australia the provision of care and treatment promoting rehabilitation for users of mental health services had been regarded as the province of clinical providers. Although the expertise of non-clinical providers of psychosocial rehabilitation services was recognised in neighbouring states, this service sector had little presence in South Australia prior to the inception of Returning Home.

A further significant difference in context between the two states relates to stresses experienced by agencies managing public housing. These increased substantially in both states in the decade leading up to the establishment of Returning Home. The

supply of public housing had become increasingly restricted. This occurred concurrently with a dramatic escalation of costs for home ownership, which led in turn to increased demand for private rental properties and consequent increases in the cost of private rental. At the same time, administration of public housing in South Australia was in the midst of a major restructure that generated as an unintended consequence significant loss of corporate knowledge and high levels of demoralisation among staff.

The second significant area of difference between the two states is in the model of supported housing adopted for the programs. In Victoria, the program was initiated with funding for purchase of properties to house the expected number of clients, and was established as a partnership with a specialist community housing agency that would undertake the functions of landlord and property manager. This agency saw itself as having no role in vetting potential tenants, instead having confidence in Neami to provide support that would be sufficient to enable them to maintain their tenancies. When clients encountered problems and needed to move but wished to continue to receive support, in most cases Neami was able to place them in properties provided through other avenues of funding. In contrast, Returning Home was established with the expectation that clients would be able to access public housing through the Housing SA segmented waiting list. This turned out to be problematic, firstly because properties were not always available in areas where clients wished to live, and secondly because staff of Housing SA were not confident that support provided through Returning Home would be adequate or appropriate for potential tenants. The programs differed also in their arrangements for community-based clinical support. Clients referred to the Neami Community Housing Program had support from dedicated teams of clinical staff that had been established for that purpose, located with existing community mental health services. Clients discharged with support under Returning Home received clinical support from staff working in local community mental health services that had received only a relatively small amount of extra resources for this purpose.

A final area of difference between the two programs concerns the strategy adopted for implementation. While the Neami Community Housing Program was promoted through forums held to provide information for clients, family members and local people who might be affected, implementation of Returning Home was distinguished



by its low profile. Returning Home had a strategic objective: to show that individuals who had had long stays in Glenside could live successfully in the community if appropriate support was provided. Implementation proceeded ‘under the radar’ so that the program had time to show that it could work, before it began to attract potentially unfavourable media attention. This strategy was effective as a way to lever change in the environment of the time, but it had unintended consequences. With very little information available in the public domain, misinformation proliferated to an extent that undermined the program’s credibility with service providers, families and clients.

## **14 Conclusion**

Compared with the situation in Victoria a decade previously, planning for redevelopment of mental health services in South Australia has been advanced in an environment that is suspicious of deinstitutionalisation and where public discussion of mental health policy has been politically sensitive in the extreme. In 2008, the ideal of care delivered in the least restrictive possible settings is still the dominant narrative in debate around mental health services, but a counter-narrative that advocates a return to institutionally-based service delivery has had more visibility in this decade than it did in the 1990s. In South Australia, the counter-narrative to deinstitutionalisation was harnessed effectively to oppose the possible closure of Glenside. Arguments against deinstitutionalisation made use of the evident increase in homelessness compared to a decade previously. Attempts to find housing for people with high and complex needs were hampered by problems with the supply of housing that had not existed when the National Mental Health Strategy was established.

Redevelopment of mental health services in South Australia towards a model based on deinstitutionalisation faces challenges that were not present in Victoria ten years earlier. It is no wonder that implementation of the Returning Home Program has been difficult.

Gerrand (2005a) argues that the lessons to be learned from service redevelopment in Victoria in the 1990s are, firstly, that in order to generate sufficient savings in the mental health budget to adequately fund a community-oriented system of care it is

necessary to close all psychiatric institutions; and secondly, that additional funding must be provided to enable replacement services to be established and operating before the institutions are closed. Findings from the present study would add a further point: in an environment in which the cost of housing is high and increasing, and supply available through public programs has substantially decreased, dedicated funding is needed to provide housing as well.

Studies examining outcomes for clients living in supported housing indicate the extent to which programs have succeeded in delivering what they are funded to deliver, but they are unable to say what happens to people who leave services and lose contact with their support agency. To find out if support and housing provided as part of a deinstitutionalised service system is effective, research would need to follow individuals as they use, and exit from, and move between a variety of services. It is possible to do this. A project that accessed quantitative data held by health services, housing providers, homelessness services and possibly Centrelink, and supplemented this with qualitative material collected through a longitudinal panel study supported by incentives to minimise sample attrition, would be a good place to start.

## REFERENCES

- Appignanesi, L. (2008) *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present*, Virago, London.
- Arthurson, K. and Worland, P. (2007) *A Place to Call My Own: Identifying Best Practice in Housing and Mental Health*, paper presented to State of Australian Cities Conference, Adelaide, 28-30 November.
- Ash, D. (2007) 'Mental health services in the Australian states and territories: South Australia' in Meadows, G., Singh, B. and Grigg, M. (eds) *Mental Health in Australia: Collaborative Community Practice*, Oxford University Press, Melbourne.
- Australian Government Department of Health and Ageing (2002) *National Mental Health Report 2002*, Canberra,  
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-report02>>.

- (2003a) *National Mental Health Report 2004: Eighth Report: Summary of Changes in Australia's Mental Health Services Under the National Mental Health Strategy 1993-2002*, Canberra.
- (2003b) *National Mental Health Plan 2003-2008*, Canberra, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-plan03>>.
- Australian Health Ministers (1992) *National Mental Health Policy*, <[http://www.mhnocc.org/resources/national\\_outcomes\\_and\\_casemix\\_collection/nmhp.pdf](http://www.mhnocc.org/resources/national_outcomes_and_casemix_collection/nmhp.pdf)>.
- Australian Institute of Health and Welfare (2008) *CSHA Community Housing Data Collection 2006-07: Results for the Trial Collection of Unit Record Level Dwelling and Organisation Administrative Data*, Welfare and Housing Working Paper series no. 58, Cat. no. WP 58, Canberra.
- Barrett, R. (1996) *The Psychiatric Team and the Social Definition of Schizophrenia: An Anthropological Study of Person and Illness*, Cambridge University Press, Melbourne.
- Barrett, R. and Parker, D. (2006) 'Symbolism of *community I*: The boundary between hospital and community', *Australian and New Zealand Journal of Psychiatry*, 40(4): 310-17.
- Bleasdale, M. (2007) *Supporting the Housing of People with Complex Needs*, Final Report, Australian Housing and Urban Research Institute, Melbourne.
- Breggin, P. (1994) *Toxic Psychiatry*, St Martin's Press, New York.
- Brooks, M. (ed.) (2002) *Psychosocial Rehabilitation: Working with People with a Psychiatric Disability, Volume 2: Sharing the Journey*, New Paradigm Press, Melbourne.
- Burke, T. and Hulse, K. (2004) *Allocating Social Housing*, Final Report, Australian Housing and Urban Research Institute, Melbourne.
- Carter, M. (2004) 'The Ivy Compton-Burnett school of sociology: Family culture and everyday life' in Richmond, K. (ed.) *Revisioning Institutions: Change in the 21st Century: Annual Conference of the Australian Sociological Association*, Beechworth.
- (2006) 'Uncovering the cover story: Research methods and domestic labour' in *Sociology for a Mobile World: Annual Conference of the Australian Sociological Association*, Perth.

- (2008) *Tidy House, Tidy Mind: Contesting the Boundaries of Self-Determination and Acceptable Risk in PDRS Clients' Management of 'Home'*, paper presented to 'Joining the Dots: Creating Community' Mental Health Conference, VICSERV, Melbourne, 8-9 May.
- Chamberlain, C., Johnson, G. and Theobald, J. (2007) *Homelessness in Melbourne: Confronting the Challenge*, Centre for Applied Social Research, RMIT University, Melbourne.
- Chamberlain, C. and MacKenzie, D. (2003) *Australian Census Analytic Program: Counting the Homeless 2001*, Cat. no. 2050.0, Australian Bureau of Statistics, Canberra.
- Chesters, J. (2004) 'Closing asylums and hospitals – not deinstitutionalising people' in *Has Deinstitutionalisation Worked? Annual Conference of the Australian Sociological Association, Health Day*, Beechworth.
- (2005) 'Deinstitutionalisation: An unrealised desire', *Health Sociology Review*, 14(3): 272-82.
- Clanchy, M. and Clarke, D. (2002) *Defining the Role and Functions of the PDSS Sector: The VICSERV Consultation Report and Recommendations to DHS*, VICSERV, Melbourne.
- Clarke, D. (2003) *The Development of Psychiatric Disability Rehabilitation and Support Services in Victoria*, New Paradigm Press, Melbourne.
- Clear, M. (2007) 'Editorial', *New Paradigm: Special Issue: 21 Years of Psychosocial Rehabilitation*, March.
- Connellan, J. (2007) Research interview.
- Costar, B. and Economou, N. (1999) 'Conclusion: Revolutionary or adaptive?' in Costar, B. and Economou, N. (eds) *The Kennett Revolution: Victorian Politics in the 1990s*, UNSW Press, Sydney.
- Council of Australian Governments (2006) *National Action Plan on Mental Health 2006-2011*, Canberra,  
<[http://www.coag.gov.au/meetings/140706/docs/nap\\_mental\\_health.pdf](http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf)>.
- Cox, M. (1996) *An Evaluation of the Neami Community Housing Program*, Community Enterprise Network, Melbourne.
- Deegan, P. (1996a) 'Recovery and the conspiracy of hope' in *'There's a Person in Here': Proceedings of the Sixth Annual Mental Health Services Conference of Australia and New Zealand*, Brisbane, September.

- (1996b) 'Recovery as a journey of the heart', *Psychiatric Rehabilitation Journal*, 19(3): 91-8.
- (2005) *Silence: What We Don't Talk About in Rehabilitation*, paper presented to SKUR conference, Bodo, Norway, 14 June.
- Duff, R. (2008) *Opinion Article*, <<http://www.mindaustralia.org.au/media-opinion-no-institutions.htm>>.
- El-Hai, J. (2005) *The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness*, John Wiley, Hoboken, NJ.
- Fisher, D. (2007) Home page, National Empowerment Center, <<http://www.power2u.org/who.html>>.
- Fossey, E. (2007) 'Conceptual models used in mental health practice: Models of disability and functioning' in Meadows, G., Singh, B. and Grigg, M. (eds) *Mental Health in Australia: Collaborative Community Practice*, Oxford University Press, Melbourne.
- Gerrand, V. (2005a) 'Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*, 13(4): 255-71.
- (2005b) *Transforming Mental Health Services from 1993 to 1998 in Victoria, Australia: A Case Study of Policy Implementation*, PhD thesis, Department of Political Science, University of Melbourne.
- Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*, Prentice-Hall, Englewood Cliffs, NJ.
- Gordon, R. (2008) 'What is Housing First and Supportive Housing?', *Parity*, 21(2).
- Gosden, R. (2001) *Punishing the Patient: How Psychiatrists Misunderstand and Mistreat Schizophrenia*, Scribe, Melbourne.
- Government of South Australia, Department for Families and Communities (2007) *Guidelines for Writing Support Letters for Early Housing Assistance*, Adelaide, <<http://www.familiesandcommunities.sa.gov.au>>.
- Government of South Australia, Department of Health (2007a) *Stepping Up: The State Government's Response to the Social Inclusion Board's Report*, Adelaide.
- (2007b) *Glenside Campus Concept Master Plan*, Adelaide.
- Government of South Australia, Department of Health, Mental Health Unit (2005) *Email Newsletter, 2005, Volume 2*.
- Gray, J. (2007) 'Mental health services in Australia: Non-government and not-for-profit services' in Meadows, G., Singh, B. and Grigg, M. (eds) *Mental Health in*

- Australia: Collaborative Community Practice*, Oxford University Press, Melbourne.
- Hall, J. and Berry, M. (2006) 'Making housing assistance more efficient: A risk management approach', *Urban Studies*, 43(9): 1581-1604.
- Hayward, D. (1996) 'The reluctant landlords? A history of public housing in Australia', *Urban Policy and Research*, 14(1): 5-33.
- Henderson, L. (2006) 'Discovering the gene for schizophrenia: Analysis of the presentation of molecular genetics in *The Australian and New Zealand Journal of Psychiatry*' in *Sociology for a Mobile World: Annual Conference of the Australian Sociological Association*, Perth.
- Hulse, K., Phillips, R. and Burke T. (2007) *Improving Access to Social Housing: Paradigms, Principles and Reforms*, Final Report, Australian Housing and Urban Research Institute, Melbourne.
- Jacobs, K. and Arthurson, K. (2003) *Developing Effective Housing Management Strategies to Address Problems of Anti-Social Behaviour*, Final Report, Australian Housing and Urban Research Institute, Melbourne.
- Jacobson, N. (2004) *In Recovery: The Making of Mental Health Policy*, Vanderbilt University Press, Nashville.
- Jamrozic, A. (2001) *Social Policy in the Post-Welfare State*, Longman, Sydney.
- Kesey, K. (1963) *One Flew Over the Cuckoo's Nest*, Signet, New York.
- Laing, R. D. (1960) *The Divided Self: An Existential Study in Sanity and Madness*, Penguin, Harmondsworth.
- (1967) *The Politics of Experience and the Bird of Paradise*, Penguin, Harmondsworth.
- Lapsley, H., Nikora, L. W. and Black, R. (2002) '*Kia Mauri Tau!*': *Narratives of Recovery from Disabling Mental Health Problems*, Mental Health Commission, Wellington.
- Lewis, M. (1988) *Managing Madness: Psychiatry and Society in Australia 1788-1980*, Australian Government Publishing Service, Canberra.
- Litvak, A. (1948) *The Snake Pit* (DVD), Cinema Classics.
- McLaren, S. (2004) *Don't Panic: You Can Overcome Anxiety Without Drugs*, Scribe, Melbourne.
- Meadows, G. and Singh, B. (2003) "'Victoria on the move": Mental health services in a decade of transition 1991-2002', *Australasian Psychiatry*, 11(1): 62-7.

- Meadows, G., Singh, B. and Grigg, M. (2007) 'Mental health services in Australia: The National Mental Health Strategy' in Meadows, G., Singh, B. and Grigg, M. (eds) *Mental Health in Australia: Collaborative Community Practice*, Oxford University Press, Melbourne.
- Meehan, T., Stedman, T. and Robertson, S. (2007) *Resettlement from Psychiatric Hospital to Community Under 'Project 300': Outcomes from Consumers at Seven Years Post-Discharge*, Queensland Department of Health, Brisbane.
- Mental Health Council of Australia (2005) *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Canberra,  
<[http://www.mhca.org.au/notforservice/documents/NFS\\_Finaldoc.pdf](http://www.mhca.org.au/notforservice/documents/NFS_Finaldoc.pdf)>.
- Mind Australia (2008) *Supporting Recovery*, <<http://www.mindaustralia.org.au/>>.
- Muir, K., Dadich, A., Abello, D., Bleasdale, M. and Fisher, K. (2007) *Housing and Accommodation Support Initiative Evaluation, Report III*, Social Policy Research Centre, University of New South Wales, Sydney.
- Neami and Lyell McEwin Health Service, Mental Health Division (2005) *Assessment Report, Glenside Campus*,  
<<http://www.neami.org.au/publications/AssessmentReportGlensideCampus-March2005.pps#2>>.
- New Zealand Mental Health Commission (1998) *Blueprint for Mental Health Services in New Zealand*, Wellington.
- Newman, S. (2001) 'Housing attributes and serious mental illness: Implications for research and practice', *Psychiatric Services*, 52(10): 1309-17.
- O'Brien, A., Inglis, S., Herbert, T. and Reynolds, A. (2002) *Linkages Between Housing and Support: What Is Important from the Perspective of People Living with a Mental Illness*, Final Report, Australian Housing and Urban Research Institute, Melbourne.
- O'Hagan, M. (2004) 'Recovery in New Zealand: Lessons for Australia?', *Australian e-Journal for the Advancement of Mental Health*, 3(1),  
<<http://www.auseinet.com/journal/vol3iss1/ohaganeditorial.pdf>>.
- (2007) *A Vision for Recovery-Oriented Services and Systems in the Future for People with Mental Health Problems*, keynote speech, TheMHS Conference, Melbourne, 5-7 September.
- Papakotsias, A. (2007) 'Interview', *New Paradigm: Special Issue: 21 Years of Psychosocial Rehabilitation*, March.

- Parliament of South Australia, Social Development Committee (2003) *Inquiry into Supported Accommodation: The Eighteenth Report of the Social Development Committee*, Adelaide,  
<http://www.parliament.sa.gov.au/Committees/Standing/LC/SocialDevelopmentCommittee/>.
- Pepper, S. (ed.) (2002) *Psychosocial Rehabilitation: Working with People with a Psychiatric Disability, Volume 1: Towards Recovery*, New Paradigm Press, Melbourne.
- Premier and Cabinet of South Australia (2000) *News: Rebuilding and Restructuring Mental Health*.
- Productivity Commission (2008) *Report on Government Services*, Productivity Commission, Melbourne.
- Real Estate Institute of Australia (2008) *Market Facts*, Canberra.
- Ribbens McCarthy, J., Holland, J. and Gillies, V. (2003) 'Multiple perspectives on the "family" lives of young people: methodological and theoretical issues in case study research', *International Journal of Social Research Methodology*, 6(1): 1-23.
- Richmond, K. (2006) *Examining Medical Prescribing Patterns in the Treatment of Psychosis*, paper presented to annual conference of Australian Sociological Association, Perth, December.
- Richmond, K. and Savy, P. (2005) 'In sight, in mind: Mental health policy in the era of deinstitutionalisation', *Health Sociology Review*, 14(3): 215-29.
- Robson, B. (1995) *Can I Call This Home? An Evaluation of the Victorian Housing and Support Program for People with Psychiatric Disabilities*, VICSERV, Melbourne.
- Rose, D., Wykes, T., Leese, M., Bindman, J. and Fleischmann, P. (2003) 'Patients' perspectives on electroconvulsive therapy: Systematic review', *British Medical Journal*, 327(7403): 1363-5.
- Rosen, A. (2006) 'The Australian experience of deinstitutionalisation: Interaction of Australian culture with the development and reform of its mental health services', *Acta Psychiatrica*, 113: 881-9.
- Rosen, A., Hadzi-Pavlovic, D. and Parker, G. (1989) 'The Life Skills Profile: A measure assessing function and disability in schizophrenia', *Schizophrenia Bulletin*, 15(2): 325-37.
- Rosen, A., Hadzi-Pavlovic, D., Parker, G. and Trauer, T. (2006) *The Life Skills Profile: Background, Items and Scoring for the LSP-39, LSP-20 and the LSP-16*,



- Black Dog Institute, Sydney,  
 <<http://www.blackdoginstitute.org.au/public/research/researchtools.cfm#LSP>>,  
 accessed 28 May 2008.
- Rosenhan, D. L. (1973) 'On being sane in insane places', *Science*, 179: 250-8.
- Rowe, D. (2002) *Beyond Fear*, 2nd edn, Harper Collins, London.
- Saks, E. (2007) *The Center Cannot Hold: My Journey Through Madness*, Hyperion, New York.
- SANE Australia (2007a) *Bipolar Disorder*, Melbourne, <<http://www.sane.org/>>.  
 — (2007b) *Schizophrenia*, Melbourne, <<http://www.sane.org/>>.
- Scotman, G. (2004) 'What is recovery? What are the current debates?', *Synergy*, 3: 4-5.
- Singh, B. (2007) 'Mental health services in Australia: Australian psychiatry into the twentieth century' in Meadows, G., Singh, B. and Grigg, M. (eds) *Mental Health in Australia: Collaborative Community Practice*, Oxford University Press, Melbourne.
- Singh, B., Benson, A., Weir, W., Rosen, A. and Ash, D. (2007) 'History of mental health services in Australia' in Meadows, G., Singh, B. and Grigg, M. (eds) *Mental Health in Australia: Collaborative Community Practice*, Oxford University Press, Melbourne.
- Smith, M. (2007) 'Seventeen years in the PDRSS sector', *New Paradigm: Special Issue: 21 Years of Psychosocial Rehabilitation*, March.
- South Australian Department of Human Services (2001) *A New Millennium – A New Beginning: Mental Health in South Australia – Action Plan for Reform of Mental Health Services*, Adelaide.
- South Australian Social Inclusion Board (2007) *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*, Adelaide.
- Sweet, M. (2005) *Inside Madness: How One Woman's Passionate Drive to Reform the Mental Health System Ended in Tragedy*, Macmillan, Sydney.  
 — (2008) 'High Court announces retrial of Jean Eric Gassy', *Crikey*, 14 May.
- Szasz, T. 1974 (1961) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. Harper & Row, New York.
- Tobias, G. (2007) Research interview.
- Trauer, T., Farhall, J., Newton, R. and Cheung, P. (2001) 'From long-stay psychiatric hospital to Community Care Unit: Evaluation at one year', *Soc Psychiatr Epidemiol*, 36: 416-19.

- VICSERV (2006) *Into Community: Day Programs Past, Present and Future*, VICSERV, Melbourne.
- Victorian Auditor General's Office (2002) *Mental Health Services for People in Crisis*, Melbourne,  
<[http://archive.audit.vic.gov.au/reports\\_par/agp81cv.html](http://archive.audit.vic.gov.au/reports_par/agp81cv.html)>.
- Victorian Department of Health and Community Services (1994) *Framework for Service Delivery*, Melbourne.
- Victorian Department of Housing (1989) *Annual Report*, Melbourne.
- Victorian Department of Human Services (2003) *Psychiatric Disability Rehabilitation and Support Services: Guidelines for Service Delivery*, Melbourne,  
<[http://www.health.vic.gov.au/mentalhealth/pdrss/pdss\\_guide.pdf](http://www.health.vic.gov.au/mentalhealth/pdrss/pdss_guide.pdf)>.
- (2007) *Psychosurgery: About Your Rights*, Melbourne,  
<<http://www.health.vic.gov.au/mentalhealth/patientrights/downloads.htm>>.
- Warner, R. (1987) *Recovery from Schizophrenia: Psychiatry and Political Economy*, Routledge and Kegan Paul, London.
- Western, M., Baxter, J., Pakulski, J., Tranter, B., Western, J., van Egmond, M., Chesters, J., Hosking, A., O'Flaherty, M. and van Gellecum, Y. (2007) 'Neoliberalism, inequality and politics: The changing face of Australia', *Australian Journal of Social Issues*, 42(3): 401-18.
- Wissmann, D. (2003) *Psychosocial Rehabilitation: Working with People with a Psychiatric Disability, Volume 4: To Be a Keyworker*, VICSERV, Melbourne.
- Wykes, T. (2007) *From Subjects to Participants: Service User Involvement in Research*, keynote speech, TheMHS Conference, Melbourne, 5-7 September.
- Yates, J., Wulff, M. and Reynolds, M. (2004) *Changes in the Supply of and Need for Low Rent Dwellings in the Private Rental Market*, Final Report, Australian Housing and Urban Research Institute, Melbourne.

## APPENDIX 1: SUMMARY OF SUPPORTED HOUSING PROGRAMS IN THREE STATES

	Victoria 1992: HASP	Qld 1995: Project 300	NSW 2002: HASI
<b>Target group</b>			
– criteria	People with psych disability and intensive support needs, eligible for public housing, currently in inappropriate housing, willing to receive support	People leaving psych hospital and needing support. (Evaluation found 70% of clients had diagnosis of schizophrenia)	High level of psych disability (This is HASI phase 1. Evaluation found 86% of clients had diagnosis of schizophrenia or schizo-affective disorder)
– numbers	By 1995 19 NGOs funded to support 81 clients	Aim 300, actual after 4 years 194	100 places in phase 1 (later phases 850 places, at varying levels of support)
<b>Evaluation</b>			
– date	1995	2004, 2007	2007
– who	VICSERV	Qld Dept Health, University of Queensland	UNSW Social Policy Research Centre
– method	Qualitative, interviews with govt staff, NGO staff, tenants (35)	Quantitative, longitudinal. At discharge, 6mth, 18mth, 3yr, 7yr. Interviews with support workers.	Mixed, longitudinal. 3 rounds of data at 6mth intervals. Interviews with clients, families, NGOs, clinical workers, managers. Access to quant data from Dept records
– concern	Clients' experience of housing and support	Clinical measures and measures of disability	Tenure, clinical outcomes, support outcomes.
<b>Clinical</b>			
– funding	Access to existing clinical services through Area Mental Health Services (AMHS).	Funding for dedicated community-based positions for first 3 yrs, then absorbed into general clinical team.	Access to clinical services through Area Mental Health Services (AMHS)
– nature	Includes mobile outreach support, crisis support	Devise care plan, monitor and review clients' progress.	AMHS refer clients to ASPs
<b>Non-clinical</b>			
– funding	NGOs funded through Psychiatric Services Division of Dept H&CS	Dept Disabilities fund 'host agencies' (most formerly in ID sector) that subcontract.	AMHS contract NGOs to provide accommodation support as ASPs.
– nature	Psycho-social rehab, flexible in reponse to need. Visit once daily to once fortnightly	Subcontracted workers provide 'lifestyle support', 'similar to that provided by family'. 'Paid friends'	'Rehabilitation, recovery and disability support'
– duration	For as long as needed		
– name	1992 psychiatric disability services (PDS): from 1994 rehabilitation services (PDRS). Keyworker.	Disability support. Support worker, keyworker	Accommodation Support Provider (ASP), keyworker
<b>Housing</b>			
– funds	Funds for purchase of new properties, some purpose built. Access to existing public housing	Priority access to existing public housing	Phase 1 \$9.7m for purchase of housing
– properties	1 or 2 bedroom units	<i>No info</i>	Units, townhouses, apartments, stand-alone houses. Mostly 2-bedroom.
– furnishing	\$2,500 per client	\$5,000 per client	Yes <i>amount not stated</i>
– landlord	Separation of roles between housing and support. Clients lease from OoH or community housing agency. Some NGOs headleasing.	<i>No info</i>	Separation of roles between housing and support. Department of Housing or community housing agency as landlord. Properties leased or owned by housing providers

– tenure	Ongoing with standard lease. Continues if no longer need support.	<i>No info</i>	Ongoing with standard lease.
– locations	Most in dispersed locations. Some clusters.	<i>No info</i>	Most in dispersed locations. Some clusters.
– alone/share	Clients live alone or with one other.	<i>No info</i>	Clients lease as sole tenants. Some informal sharing
<b>Outcomes</b>			
– tenure	<i>Evaluation interviewed existing tenants only</i>	After 7 years 13 returned to institutional care (includes aged care)	At 2 years 70% still in original accommodation, 85% with same housing provider
– clinical	Clients and workers reported clients more able to recognize and manage symptoms, leading to reduced use of clinical services.	30% had one readmission in first 6 months, rising to 80% by 7 years. Level of symptoms reduced overall: declined over first 3 years then increased between 3 and 7 years	84% had few admissions and of shorter duration than in previous year. 66% of clients for whom info was available showed improvement on clinical measures.
– disability	Support needs high at first, decreased over time.	Support hours decreased over time: average at 6 mth 26hpw, at 7 years 21hpw (range 0 – 69hpw)	Living skills improved consistently over time
– activity	Social networks improved for residents of cluster housing only.	Support workers reported lack of available activities as a problem.	Social participation increased over time. Access to variety of activities seen as most useful.
– quality	Clients reported valuing housing for providing stability, workers for providing practical help and relationship.	Ratings on self-rated quality of life measure unchanged over 7 years.	Clients reported increased independence. Reported satisfaction with physical health decreased. 50% reported loneliness as problem.
<b>Issues</b>			
– housing	Difficulties with sharing. Clients living alone more satisfied. Mixed views about cluster housing – good b/c promotes networks, bad b/c stigmatized	<i>No info</i>	Housing providers reported HASI clients less problem than clients that have no support, and properties no less well kept,
– support	Difficulties establishing delineation of roles between clinical and PDRS. Workers report tension between rehab and disability support – doing with client or doing for.	Inconsistencies in views about support worker role. Support workers feel lack of understanding of and respect their work. Wanted training to improve understanding of symptoms and deal with crises.	Difficulty in working relationships between clinical and ASP in some sites. Practice of some ASPs does not incorporate psychosocial rehabilitation approach. May be workplace issue, as is less work to do things for clients.
– relationships	Clients value relationship with individual worker	Clients see workers as paid friends. Some workers see role as friendship.	Clients see worker as friends. 74% said worker is companion.
– families			Families happy with support. 'Takes the pressure off'

## **APPENDIX 2: FINDINGS FROM SURVEY OF GLENSIDE STAFF**

A copy of the survey was given to each member of staff working in the Rehabilitation Services area of Glenside in late 2006. Open-ended questions sought respondents' views about the policy of deinstitutionalisation and its implications for people with mental illness, what an appropriate system of housing and support would look like, and what they anticipated would be the impact of changes at Glenside on their own professional practice and careers. Of approximately 100 staff to whom the survey was distributed, 20 responded. Respondents ranged in age from their 20s to their 60s, and had worked at Glenside for between one and 27 years in positions including psychiatric nurse, general nurse, psychiatrist, psychologist, social worker and ancillary therapist. Eleven respondents were women, seven were men and two did not identify their gender.

Responses were striking in the intensity with which views were expressed. We cannot assume that all staff would be so passionate in their opinions; but many who responded to the survey had passionate views.

When asked for their opinion of the policy of deinstitutionalisation, respondents expressed a range of views. A few were dismissive (one said, 'What policy?'), but most were thoughtful. Positive responses framed deinstitutionalisation as good thing, negative responses framed it as irresponsible and cruel. Most respondents gave qualified support for establishment of community-based services as part of a range of options that includes a continuing role for institutional care at Glenside.

A small minority of respondents expressed the view that the Returning Home Program is doing well. One said: 'Traditionally the SRFs have been a step backwards, [leaving the] burden of support falling onto an already burned-out family network. The Returning Home project appears to select patients wisely, and level of support is well established prior to discharge.' These respondents identified the program's viability as resting on the availability and quality of housing, and on the level and duration of support provided. Both areas were seen as problematic. One said: 'I do not believe planning is developed to provide long-term support. I am concerned that in 3-5 years the support funding will be withdrawn, and that savings from loss of services will not [be sufficient to cover] new costs.'

A larger minority of respondents characterised deinstitutionalisation as a ‘failed policy’ that has led to an increase in numbers of people sleeping on the streets. These respondents saw no possibility of extended-care patients being able to cope outside of hospital. Patients were described as being ‘at best, boarding-house material’. One said: ‘Since Hillcrest closed and Glenside is devolving there are hundreds of people in jail, or surviving in parklands/streets. The few that reside in Glenside are the most chronic, treatment intensive, institutionalised people [underlining in original]. They are unlikely to be “cured”.’ This respondent described deinstitutionalisation as ‘institutionalised genocide’. Another said: ‘It is a pity that this government is following the failed Victorian/New South Wales models. Perhaps, after a few murders, they might take sane advice after all.’ One respondent described cluster housing as ‘a licence for drug culture [in which] staff have no back-up at all’. This respondent argued that a burgeoning drug culture will increase the need for institutional care as ‘new drugs like ice will produce unprecedented hordes of psychotic clients’, and asked: ‘Where will they go?’

Most respondents expressed cautious and qualified support for community-based care. A common view was that ‘most of the clients who would best benefit from the move are [now] reasonably settled in their respective homes. The clients we are working with now have more complex needs. A carefully planned risk evaluation [is needed] before even contemplating future community tenure.’

Several respondents described a workable system as comprising multiple levels of support, noting that ‘at present we [have] no option but to match the client to independent housing offered by government-backed accommodation providers. The alternative is a residential Care Facility.’ One described an effective system as comprising four levels: independent housing, with support from a MAC team and an NGO; share housing, with MAC team support and ‘increased input’ from an NGO; supervised housing, with clinical or NGO staff on site from 7 am to 5.30 pm; and ‘24 hour support provided in an institutional-type setting’. Many respondents specified an ongoing role for Glenside, as ‘there is and always will be a certain group of patients who will need institutional care.’ Another said: ‘I believe there should always be some sort of specialist service available at Glenside Hospital no matter how small it turns out to be.’ Among respondents who envisaged a range of options for community-

based care, most identified difficulties with access to affordable housing as an obstacle. Several noted that, for some patients, support needs would be life-long, and identified uncertainty about continued funding as a risk.

A substantial number of respondents regarded non-institutional care as acceptable only if it was provided with a very high level of staffing and support. One said: 'Selected patients could possibly manage in a "cluster housing" set-up provided adequate care was provided to ensure patients complied with medication, maintained hygiene and organised activities. Support should be provided 24 hours a day.' Several stated that clinical support should be located on-site, as 'a 'presence' not just a visit'. Some observed that such arrangements create what is effectively a 'mini-institution'. One respondent said: 'The hospital/institution is part of the community and always has been. The houses/hostels are mini-versions of the hospital. Why reinvent the wheel by creating a mini-hospital in the community?' Some respondents said many patients would prefer to stay in an institutional setting, although they may be 'brainwashed' into thinking otherwise.

Respondents saw it as essential that 'trained staff' take a lead role in any system of care, devising and monitoring 'an ongoing care plan which encompasses review of mental state, treatment compliance, risk factors and motivation'. Professional staff should also provide supervision to 'semi-trained staff' whose work is to provide 'functional support'. Respondents who identified support provided by NGOs as part of a service system noted that 'community workers need supervision by adequately trained staff'. Several stated that NGO support should focus on ADLs (Activities of Daily Living), especially 'food preparation and personal appearance'. Some respondents expressed misgivings about the approach to support adopted by some NGOs. One said: 'Support groups/workers are a mixed bunch. Some workers are better at working together with our multidisciplinary teams and incorporate the assessments presented to them. Clients usually do well when this happens. When the opposite happens, the client is usually the one to suffer.' This respondent concluded: 'Functional support does not mean taking clients out for coffee all the time. [It] should provide the most basic assistance, until a routine has been established.'

Some respondents saw NGO workers as inadequately skilled. One said: 'I am concerned that a majority of staff employed to manage clients with mental illness in

the community are either volunteers or have minimal/brief training and experience. I believe this devalues my own qualifications and undermines my professional role. Furthermore, clients receive a lower standard of care.’ Others were concerned for the safety of NGO staff: ‘I am deeply concerned for the support workers who visit clients, for their safety. They seem unaware of the potential risks of unprovoked violence in the clients. At hospital, workers are more protected, have alarms to call for help.’

A small minority of respondents expressed the view that remaining in hospital can be to the detriment of patients, as they ‘sit most of the time [and] smoke and drink coca-cola’. One said: ‘There are many patients who have been in the institution for many years and have been allowed to lose their living skills.’ Another emphasised the need to ‘deinstitutionalise the patient’. This respondent continued: ‘Look at what the client has to do – nothing! They are reminded about everything. They are reminded to tidy their room and they don’t have to think about anything.’ These respondents argued that support provided outside of hospital could more readily employ ‘positive programming, strengths based, individual plans and staff who honour dignity, respect and individuality, not punishment and deprivation’.

Several respondents characterised a policy of deinstitutionalisation as determined by an agenda that places saving money ahead of the interests of patients. One said: ‘Governments should be ashamed of their policies. They basically do not give a damn about the mentally ill, only making profits. If you think they do, you are very naïve.’ Some identified NGOs as motivated by self-interest. One said: ‘Private NGOs have their own agendas and totally ignore the professional opinions of professors, psychiatrists or nurses.’ These respondents argued that managers and policy makers do not want to hear about risks or adverse effects to clients: ‘The powers that be glaze over when we try and tell them [about risks to clients] because all they are interested in is putting people out there and adding to their list another success story! It makes them look good, they could never admit being wrong.’ For these respondents, ‘The biggest loser is my patients.’

Several commented on research, and its potential for manipulation. One said: ‘Do some research (no predetermined outcomes) and you will see this policy has been an abject [sic] failure in all western democracies and in Australia – NSW, Vic etc.’



Another said: 'Statistics and surveys can be twisted any way you like, to suit the government's whims.' And another: 'This survey is just silly.'

A number of respondents said they planned to retire within the next three to five years, some doing this sooner than they would have liked in response to changes in their workplace. Not all regarded these changes as negative. One respondent described them as an opportunity to 'shift the focus of my [practice] to enhance my skill base by requiring me to formulate new strategies so as to give the patient a more comprehensive skill base to cope with community living'. Several expressed concern about future career opportunities, and about stigma associated with having worked at Glenside. One said: 'I work in the recovery model as much as possible in an institutional setting. However, hospital staff tend to be seen as part of the problem instead of [as] having experience and knowledge which can help with the solution. Many [disciplinary] staff have felt constrained and frustrated by working in the institution and are keen to contribute to a better future for mental health. However they can be stigmatised and discouraged from moving forward.'

Overall, the tenor of responses to the survey ranged from optimistic and cautious to pessimistic and cynical. Many indicated strong feelings of hurt, of feeling not listened to and not shown respect. Views expressed were not associated with age: those who were most positive about change were among the oldest respondents. There was some association between attitudes expressed and the length of time respondents had worked at Glenside, but this was not uniform.

A return of 20 surveys out of a possible 100 does not allow for meaningful statistical analysis. They provide qualitative data that indicate a range of views, and give voice to the opinions of some people who feel that their views are not otherwise heard. If the responses are representative of staff working in Rehabilitation Services, they would suggest that most staff see the redevelopment of services as a good thing if it is planned for and resourced, offering a range of options for accommodation and support, underpinned by adequate and ongoing funding. These staff members are apprehensive that planning has been patchy, offering too few options, with inadequate access to housing, and that funding may be cut later, leaving clients unsupported.

A minority of staff members regards devolution of services from Glenside as bad, because they see their patients as having no capacity for improvement and as needing to be confined and supervised. Their views are incompatible with the approach taken by NGOs funded under Returning Home, whose work is informed by a recovery framework.

It would be interesting to do another survey to see how views have shifted since 2006-07.